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# REACH

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RESPONSIBLE EMPOWERING ACCESSIBLE COMMUNITY HEALTHCARE:  
A GUIDE TO IMPLEMENTATION

VERSION 1  
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# REACH: An Implementation Guide

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## AUTHORS

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Martin Morse is the founder of Morse Analytics, a company that offers quantitative analysis, modelling and tool development for healthcare organisations and social enterprises.

Prior to forming Morse Analytics, Martin held the position of Director of Professional Services for marketRx, a leading provider of analytics and related software services to global pharmaceutical, biotechnology and medical device companies. Martin focussed on developing the company's European capabilities in sales force effectiveness, marketing effectiveness and market research. Martin has also worked for the UK consultancy WestawayGillis as Director of Analytical Services, developing cost-effectiveness models, patient audits and bespoke software solutions for the pharmaceutical industry and NHS.

Martin holds an MA in Mathematics and Management Studies from Cambridge University and a Market Research Society Certificate

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Dr Tim Lyttle is a UK General Practitioner (family doctor) and Healthcare Entrepreneur with a passion to raise the standard of healthcare services in the UK and internationally. He is particularly concerned about the needs of the poor and disadvantaged.

Tim is currently Medical Director of Hope Citadel Healthcare, a social enterprise company developing primary and community care in Greater Manchester ([www.hopecitadel.org](http://www.hopecitadel.org)), Associate Medical Director of North East Wales Doctors On Call (NEWDOC) and a specialist substance misuse GP with Betsi Cadwaladr University Health Board (North Wales). He also provides clinical healthcare consultancy to a number of primary care organisations.

Tim is a member of the Royal College of General Practitioners and has attained a wide range of skills and additional qualifications in Travel Medicine and Substance Misuse Management. From 2005 to 2009, Tim served as Medical Director of Wrexham Local Health Board (Welsh PCT equivalent) where he gained experience in commissioning and developing healthcare services for the people of Wrexham.

Internationally, Tim has founded a number of organisations and projects, including REACH and "Medeserve", now part of HealthLink360 ([www.healthlink360.org](http://www.healthlink360.org)), providing medical advice by email.

Tim's vision and passion is to improve the health and well-being of needy individuals and communities, both in the UK and overseas. He supports the development of innovative programmes and organisations which will improve the quality and effectiveness of healthcare provision.

### **Dr Tony Dale**

is a former GP, founder of the Karis Group, an organisation that manages medical cost containment and patient advocacy in the United States.

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## 1 INTRODUCTION

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### 1.1 A VISION FOR EMPOWERMENT

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Ill health is a universal problem and affects all races, castes, classes and levels of economic status. However, managing the healthcare needs of those in poverty is particularly problematic. Poor health can be devastating to those in poverty. Hospitalised Indians spend more than 58% of their total annual expenditure on healthcare<sup>1</sup>. In one poor district in central India, it was found that average annual expenditure on healthcare was 130% of annual income<sup>2</sup>. More than 40% of those hospitalised borrow money or sell assets to cover expenses<sup>1</sup>.

Because of the financial burdens on those who need healthcare, there is a particularly unequal relationship between those who need healthcare, and those who provide it. Healthcare providers have capital and considerable power over those wishing to use the services. Even where healthcare provision is a charitable act, providers continue to exercise power over those needing their skills, technologies and care. Individuals in poor health are extremely vulnerable.

For poor individuals and their immediate families, ill-health is too uncertain an event to predict and the cost too great if it occurs.

In empowering the poor, enabling them to access quality healthcare and effectively manage healthcare needs, community responsibility is essential. A community-based approach will enable the risk to be shared and provide an environment where healthcare can be better managed. Individuals will no longer be at the mercy of the healthcare provider institution, but as a community member can feel less intimidated by healthcare institutions and begin to negotiate better terms for provision.

In much the same way that micro-finance has empowered individuals to access credit previously denied them, healthcare empowerment through the community should bring increased accessibility to healthcare management on terms dictated by the community, not the healthcare provider.

### 1.2 FULFILLING THE VISION

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Providing effective and affordable healthcare is clearly a complex problem, but one of the key areas that must be addressed before poverty can be eradicated is that of the role of effective, sustainable healthcare models for the poor.

By building on the lessons learnt from past and current community financing projects, our vision is to develop an effective model that enables financial sustainability and multiplication, and is flexible across a number of environments. An effective model will achieve two key objectives:

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<sup>1</sup> Peters, D. et al. (2002) Better Health Systems for India's Poor: Findings, Analysis and Options, The World Bank, Washington DC

<sup>2</sup> Team for Community Development, Coca-Cola India. Presentation on Group Health Financing Scheme to Chhatarpur Mission Hospital, 10 January 2004

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1. To provide a mechanism to manage the balance between affordability and better access to appropriate healthcare, and
2. To empower a community in improving the status of its health.

From this basis, the concept of the REACH (Responsible, Empowering, Accessible Community Healthcare) model was developed, and is the subject of this document.

## 1.3 THE PURPOSE OF THIS DOCUMENT

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REACH as a concept has been tested through a pilot scheme in southern India. This pilot clearly demonstrated the significant value to healthcare that such a model could bring and, although not fully achieving financial sustainability itself, demonstrated that full sustainability is also possible.

Keen to extend the implementation of the REACH model into other contexts, and broaden experience of implementation, we have developed this document to encourage other organisations to adopt the REACH model in providing valuable healthcare provision to deprived communities. Our intention is that the document provides both an overview into what may be involved in implementing such a scheme, and also a practical guide, based on past experience of how to conduct a successful implementation.

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## 2 THE REACH MODEL OF HEALTHCARE

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### 2.1 PRINCIPLES OF REACH

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The REACH model of healthcare for the poor is founded on 5 key principles:

**Responsible** – People should be enabled to take responsibility for their own healthcare. All healthcare provision must be sustainable and within the means of the population it serves.

**Empowering** – People should have control over what is appropriate healthcare for them. Therefore, healthcare choices and priorities should be governed by the people.

**Accessible** – Healthcare provision that is owned and managed by the people should be accessible to the people, geographically, financially and socially.

**Community** – Healthcare is seen as primarily a community investment and should be managed through the community rather than through individual engagements.

**Healthcare** – Improving the health of the community is at the heart of the model.

In a community that successfully adopts a healthcare system based on the REACH model should observe the following impacts:

- Measurably improve the health levels within the community.
- Improve the quality of local healthcare provision, and exclude providers that provide poor service
- Decrease the debt burden on communities and individuals because the cost of healthcare will be managed more effectively.
- Reduce the need for using credit services at high interest rates to pay for unexpected healthcare costs
- Increase productivity and wealth creation in the community through a more actively managed healthcare policy
- Increase opportunities for healthcare education and preventative measures. The community will have an increased interest in ensuring all its members are addressing health needs
- Improve linking of healthcare issues with wider public issues, e.g. clean, safe drinking water.

### 2.2 COMPONENTS OF THE REACH MODEL

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Based on these principles, the model consists of two primary components:

1. **Financing** of a healthcare service through regular contributions by individuals into a community scheme, such as a microfinance self-help group .
2. **Provision** of healthcare services that are funded entirely from community contributions and designed around community needs.

Within these two components, the REACH model is quite flexible. The level and regularity of financing entirely depends on the level of affordability of the communities concerned, though it is likely to be a relatively small percentage of regular income. The collection mechanism may also be

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any community-based organisation that provides a degree of financial administration, such as an employer or religious group. Equally, provision of healthcare services will depend entirely on the specific needs of the community, what is affordable within the local economy, and what existing provisions currently exist, if any.

The distinguishing element of a REACH model is that its funding is principally supported by community contributions, and that services are tailored specifically for the contributing communities. Such a model distinguishes itself from a charitable model of healthcare, where provision and resources are primarily or exclusively donated from outside the community, or from commercial healthcare operations, which seek to generate only profits from the community. The uniqueness of REACH is that it is based on an enterprise approach to healthcare provision which measures itself by social and healthcare values.

## 2.3 THE REACH PILOT SCHEME

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The concept of REACH was originally conceived through discussions between members of the Transformational Business Network<sup>3</sup> in considering whether business and enterprise had any role to play in the alleviation of poverty through healthcare. A potential opportunity was considered in the context of microfinance – self-help groups (SHGs) provided an excellent mechanism for management of finances for the poor, and also provided an excellent platform for communication. However, although the majority of the wealth that is generated through such schemes is spent on education of children and healthcare<sup>4</sup>, there are few mechanisms within current microfinance schemes that facilitate such expenditure efficiently. This may be partly due to the fact the microfinance has been championed as a form of banking, and has not had comparable support from education and healthcare as it has had from financiers.

Following the conception of the potential idea for building a healthcare provision model upon a stable microfinance network, three members of the Transformational Business Network, Martin Morse, Tim Lyttle and Tony Dale, collaborated with The Bridge Foundation, a microfinance consultancy organisation based in Bangalore, India, in exploring the feasibility and practicality of such an approach.

Following research during April 2006 with the Meenakshi Mission Hospital & Research Centre, Madurai, and the Psycho Trust, Karur, the Bridge Foundation concluded that the model was potentially feasible, and proposed the development of a pilot with one of their partner organisations, the Centre for Rural Education and Development (CRED)<sup>5</sup>, a non-governmental organisation dedicated to the alleviation of poverty and empowerment of women in the Karur district of Tamil Nadu, India.

10 healthcare workers (HCWs) were recruited in March 2007 and trained at the Meenakshi Mission Hospital. They began work in May 2007 in 53 villages providing healthcare coverage for a population of 130,000. A project manager from the Bridge Foundation was employed to oversee the recruitment, training and development of the model, with the day-to-day administration of the scheme run directly from CRED's offices in Vadipatty near Madurai. Although not initially

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<sup>3</sup> [www.tbnetwork.org](http://www.tbnetwork.org)

<sup>4</sup> Makonen Getu, 2005

<sup>5</sup> Centre for Rural Education and Development, 301 Main Road, Vadipatty, Madurai, Tamil Nadu, India Tel: + 95 4543 54453 Email: [cred@eth.net](mailto:cred@eth.net) Web: <http://www.crin.org/organisations/vieworg.asp?id=1743>

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considered as part of the healthcare plan, an ambulance service and regular health camps run by local doctors was also provided in addition to the HCW services.

In April 2008, a year following the commissioning of the HCWs, the scheme had recruited 5,739 members from 395 SHGs based in 74 villages. The HCWs had made 3,694 consultations and had 3,545 individuals attend 72 health camps during the month of April. The average monthly contribution made by each member was Rs 5.6, ranging from Rs 2 to Rs 10.

