Understanding Healthcare Social Enterprises: A New Public Governance Perspective

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Abstract

In recent years 'social enterprises' have become important partners in the delivery of key public services such as healthcare. However, little is known about how healthcare social enterprises contribute to public service provision in the health sector. We analyzed 172 social enterprises from four continents involved in healthcare to assess the types of interventions, processes, and roles they play responding to rapidly evolving healthcare systems. We found that they are engaged broadly in three dimensions of health service provision: improving access to health services; improving the quality of health services; and building public health capacity. We contribute to social policy theory by enhancing understanding of the micro-level interventions of social enterprises in the healthcare sector and articulating new dimensions of NPG that include co-innovation, co-lobbying, and co-integration in the context of healthcare.

Keywords: social enterprise, healthcare, health, intervention, New Public Governance

Introduction

Healthcare has become an increasingly complex and intricate policy area and the recent responses precipitated by the COVID-19 outbreak have strained health systems worldwide, raising concerns about the capacity of public health systems to respond to the virus. Reassuringly, we have also witnessed a wave of solidarity, mutual aid, and collaborative efforts initiated by civil society actors and grassroots innovators to generate community-based responses, such as producing locally made hand sanitizers and supporting local workers and families most affected by the virus. A global health emergency like the COVID-19 pandemic has revealed an urgent need for a profound re-examination of the ways in which health and healthcare are organised and managed, involving the public, private and third sectors to tackle health and social care issues. Under these circumstances, New Public Governance (NPG), which has highlighted the increasing involvement and engagement of civil society actors in policy and service delivery (Jenson, 2017; Mendell, 2010), has become an important lens through which the management of public services, in the era of collaborative governance, can be understood (Osborne, 2010; Lindsay *et al*., 2014).

In recent years, there has been an increasing interest in the role of social enterprises[1] – a type of enterprise that seeks to create public benefits (e.g., Chandra and Paras, 2020;

[1] There is no single definition for 'social enterprise' as the field lacks a unifying paradigm and the boundaries are fuzzy. In the business literature, social enterprise is characterized as hybrid organization that combines social and commercial logics (Battilana & Lee, 2014). In social work and non-profit studies, it is also defined as social work and non-profits embracing business practices (Eikenberry & Kluver, 2004; Gray et al., 2003). In development studies, it is defined as an alternative development model (Venot, 2016). In public administration, it is seen as hybrid organization that mixes the characteristics of the state, market and civil society (Brandsen and Karre, 2011). In political science, it has been seen as a tool to enact social change (Ganz et al., 2018). Hoogendoorn et al (2012) has offered a rich analysis of the different schools of thoughts in social entrepreneurship: The American School (innovation vs enterprise school) and the EMES and UK approaches. While there are no strict boundaries between them, they all share common characteristics, which is the emphasis on creating social value (Hoogendoorn et al., 2012). Social enterprises have been financed and established by individuals, non-profits, for-profit companies, as well as governments.

Defourny and Nyssens, 2010; Kerlin, 2013; Mendell, 2010; Roy *et al*., 2013) using business strategies. While social enterprises operate in various fields of work, they have played an increasingly significant role in the provision of healthcare services (Mazzei *et al*., 2019; Miller *et al*., 2012). In this article, we use the term *healthcare social enterprises* (HCSEs) to refer to those social enterprises that work primarily in the provision of healthcare. With an increasing emphasis on inter-organisational relations in policy delivery embedded within the NPG approach, HCSE has been framed as an ideal civil society business model that can provide alternative and effective ways to deliver healthcare services and, in places where the state has traditionally provided the majority of healthcare services, can compensate for the withdrawal of the state somewhat from direct welfare provision through community-based action (Macaulay *et al*., 2018).

However, despite an increasing interest in the promise of HCSE in engaging a collaborative approach to influence health services production and delivery under the NPG framework (Barraket and Yousefpour, 2013), there is a dearth of understanding of what HCSEs actually *do* (i.e., their 'interventions' – see Craig *et al.*, 2008) and the nature of their collaborative relationships with other actors, especially the public sector, in these processes. The few articles on social enterprise in relation to health have been primarily *conceptual* (e.g., Ferguson, 2012; Roy *et al*., 2014; Roy *et al*., 2018) or have used a *case study approach* with single or a few cases, in which the findings offer limited insights into larger number of cases or wider contexts (e.g., Macaulay *et al.*, 2018; Farmer *et al*., 2016). Very little research has examined the contributions of HCSEs in the cross-sectoral and inter-organisational deliberations within the public sphere from the perspective of NPG. In other words: to date, we know little about the interventions, processes, and roles of HCSEs in facilitating public value creation (Moore, 1995), and how and where HCSEs come into the picture of being involved in health service production and delivery. Therefore, in this study, we asked an important

question: *How do healthcare social enterprises (HCSEs) contribute to public service provision in the health sector?*

New Public Governance and Healthcare Social enterprises

In the past two decades or so, public sector institutions have become more reliant on interdependent relationships with the private sector and civil society actors to address public policy problems (Elliott and Salamon, 2002). New Public Management (NPM), which represented an attempt to make the public sector more business-like and to improve the efficiency of the public sector (Ferlie *et al*., 1996), has been criticised for its limitation and narrow focus in capturing and contributing to the management and governance of public services delivery (Osborne, 2010). Scholars argued that the intra-organisational focus of NPM could not reflect the inter-organisational and interactive nature of contemporary public services provision (Lindsay *et al*., 2014).

In contrast to NPM, NPG, which is rooted within organisational sociology and network theory, acknowledges the plural and pluralist worlds and the increasingly fragmented and uncertain nature of public management (Brandsen *et al*., 2013). NPG captures a shift in the roles and responsibilities of bureaucracies and the engagement of private agencies, civil society organisations, and citizens which, in part, is due to demands for better-quality services, the drive for efficiency and the shrink in the budgets for some public services (Osborne, 2010). NPG recognises: the broad range actors involved in service delivery, including individuals and organisations; diverse processes of service delivery; and emphasises how services are increasingly 'co-produced' in collaboration with stakeholders (Lindsay *et al*., 2014; Mazzei *et al.,* 2019).

Co-production refers to the involvement of individuals and organisations in collaborating with government agencies in both the design and management of services as well as their delivery (Howlett *et al.*, 2017). Co-production is closely linked to the concept of value co-creation (Osborne, 2018) where value is co-created with users. A service creates value only when users interacts with the service (Osborne, 2018). Co-creation concerns service experience, not just its delivery.

In the past decade or so, third sector organisations (TSOs) have played more active roles as co-producers of a range of public services in many countries. These new forms of relationship represent alternative ways of harnessing the capacities of various partners, bringing about innovative responses to complex social issues (Brown *et al*., 2013) and offering a potentially sustainable solution to public problems (Hall *et al.*, 2012). For policymakers, the involvement of TSOs in co-producing public services can ensure more specialist services shaped to the needs of users with complex issues (Teasdale and Dey, 2019) and also strengthen the 'contestability' between possible providers in social service provision markets (Brandsen *et al*.,2013).

In relation to healthcare social enterprises (HCSEs), existing literature suggests that social enterprises are symbolically legitimate in a predominately neoliberal era, given that these organisations employ business principles in the service of some form of 'social good' (Dart, 2004). Social enterprise is characterised as a complex entity that has the characteristics of public, private, and non-profit sectors (Brandsen and Karre, 2011; Calò *et al*., 2018; Defourny and Nyssens, 2010; Chandra and Paras, 2020). The complex nature of social enterprise is further enriched by the heterogeneity of its organizational forms, operating models, fields of work, the involvement of public sectors in public and social services in different country contexts. Scholars have highlighted how historical context that drives social enterprises

emergence differs across countries and regions (Chandra *et al*., 2021; Defourny *et al*., 2020; Kerlin, 2013) which include welfare governance, civil society structure, legal and tax system as well as regimes of support for social enterprises which include the government, foundations, incubators, and umbrella organizations that support social enterprises including Ashoka.