## 2.3.1 POSITIVE OUTCOMES

The pilot has demonstrated a number of very significant outcomes for the community it has served:

- It is clearly evident that the HCWs are valued by the local communities. They appear to be increasingly able to influence health behaviour of the members of the Self Help Groups. Initially the HCWs' husbands were reluctant to allow the HCWs to hold SHG meetings in the evenings but having seen their value, the husbands have given their support. The HCWs have also formed links with school teachers and elected leaders in the villages.
- 9 out of 10 original HCW's were still in post one year following the launch, with the tenth replaced by an HCW who participated in the original training programme. All are very enthusiastic about their role and receive excellent support and leadership from CRED, in particular its director, Mr Alagesan.
- Members appear to be acting collectively in addressing both individual and community health concerns. For example one SHG had collected additional money to help a member with a healthcare bill. We sense the early signs of a change in health culture, a willingness to take on board health promotion, and prevention of illness.
- The Self Help Groups (SHGs) appear to be providing an ideal environment for the dissemination and collection of health information, and the implementation of HCWs through the SHG network has facilitated such information exchange.
- Some measures of health & sanitation behaviour show marked improvement: there has been a big reduction in the demand for loans for healthcare from 100 to 57 (an encouraging indirect secondary financial benefit from the work of the HCWs), and a 50% increase in the number of clean-up drives in targeted villages. The following table demonstrates the measured impact of the scheme:

	2004/5	2005/6	2006/7	2007/8 REACH
<b>Health loans for SHG members</b>	75	82	100	57
<b>Loan repayment rate</b>	97%	98%	98%	99%
<b>Members hospitalised</b>	95	96	96	92
<b>Clean up drives in target villages</b>	30	35	30	47
<b>Follow up by solid waste management</b>	25	29	32	35
<b>Individual toilets constructed</b>	-	25	32	57
<b>Members participating in REACH</b>	-	-	-	5,739
<b>Health Camps conducted</b>	-	-	-	72
<b>Members benefiting through Health Camps</b>	-	-	-	3,706

- The pilot has initiated a fundamental change in thinking about healthcare with the NGO about financing community development programmes. Normally such organisations simply accept donor funds and do not consider receiving anything monetarily from the communities they serve.

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On 15 August 2007, in recognition of the scheme's impact, CRED was awarded "Best NGO award" in Madurai district out of approximately 240 contending organisations for its work<sup>6</sup>.

On 22 November 2007, The Hindu, India's national newspaper published an article on the impact of REACH<sup>7</sup>.

### 2.3.2 CHALLENGES

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Although the pilot demonstrated significant positive health outcomes for the community, it must also be acknowledged that a number of challenges also presented themselves:

- Support by local doctors for HCWs was inconsistent, and there were other concerns about the healthcare administered by doctors. In particular, there was widespread inappropriate prescribing of medicines. The doctors seemed to follow the desires of the patients for medication (especially injections), rather than providing more appropriate advice and empowering the HCWs. It is also uncertain whether or not the doctors were taking steps to address recognised public health problems such as worm infestations and anaemia. For example one doctor stated that 70% of her diagnoses were "weakness and malaise".
- Although leadership support through CRED was strong, the leadership needed a more holistic understanding of health and healthcare itself. For example, there was a feeling that giving injections for all illnesses is good healthcare. Leadership exhibited the same perception as the community in-terms of their knowledge and attitude, and sometimes direction from leadership with regard to healthcare issues was misguided.
- Training for the HCWs was inadequate and ongoing development was lacking, principally because the HCWs had inadequate clinical support the doctors.
- Because of the need to use unqualified HCWs in order to minimise costs, legal constraints prevented the HCWs providing additional medical treatment. This was viewed by the communities as a major disadvantage and led to the development of local doctor-run Health Camps in order to provide prescribing, incurring additional costs and manifesting the problems stated above.
- There was little demand for the HCWs' services by non-members. Individuals needing care simply joined the programme through joining existing or creating new self-help groups. Whilst this in itself became a positive aspect of the programme, financial projections were based on income generated through non-member interactions, which never materialised.
- There was significant difficulty in convincing the communities to make full regular contributions in order to achieve sustainability, for a number of reasons:
  1. The perception of healthcare for the poor was that it should be free, since any past experience they may have had had been through mission-based healthcare programmes which demanded no community contribution
  2. Furthermore, the presence of government-run programmes, such as the National Rural Health Mission (NRHM) and the Village Healthcare Nurses (VHNs) provided similar services to those offered by the HCWs but were free. In the context of the government-run programmes, it was difficult to justify a REACH programme to the community.
  3. The strategy to start contributions at Rs 2 and work up to Rs 5 then Rs 10 per month was in hindsight a misguided one. Once communities started paying Rs 2, it was

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<sup>6</sup> [http://circle.winrock.org/docs/nl/2007,08-sa\\_en.pdf](http://circle.winrock.org/docs/nl/2007,08-sa_en.pdf), page 7 "CRED Wins Best NGO Award"

<sup>7</sup> <http://www.hindu.com/2007/11/22/stories/2007112260640300.htm>

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difficult to convince them to contribute more unless additional services were offered on top of the core HCW service.

4. Health Camps offered health checks under the scheme, but for any prescribed medicines, members had to pay for in addition to the regular contribution. The perception was that members did not distinguish between a health-check and the medicine, and struggled to understand why they had to pay “twice”.
- Consequently, although the costs of running the scheme were lower than originally projected, the pilot did not meet the goal of financial sustainability because income generation was much lower than predicted.

### 2.3.3 SUSTAINABILITY

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As of April 2008, the monthly costs of the scheme were running at Rs 76,630, whilst the monthly income generated through contributions was Rs. 36,210. The scheme has therefore reached a level of sustainability of 47%.

In order to encourage CRED to reach 100% sustainability of the scheme, and therefore provide a, a number of recommendations were made over the second year of operation. These included:

- A strong need to understand how existing members can be encouraged to make the full Rs 10 contributions on a regular basis. One proposed method was to develop a voucher scheme to provide increased “tangibility” to the regular contributions.
- Consideration of reducing the regular monthly costs through a reduction in the use of local doctors at health camps
- Consideration of whether all HCWs are sustainable, in view of village locations and level of ability to pay of members.

Despite a keen desire to reach full sustainability of the scheme, the pilot has struggled to achieve this aim. The relocation of a significant number of members because of harvest and the development of a major highway through a number of villages resulted in a significant drop in income for certain HCWs. However, we believe the most significant factor was that CRED, as a charitable NGO providing empowerment to women, felt ethically unable to refuse healthcare provision to members who were unable to pay. Critically, this meant that HCWs maintained a membership that was not generating a self-sufficient income. Whilst the primary objective of REACH is to provide healthcare provision, this must be done in a sustainable environment. Only from a sustainable base can such a model subsequently grow to encompass support for those who are less able to contribute.

Following a further review in September 2008, it was agreed that the scheme should attempt to reach full sustainability by May 2009. In order to achieve this, costs were reduced to 7 HCWs and a reduction in the number of health camps. Unfortunately this was not achieved, and the pilot was declared completed from May 2009. A final evaluation of the clinical impact of the programme was conducted in June 2009.

Whilst we were disappointed that the pilot itself did not achieve our primary aim of a healthcare service at 100% sustainability, it did demonstrate the significant positive impact that a healthcare service can have on a community. We also believe that we now understand the primary reasons for why sustainability was not achieved and would therefore seek to avoid these mistakes in future implementations.

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## 3 REACH MODEL IN DETAIL

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This chapter provides details of how a REACH model of healthcare should operate. There are two key components that must be considered:

1. Raising the required finances from the community to support all healthcare provision requirements,
2. Establishing the level and content of healthcare that is appropriate for the community and can be provided through the available finances generated by the community.

In both aspects of the REACH model, the **community** plays a central role. A clear definition of the community must therefore be first established.

### 3.1 THE COMMUNITY

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The REACH model does not restrict which communities it may operate within. However, the viability of the scheme will depend on certain factors about the selected community itself. We believe that communities that demonstrate the following key characteristics are most suitable for a REACH model of healthcare:

- The community demonstrates “solidarity” - a regular and positive interaction between its members, where support is given to members in need. REACH depends on the regular contributions of all members, but only those members in need will see benefits. Without solidarity, it would be difficult to mobilise the community to make regular contributions.
- The community demonstrates a motivation to invest in healthcare. In addition to having solidarity, the community must have a desire to improve the healthcare of its members, and must be prepared to spend resources in achieving this.
- The community has in place mechanisms or an infrastructure that facilitate the collection and management of member contributions. It would be possible to establish such a mechanism for REACH if it did not already exist. However, the additional costs involved may jeopardise the viability of the scheme; it is far better to utilise existing finance collection mechanisms if they exist already.
- The current provision of healthcare available to the community is non-existent, inadequate or unaffordable for the majority of the members. The REACH model is a cost to its members, and therefore in environments where alternative healthcare provision is available, REACH may be considered uncompetitive.

*The recent implementation of the Government-run scheme, the National Rural Health Mission has meant that in some districts in the CRED pilot, health workers have been provided free-of-charge. Consequently, REACH services have no longer been required in such areas, and members are unwilling to continue paying.*

The focus of REACH development is therefore most likely to be successful in the following four community groups:

1. Rural or remote environments where microfinance has been successfully established. The self help groups (SHGs) of microfinance schemes provide ideal locations for community learning and interaction, as well as a perfect mechanism for managing the small regular

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contributions from members. Furthermore, there is likely to be motivation from SHG members to use the wealth generated through microfinance in an efficient way.

2. Established faith-based community groups, such as church groups. These groups are likely to have the motivation to provide healthcare services for its members, and are likely to have established their own mechanisms for collecting contributions from members, for example at weekly worship meetings.
3. Employees of a large, established organisation or business in a remote area or an area with inadequate local resources. The employment structure can provide the mechanisms for managing contributions (e.g. through pay packets) and a centralised location for provision of services. Enlightened organisations may also consider the significant benefits to them of a healthier workforce.
4. Members of an insurance scheme, which may or may not have a health component. Whilst this community may not demonstrate as much “solidarity” as other groups, the willingness to make regular insurance contributions is likely to demonstrate a willingness to contribute to REACH. For health insurance companies, where payouts are required for hospitalisations, for example, there is a significant business case that provision of a scheme such as REACH is likely to reduce costs significantly.

*CRED demonstrated that, in the first year of implementation of the REACH pilot, loans for healthcare costs reduced by 43%<sup>8</sup>. Had those individuals been covered by a health insurance policy, the savings made from the reduction of claims to the insurance company would have been significant. Although the statistical basis for this anecdotal evidence is small, we would like to see firmer evidence in future studies.*

There may be a number of other key communities that would also benefit significantly from a REACH implementation. However, this document focuses on implementation within these four key groups.

## 3.1.1 THE COMMUNITY ORGANISATION

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These community groups are highly likely to have a formal organisation supporting them. The microfinance network will have an NGO, the faith-based groups will have a church network, the employees will have an employer, and the insurance scheme will have an insurance company. In all of these cases, the organisation will also need to be a key partner in the implementation of a REACH scheme, and may even be the main driver behind it.

Any REACH implementation must therefore take into consideration the organisation’s key role. The perspective of the organisation must also be considered; whilst the concept of REACH may be understood and accepted by the community members, further education and development may be required with the organisation itself.

*REACH forces a global change in the mindset of NGOs. Such groups approach community development programmes with donor funds and do not consider receiving anything monetarily from the communities.*

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<sup>8</sup> In 2006/07, CRED received 100 requests for loans to cover healthcare related expenses; in 2007/08, the year in which REACH was introduced, CRED received 57 requests for healthcare-related loans.

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## 3.2 HEALTHCARE FINANCING

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In the REACH model of healthcare, the provision of healthcare is entirely dependent on regular contributions from the community, and does not rely on third-party donations for ongoing sustainability. It is therefore critical that a regular, reliable mechanism is established for generating income. Whilst this may be achieved with a relatively straightforward marketing exercise for most of the developed world, the poor themselves have particular challenges when it comes to funding healthcare expenditure.

In rural India, for example, if someone who is poor has a healthcare problem, the general pattern of treatment is to try to manage the problem with no professional healthcare support. If the problem is sufficiently serious as to require professional attention, then the person will go to a local practitioner, who is most probably a “quack” and receive usually poor advice for about Rs 35. The other options are to go to a local government hospital, which requires at least a days’ travel (thereby forfeiting a day’s wages, plus the cost of travel), however, many doctors in such institutions demands bribes in exchange for treatment<sup>9</sup>. If the bribe is paid, treatment is usually poor and any drugs purchased from a pharmacy are likely to be a placebo. Treatment costs for more serious cases are likely to be way beyond the ability of the person’s family to pay, and are likely to require the sale of significant assets, enter into crippling agreements with money lenders, or enter into bonded labour agreements for themselves or family members, usually children.

In short, the primary challenge tends to be cash flow, and the consequence of not being able to finance at the time the infrequent but relatively huge costs of healthcare causes families to remain in the poverty trap. Financing for REACH therefore is focussed on ensuring that costs to communities are shared, manageable and regular, and therefore affordable to the poor.

### 3.2.1 FINANCING THROUGH SELF-HELP GROUPS (SHG)

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The advent and success of the self-help group (SHG), through the development of micro-finance initiatives, provides an ideal vehicle for a REACH model of healthcare. The regular, small savings that such groups are able to manage can also be used to secure regular contributions to healthcare financing.

The concept of REACH funding through SHGs is very straightforward. In addition to the regular savings or loan repayments that SHG members make at each meeting, each member will make an additional contribution towards REACH. The funds are then collected by the loans officer and distributed to a central office or the healthcare provider.

It is important to recognise that health care financing of this nature – regular saving, where the benefits may not be directed back to the individual immediately – requires a level of community maturity within a group. The scheme would also have to be compulsory for all SHG members and all SHGs within a network to prevent adverse selection. It is important therefore that the SHG network has the ability to make group-wide decisions about initiating such a scheme. A REACH implementation is likely to be co-ordinated and managed centrally, with the SHG network leads providing community leadership.

Secondly, because the scale of such contributions from members will necessarily be a relatively small contribution relative to the regular amount of saving – typically an Indian SHG might save Rs

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<sup>9</sup> Personal communication from community members and from personnel involved in healthcare in India

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50 per month; the REACH contribution would be around RS 10 per month – a healthcare service would only be viable when such numbers of individuals and groups have critical mass. The determining factor for the viability of such a scheme is that members contributing to such a scheme have sufficient “density” to justify sharing of health care resources. The calculation for assessing the critical density of groups can be found later in the document.

Thirdly, because health care provision would need to be shared across a relatively geographical area – there is not likely to be a sufficient number of SHGs in a single village to support a dedicated health care worker – communication between communities and the health care worker is vital. Geographical and transportation limitations restrict a worker’s ability to meet patients directly, however the provision of a mobile telephone would enable significantly greater access, including emergency services and consultations with physicians at a local hospital.

## 3.2.2 FINANCING THROUGH OTHER MECHANISMS

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The SHG is by no means the only route to generating regular financial support for a REACH scheme. Although we lack direct experience of alternative financial mechanisms, we believe there is significant potential for constructing a REACH scheme based financially on the following:

- **Churches.** Churches are organisations where there is often regular collection of funds from community members. Mechanisms could be established to set aside a portion of such regular giving to finance a REACH scheme serving church members, or the community in which the church operates.
- **Employment.** Employers will have mechanisms for paying employees on a regular basis. Enlightened employees with a sufficient size and infrastructure to justify a REACH scheme may consider establishing a mechanism for employees to set aside a portion of their income (in a tax-efficient way, if applicable) and/or make employer contributions to fund such a scheme for the benefit of the employees and their families and/or communities.
- **Insurance.** The provision of primary healthcare through a scheme such as REACH may be desirable for certain insurance organisations, especially if the benefits of primary prevention lead to reduced secondary care costs. A mechanism could therefore be established in partnership with an insurance company, where the organisation subsidises or takes on fully the costs of running a REACH scheme for a community, in return for insurance policies and the knowledge that costs will be reduced.
- **Others.** Other innovative mechanisms could also be considered. The REACH scheme is not limited any particular type of organisation of the community.

This section will be developed further as we develop experience in these areas

## 3.2.3 PURPOSE OF FINANCING

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The regular supply of income for healthcare provision may be utilised in a number of ways:

1. Expenditure on **direct healthcare provision.** The primary, core purpose of REACH is to raise income in order to mobilise appropriate healthcare provision for the community.
2. Development of a **corpus fund.** It should also be recognised that, despite the provision of a regular healthcare service to the community, some individuals will require more significant intervention which is likely to be beyond their means to pay. Mechanisms may already be place, such as microfinance, that enables them to take loans to meet their needs without resorting to money lenders. However, the community may also decide to establish a corpus

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fund to provide assistance for individuals with significant healthcare-related financial difficulties.

3. Generate **profits**. It may be possible that the level of regular contributions contains a small profit element for the scheme. This may be desirable for a number of reasons:
  - a. The nature of income generation from the community is variable, or has a degree of uncertainty in it. For example, if the scheme were in an agricultural area, the seasonal migration (and payment) of workers may mean that the scheme is affordable to them at certain times of the year only. In such cases, a fund to help manage the fluctuations in income may be necessary.
  - b. The development of an investment fund to improve the service provision over time. For example, such investment could be utilised to reduce or subsidise regular contributions for the poorer members of the community, or used to improve quality and scope of provision within the community, or to reach a wider community.
  - c. Shareholder dividends in a for-profit model. The shareholders may be external investors, who had provided seed funding, for example, or it could be the community itself if set up as a co-operative model.

Clearly, the balance of utilisation needs to be researched carefully, and may be reviewed and modified on a regular basis.

### 3.2.4 MEMBERSHIP

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The definition of who is a member of the scheme is also a vital component. Core membership entitlement is clearly for those who make regular contributions to the scheme. However, often the contributors may be women with potentially large families, and therefore the scheme must decide whether family members (and who in the family) are also entitled to benefits of the scheme. Whilst the viability of including family members depends on each particular situation, it is recommended that as many family members be included without causing capacity problems for the service itself. A "family" may be able to afford a larger regular contribution than an individual, and it also avoids the potential problems observed in CRED where family members (considered non-members) used HCW services through individual payments.

Secondly, consideration must also be given to whether other non-members may access services. A successful programme is certain to attract wider interest, and therefore it is important that clear policies are laid out.

The healthcare services offered by the HCW should be available only to community members who are making regular contributions. However, it will be inevitable that non-members will seek the HCW services if it is perceived of being some value. It is therefore important that the issue of how to treat non-members is laid out clearly. A number of policies may be taken, for example, non-members may use the services on a per-consultation fee basis, though this opens up a number of potential problems with preference and corruption. Within a microfinance network, for example, an alternative policy might be that non-members must first join or create an SHG who contributes. HCWs may also be given a degree of discretion in determining whether a non-member should be permitted services under exceptional services, but must always bear in mind that such support is not a core part of the service offering.

*As observed by CRED, there has been little demand for the HCWs' services by non-members – people needing care join the programme through joining or creating new self-help groups.*

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## 3.3 HEALTHCARE PROVISION

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The nature of provision of a healthcare service will depend entirely on the needs of the community. One of the key stages in establishing a REACH scheme is to conduct a thorough health needs assessment to understand the requirements of the community, identify any existing suitable health care provision, and assess the local health economic status – what is the price of implementation.

However, the existing level of healthcare provision is likely to be very rudimentary if it exists at all, and the level of the ability to pay is likely to be very low indeed. Therefore, a REACH model should consider the following basic healthcare interventions that are most likely to be both effective and affordable:

- **Health care workers (HCWs):** Individuals from the community who are given local, basic training and focus on primary areas of need, without breaking legal requirements.
- **Ambulance (or any transportation option):** For mobilising both the healthcare provision to the community, and community members to hospital or other healthcare centres.
- **Qualified medical support:** Access to qualified healthcare practitioners to address more complex needs. Access may be provided directly, such as in community health camps, or through transportation, or telemedicine (access via mobile phone).
- **Medicines:** Direct provision of or subsidisation of medicines, either dispensed by health care workers, or by local qualified healthcare practitioners

### 3.3.1 HEALTHCARE WORKERS (HCWs)

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The backbone of REACH healthcare provision is the Healthcare Worker, whose primary role is to provide a range of healthcare services directly to the community.

#### 3.3.1.1 RECRUITMENT

Experience and professional qualifications of the HCW will primarily depend on the level of contributions that can be raised by the community to support the HCW's income. However, the communities that a REACH scheme is designed for is likely to support no or relatively low levels of qualifications. In most cases, a HCW will be an individual recruited from the local community and given basic training. Alternatively, a HCW may be a nurse with basic nursing qualifications. It is unlikely that the more comprehensive qualifications held by doctors will be affordable by such communities.