From the perspective of NPG, social enterprises are conceptually interesting to study due to their 'hybrid' nature (Battilana and Lee, 2014), which allows them to bridge business and civil society functions, drawing on different 'institutional logics' (Battilana and Lee, 2014) and recognises their increasing role in policy arrangements and service delivery (Millar and Hall, 2013). To date, some forms of social enterprise have become active agents for public service delivery, either directly on behalf of the state, or in response to the gaps produced by the shrinking of the welfare state (Roy *et al*., 2014). A social enterprise approach which marries public service and business models arguably improves their organisational sustainability, as well as the quality of services delivered (Powell *et al*., 2019). Nevertheless, managing hybridity can be challenging. Scholars have cautioned against the negative aspects of hybridity, including the potential financial, cultural and political risks (Brandsen and Karre, 2011) and mission drifting (Ebrahim *et al*., 2014).

An Overview of Healthcare Social Enterprises

One reason for the growing interest in social enterprise is its involvement in the provision of health services in places where healthcare has traditionally been considered as the responsibility of government (and, indeed, in places where the third sector or private for-profit sector is the dominant mode). Prior research has widely discussed the potential of social enterprises to improve the health and well-being of individuals and communities (e.g., Roy *et al*., 2014; Farmer *et al*, 2016), broaden opportunities for social connection (Farmer, 2020), and empower disadvantaged people to make choices (i.e., Chandra and Shang, 2021). In particular,

extant studies have uncovered that the functions of HCSEs as a socially innovative response to complex health issues are two-fold.

First, HCSEs have been regarded as an *alternative mode of delivery of healthcare services* in some jurisdictions, responding to gaps in mainstream service provision (Roy *et al*., 2013). For example, in the United Kingdom, the government has facilitated the development of social enterprises to deliver health and social care and has transferred some National Health Services (NHS) to social enterprise 'spinouts' (Hall, *et al.*, 2012; Roy *et al*., 2013). NHS employees were given a 'Right to Request' to set up 'social enterprises' to deliver community health services as part of a purchaser-provider split (Miller *et al*., 2012; Hall *et al*., 2012). In these cases, social enterprises have been viewed by policymakers as a vehicle within the formal healthcare system to offer higher levels of innovation, cost-efficiency and responsiveness to societal needs (Allen, 2009). Similarly, in Italy, 'social cooperatives' have been increasingly involved in delivering medical and healthcare services as an innovative approach to reducing costs of public health expenditure (Borzaga and Fazzi, 2014). However, in so-called 'developing' and 'less developed' countries – often characterized by market and the government failure in the healthcare services – the contribution and roles of healthcare social enterprises is relatively unknown.

Secondly, social enterprises also impact the health and wellbeing of individuals and communities by *addressing social determinants of health*: the factors in the social environment which shape how people are born, grown, live, work and age (Solar and Irwin, 2010). Existing studies have pointed out that social enterprises also play a role at addressing the individual and daily living conditions that will eventually create, enhance and improve the physical, mental and social well-being of individuals (Roy *et al*., 2013; Mason *et al*., 2015). For example, through engaging disadvantaged people in meaningful employment, social enterprises that

provide work-integration opportunities have been effective in improving beneficiaries' mental health, self-reliance/esteem, health behaviors, life satisfaction, and social relations (Krupa *et al*., 2019). Importantly, research has also found that activities delivered by social enterprises can support improvements in physical activity and decrease depressive symptoms (Calò *et al*., 2019).

Overall, prior research has pointed out the two (quite separate) functions of social enterprises in improving health and well-being of individuals: either directly engaging in service provision; or in addressing social determinants of health (Farmer *et al*., 2016; Roy *et al*., 2014; Calò *et al*., 2019). However, despite the growing interests on the contributions of HCSEs, research that has adopted an NPG perspective has largely focused on their role as direct service providers (i.e., Pestoff, 2012), while ignoring other possible contributions of social enterprise in public service management. Moreover, extant studies in the NPG context have mainly adopted a public sector perspective by investigating how governments collaborate with different actors in the design, management, and delivery of public services (i.e., Pestoff and Brandsen, 2010; Lindsay *et al.*, 2014). Crucially, previous research has not considered the micro-level interventions of HCSEs in a sufficiently broad context, and has also insufficiently dealt with the heterogeneity of social enterprises (Macaulay *et al*., 2018). Different historical antecedents (Defourny *et al*., 2020; Kerlin, 2013) may result in different models and functions of healthcare social enterprises, however we do not seek to theorize about antecedents of country or regional differences in the work of HCSEs. Rather, we seek to explore what HCSEs do, and their contributions.

Methodology

To answer the research question, we conducted a qualitative content analysis, combining a qualitative grounded theory approach (Glaser and Strauss, 1967) with the Gioia methodology

(Gioa *et al*., 2013) using open (first-order), axial (second-order), and selective (aggregate dimension) coding to analyze a sample of 172 social entrepreneurs whose organisations operate in healthcare-related sector to unpack their interventions and contributions in tackling healthcare challenges.

Sampling

Our sample came from HCSEs that have been supported by Ashoka, Schwab and Echoing Green (see Supplementary Material). These organisations are among the world's largest platforms supporting social entrepreneurs at country, regional and global levels. As such, although they could not be said to be representative of *all* social entrepreneurs, nor, indeed, social enterprises everywhere, they provide an excellent cross-section and a useful repository of information for systematic analysis of this kind. The HCSEs supported by Ashoka, Schwab and Echoing Green are selected using rigorous criteria (see Supplementary Material).

From this we retrieved the organizational profiles of those Fellows and focused on their *interventions* to address healthcare problems. The "profiles" formed the core of the data analyzed in this article. The profiles were written and maintained by the three platform organizations respectively based on interviews with social entrepreneurs and presented in unified formats on their websites. Ashoka had more than 3,000 Fellows as of November 2016 and categorised its Fellows into six fields of work – civic engagement, economic development, environment, healthcare, human rights, and learning/education. Out of these Ashoka Fellows, there were 388 (or 12.9%) working in the healthcare field. The Schwab Foundation, by the time of data collection (November 2016), had a total of 325 Schwab Fellows in different fields of work, with 93 of them (28.6%) working in the health sector. Echoing Green had 582 Fellows by 2016, across various fields of work with 84 of them (or 14.4%) working in the health sector.

From this population of 565 (388+93+84) HCSEs, we randomly selected 60 from each platform organisation. Using a random generator in R (a programming language), we randomly selected 60 out of 388 Ashoka HCSEs. We repeated the same sampling process for Schwab and Echoing Green HCSEs. Due to some data overlap (8 cases), because some social enterprises were affiliated with more than one platform (e.g., being both an Ashoka and Schwab Fellow), we ended up with 172 unique cases in the analysis, in which 60 from Ashoka, 55 from Schwab, and 57 from Echoing Green). The sample breakdown (see Supplementary Material) shows how the samples were spread across Africa, Asia, Europe, South, Central and North America.

Qualitative Data Analysis

The 172 randomly selected Ashoka, Schwab and Echoing Green *intervention texts* extracted from the websites were imported into computer-assisted qualitative data analysis software (CAQDAS) for analysis. Before the actual analysis, two research members coded five profiles on Ashoka HCSEs and manually read each of them to become familiar with the nature of these narratives. In the actual analysis, two research team members conducted qualitative "open coding" (Corbin and Strauss, 1990) on these intervention texts independently. The open coding process was iterative and extensive and generated 1162 first-level (and highly detailed) codes for the HCSEs interventions (e.g., *used hospital halls and waiting rooms as classrooms to educate patients and their families*).

Developing the coding structure in an iterative fashion, involving eight meetings over an 18-month period, we reached a consensus with regard to the topics and themes apparent from the data. We combined all first-level codes into 10 second-order categories (e.g., *enhancing social and economic competence through skills development*), and finally reduced them to three aggregate dimensions (e.g., *improving quality of health services*). In doing so, we cycled between the codes and the literature (Gioia *et al*., 2013) to make sense of the findings

and to better ground them in existing research. We present our findings using "power quotes" whenever necessary to highlight salient points, increase understanding, and increase the credibility of our findings.

Findings

Our study revealed the HCSEs have worked on three different dimensions to improve the health and well-being of individuals and communities, which are: 1) *improving access to health services*; 2) *improving quality of health services*; and 3) *building community health capacity*. Each is discussed in turn.