*CRED: It is clearly evident that the HCWs are valued by the local communities. They appear to be increasingly able to influence health behaviour of the members of the Self Help Groups. Initially the HCWs' husbands were reluctant to allow the HCWs to hold SHG meetings in the evenings but having seen their value, the husbands have given their support. The HCWs have also formed links with school teachers and elected leaders in the villages.*

#### 3.3.1.2 CORE SERVICES

The nature of services provided by the HCW will depend on the specific needs of the community, but are likely to include at least the following:

- basic health checks, e.g. weight measurement, blood pressure, urine testing and blood sugar measurements for diabetic patients

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- health education, e.g. child development, nutritional advice, antenatal advice & feminine hygiene (Street Drama has been used)
- simple first aid and dressing of wounds
- simple treatments involving non prescriptions medications, e.g. paracetamol and oral rehydration
- supporting vaccination initiatives and other local programmes, e.g. TB awareness days
- referral of patients to local doctors and hospital
- social care, for example after a house fire

See Appendix 1 for a more detailed list of services that may be offered by an HCW.

Any conditions falling outside of this defined list would need to be referred to other health-care professionals, outside the remit of the HCW. Remote consultation may be conducted using the HCW's mobile telephone. It is possible that the HCW would be affiliated with a local hospital, and would also need to be aware of other quality healthcare professionals in the area. Funding for such treatment would be entirely outside of the regular contribution scheme. An arrangement can be made so that when such services are accessed they are subsidized for SHG members. This can be worked out later.

It is vital to establish what the legal position of the HCW would be in relation to services they provide, for example, whether they are permitted to prescribe or dispense medicines.

*CRED: Some measures of health & sanitation behaviour show marked improvement: there has been a big reduction in the demand for loans for healthcare, and a 50% increase in the number of clean-up drives in targeted villages*

*Blood pressure measurement is particularly welcomed by the communities, resulting in a concern that the referral of large numbers of people would increase the health burden on the community. However in one sample of patients, only 8 out of 55 patients identified with raised BP were referred to a doctor, the remainder managed by advice on diet and exercise etc.*

### 3.3.1.3 EQUIPMENT

In order to provide these services, the HCW should be equipped with a mobile phone and an appropriate medical kit bag (see Appendix 2 for a detailed list of items which may be provided).

The primary responsibility of the HCW would be the primary point of contact for all healthcare issues. Opportunities for the community to communicate with the HCW regularly is vital and therefore suggests that HCWs should visit the community on a regular basis and be as accessible to the community as possible.

### 3.3.1.4 ACCESS

The location of such visits will depend on the community, but we have found that the regular SHG meetings are ideal locations, since the meetings are the point at which members get together, have contributions ready, and are in a mindset to discuss issues. The extent to which HCWs can participate in SHG meetings will depend on the number and location of groups they are serving.

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*CREDs HCWs each had responsibility for 40 to 50 SHGs. Most villages had at least 5 SHGs, so with two visits per SHG per day, a HCW would visit each SHG once every 5 weeks, but be available in any given village once a week*

In addition to direct consultations, the HCW is equipped with a mobile phone (assuming there is a mobile network available). The primary uses of the phone should be to enable any community member to access the HCW when they are not in the village, to enable the HCW to contact a local doctor or emergency transportation on behalf of any patients that may require these services, and for direct communication between the HCW and the central organisation.

*CRED: Each HCW gets about 10-12 calls per day from patients.*

## 3.3.1.5 CONNECTING TO OTHER SERVICES

The HCW should also take responsibility for connecting the community with other healthcare services: Such services may include

- Government- and NGO-run programmes, such as immunisations, TB, malaria, AIDS
- Organising provision of direct medical support in villages through health camps, either fee-paying or charitable.
- Becoming the point of knowledge for other affordable services that may be available locally, such as local mission hospitals.

*CRED: Three of the HCWs have been accredited within a local Tuberculosis DOTS scheme*

Although any costs associated with extra services would not be covered under the REACH scheme, such costs may be subsidised by a “hardship” fund, if one has been established.

## 3.3.1.6 EMPLOYMENT STATUS

The employment status of the HCW may be either as an employee of a local organisation implementing REACH, or as an independent “entrepreneur” contracted by the REACH organisation to provide services.

Whilst the employment model gives more stability to the HCW, the entrepreneurial model offers the HCW greater incentive to establish more sustainable partnerships with the community, and is likely to be cheaper to establish, since more of the financial risk is borne by the HCW.

The choice of model will depend on the nature of the community to be served, and the degree of empowerment that is given to the HCW to manage services and generate income.

## 3.3.1.7 INCOME GENERATION

It is important that HCWs are not financially incentivised to treat non-members over members of the scheme. The management of income should therefore be very clear to both the community and the HCW. Any income collected from the community must be documented so there is a clear audit trail. If the community already has in place a mechanism for managing community finances, such as microfinance savings scheme or an employment payroll, then this should be utilised to managing the REACH scheme finances too. If non-members are permitted to consult with the HCW on a one-off basis, then it should be clear how payments from non-members are accounted for. For example, a non-member may need to approach a SHG first and purchase a token from them before being granted access to the HCW.

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Depending on the nature of the existing financial infrastructure, the HCW may or may not have a role in collecting funds. However, mechanisms must be in place to minimise the potential for the HCW to be paid “privately”.

However, the HCW may need to be actively involved in promoting membership of the scheme in order to maintain and grow membership. The HCW should therefore also be equipped with training on how to recruit new members, and provided with appropriate materials to do so. The HCW may therefore be incentivised to recruit members to the scheme, through a bonus scheme if employed; in the entrepreneurial model, the HCW is likely to have a large component of their income dependent on member numbers.

The scheme may also consider incentivising the HCW to provide other specific services, for example, introducing immunisation programmes or organising eye or dental clinics. However, incentives must be carefully considered to ensure they avoid unintended consequences. For example, an incentive to refer to a local hospital has the potential to distort appropriate referrals and may tempt HCWs to accept illegal “kickbacks”.

### 3.3.1.8 DEVELOPING HCW SERVICES

As the role of HCW develops, ongoing training and education will be necessary, and turnover of HCW staff must be expected. The defined responsibilities may also change over time and adapt to the changing healthcare needs of the population. It is therefore important that monitoring is established to ensure that the most appropriate service is constantly offered to the populations, and that the HCWs are given regular training opportunities to refresh and develop their skills.

### 3.3.2 TRANSPORTATION

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The community may wish to consider whether transportation is a key factor in the provision of healthcare. Do community members have to make expensive journeys, in terms of time lost in travelling or transportation costs, in seeking healthcare? Are communities losing out to healthcare provision because it is difficult for healthcare providers to engage with communities?

To a large extent, the provision of a HCW who is locally based within the community is likely to largely address the access problem. However, even with HCW support, the need for additional transportation may need to be considered.

Such transportation would have three primary purposes:

1. Providing emergency transportation for community members to local healthcare providers, such as a hospital.
2. Providing additional transportation for HCWs to access more remote areas.
3. Providing transportation for other healthcare professionals to access the community in support of the HCW, such as the running of health camps.

The choice of vehicle and how it is equipped will depend entirely on local needs and terrain. However, in order to maintain affordability of the scheme, lower end specifications are likely to be the only options. The capital cost of such a vehicle is likely to be the greatest outlay, though it may be possible to have this provided through donations or considered part of the seed funding. However, it is important that the regular running and maintenance costs are fully covered through the regular contributions. Such costs may need to include the salary of a driver if the vehicle is dedicated to the REACH scheme.

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If the anticipated need for such a vehicle does not fully meet its capacity, a significant part of its running costs may be offset through private hire, and may even generate a profit for the scheme. For example, it may be made available as an emergency ambulance to non-members for a nominal fee. However, it is important that its terms of use are clearly defined and monitored, so that income generation does not adversely affect its primary purpose as transportation for members, HCWs and healthcare professionals supporting the scheme.

*CRED has a basic ambulance, provided through funding from British donors, the local Vadipatty State Governor and the Federation of SHGs. It is used several times a week to transport HCWs and doctors to Health Camps, and to take patients to hospital.*

### 3.3.2.1 PERSONAL TRANSPORTATION FOR HCWS

An additional solution may be to offer the HCWs the opportunity to own and use their own transportation, such as a two-wheeler motorcycle. This may be more appropriate if certain HCWs have differing transportation needs than others (e.g. some need to access more remote villages where public transportation links are poor).

The funding of such vehicles may be initially beyond the reach of the scheme or the individual HCW. However, it may be possible to devise a package for HCWs to take a low cost loan to purchase the vehicle. The two-wheeler would then be fully owned by the HCW, ensuring that it is maintained and utilised effectively.

### 3.3.3 QUALIFIED MEDICAL SUPPORT

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Because the HCW is unqualified and will have a limited level of education and training, the community will have a number of healthcare needs for which the HCW is unable to address. Unfortunately, providing full-time professional medical support would render a REACH scheme unaffordable.

The REACH model assumes that qualified healthcare professionals provide at most a support role to the HCWs. However, although the scheme may not provide significant (or any) professional support, it should at least offer access to such individuals. Such access may be through:

- Direct referral from the HCW. The HCW should be sufficiently equipped to know about all the local healthcare providers, and which providers are the most appropriate for the patient in question. The HCW would be able to give advice to the patient on where to go, who to ask for, and may even arrange an appointment through the mobile phone.
- Consultation over the mobile phone. The HCW's mobile phone may also be used to put the patient in direct contact with a healthcare professional for advice.
- The ambulance service can provide emergency transportation for any member to a local healthcare provider.
- The HCW may organise healthcare professionals to practice directly to the community through health camps.

*CRED's experience with health camps*

*Currently three doctors participate in the Health Camps, and are paid Rs 500 per half day camp. Each camp receives 70-80 patients per time. The doctors have basic medical qualifications rather than a qualification in family medicine or community health.*

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*The primary role of the doctor in these camps is to provide health check-ups, and diagnose and treat health problems. The role of the HCW is to assist the doctor, learn from their practice, and dispense medicines. Normally, two or three HCWs assist with each Health Camp, which attends a village approximately once a month.*

*Both members and non-members are permitted to attend. The vast majority of Health Camp attendees are women, but men are increasingly encouraged to attend. Attendance with children was surprisingly low.*

*Seeing the doctor was free, but any medicines given were charged at Rs 5-10. This approach does appear to cause some confusion and concern. Although the payment is principally to cover some of the costs of the drugs, it is actually seen as a cost to attend the Health Camp, as the Health Camp is synonymous with the receipt of medicine. Therefore some members question why they should pay for both regular contributions and Health Camp costs, when non-members can also turn up and just pay the Health Camp costs.*

The scheme should consider potential costs involved in providing access to healthcare professionals. Costs involved in referral or transportation to healthcare professionals will be covered already within HCW and vehicle costs. However, the scheme may consider whether costs are involved in organising health camps.

Ideally, healthcare professionals may not consider a fee for participating in health camps, either through altruistic intentions, or a recognition that they are able to generate sufficient income through consultations with the community. However, it would be more realistic to consider that the healthcare professional should be paid an agreed fee for attending a health camp, so that for the community there are no additional consultation costs.