Improving Access to Health Services

Firstly, *improving access to health services* includes strategies to improve *availability*, *accessibility*, and *affordability* of health services so that more people would have access to health resources. In doing so, HCSEs have interacted with a wide range of stakeholders including communities, health workers, governments and business sector and made efforts in four aspects: 1) *filling the gaps in health service provision*, 2) *connecting patients to existing health providers*, 3) *strengthen healthcare workforce*, and 4) *lowering prices for health services*. The findings suggested that the roles and functions of HCSEs are multi-dimensional and operate with diverse stakeholders at different levels (i.e. individual, community, public policy levels) in their interventions.

Filling the gaps in health service provision

The most common intervention employed by HCSEs to improve the accessibility of health services is providing health services *directly outside* public health systems to fill institutional voids. These gaps might be caused by shortages of healthcare professionals, inaccessible geographic areas of residence or strict working hours to see a doctor. Through delivering

community-based health services directly to people in need, HCSEs compensate for inadequate health services provided by public institutions. Some HCSEs have developed online platforms for *online health consultations* (e.g., CIES by Ashoka Fellow Roberto Kiwaka, Brazil). Moreover, to address the issues of lacking availability of health services in rural areas, some HCSEs in our study provided flexible *mobile clinic services* for treating isolated and vulnerable groups, as noted in the profile of the Echoing Green Fellow Christopher Ategeka (Uganda), founder of Rides for Lives:

> *"We [Rides for Lives] manufactured locally sourced medical vehicles with the mission of improving medical access to those that are the most vulnerable… Our mobile Health unit is a refitted bus that contains three different medical stations: a pharmacy that is attended by a full-time pharmacist, a lab that has the ability to carry out different medical tests, and a medical station staffed by a full-time general health practitioner to see patients daily"*

Connecting patients to health providers

Second, connecting patients to health providers operates as a form of intervention by acting as a *bridge* between patients and health providers. In doing this, some HCSEs have collaborated with health professionals directly by building a network that integrates health workers with different specialties, so that patients with fewer networks could find suitable doctors and seek medical advice more easily than before. One example is the Commonwealth Care Alliance (by Ashoka Fellow Robert Master, United States) that connected patients with a team of physicians and nurses to provide medical assessments, intensive medical and behavioral healthcare, and social support services in the home and community. Some HCSEs provided *referral services* by referring patients to health facilities to ensure that they receive the best possible care at the appropriate level. Other HCSEs recognised a lack of transportation as a key problem facing

disadvantaged populations and provided *transportation services* using boats or modified bikes as ambulances to transport patients to health providers. An example of this was a ship ambulance provided by Friendship by Schwab Fellow Runa Khan (Bangladesh).

Strengthening the healthcare workforce

The HCSEs also engaged in *strengthening the healthcare workforce* by empowering community and local health workers, many of whom lack sufficient supervision and health training, through a series of training programs. They have employed multifaceted strategies to increase both the quantity and quality of community health workers through training, mobilisation and empowerment. For instance, some HCSEs *trained villagers* to become community health workers to provide primary care in their villages to reduce the burdens of public health institutions. As quoted from a Schwab Fellow, Sakena Yacoobi (Afghanistan), founder of Afghan Institute of Learning (AIL):

> *"Working with the Ministry of Health, AIL trained community health workers (CHWs) who are chosen by the villagers… CHWs refer villagers to the clinics, give first aid…and give health education… The CHWs program has been very successful in being a point of triage taking care of some things that do not need clinic care which relieves clinic numbers and…helps prevent illness in the first place"*

Lowering prices for health services

Another HCSE intervention was to improve the *affordability* of health services by lowering prices for health services and products and improving health financing systems. This intervention typically comes in two forms: *self-manufacturing and policy reform*. For instance, some HCSEs in our study partnered with medical companies in developing and manufacturing health products and medicines and offered them at lower than market price. Others advocated

for *health policy reforms* to lower healthcare costs, such as the work of Network Access to Essential Medicines by Ashoka Fellow Simon Kabore (Burkina Faso) that: "*[We] built a coalition to lobby the government to provide antiretroviral drugs at zero cost, which it was receiving for free from an international donor, but selling to HIV positive citizens for 8,000 cfa (US$16.75) per month*".

In addition, we identified that some HCSEs in our study have developed pro-poor health financing schemes such as providing *low-cost health insurance* in partnership with insurance companies and other stakeholders to promote health coverage of poorer communities (e.g., Naya Javeen by Schwab Fellow Ansher Hasan, Pakistan).

Improving the Quality of Health Services

The HCSEs collaborated with a wide range of stakeholders such as health professionals, medical scientists, and governments to improve the quality of health service delivery. There are three major interventions to achieve this: 1) *optimising treatment options through innovations*, 2) *strengthening the capacity of health professionals*, and 3) *monitoring health service performance*.

Optimising treatment options through innovations

Providing more choice to existing health providers to improve the quality of their health services was also a key approach. This innovation can take place at different levels: the health product or service, the process of service delivery, and health system management method. For instance, some HCSEs focused on developing *new disease detection and prevention systems* such as the work of Alois (by Ashoka Fellow Bénédicte Défontaines, France) that offered integrated services of early detection, psychological support, risk prevention, medical care, and palliative care for patients. Other examples include utilising information communication

technology and other advanced technologies to improve healthcare management systems particularly in organising patient-related medical or healthcare data in health institutions. For example, Koe Koe, Echoing Green Fellow Michael Lwin (Myanmar), developed a health information system for various Myanmar hospitals to track patients, and mobile apps for doctors to access patient's information.

Strengthening the capacity of health professionals

We also found that the HCSEs developed close collaborations with health institutions and medical schools to empower in-service and future health personnel through education and training. For example, CISEPO, by Ashoka Fellow Arnold Noyek (Canada), combined education/training, research and service for medical students and professionals and whose curriculum have been used by 30 medical institutions. Moreover, some HCSEs have developed *online platforms* that integrate health professionals with different specialties at different levels and different geographical locations to facilitate *knowledge exchange*. For example, BE MORE, by Echoing Green Fellow Anurag Gupta (United States), developed an online training program to encourage the use of evidence-based medicine and improve physician-patient trust and communication.

Monitoring the performance of health services

HCSEs also acted as a *third-party evaluator* to monitor the performance and effectiveness of public health services. We found that some HCSEs have developed *new protocols* and standards for healthcare services to ensure that health services could be delivered effectively. The HCSEs also mobilised community volunteers as the watchdog in holding health providers accountable by verifying and monitoring medical treatment and care services at health institutions. This is well illustrated in Karuna Trust, by Schwab Fellow Sudarshan Hanumappa (India):

> *"Through the village council, the community is an active stakeholder participating in the planning and monitoring of the PHC's functioning instead of being a passive recipient of inadequate services… Village councils hold their PHCs accountable for achieving better health outcomes and functioning as zero-corruption zones"*.

Building Community Health Capacity

The last type of function performed by HCSEs we identified was in relation to *building community health capacity*. In doing so, the HCSEs employed three major interventions: 1) *improving public health knowledge and behaviors*; 2) *enhancing social and economic competence*; and 3) *strengthening community care and self-care capacity*.

Improving public health knowledge and behaviors

The HCSEs emphasised improving public health knowledge and promoting good health behaviors at both individual and community levels through collaborations with different stakeholders. For instance, some HCSEs partnered with schools and governments to deliver *public education* on health and hygiene. They adopted various media to disseminating health information through different media channels (e.g., documentation, social media platforms). For example, Félúton Alapítvány, by Schwab Fellow Csaba Kovács (Hungary), conducted partnerships with schools and businesses, and launched programs educating young people to address alcohol addiction. Other HCSEs employed *behavioral incentives* to stimulate change that enables low-income customers to purchase affordable fresh food (e.g., Wholesome Wave, by Ashoka Fellow Michel Nischan, United States).