It should be noted that the likely level of quality of healthcare support from such professionals is lower than normal standards. It is therefore important that a review of local healthcare professional capabilities is conducted to identify which providers are more likely to provide an acceptable service than others. The HCWs will require such information in order to provide good advice to the community about where to go for further support.

*As observed in the evaluation report on CRED, support by local doctors for HCWs has been inconsistent, and there are other concerns about the healthcare administered by doctors. In particular our view is that there is widespread inappropriate prescribing of medicines.*

### 3.3.4 MEDICINES

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An important element of the service that a REACH scheme needs to consider offering is that of prescribing and dispensing medicines.

It is especially important to develop an appropriate policy on how the scheme provides for medicines. There may be a number of challenges within the community with regard to medicines:

- The community may not fully understand the specific role of medicines in appropriate healthcare. There may be an expectation that the HCW or healthcare provider should give them medicines, even though this may not be the appropriate course of action.

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*CRED: Everyone wants an injection! We were challenged to change the perception of much of the community, that when they go to the doctor they should have an injection.*

- Healthcare professionals may prescribe inappropriately. This may be driven by poor medical education, a misguided desire to give the patient what they want or can afford rather than what is appropriate, or worse, for pure financial gain.
- The HCWs may be legally restricted in what they can personally prescribe or dispense because of their unqualified status.
- The cost of appropriate medicine may not be affordable by the patient, presenting them with the difficult choice of not treating their condition or otherwise taking out loans to pay for it.

The REACH scheme therefore needs to establish how it will offer the following:

1. To what extent HCWs are legally permitted to prescribe medicines. It is likely that HCWs should not participate in any prescribing at all. However, it may be considered that HCWs are entitled to provide a limited list of medicines because they are given the authority by another healthcare professional, or that the list contains only those medicines that have no legal restrictions. In either case, it is vital that the HCWs receive sufficient training and guidance on the appropriate prescribing of these medicines, however straightforward this may be. Appendix 3 offers a list of what may be considered appropriate areas for prescribing for an HCW, though this will clearly depend on local need, availability and laws.
2. Will the REACH scheme provide a medicine dispensing service? For example, in partnership with a health camp, the scheme may provide an accompanying pharmacy to support any prescribing by the healthcare professional. This provides immediate access to medicines, which would otherwise require a patient to travel to a local pharmacy (which may not be accessible), and it also enables the scheme to guarantee the quality of medicines. However, the stock of medicines would therefore need to be managed, either by the HCWs directly, or through a central administration
3. If the scheme has agreed to provide dispensing of medicine, what range of medicines with be stocked? This needs to be carefully considered, as it would need to focus on the most common conditions encountered for the field, and everything should be affordable.
4. To what degree should the costs of dispensed medicines be subsidised by the scheme? Managing such stock may incur costs, in terms of administration, stock control and transportation and this would need to be borne by the scheme. However, it may also consider offering the medicines for free or below cost to members.

## 3.4 ADMINISTRATION

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In addition to the mechanisms for financing and provision of healthcare services, appropriate administration systems need to be established to ensure ongoing support for the services and the community. The role of the REACH Administrator is central to fulfilling the administrative requirements of a REACH scheme. The Administrator may be an individual or an organisation, whose primary role is to provide all necessary support to HCWs and other healthcare providers, as well as ensuring the scheme maintains regular income generation.

It is likely that the organisation that supports the community (e.g. NGO) will play a significant role in the administrative elements of the scheme. Although many of the administrative tasks may be

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delivered through the Administrator, this is likely to be in close partnership with the organisation, if not within the organisation itself.

## 3.4.1 LEADERSHIP

It is vital that the scheme is led by a strong leader (or leadership team) who understands the rationale of REACH and the business model required to maintain sustainability. The leadership team should be able to demonstrate the following key characteristics:

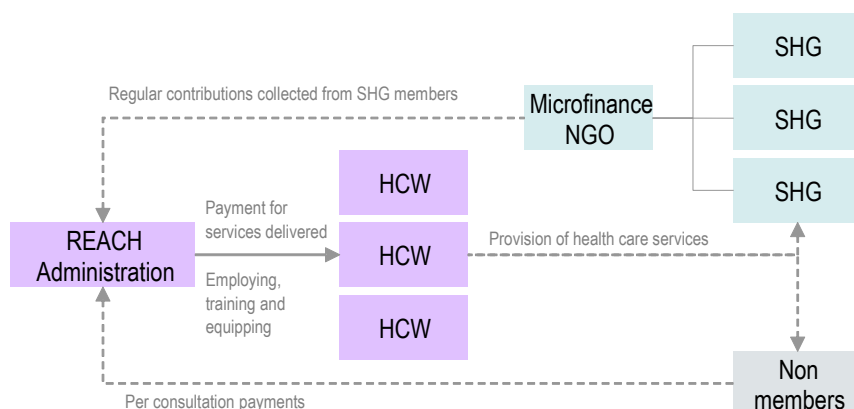
- A full appreciation of the value of principles behind REACH, and the need for the scheme to achieve sustainability.
- Good business experience and understanding of income, expenditure and cash flow.
- Good understanding of the health needs of the communities
- A good ability to network with local organisations, particularly local healthcare organisations.
- Fully trusted by the community
- Ability to make difficult decisions – the scheme may need to reject community members from the scheme who are unable to make the required contributions.

*The HCWs receive excellent support and leadership from CRED, in particular its director Mr Alagesan*

## 3.4.2 ORGANISATIONAL STRUCTURE

### 3.4.2.1 EMPLOYMENT MODEL

The proposed organisational structure is represented in the following diagram for a microfinance-based REACH scheme:



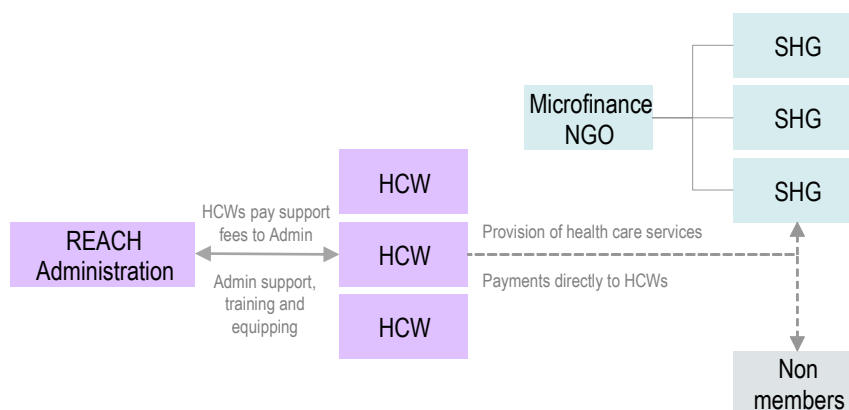
The REACH Administrator as an organisation employs the HCWs, who in turn provide services to the community. In addition to employing the HCW, the Administrator organises training and equipment for the HCWs, and other healthcare provision.

Contributions from the community are collected by the REACH Administrator, either through the membership mechanisms (such as SHGs) or directly from non-members, if that is permitted.

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It is possible that the REACH Administrator and the community organisation (e.g. NGO) are the same organisation, though for the sake of accountability and clarity, it is recommended that the two are kept as separate organisations that are in partnership through a contract arrangement.

## 3.4.2.2 ENTREPRENEURIAL MODEL



In the entrepreneurial model, the REACH Administrator organisation does not employ the HCWs directly but provides a support service to the HCWs in the form of training, admin support, central communication, marketing, etc.. In return, the HCWs will pay a fee to the REACH Administrator.

Income generated from the community likewise will go directly through the HCWs rather than through the Administrator organisation. However, it is possible that the Administrator may provide certain financial administration services (e.g. banking) that support the HCWs in income management.

## 3.4.3 CLINICAL TRAINING AND MONITORING

Despite the focus of healthcare being on affordability rather than highest quality, it is nevertheless important that the scheme offers regular training and clinical monitoring support to all the services provided.

The role of the REACH Administrator in either organisational model is to ensure that the HCWs and other local healthcare providers are adequately trained, and that their performance is monitored and corrected when required. In addition, the scheme may want to monitor the healthcare requirements of the community to ensure that services are always tailored to needs.

To fulfil this role, it is likely that the REACH Administrator should contract with suitable healthcare professional support, in the form of a local training centre, for example, or other suitably qualified medical personnel to provide training materials and assessment.

With a small number of HCWs, clinical support may most effectively be contracted out. However, with growth in the number of members and HCWs, it may be possible and preferable that suitably qualified medical personnel are employed.

## 3.4.4 LOGISTICS

The REACH Administrator may need to provide logistical support for HCWs, in the form of organising meetings, coordinating health camps, distributing equipment and ensuring stocks are maintained, and so on.

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## 3.4.5 FINANCIAL MANAGEMENT

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Under the employment model in particular, the REACH Administrator will take responsibility for financial management of the scheme. This may include receiving the regular payments from the community, monitoring levels of payment, and paying all expenses, including HCW salaries (if appropriate). Appropriate banking arrangements will therefore need to be set up to manage the cash flow.

## 3.4.6 CORPUS FUND MANAGEMENT

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In addition to the regular financial management, the REACH Administrator may take responsibility for managing the corpus fund. The purpose of this fund is to provide financial capital to the community for use in exceptional circumstances. Decisions about how the corpus fund is used should primarily fall to representatives in the community. However, the REACH Administrator will provide the necessary banking arrangements to maintain the fund efficiently, and appropriate distribution mechanisms to the community.

## 3.5 BUSINESS CASE

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The financial viability and sustainability of providing the healthcare provision with the feasible level of contributions from the community is dependent on understanding the numbers involved. The estimation of viability will vary for each potential scheme, but the principles of the sustainability calculation will be applicable to most schemes.

The following steps outline how such a business case may be made, and uses the CRED pilot scheme to provide a working example. However, the process of reconciling the figures may be an iterative one. For example, the potential income will determine what can be spent on healthcare services; however the capacity to deliver services will set the benchmarks on what needs to be raised.

The recommendation is to first assess what potentially can be generated by the community, then set what can be provided within this income. However, this should then be reviewed, and either the level of provision or the level of required income adjusted to ensure the two reconcile, where both the level of provision and the level of contributions are both acceptable.

Note that this business case only assesses the viability of the scheme when it reaches 100% potential. There may be a number of initial set up costs to establish the scheme, and it may take some time to establish a fully contributing membership. Therefore, the question of cash flow has also be to considered. This is addressed more fully in the implementation plan.

### 3.5.1 DETERMINE COMMUNITY POPULATION

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Understanding the community population to be served provides a measure of the capacity to generate income, but also the potential demand and geographical span to be met by the service.