Enhancing the social and economic competence of the public

The HCSEs implemented multiple interventions to provide skills, knowledge, and competencies that people require to become more independent and take greater control of their

lives. This is a form of empowerment approach that has been used by many social enterprises. We identified that some of these interventions have focused more on *social aspects*, such as providing *free legal services* to vulnerable communities, *fulfilling their basic needs* by providing shelter and food or facilitating *social connections* within communities. For example: Heartlines, developed by Schwab Fellow Garth Japhet (South Africa), uses a mobile-phone-based social networking tool called "Forgood" to connect people based on similarity in location and interests to enhance social connectedness. Other HCSEs focused more on *economic empowerment* approaches to support community members via vocational training, employment opportunities, and financial support. One example is the work of Community Enterprise Solutions by Ashoka Fellow Gregory Van Kirk (Guatemala), as follows:

> *"[The] model creates access to healthcare-related goods and services in isolated rural communities [by empowering] local women to become entrepreneurs to sell [healthcare-related] goods and services in their communities… It gives individuals with no prior business experience the opportunity to develop entrepreneurial skills"*

Strengthening community care and self-care capacity

Finally, the HCSEs implemented interventions to enable community members to *provide care for themselves*, their families and neighbors through a series of health skills training programs, which allows more efficient use of available human resources and quicker responses to community members' needs for healthcare and reduces burdens of public health providers. This is well illustrated in the work of Noora Health, by Echoing Green Fellow Katy Ashe (United States):

> *"[The HCSE] delivers health skills training to at-risk patient families – certifying them in everything from hygiene to recognition of early warning signs. They meet users where they are by turning hospital hallways, waiting rooms and wards into classrooms.*

By certifying families in the conditions they face, they give community members the ability to heal and prevent disease when they return home".

Theorizing Healthcare Social Enterprises in the Public Health Context

To 'reach closure' in the qualitative analysis, we cycled back and forth between the findings (Gioia *et al*., 2013) and the public health literature, particularly the social enterprise and NPG literature, and identified eight major activities and contributions that HCSEs played in healthcare services (see Table 1), which are: *1) policy implementer, 2) service coordinator, 3) industry watchdog or regulator, 4) performance monitor, 5) lead service providers, 6) service or process innovator*, *7) policy lobbyist,* and *8) institutional integrator*. To provide a framework to summarise the findings, we juxtaposed our typology of HCSEs with three modes of co-production (i.e., co-production, co-management, and co-governance, following Brandsen and Pestoff, 2006; and co-planning, co-design, co-prioritisation, co-financing, co-managing, co-delivery, and co-assessment, following Bovaird and Loeffler, 2012) as a lens to understand how HCSEs are drawn into health service provision and to characterise their roles in the NPG framework.

Our findings reveal that HCSEs have the capabilities and promise in engaging in various types of co-production in healthcare services that converge with and add new dimensions to those known in the NPG literature (see Table 1).

----------*Insert Table 1 about here*----------

As shown in Table 1, HCSEs can act as *policy implementer*. This role is consistent with the *co-management and co-delivery* mode of NPG in which HCSEs help implement government policies to deliver health and social services directly to citizens through contractual relationships. This reflects the public-private partnerships (PPPs) model employed by social

enterprises to provide public goods and services by utilising their specific expertise and skills (Nisar *et al*., 2013).

Second, HCSEs also play the role as *service coordinators* to match unmet needs or unused resources or poorly connected resources. This aligns well with the *co-management* mode of NPG. Examples include providing transportation services to connect patients in rural areas to existing health providers, which enables more efficient use of existing health resources. This shows that in the co-management process, the HCSEs can harness the productive capability civil society and government sectors to resolve complex health problems (Brown *et al*., 2013).

Third, HCSEs play a critical role as *industry regulators* such as by taking active part in regulating the service standards in the health sector as well as influencing policy formulation and community governance at the local and national levels. Fourth, they also act as *performance monitors* that evaluate and monitor the service performance and accountability of public service provision, working to enhance the *co-governance and co-assessment* mode of NPG.

The subsequent findings below reflect some *new types* of contributions for HCSEs that offer new contribution beyond the typology of co-production (Brandsen and Pestoff, 2006; Bovaird and Loeffler, 2012) that we found in this study. That is, fifth, HCSEs can act as *lead service providers* to fill institutional voids through using their own hobbies and expertise to develop pioneering services not yet available in the market, such as using mobile clinics to provide healthcare services to patients in rural areas and developing e-platforms to provide online medical consultations. Sixth, HCSEs also act as *service or process innovators* by developing new services and products for healthcare provision. Examples include developing innovative infant incubators to protect vulnerable new-borns from hypothermia or designing

more effective and sustainable mobility aids and appliances to support people with disabilities. We identify these roles as the *co-innovation* mode of NPG, in which HCSEs introduce innovative practices into health service provision and delivery (see Farmer *et al.*, 2020).

Seventh, HCSEs also play a role as *policy lobbyis*t. HCSEs can influence the policy formulation and improve policy processes and outcomes by ensuring that policies are implemented and informed by local context and relevant to local needs, and at times using local wisdom. For example, HCSEs have lobbied the government to offer life-extending medications to the public and especially to the poor communities at lower prices. We call this role the *co-design* mode of NPG. Lastly, HCSEs can serve as *institutional integrators* by mobilising and coordinating public health improvement activities and bridges the interests of the government, academic, private sector and the community with new governance structures that encourage broad participation in public health issues. By doing so, different sectors and organisations become increasingly interdependent and resilient in adapting to continuous changes needed to improve health services. We call this role the *co-integrator* mode of NPG.

Overall, the findings reveal new empirical evidence on the distinctiveness, richness, heterogeneity of HCSEs beyond a specific setting in addressing health problems.

Discussion and Conclusion

To answer the question 'How do healthcare social enterprises (HCSEs) contribute to public service provision in the health sector?', we conducted a study of 172 HCSEs from three major platform organizations. As we have shown, HCSEs employ multifaceted interventions, collaborating with different stakeholders including community, health workers, health institutions, governments, and the business sector. Importantly, our findings have demonstrated that social enterprises not only diversify public service provision – as co-producers within the

NPG framework – but also have the potential to take on a wide range of roles (such as coordinating health service provision or advocating for health policy reforms) in achieving the ultimate goal of improving health for all, as shown in Figure 1.

----------*Insert Figure 1 about here*----------

As we stated at the outset, there has been increasing interest in the role of civil society organisations in the provision of health services (e.g., Roy *et al*., 2013). Building on the conceptualisation of social enterprises as an instrument to improve the health and wellbeing of individuals and communities (viz. Roy *et al*., 2014), we have examined the interventions of, and roles played, by 172 unique HCSEs (i.e., whose work primarily focus on the healthcare sector) across Africa, Asia, Europe, South, Central and North America that were developed as part of Ashoka, Echoing Green and Schwab fellowships. Our study reveals that social entrepreneurs could play different roles and use different interventions across different contexts of health systems. By adopting a qualitative content analytical approach using grounded theory to analyze the intervention profiles of the HCSEs, we have identified that HCSEs interventions can be categorised into three dimensions: *improving access to health services*; *improving the quality of health services*; and *building public health capacity*. We also found eight major roles that HCSEs play in the provision of health services that are consistent with, and offer new dimensions, beyond a narrow reading of the concept of co-production; namely: *policy implementer, service coordinator, industry watchdog or regulator, performance monitor, lead service providers, service or process innovator, policy lobbyist,* and *institutional integrator*.

Our contributions are thus twofold. Firstly, this article contributes to an enhanced understanding of the *micro-level interventions* of social enterprises that focus on solving complex health problems. This extends and advances prior research, which has tended to focus on the organisational or institutional aspects of social enterprises in the healthcare setting, or

on the indirect outcomes of the actions of social enterprises on health and wellbeing (e.g., Hall *et al*., 2015; Hall *et al*., 2012; Mason *et al*., 2015; Roy *et al*., 2017). We have shown that interventions by HCSEs (see Figure 1) are *rich, diverse, yet also multi-level and multi-dimensional* (e.g., connecting patients to health providers, strengthening community care and self-care capacity, optimising treatment options through innovations) to produce health services and influence the process and outcomes of health service provision. Therefore, this article deepens our understanding of the nature, process and, to some limited extent, the outcomes of HCSE interventions.