Assess the population in terms of the potential number of regularly contributing members that REACH can attract, the potential number of individuals that may utilise the healthcare services, and the geographical spread of membership.

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Locality population	130,000
Number of SHGs	840
% of SHGs participating in REACH	500
Average number of members per SHG	15
Potential REACH membership	7,500
Average number of family members per member	6
Potential population served by REACH	45,000
Average number of SHGs per village	5
Potential villages served by REACH	100

## 3.5.2 INCOME POTENTIAL

The scheme first needs to assess where income may potentially be generated. The primary source of income will be regular member contributions, however, other sources of income should also be considered.

### 3.5.2.1 REGULAR MEMBER INCOME

Assessing the potential level of income from members will depend on considering a number of factors:

- The level and range of poverty faced by the community
- The average and the range of income generated daily by the population
- Whether the income levels of the community may vary significantly throughout the year. This is particularly the case for agricultural workers who are affected by harvests.
- Whether income levels for the community is relatively stable
- The level of savings or loan repayments that the community can manage, for example determined through SHG membership

In the CRED pilot, it was felt that an affordable level of income for most SHG members was Rs. 10 per month. Many SHG members were regularly contributing Rs. 50 per month as savings, and that 20% of this was deemed reasonable.

Based on the benchmark of being able to raise on average Rs. 10 per month per scheme member, the community had the potential to raise...

Potential REACH membership	7,500
Average monthly contribution (Rs.)	10
Potential monthly income (Rs.)	75,000

### 3.5.2.2 OTHER SOURCES OF INCOME

In addition to regular member income, the scheme should also evaluate the potential monthly income from the following sources:

- Income generated from non-members. This may be in the form of consultation fees, though the level and feasibility will depend on how non-members should be treated in terms of provision. It is recommended that the scheme has a policy that non-members do not receive support unless they become members.

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- Private hire of transportation. Any vehicle used for healthcare transportation has the potential for income generation through private hire. Again, the scheme must be clear about usage policy for such vehicles, and income generation should take second place to provision of healthcare services.
- Subsidisation from interested parties. Local hospitals and health insurance companies may potentially benefit from the implementation of a REACH scheme. They may therefore be persuaded to subsidise the scheme to ensure its success.

The CRED pilot did not implement further income generation activities beyond the regular member contributions. Although it initially set out with the purpose of generating income from non-members, it was quickly realised that those non-members simply joined SHGs and became members. Income was also generated through nominal charges of medicines, however this was below the cost of medicines, and was therefore simply accounted for as a net cost of medicines (see below).

### 3.5.3 COST OF PROVISION

A rough benchmark for what level of income may be potentially generated by the community will establish the level of services that could be offered.

Since the HCW is central to provision, the primary task is to determine the number of HCWs that are affordable for the community. However, the costs of other services also need to be considered.

#### 3.5.3.1 HCW CAPACITY AND COST

One approach would be to consider the potential demand for services from a given population. However, this is dependent on the nature of services that the HCW may provide. An assessment of the level of demand from individuals may be impossible to do initially and is very likely to change significantly over time. Therefore, a demand-driven calculation is not likely to be appropriate.

A better approach is to consider the question from two other points of view:

1. If geography is an issue, as it may be in more remote rural locations, what population can a HCW visit physically?
2. What size of membership could generate a sufficient income to support one HCW?

The following example calculation assesses the physical capacity for a HCW...

<b>Number of SHGs visited per day</b>	2 (1 x am, 1 x pm)
<b>Number of SHGs per week</b>	10
<b>Repeat visit to SHG every ... weeks</b>	5
<b>Total SHGs per HCW</b>	50
<b>Potential membership per HCW</b>	750
<b>Potential population served per HCW</b>	4,500
<b>Number of HCWs required</b>	10

Based on geographical considerations, the CRED pilot would require 10 HCWs to serve the membership population.

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To assess the financial viability of this number of HCWs, the following ongoing costs were estimated for one HCW:

Item	Monthly cost (Rs.)	Notes
<b>Basic salary</b>	2,500	The HCWs are unqualified community members, and are salaried employees of the NGO. Therefore this rate reflects a reasonable salary for someone in that position in the local community
<b>Bonus</b>	250	Incentive bonus for achieving target membership
<b>Travel</b>	1,000	Cost of bus fares or other transportation to and from villages
<b>Mobile phone</b>	250	Cost of rental and calls
<b>TOTAL</b>	<b>4,000</b>	

The total costs for employing the 10 HCWs in the CRED pilot was therefore **Rs.40,000**.

### 3.5.3.2 HEALTHCARE PROFESSIONAL SUPPORT

If the scheme provides access to healthcare professionals, for example, through regular camps. This cost also needs to be included.

The CRED pilot provided monthly health camps attended by three local doctors. Since the cost of the doctor consultations was provided for free to members and non-members, the scheme bore the cost:

Item	Monthly cost (Rs.)	Notes
<b>Health camp</b>	10,000	Monthly cost of providing health camps to SHGs.
<b>TOTAL</b>	<b>10,000</b>	

Although the doctors could be contacted by the HCWs via mobile phone, any additional services offered to community members by the doctors were charged as consultations by the doctors. Therefore, the scheme did not pick up any of these costs.

### 3.5.3.3 MEDICINE SUBSIDISATION

The scheme may consider providing medicines for free or at below costs to the community. This may typically be done alongside the health camps, where local doctors are likely to provide prescriptions.

The CRED pilot offered a subsidisation of medicines at the health camps. Medicines were normally dispensed for a nominal charge, around Rs. 5-10 per tablet or injection, or given free for the destitute. However, the full medicine stock was purchased and managed by CRED. The net cost to CRED of supplying such medicines was therefore borne by REACH:

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Item	Monthly cost (Rs.)	Notes
<b>Medicine stock</b>	10,000	Monthly cost to maintain stock levels of medicines for health camps
<b>Income from sale of medicines</b>	(5,000)	Income from nominal medicine charges
<b>NET COST</b>	<b>5,000</b>	

### 3.5.3.4 TRANSPORTATION

The running and maintenance costs of any transportation provided by the scheme should be included. Consider the cost of maintenance, fuel and driver costs. The capital cost of the vehicle may or may not be included in the cost calculation, depending on how the vehicle had been obtained, and whether it is anticipated that the scheme would need to purchase a new vehicle using the regular contributions.

The CRED pilot was donated a VW van for use as an ambulance, but employed a driver to run it. The costs of transportation were therefore:

Item	Monthly cost (Rs.)	Notes
<b>Transportation costs</b>	5,000	Includes maintenance, fuel and driver costs
<b>TOTAL</b>	<b>5,000</b>	

### 3.5.3.5 ADMINISTRATION

Depending on whether the community organisation can absorb the administrative work within its existing infrastructure, some costs may need to be given to supporting administration.

The CRED pilot required a degree of time from the NGO secretary, Mr Alagesan, and also employed a part-time administrator to organise meetings and health camps for the HCWs, as well as purchase and maintain the medicine stock. The cost of administering the scheme by CRED was...

Item	Monthly cost (Rs.)	Notes
<b>CRED administration</b>	10,000	Support for Mr Alagesan, part-time administrator
<b>TOTAL</b>	<b>10,000</b>	

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### 3.5.3.6 TOTAL COST OF PROVISION

The overall monthly cost of provision for the CRED pilot was:

Item	Monthly cost (Rs.)
HCWs	40,000
Healthcare professional support	10,000
Medicine subsidisation	5,000
Transportation	5,000
Administration	10,000
<b>TOTAL</b>	<b>70,000</b>

### 3.5.4 FINANCIAL VIABILITY ASSESSMENT

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The difference between the potential income and estimated running cost of provision will determine whether the scheme is financially sustainable. In the CRED pilot, the scheme was:

Item	Rs.
Potential community income (per month)	75,000
Cost of healthcare provision (per month)	(70,000)
<b>Net monthly profit</b>	<b>5,000</b>

A net loss would require a reconsideration of the structure of the scheme:

- Can more members be found to contribute to the scheme without requiring an increase in the overall cost of provision?
- Can other sources of income be identified to make up the net difference? For example, non members, private hire of transportation, subsidisation of the scheme by interested third parties, such as local hospitals or insurance companies?
- Can the regular level of contribution by members be increased?
- Can the cost of healthcare provision be reduced?

A scheme with a net profit can be considered to be viable for reaching sustainability. Any net profits therefore can be used to build or maintain a corpus fund, or be used as an investment into healthcare services.

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## 4 IMPLEMENTING A REACH MODEL

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This chapter provides an outline of the steps required to implement a REACH scheme. Timelines and the precise order of tasks will depend entirely on the implementing organisation and seed funding availability.

### 4.1 BRING TOGETHER PARTNERS

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The initial task is to bring together as partners the key organisations who will be committing to implementing the REACH scheme. The principal lead is likely to be the community-based organisation, such as the NGO operating the microfinance scheme, the church, the employer or the insurance company. Within that organisation key departments and individuals need to be identified and give responsibility for implementing the scheme.

In particular, it is vital to identify the individual who will lead the implementation. This leader must fulfil the criteria outlined in the REACH model details, above. Other individuals will also need to be considered from the organisation, including those providing administrative support..

The lead organisation should also consider what partnerships should be established in order to provide the full range of resources and skills required. For example, other organisations could provide expertise in clinical education and training, local healthcare professional support, seed financing, financial management, etc..

*The partners involved in the CRED pilot were:*

- Martin Morse, Tim Lyttle, Tony Dale: the "conceivers" of REACH who proposed the business model, and provided seed funding.*
- The Bridge Foundation, providing the overall management of the pilot, networking to establish training links, financial management and technical advice*
- CRED, the local NGO implementing the scheme, employing the HCWs, organising health camps and deploying the vehicle.*

*The partners were co-ordinated by the Bridge Foundation, who identified CRED as a suitable NGO with a good track record of implementing microfinance programmes.*

### 4.2 ASSESS SCHEME VIABILITY

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Before any significant resources are committed, it is worthwhile determining whether a REACH model of healthcare is feasible for the community concerned. The key question to be answered is "Is it conceivable that the community could successfully implement a REACH model, as outlined in this document?"

The assessment should consider the following:

- Is the community sufficiently mature to adapt such a model in principle? Does it have suitable mechanisms in place, and is the attitude towards collective development present?
- Based on a top-line assessment, what is a realistic level of contribution that the community could deliver, and are there healthcare services that could be provided within their means?

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This assessment need not be in any great detail, but will potentially avoid the waste of valuable resources if there are significant barriers to implementation of a REACH model. It would be better to address those barriers first. For example, a community may like the idea of REACH in principle, but unless there is in place an infrastructure for regular contribution collection, it will be very difficult to implement. It would be better to invest in a microfinance scheme first, then implement REACH when that scheme has matured.