Secondly, using an NPG perspective as an initial framework to explore the interventions and roles of HCSEs, this article is the first to show that HCSEs are important co-producers of public health services (c.f. Howlett *et al.,* 2017). We identified eight major roles that HCSEs play in the health services provision and delivery: *policy implementer*, *lead service provider*, *service coordinator*, *service/ process innovator*, *industry regulator*, *performance monitor*, *policy lobbyist*, and *institutional integrator*. We also showed how they corresponded with the concepts of co-management, co-delivery, co-governance and co-assessment (viz. Brandsen and Pestoff, 2006; Bovaird and Loeffler, 2012). Importantly, our new contribution comprises the identification of the roles of *co-innovation*, *co-lobbying*, and *co-integrator* as new dimensions of NPG framework by situating it in the context of healthcare.

Overall, the key contributions of this study have been to unpack the heterogeneity of the interventions of and roles played by HCSEs in addressing health problems as a means to create public value (Moore, 1995) and providing theoretical and practical insights into how the concept of NPG can be applied to the healthcare setting. These findings could enable social enterprise and public health/management scholars to define and/or expand upon the forms of collaboration, funding, piloting, scaling, and competition that the public sector could establish

with citizens and civil society organisations, particularly given the growing complexity of health problems and pressing global health challenges. For example, there is a growing trend of citizen innovators and social enterprises developing translation apps, creating face shields or other medical devices during the COVID-19 pandemic in the West and the East. This study offers new insights into how governments and businesses can work with citizens and civil society to improve health services.

Our study does, however, have several limitations. Firstly, the sample of HCSEs in this study was drawn from Ashoka, Echoing Green and Schwab platform organisations, which are not representative of social enterprises generally, particularly bottom-up, grassroots action initiated by citizens. Each of the platforms we focused upon employs strict criteria in the selection process of who they support: they seem to have selected especially prominent or impactful healthcare social enterprises. Future research could expand the study by examining social enterprises not connected to these foundations in specific regional contexts, particularly in terms of differences in interventions, collaborations and outcomes in the health service provision.

Moreover, which HCSEs interventions produce what health and social outcomes remain understudied. Future research could look into the effectiveness and efficiency of HCSEs interventions in comparison with those provided by other sectors (e.g., government, private, non-profit) and which of the eight types of HCSE roles produce better outcomes for specific regions or health problems. This opens us new avenues to conduct randomized controlled trials, quasi-experimental methods, and laboratory and field experiments to investigate which interventions produce better outcomes in comparison to a control or ‘usual’ treatment.

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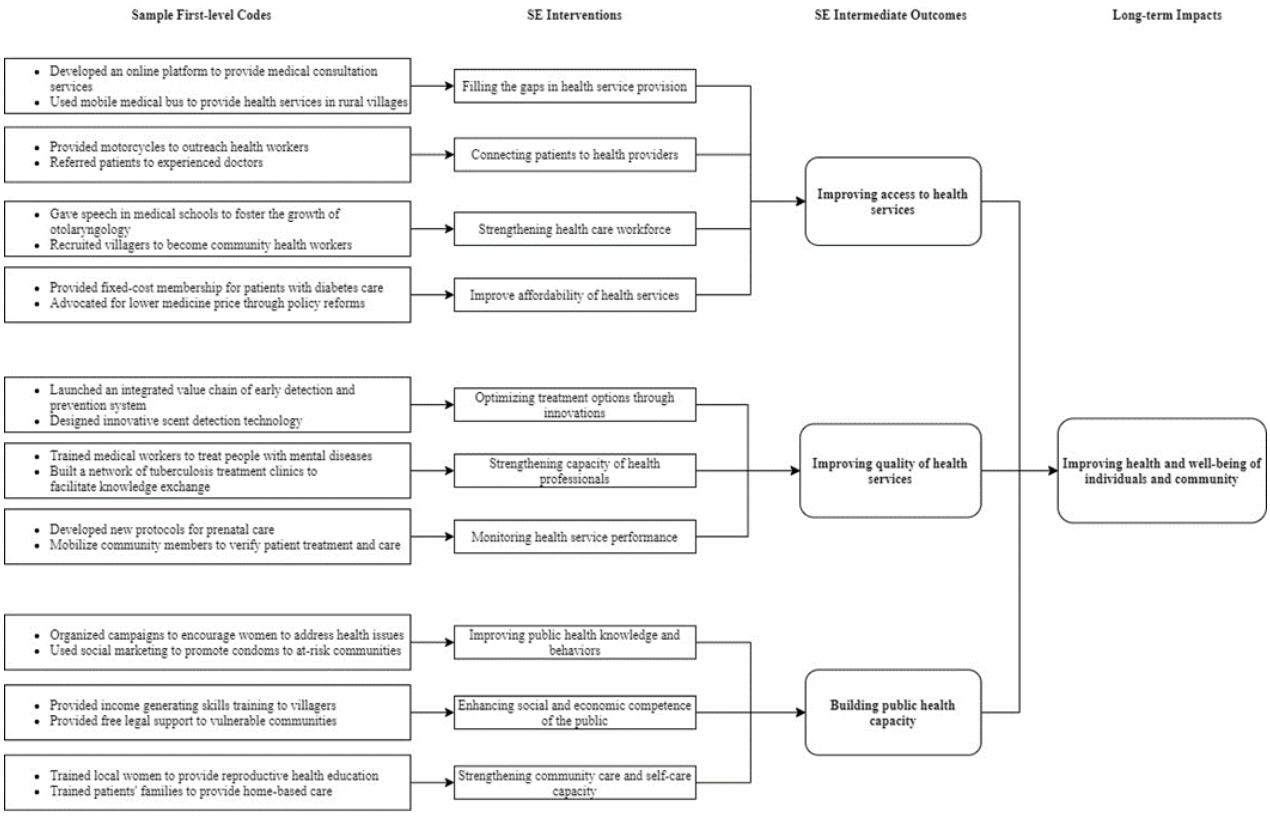
Table 1. Theorizing Social Enterprise Contribution in Healthcare Services

SE Contributions	Linkage to Brandsen & Pestoff (2006) or Bovaird & Loeffler (2012) NPG typology	Characteristics of SE Roles	Sample Quotes from SE Profiles
Policy Implementer	Co-management, Co-delivery	Providing public services as alternative service providers through contractual relationships with public sectors	*By providing medical care and training, the Alliance for Rehabilitation works to integrate disabled adults into Hungarian society. Its operations are primarily financed through government aid based on long-term contracts with*
Service Coordinator	Co-management, Co-managing	Coordinating the process of service delivery by matching patients with appropriate health services and providers	*Maniapure arranges all transport and appointments for patients require transport to Caracas or other major cities for in-person treatment, minimizing the time patients are away from home and the time commitment of the specialists*
Industry Regulator	Co-governance	Setting performance standards or protocols to regulate performance of health care services	*Carlos Vargas García has developed new protocols for prenatal care which transfer responsibility from doctors to other specially trained health care professionals*
Performance Monitor	Co-governance, Co-assessment	Monitoring health service performance and quality	*To create and spread community watchdog groups, RAME partners with local citizen organizations (CO) in each region that monitor quality and aggregate complaints… Simon is initiating and mobilizing community health watchdog committees to verify that patient treatment and*
Lead Service Provider	Co-innovation (new)	Delivering public services as key providers through innovations to fill the institutional voids	*HTT [name of the SE] also has an outreach program through mobile clinics to ensure that workers even from distant farms and game reserves are accessing the services*
Service/ Process Innovator	Co-innovation (new)	Introducing new changes to health services, products or the process of service delivery	*By developing innovative evidence-based algorithms for diagnosis and disease management, and by creating a chain of low-cost diabetes clinics, Clinicas del Azucar is revolutionizing the way diabetes care is delivered in developing countries and for the fourteen million patients*
Policy Lobbyist	Co-lobbying (new)	Advocating for changes in health systems; influencing health policy formulation through co-designing the policy systems	*To ensure the mental health service is widely spread, Bagus is participating in the policy advocacy work for the new Mental Health Act, by which he hopes that the upcoming National Health Insurance will provide options to the current severe side effect generic drugs.*
Institutional Integrator	Co-integrator (new)	Developing new institutional structures by mobilizing and coordinating public health improvement activities across different sectors	*In Venezuela, the traditional medical system has collapsed and has been replaced by a faltering state system, Martín ignites a transformation in Venezuelan healthcare policy at municipal, state and national levels… Rather than building a parallel system, Martín acts as a catalyst to integrate schools, the optometry profession, public sector agencies, and the public behind his initiative.*