*The assessment of the viability for the pilot was based on prior model development work by Martin, Tim, Tony and the Bridge Foundation through research conducted in the Karur district. This research determined that Rs. 10 per month was a feasible level of contribution, and that HCW salaries could easily be met within that level assuming there was at least 640 members contributing to a scheme.*

*The CRED pilot was also a proof of principle exercise to determine whether such a model could be successfully implemented*

## 4.3 DEVELOP A PLAN

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Assuming that it is agreed by the implementing partnership that a REACH model has potential for success within the community, the next stage will be to develop a detailed plan of action.

Clarity on a plan of action is vital because the model takes a very innovative approach and is likely to be unfamiliar to participants.

Note that this document is not intended to be a tutorial on project management, and it is expected that the organisation that plans to implement a REACH programme will have the mechanisms and personnel in place to manage the project successfully. This guide therefore focuses on those aspects of a plan that merit particular consideration.

*It should be noted that the implementation of the CRED pilot was initiated without consideration of many aspects of the detailed plan as laid out below. The consequence of this was that a number of issues arose during the implementation itself. Having now understood those issues, we are better able to know what needs planning for.*

*In particular, prior education of the value of a health service and the absolute need for full regular contributions was not sufficiently addressed. Consequently, we had great difficulties in persuading the community to make full regular contributions and therefore full sustainability was not achieved.*

### 4.3.1 UNDERSTAND COMMUNITY NEEDS AND RESOURCES

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#### 4.3.1.1 CONDUCT A HEALTH NEEDS ASSESSMENT

The starting point for the development of a plan will be to understand the specific healthcare needs for the community. Each community will have a unique set of challenges with respect to healthcare, driven by environment, demographics, working conditions, access to existing healthcare provision, level of poverty, social status, and so on.

Since a REACH scheme needs to focus on the priority areas for healthcare, it is vital that the health needs assessment (HNA) identifies those conditions that are most pressing for the community, along with an assessment of the most effective clinical routes for address those conditions.

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It is important that such an assessment is conducted by personnel with expertise to make such assessments. This may be contracted to a local medical college with community healthcare experience, for example, or a clinician with expertise in this area.

## 4.3.1.2 ASSESS THE SCOPE FOR INCOME GENERATION CAPACITY IN THE COMMUNITY

In addition to an assessment of the community from a healthcare needs perspective, it is equally important to understand the capability of the community to meet financial commitments. Again, these will be unique to the community itself, and will vary according to numerous factors, as stated in the HNA.

This financial capacity assessment (FCA) should identify the range of incomes that may be generated by individuals and families within the community, and how financial transactions take place. For example, some communities dependent on agricultural labour may have a seasonal capacity to pay, and therefore may find it difficult to make regular contributions. Some communities may only deal in cash in hand, whilst others have access to bank accounts and credit.

It is likely that the communities will have some form of financial transaction infrastructure in place, such as a microfinance scheme. Therefore, understanding the financial mechanisms and level of income generation capacity is best conducted through these channels, for example the organisation that manages the microfinance scheme. They are best placed to understand the financial situation of their clients.

## 4.3.2 DEVELOP THE BUSINESS CASE

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Based on the assessment of the particular nature of healthcare need and capacity to generate income, a draft business case should be developed, and guided by this implementation guide. This will involve deciding the range and nature of income generation from the community, and the particular level of services that will be offered.

The business case may also consider timing of income and services, and critical points of sustainability in the scheme. Sensitivity and risk analysis may also be introduced to

The business case should have the rigour of a full business plan, and quantify all aspects of how the scheme will operate both initially and in the longer term.

It may be decided at this stage that the model is simply not feasible in the long term, or requires a level of initial subsidisation before long term sustainability can be achieved. This may be an important decision point about whether the programme should be aborted, or postponed until more favourable conditions are met.

### 4.3.2.1 ESTIMATE CASH FLOW REQUIREMENTS

It has been observed that micro-finance schemes have taken 5 years to achieve success. It should therefore be expected that a REACH scheme may take a similar time period to achieve the status of financial stability and sustainability. An understanding of the financial implications to achieve this point is therefore vital, and that the cash flow status of the scheme is planned very carefully.

In addition to an “operational” business case, which lays out how the scheme would deliver sustainable healthcare on an ongoing basis, a plan for initiating the scheme, laying out the cash flow requirements, is equally necessary.

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The objectives of the cash flow assessment is to determine the full amount of seed funding that would be required to take the scheme to a point of full sustainability. Initial cash flow is required both for initial investments in the development of the scheme, and also, potentially, to subsidise any shortfalls between cost of provision and income generation in the short term.

In particular, the following elements should be considered and built into the business case:

Area	Details of potential costs	Timing
Health Needs Assessment	Recruitment of personnel qualified to conduct needs assessment, plus travel, research costs, report writing	Initial phase
Financial Capacity Assessment	Recruitment of personnel qualified to conduct a financial capacity assessment, plus travel, research costs, report writing	Initial phase
Project management	Personnel to develop business case and manage implementation. Time, travel	From initial phase to full launch, maybe beyond
Recruitment of HCWs	Identifying, hiring, relocating (if necessary)	Few months pre-launch
Training	Identifying and developing suitable training locations and materials, training personnel	Immediate pre-launch
Equipment and administration	Initial investment in equipment, uniform, paperwork, stationery, etc. to get HCWs and organisation fully equipped	Immediate pre-launch
Communication materials	Development of suitable materials for communicating scheme to community, including branding, materials, signage	Immediate pre-launch

### 4.3.3 DEVELOP A MARKETING AND EDUCATION STRATEGY

A key element of the implementation of the scheme is the communication of the scheme to the community itself. What does the organisation itself need to learn and accept about the scheme? What is required to ensure that communities to buy into the concept of the scheme and are willing to make regular contributions?

The initial stage of communication must be with the organisation itself. Unless the organisation has a good grasp of the scheme's concept and participants fully accept the nature of the scheme, it will be impossible for the organisation itself to communicate effectively with the community.

Healthcare education is critical to the success of the project. Because the scheme relies on compulsory contributions from all community members, it will be vital that all members fully support the scheme. Therefore, all members will need to understand the implications of the scheme – that for many, they will not personally see the benefit of the scheme in the short term, and that it is primarily for the benefit of the community as a whole. A comprehensive healthcare education programme must be a key component of implementation.

Where contributions from membership is "compulsory", a democratic process may also need to be implemented to accept the whole organisation's buy-in to the scheme. However, there may need to be some flexibility for certain groups. The extent of the flexibility permissible will need to be carefully judged, so that the scheme is acceptable, but does not introduce too much adverse selection. It may be that the number of groups required to participate is set at a minimum.

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It is vital that the community has a level of maturity to be able to consider the concept of investment into a scheme from which they may not immediately benefit from, and accept the compulsory nature of the scheme. There also needs to be a level of financial stability in the groups. Financial stability may be judged through the repayment rates and levels of interest charged in a self help group, for example. However judgment of “empowerment maturity” may be more difficult.

The nature of communication to the community will depend on accepted cultural practices. This may be through literature (if it is a literate population), town hall meetings, drama, music, personal presentations, mobile phone texting, or whatever media is considered normal for the community. Communication should also be two-way and there should be the facility for the community to feedback ideas and challenges about the scheme, and for the community to inform development of the scheme.

## 4.4 IMPLEMENT THE PLAN

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### 4.4.1 OBTAIN SEED FUNDING

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In order to deliver the plan, funding must be first secured to deliver the preparation for the scheme. Sources for such funding are not covered in this document, but potential donors will find the scheme much more attractive if it is based on a solid business case with a clear indication of the level of funding required, and the level of risk involved.

### 4.4.2 ESTABLISH ADMINISTRATION

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The mechanisms for administering the scheme must be considered and implemented. It is likely however, that financial administrative schemes are already largely in place, for example, mechanisms for collection of funds from microfinance schemes. Therefore, the design of the administration should utilise as much of the existing mechanisms as possible.

Nevertheless, implementation of administration may require the generation of new processes, forms and templates, establishing new bank accounts, and potentially hiring additional administrative staff.

### 4.4.3 PURCHASE EQUIPMENT

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As for the establishment of administration, the scheme will require an initial supply of equipment for the HCWs and other services. A list of requirements should be included within the business case, then procured when funding is available.

It may also be important to establish processes for renewal of equipment, management of stocks for disposable items (such as bandages, pharmaceuticals), contracts for mobile phones, and maintenance schedules.

### 4.4.4 RECRUIT AND TRAIN HCWS

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Selection of suitable HCWs and local healthcare professionals is clearly another key aspect of implementation of the plan. Carefully thought through profiles should be produced for any staff or contractors potentially participating in the scheme. These profiles should take into account the local

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health needs of the community, the likely levels of remuneration offered, local availability of individuals with certain levels of education, experience, qualifications and skills.

Furthermore, recruitment of HCWs may also need to consider the personality of candidates, as well as their standing within the local communities themselves. It should be recognised that there may be a disconnect between the profile of the ideal candidate on paper (based on education and skill level) and the ideal candidate in the eyes of the community (based on reputation and social standing), and therefore recruitment will require careful balancing of these two factors.

Following recruitment of either HCWs or healthcare professionals, a suitable training programme should be designed and delivered with appropriate local partners. Such a programme should take into account the current level of qualification and experience, and the required level of experience dictated by the level of healthcare need for the community.

Training programmes should not only be considered following recruitment, but also on a regular basis in order to maintain continuing professional development.

## 4.5 MONITOR PROGRESS

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A REACH scheme that has been established successfully needs to be continually monitored to ensure that problems are addressed quickly and efficiently, and that the scheme evolves as the needs of the community evolves.

### 4.5.1 REVIEWING OPERATIONAL EFFECTIVENESS

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A key element in the administrative implementation is to establish good monitoring mechanisms. This may involve engaging with stakeholders at regular intervals to gauge level of progress or identify problems, and establishing measures and key milestones.

One of the key measures will be monitoring on a regular basis the state of financial sustainability. It is vital that initial seed funding is sufficient to take the project to a point of self-sufficiency, and therefore any unanticipated variation from the plan needs to be addressed quickly.

### 4.5.2 REVIEW ONGOING HCW TRAINING AND HEALTHCARE SERVICE PROVISION

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In addition to operational and financial effectiveness, healthcare monitoring is equally vital. Such monitoring should ensure that all providers are delivering to the agreed level of quality expected of them (through review of their clinical practice), and that any future training needs are identified and actioned through the provision of additional training.

Such monitoring may also highlight poor practice, so that it can be addressed quickly before adverse effects are noted in the community. This may involve the ending of contracts, or the replacement of HCWs.

Part of the monitoring process may involve collection of healthcare data and enabling the scheme to quantify its healthcare impact on the community.

### 4.5.3 WHAT IS YOUR EXIT STRATEGY?

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A third key role for monitoring should be measuring the overall value of the scheme to the community itself. The fundamental purpose of the scheme is to provide the community with effective healthcare services. If the scheme fails to do so, through providing poor or inappropriate healthcare, or where viable healthcare is available from an alternative source for the community, or the scheme cannot maintain sustainability, then consideration should be given to closing the scheme.

Therefore, the scheme should be constantly monitored with respect to it delivering its objectives, and there should be clear rules for how a failure of objectives should be handled. Setting a clear exit strategy will help both the community and organisation to be clear with each other if the scheme fails to deliver on its promises, and prevent unnecessary waste of the community's valuable resources.

## 5 GLOBAL SUPPORT: REACHVISION

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### 5.1 THE NEED FOR GLOBAL SUPPORT

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As an increasing number of REACH models are developed, so will grow the need for a supporting infrastructure. "REACHVision" is our model for the infrastructure required to ensure that the concept of REACH is implemented effectively in a diverse range of communities.

The strategic purpose of REACHVision is to provide four core services:

1. To develop the concepts of REACH so that programmes can be implemented effectively in a wide variety of situations, and that there is constant improvement in the effectiveness of existing REACH programmes.
2. To develop partnerships with NGOs in implementing REACH programmes successfully
3. To develop resources to help interested parties obtain seed funding for initiating REACH programmes without incurring significant financial difficulties
4. To publicise widely the concept of the REACH programme in order to encourage greater uptake and also generate funding to support core activities and seed funding generation

#### 5.1.1 DEVELOPING THE CONCEPT OF REACH

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REACHVision has developed a model for sustainable healthcare and piloted an implementation through the Bridge Foundation and CRED. However, the numerous lessons learned from this pilot implementation should be utilised to ensure that future implementations are more effective and efficient.

It is also important to recognise that implementations in other environments will have different needs, and therefore REACHVision will develop understanding for how plans would need to be adapted for each environment.

Furthermore, it is anticipated that successful REACH schemes will seek to develop more comprehensive and sophisticated services. REACHVision will support the development of programmes to ensure that growing and changing health needs of communities can be met through REACH.

#### 5.1.2 PARTNERING REACH IMPLEMENTATIONS

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REACHVision will provide detailed guidance on every aspect of support for NGOs seeking to establish a successful REACH programme. This will be in the form of documentation, such as this implementation guide, and on-site facilitation.

REACHVision will also recruit and deploy medical supervisors who will provide regular training and monitoring of REACH programmes to ensure that the high quality standard of healthcare offered is met.

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Financial sustainability is a key element of a REACH programme, and REACHVision will work closely with NGOs to ensure a sound financial plan is developed and adhered to.

## 5.1.3 SOURCING AND FACILITATING SEED FUNDING

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REACHVision recognises that REACH programmes require reasonably significant seed funding to enable Health Care Workers to be recruited and to ensure that expenses are met before the scheme reaches full sustainability. Therefore, REACHVision will work with groups to help them raise the required funds to ensure that NGOs are not financially burdened by the programme.

## 5.1.4 PUBLICISING REACH

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REACHVision will ensure that the concepts and successes of REACH programmes reach a wide audience. This publicity is for two primary reasons:

1. To maximise the uptake of REACH programmes across communities
2. To reach out to sources of funding and other resources for REACH schemes.

REACHVision will establish appropriate communication channels, such as through the Internet, to maximise exposure to the concept, and also develop and maintain a network of individuals and organisations actively engaged in or wishing to be engaged in REACH.

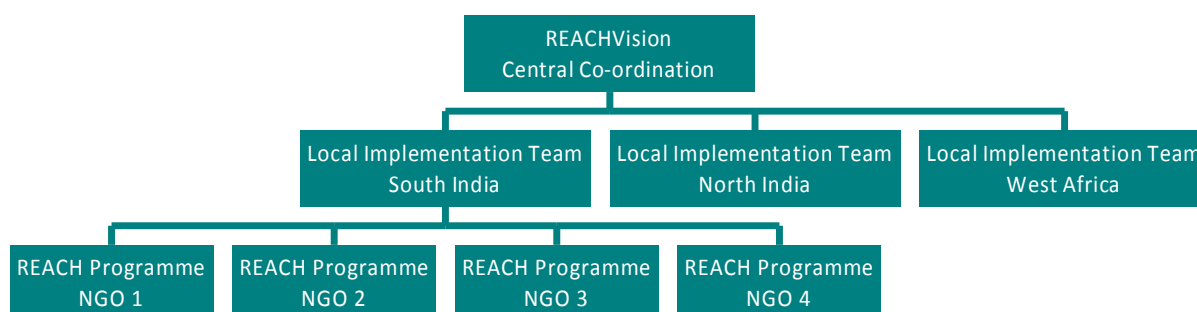
## 5.2 ORGANISATIONAL STRUCTURE OF REACHVISION

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REACHVision will consist of a central co-ordinating team and numerous, geographically defined local implementation teams.

The primary role of the central co-ordinating team will be fund raising and management, publicity and promotion, and development of centralised expertise that is distributed across local implementation teams

The role of each local implementation team is to provide locally appropriate clinical supervision, implementation support for new programmes, monitoring and oversight of existing REACH programmes, and identification of potential new organisations. The precise geographical scope of a single local implementation team is yet to be determined, but will depend on the density of REACH programmes and the level of input each requires.



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## 5.3 THE REACHVISION BUSINESS MODEL

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We intend that REACHVision operates not as a charity, but as a sustainable enterprise with social and healthcare objectives.

The primary costs identified in running REACHVision will include all employment and running costs of local implementation teams and the central team.

Initially it is anticipated that REACHVision provides support in sourcing seed funding donors. However, it may be possible that in the long term, REACHVision may establish its own loan fund, from which additional income may be generated.

The value of REACHVision is also found in its intellectual property developed through experience of implementing REACH programmes. Over time, this will become a valuable asset to sell consulting to organisations wishing to implement REACH. This may be in a number of alternative forms:

- A fee may be charged to organisations to cover costs of implementation of a REACH programme, ongoing monitoring or any other services provided by REACHVision
- A percentage of the interest payment from seed fund loans to organisations may be taken
- An administrative fee may be charged to potential donors who wish to give or loan funds to organisations for seed funding a new REACH programme

Additionally, REACHVision may consider investing in an equity stake of REACH programmes that are run as sustainable enterprises. This clearly depends on the ownership model of such schemes, and is an area requiring further development.

## 5.4 SPECIFIC REACHVISION TARGETS

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An initial goal for REACHVision is to establish a network of REACH programmes through South India, building on what we learned from the initial pilot. A realistic estimate of the number of communities, HCWs and medical supervisors that could be placed across South India might be as follows:

	2008	2009	2010	2011	2012
# new REACH programmes			1	3	5
# NGOs running REACH programmes	1	1	2	5	10
# HCWs	10	10	20	50	100

## 5.5 REQUIRED RESOURCES

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### 5.5.1 LOCAL IMPLEMENTATION TEAM

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It is initially envisaged that REACHVision will begin with the development of one local implementation team in South India. Although the vision for multiple local implementation teams exists, the target numbers are based on the assumption of the development and growth of one local implementation team.

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In order to initiate the development of a local implementation team, it is suggested that a local management committee be established to regularly monitor and manage the REACH programmes. Members of the committee may include senior managers from The Bridge Foundation or other participating organisations, representatives of local healthcare support, and REACHVision members.

The key roles that will be required at a local implementation level will include:

- Local implementation lead to co-ordinate activities and manage staff, including medical supervisors
- Communication of programme activities with the central co-ordination team
- Employment of medical supervisors to provide training, monitoring and oversight of HCWs. We estimate that we would need one medical supervisor for every 60 HCWs
- Additional implementation staff to establish and monitor programmes from a financial and organisational perspective. Assuming that the local implementation lead would initially perform a similar role, we estimate that we would need an additional implementer for every 8 REACH programmes

### 5.5.2 REACHVISION CENTRAL CO-ORDINATION

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Support from REACHVision central co-ordination is anticipated to come initially from volunteers or part time individuals. However, the following roles would be required:

- Operational strategy lead to oversee development of REACHVision, ensuring it has appropriate resources and structure to meet the needs of the REACH programmes
- Clinical implementation lead to oversee development of healthcare standards, and support recruitment and equipping of medical supervisors
- Financial implementation lead to oversee development of financially sustainable REACH programmes
- Promotional lead to develop and publicise REACH to wider audiences
- Fund raising lead to generate donations for operating expenses and seed funds (this is likely to be a paid position and would not hold trustee status)

It is anticipated that all roles would be required from the outset. It is not envisaged at this stage that further support would be required within the time period, though this should be subject to regular review.

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## 6 FURTHER RESOURCES

### 6.1 CRED PILOT KEY DOCUMENTS

The following list are documents generated before and during the CRED pilot phase. These files can be found in the **CRED Pilot** folder.

Resource	File name	Notes
Original proposed model	REACH – draft 5.doc, REACH – draft 5.xls	This was the original business model proposed to the Bridge Foundation, and from which the CRED pilot was developed
Proposed schedule of villages per HCW	REACH Program.doc	The proposed allocation of HCWs to villages
Financial planning	REACH HCW Analysis – 2007-05-19.xls	The spreadsheet outlining the proposed financial plans and cash flow for each of the HCWs
Review of clinical position	REACH India – Clinical May 07.doc	Assessment following visit to Vadipatty at launch of programme, of clinical requirements for HCWs
Evaluation report	Evaluation report.pdf	Clinical evaluation of programme following six months of implementation
Recommendations	Recommendation.doc	Recommendations following evaluation report
Visit report	REACH visit report – April 2008 v10.doc	Observations and recommendations of programme following visit by Tim and Suzanne Lyttle, and Martin Morse one year after launch
Second evaluation report	REACH_EVAREP.doc	Second evaluation conducted by CMC Vellore two years after launch

### 6.2 TEMPLATES

The following list useful templates to support a REACH implementation. These files can be found in the **Templates** folder.

TO BE DEVELOPED

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## 7 APPENDICES

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### 7.1 APPENDIX 1 – DETAILED LIST OF HCW SERVICES

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TO BE COMPLETED

### 7.2 APPENDIX 2 – DETAILED LIST OF HCW EQUIPMENT

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TO BE COMPLETED

### 7.3 APPENDIX 3 –PRESCRIBING AREAS AND MEDICINES APPROPRIATE FOR HCWS

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TO BE COMPLETED