Figure 1. Analytical Coding Process for Social Enterprise Interventions in the Healthcare Services Provision



SUPPLEMENTARY MATERIAL

Unit of analysis and definitions

There is a lack of clarity of the linkages and differences between the concept of *social entrepreneurship, social enterprise, and social entrepreneur*. In this article, we broadly define 'social entrepreneurship' as entrepreneurial activities, processes, orientations, and values that aim to create social value. We define 'social enterprise' as an organizational form in which social entrepreneurship activities are actualized, implemented and formalized. Certainly, social entrepreneurial activities can occur outside of the boundary of a formal organization. We define 'social entrepreneur' as the person who initiates and participates in social entrepreneurial activities. There are various typologies that classify different definitions and dimensions of social enterprises/social entrepreneurship such as those by Hoogendoorn et al (2012), Kerlin (2006, 2012), Defourny and Nyssens (2010), and Teasdale and Dey (2019), and Chandra and Paras (2020) but despite the differences in the definitions (e.g., American Tradition vs. European Tradition vs UK tradition or Asian Tradition) there is a commonality that characterize 'social entrepreneurship/enterprise' as a hybrid organization or organizing. That is, a process of combining multiple logics, goals and approaches.

The Selection Criteria for Ashoka, Schwab and Echoing Green Social Enterprises

The three social enterprise support organizations - Ashoka, Schwab and Echoing Green - use different approaches in selecting its social entrepreneurs. Ashoka uses 5-step selection process, from nomination, first and second opinion, panel interviews, to board review; and 5 criteria (newness of idea, creativity, entrepreneurial quality, social impact, and ethical fiber) (https://www.ashoka.org/en/recommend-ashoka-fellow).

Schwab uses referral and nomination from a global network of experts and partners and rely on several criteria including (market/tech/social) impact, potential to scale, ability to interact with top business and political leaders (https://www.schwabfound.org/selection-process). Echoing Green uses unsolicited application approach with expert reviewers and interviews and 4 criteria which are innovation, importance of solutions, potential for impact, and a good business model (https://echoinggreen.org/fellowship/apply/).

Procedures to Include only Unique Cases

We first created a full list of all healthcare social enterprises from Ashoka in a spreadsheet and then used a random generator in R (a programming language) to generate random numbers to randomly select social enterprises. For example, we set R to give us a random of 5 samples out of a total 10 cases in the spreadsheet. And the result is 3, 4, 8, 9, and 2. Then, we select social enterprise number 2, 3, 4, 8 and 9 and retrieve their text file and conduct the coding.

In our sampling process, we found 5 fellows who were both Schwab and Ashoka Fellows, 1 fellow who was both Echoing Green and Ashoka Fellows, and 2 fellows who were both Echoing Green and Schwab Fellows (total of 8 fellows). After adjusting the samples to avoid duplication, we ended up with a total of 172 unique cases in this study.

Analytical strategy

Our analysis was not meant to show the differences among the social enterprises across regions (e.g., Asia vs. North America vs. Europe) nor to study the "trends" of the activities of social enterprises in a particular period versus other periods as this is not relevant to our research question. Rather, we are interested in how the social enterprises contribute to healthcare

services provision generally and what we can learn from their activities to enrich and connect them with the New Public Governance literature.

Distribution of Samples Included in the Study

Year of Election	Africa	Asia	Europe	S. America	Central America	N. America	Total sample
Panel A: Ashoka Fellows (n=60)							
2010 - 2016	5	10	6	6	1	12	40
2000 - 2009	3	3	1	0	1	8	16
1990 - 1999	0	1	0	1	0	2	4
Panel B: Schwab Foundation Fellows (n=55)							
2010 - 2016	4	7	4	3	1	11	30
2000 - 2009	1	11	8	1	2	2	25
Panel C: Echoing Green Fellows (n=57)							
2010 - 2016	4	6	0	0	0	11	21
2000 - 2009	1	0	0	0	0	15	16
1990 - 1999	0	2	0	0	0	18	20

Detailed Break Down of Each Healthcare Social Enterprises in the Study

Fellow Name	Year of Election	Location	Organization	Focus of Work	Profile Weblink
Echoing Green					
Anurag Gupta	2016	North America	BE MORE America	Physician-patient Trust & Communication	https://fellows.echoinggreen.org/fellow/anurag-gupta/
Nana Amma Twum-Danso	2016	Africa	MAZA	Pregnancy & Ambulance Services	https://fellows.echoinggreen.org/fellow/nana-amma-twum-danso
Katy Ashe	2015	North America	Noora Health	Patients' Family Empowerment	https://fellows.echoinggreen.org/fellow/katy-ashe/
Sam Pressler	2015	North America	Armed Services Arts Partnership	Veterans Wellness	https://fellows.echoinggreen.org/fellow/sam-pressler/
Brittany Dejean	2014	North America	AbleThrive	Disability Wellness	https://fellows.echoinggreen.org/fellow/brittany-dejean/
Ratul Narain	2014	Asia	Bempu	Hypothermia	https://fellows.echoinggreen.org/fellow/ratul-narain/
Sumit Dagar	2014	Asia	Kriyate	Visually Impaired	https://fellows.echoinggreen.org/fellow/sumit-dagar/
Yohans Wodaje Emiru	2014	Africa	Telemed Medical Services	Chromic Disease & General Healthcare	https://fellows.echoinggreen.org/fellow/yohans-wodaje-emiru/
Anoop Jain	2013	Asia	Sanitation and Health Rights in India	Community Hygiene & Wellness	https://fellows.echoinggreen.org/fellow/anoop-jain/
Christopher Ategeka	2013	North America	Rides for Lives	General Healthcare	https://fellows.echoinggreen.org/fellow/christopher-ategeka/
Jason Panda	2013	North America	B Holding Group, LLC / b condoms	HIV/AIDS	https://fellows.echoinggreen.org/fellow/jason-panda/
T. Morgan Dixon	2013	North America	GirlTrek	Black Women Wellness	https://fellows.echoinggreen.org/fellow/morgan-dixon/
Vineet Singal	2013	North America	CareMessage	Hospital Efficiency	https://fellows.echoinggreen.org/fellow/vineet-singal/
Piyush Tewari	2012	Asia	SaveLIFE Foundation	First Aid	https://fellows.echoinggreen.org/fellow/piyush-tewari/
Touré McCluskey	2012	North America	OkCopay, Inc	General Healthcare	https://fellows.echoinggreen.org/fellow/toure-mccluskey/
Zubaida Bai	2012	North America	AYZH Health and Livelihood PVT	Newborn care	https://fellows.echoinggreen.org/fellow/zubaida-bai/
Javier Lozano	2011	North America	Clinicas del Azucar	Diabetes	https://fellows.echoinggreen.org/fellow/javier-lozano/
Mohamed Ali Niang	2011	Africa	Malo	Farmers Wellness	https://fellows.echoinggreen.org/fellow/mohamed-ali-niang/
Peter Luckow	2011	North America	Last Mile Health (known in Liberia as Tiyatien Health)	General Healthcare & HIV	https://fellows.echoinggreen.org/fellow/peter-luckow/
Aman Midha	2010	Asia	Biosense Technologies Private Limited	Diabetes Urine & Anemia	https://fellows.echoinggreen.org/fellow/aman-midha/
Deepa Gangwani	2010	Asia	Together As One	Mental Health	https://fellows.echoinggreen.org/fellow/deepa-gangwani/
Isaac Holeman	2010	North America	Medic Mobile	General Healthcare, Pregnancy & Infant Care	https://fellows.echoinggreen.org/fellow/isaac-holeman/
Kennedy Odede	2010	Africa	Shining Hope for Communities	Community Hygiene & Wellness; Girl Care	https://fellows.echoinggreen.org/fellow/kennedy-odede/
Angie Beatty	2009	North America	The J.U.I.C.E. Project	General Wellness	https://fellows.echoinggreen.org/fellow/angie-beatty/
Barbara Bush	2009	North America	Global Health Corps	Young Health Professionals Empowerment	https://fellows.echoinggreen.org/fellow/barbara-bush/
Julie Carney	2009	North America	Gardens for Health International	Malnutrition	https://fellows.echoinggreen.org/fellow/julie-carney/
Anne Tamar-Mattis	2008	North America	interACT	Intersex Children Wellness	https://fellows.echoinggreen.org/fellow/anne-tamar-mattis/
Elizabeth Scharpf	2008	North America	Sustainable Health Enterprises	Women Healthcare	https://fellows.echoinggreen.org/fellow/elizabeth-scharpf/
Jane Chen	2008	North America	Embrace	Infant Care	https://fellows.echoinggreen.org/fellow/jane-chen/
Josh Sommer	2008	North America	Chordoma Foundation	Chordoma	https://fellows.echoinggreen.org/fellow/josh-sommer/
Nathan Sigworth	2008	North America	PharmaSecure	Medicine Authenticity	https://fellows.echoinggreen.org/fellow/nathan-sigworth/
Tahir Amin	2008	North America	Initiative for Medicines, Access & Knowledge (I-MAK)	Medicine Supply	https://fellows.echoinggreen.org/fellow/tahir-amin/
Gemma Bulos	2007	North America	Single Drop for SafeWater	Sanitation & Hygiene	https://fellows.echoinggreen.org/fellow/gemma-bulos/
Nina Dudnik	2007	North America	Seeding Labs	General Healthcare & Scientists Empowerment	https://fellows.echoinggreen.org/fellow/nina-dudnik/
Anita Buel	2005	North America	Deaf Community Health Worker	Disability Wellness	https://fellows.echoinggreen.org/fellow/anita-buel/
Michael Lwin	2004	North America	Koe Koe Tech Co., Ltd.	General Healthcare & Preganancy	https://fellows.echoinggreen.org/fellow/michael-lwin/
Mimi Kim	2004	North America	Creative Interventions	Violence Prevention	https://fellows.echoinggreen.org/fellow/mimi-kim/
Alisa Gilbert	2002	North America	Unbroken Circle	Cancer-related health services	https://fellows.echoinggreen.org/fellow/alisa-gilbert/
Cynthia Willard	2002	North America	Utah Health and Human Rights Project	Torture Survivors Wellness	https://fellows.echoinggreen.org/fellow/cynthia-willard/
Damilola Adebiyi	2000	Africa	Education as a Vaccine Against AIDS	Cancer Survivor Wellness	https://fellows.echoinggreen.org/fellow/damilola-adebiyi/
Kyra Bobinet	1998	North America	Vision Youthz	High-risk Children Care	https://fellows.echoinggreen.org/fellow/kyra-bobinet/
Leslie Mansfield	1997	North America	Miners Legal Resource Center	Wellness of coal&uranium miners	https://fellows.echoinggreen.org/fellow/leslie-mansfield/
Pamela Collins	1997	North America	Society for Emotional Well-being Worldwide (SEWW)	Mental Health	https://fellows.echoinggreen.org/fellow/pamela-collins/
R. Bradley Sears	1997	North America	HIV Legal Checkup	HIV/AIDS	https://fellows.echoinggreen.org/fellow/r-bradley-sears/
Caryn Lubetsky	1996	North America	H.E.L.P., Inc	HIV	https://fellows.echoinggreen.org/fellow/caryn-lubetsky/
Marla Bear	1996	North America	Native American Advocacy Project	Youth Wellness	https://fellows.echoinggreen.org/fellow/marla-bull-bear/
Cynthia Chandler	1995	North America	Justice Now	Former Prisoners Wellness	https://fellows.echoinggreen.org/fellow/cynthia-chandler/
David Auerbach	1995	North America	Sanergy	Community Hygiene & Wellness	https://fellows.echoinggreen.org/fellow/david-auerbach/
Mark Hurwitz	1995	North America	Mental Health Project (MPH) of the Urban Justice Center	Mental Health	https://fellows.echoinggreen.org/fellow/mark-hurwitz/
Michelle McKinley	1995	North America	Amazonian Peoples' Resources	Reproductive Health	https://fellows.echoinggreen.org/fellow/michelle-mckinley/
Carolyn Bess	1994	North America	Outdoor Explorations	Disability Wellness	https://fellows.echoinggreen.org/fellow/carolyn-bess/
Samuel Myers	1994	North America	The Pendeba Project	Public Health	https://fellows.echoinggreen.org/fellow/samuel-myers/
Eric Rosenthal	1993	North America	Disability Rights International	Disability Rights and Wellness	https://fellows.echoinggreen.org/fellow/eric-rosenthal/
Laurel MacLaren	1993	Asia	Lentera AIDS Service	HIV/AIDS	https://fellows.echoinggreen.org/fellow/laurel-maclaren/
Marta Heilbrun	1993	North America	Project Concern International	Water & Malnutrition	https://fellows.echoinggreen.org/fellow/marta-heilbrun/
Uttara Bharath Kumar	1993	Asia	Nalamdana	Reproductive Health & Gender	https://fellows.echoinggreen.org/fellow/uttara-bharath-kumar/
Cheryl Dorsey	1992	North America	Family Van	Healthcare of Vulnerable People	https://fellows.echoinggreen.org/fellow/cheryl-l-dorsey/
Heather Harker	1992	North America	The Kuala Lumpur Society for the	Disability Wellness	https://fellows.echoinggreen.org/fellow/heather-harker/
Mike Lynn	1992	North America	Chagas' Disease Education Program	Disease Transmission	https://fellows.echoinggreen.org/fellow/mike-lynn/
John Stelling	1991	North America	WHONET	Hospital Efficiency	https://fellows.echoinggreen.org/fellow/john-stelling/

Schwab

Amina Laraki Slaoui	2015	Africa	Groupe AMH	Disabilities	https://www.schwabfound.org/awardees/amina-laraki-slaoui
Antonio Boschini	2015	Europe	San Patrignano Community	Drug Addiction	https://www.schwabfound.org/awardees/antonio-boschini
Carlos Orellana Aguilar	2015	North America	Salauno	Eye Care	https://www.schwabfound.org/awardees/carlos-orellana-aguilar
Ernest Darkoh	2015	North America	BroadReach Healthcare	Healthcare Improvement & HIV	https://www.schwabfound.org/awardees/ernest-darkoh
Jen Hyatt	2015	Europe	Big White Wall	Mental Health	https://www.bigwhitewall.com/
John Sargent	2015	North America	BroadReach Healthcare	General Healthcare	https://www.schwabfound.org/awardees/john-sargent
Jung-Hyeon Kim	2015	Asia	Delight	Hearing Aids	https://www.schwabfound.org/awardees/jung-hyeon-kim
Kristin Groos Richmond	2015	North America	Revolution Foods	Malnutrition	https://www.schwabfound.org/awardees/kristin-groos-richr
Mark Arnoldy	2015	North America	Possible	General Healthcare & Healthcare Quality	https://www.schwabfound.org/awardees/mark-arnoldy
Pierre Issa	2015	Asia	Arcenciel	General healthcare & Disabilities	https://www.schwabfound.org/awardees/pierre-issa
Sudarshan Hanumappa	2015	Asia	Karuna Trust	General Healthcare & Healthcare quality	https://www.schwabfound.org/awardees/sudarshan-hanumappa
Chris Underhill	2014	Europe	citiesRISE	Women Wellness	https://www.schwabfound.org/awardees/chris-underhill
Frank Beadle de Palomo	2014	Africa	Mothers2mothers	HIV	https://www.schwabfound.org/awardees/frank-beadle-de-palom
Javier Lozano	2014	North America	Clinicas del Azúcar	Diabetes	https://www.schwabfound.org/awardees/javier-lozano
Marc Freedman	2014	North America	Encore	Aging	https://www.schwabfound.org/awardees/marc-freedman
Merula Steagall	2014	South America	Associação Brasileira de Linfoma e Leucemia (ABRALE)	General Healthcare & Healthcare Improvement	https://www.schwabfound.org/awardees/merula-steagall
Shelly Batra	2014	Asia	Operation ASHA - Fighting Tuberculosis Worldwide	Tuberculosis & General Healthcare	https://www.schwabfound.org/awardees/shelly-batra
Bedriye Hulya	2013	Europe	B-fit Sport and Health Living Centers for Women	Mental Health	https://www.schwabfound.org/awardees/bedriye-hulya
Chuck Slaughter	2013	North America	Living Goods	General Healthcare, Pregnancy & Infant Care	https://www.schwabfound.org/awardees/chuck-slaughter
Jane Marie Chen	2013	North America	Embrace Innovations	Infant care	https://www.schwabfound.org/awardees/jane-marie-chen
Rebecca D. Onie	2013	North America	Health Leads	Healthcare improvement	https://www.schwabfound.org/awardees/rebecca-d-onie
Paul Scott Matthew	2012	Africa	North Star Alliance	General Healthcare, First-Aid & Sexual Health	https://www.schwabfound.org/awardees/paul-scott-matthew
Philip Gregory Van Kirk	2012	Central America	Community Empowerment Solutions	Rural Empowerment	https://www.schwabfound.org/awardees/philip-gregory-var
Runa Khan	2012	Asia	Friendship Bangladesh	Ambulance services & Primary Care	https://www.schwabfound.org/awardees/runa-khan
Asher Hasan	2011	Asia	Naya Jeevan	General Healthcare & Infant care	https://www.schwabfound.org/awardees/asher-hasan
Darell Hammond	2011	North America	KaBOOM!	Children Wellness	https://www.schwabfound.org/awardees/darell-hammond
Gisela Maria Bernardes Solymos	2011	South America	CREN Centre of Nutritional Recovery and Education	Malnutrition	https://www.schwabfound.org/awardees/gisela-maria-bernardes
Masa Kogure	2011	Asia	Table for Two International	Malnutrition & Community Health	https://www.schwabfound.org/awardees/masa-kogure
Roberto Kikawa	2011	South America	Centro de Integracao de Educacao e Saude - CIES	General Healthcare	http://www.ciesglobal.org/
Tomas Sanabria	2011	South America	Maniapure	General Healthcare	https://www.schwabfound.org/awardees/tomas-sanabria
Antonio Meloto	2010	Asia	Gawad Kalinga (GK)	General Healthcare	https://www.schwabfound.org/awardees/antonio-meloto
David Gaus	2010	North America	Andean Health and Development	Healthcare Improvement	https://www.schwabfound.org/awardees/david-gaus
Kovin Naidoo	2010	Africa	Vision Impact Institute	Eye Care	https://visionimpactinstitute.org/people/kovin-naidoo/
Sakena Yacoobi	2010	North America	Afghan Institute of Learning	Pregnancy Care & General	https://www.schwabfound.org/awardees/sakena-yacoobi
Diskul Disnadda	2009	Asia	Doi Tung Development Project	General Healthcare & Drug Addiction	https://www.schwabfound.org/awardees/diskul-dispanadda
Dája Kabátová	2009	Europe	Letohrádek Vendula	Handicaps	https://www.schwabfound.org/awardees/daja-kabatova
Flavian Mucci Gaglili	2009	Central America	Agape Association	Disabilities & Community Empowerment	https://www.schwabfound.org/awardees/flavian-mucci-gaglili
Rajendra Joshi	2009	Asia	Saath Livelihood Services	Children Wellness, Malnutrition, Sanitation & Living Condition Improvement	https://www.schwabfound.org/awardees/rajendra-joshi
Sébastien Marot	2009	Asia	Friends-International	Child & Youth Protection	https://www.schwabfound.org/awardees/sebastien-marot
Thilo Bode	2009	Europe	Foodwatch	Food Safety	https://www.schwabfound.org/awardees/thilo-bode
Csaba Kovács	2008	Europe	Félúton Alapítvány	Alcohol & Drug Addiction	https://www.schwabfound.org/awardees/csaba-kovacs
Bart Weetjens	2007	Europe	HeroRAT	Tuberculosis	https://www.schwabfound.org/awardees/bart-weetjens
Bilha Piamenta	2007	Asia	Kav-Or	Hospitalized Children Care	https://www.schwabfound.org/awardees/bilha-piamenta
Cosmas I. Okoli	2006	Africa	Mobility Aid and Appliances Research and Development Centre	Disabilities	https://www.schwabfound.org/awardees/cosmas-i-okoli
Erzsébet Szekeres	2006	Europe	Alliance for Rehabilitation	Disabilities	https://www.schwabfound.org/awardees/erzsebet-szekeres
Jorge G. Gronda	2006	Central Americaa	Centro Ginecologico Integral	Women & Children care	https://www.schwabfound.org/awardees/jorge-g-gronda
Rut Kolinská	2006	Europe	Network of Mother Centers	Mother-children Care	https://www.schwabfound.org/awardees/rut-kolinska
Yuval Wagner	2006	Asia	Access Israel	Disabilities	https://www.schwabfound.org/awardees/yuval-wagner
Cristóbal Colón	2005	Europe	La Fageda	Mental Health	https://www.schwabfound.org/awardees/cristobal-colon
Andrea Coleman	2004	Europe	Riders for Health	General healthcare	https://www.schwabfound.org/awardees/andrea-coleman
Thulasiraj Ravilla	2004	Asia	Aravind Eye Care System (AECS)	Eye Care	https://www.schwabfound.org/awardees/thulasiraj-ravilla
Rick Surpin	2003	North America	Independence Care System (ICS) Model	Disabilities & Injuries care & General healthcare	https://www.schwabfound.org/awardees/rick-surpin
Richard Jefferson	2002	North America	The Lens	Patent Protection	https://www.schwabfound.org/awardees/richard-jefferson
Sergii Kostin	2002	Europe	Way Home	HIV/AIDS & Street Children Care	https://www.schwabfound.org/awardees/sergii-kostin
David Green	2001	Asia	Aravind Eye Care System (AECS)	Eye Care	https://www.schwabfound.org/awardees/david-green
Fazle Hasan Abed	2001	Asia	BRAC	Child Education & Wellness	https://www.schwabfound.org/awardees/fazle-hasan-abed
Joseph Madiath	2001	Asia	Gram Vikas	Sanitation	https://www.schwabfound.org/awardees/joseph-madiath
Mechai Viravaidya	2001	Asia	Population and Community Development Association (PDA)	Family Planning	https://www.schwabfound.org/awardees/mechai-viravaidya
Shobha Arole	2001	Asia	Comprehensive Rural Health Project (CRHP)	Disabiltiy Wellness & General healthcare	https://www.schwabfound.org/awardees/shobha-arole
Vera R. Cordeiro	2001	South America	Associação Saúde Criança	Child care, family planning & Mental health	https://www.schwabfound.org/awardees/vera-r-cordeiro

Ashoka

Fabrice Hégron	2015	Asia	En Direct Des Eleveurs	Milk	https://www.ashoka.org/en/fellow/fabrice-hegron
Jérémy Lachal	2015	Europe	Bibliothèques Sans Frontières	Education	https://www.ashoka.org/en/fellow/jeremy-lachal
Saifuddin Ahmed	2015	Asia	Work for a Better Bangladesh Trust	Tabocco Control	https://www.ashoka.org/en/fellow/saifuddin-ahmed
Sasha Kramer	2015	Central America	Sustainable Organic Integrated	Sanitation	https://www.ashoka.org/en/fellow/sasha-kramer
Megan Mukuria	2014	Africa	Zana Africa	Reproductive health & Education	https://www.ashoka.org/en-us/fellow/megan-mukuria
Andrea Coleman	2014	Europe	Riders for Health	General Healthcare	https://www.ashoka.org/en/fellow/andrea-coleman
Bagus Utomo	2014	Asia	Yayasan Peduli Skizofrenia Indonesia	Mental Health	https://www.ashoka.org/en/fellow/bagus-utomo
Christine Du Preeze	2014	Africa	Hlokomela Training Trust (HTT)	General Healthcare	https://www.ashoka.org/en/fellow/christine-du-preeze
Silke Mader	2014	Europe	EFCNI European Foundation for the Care of Newborn Infants	Infant Care	https://www.ashoka.org/en/fellow/silke-mader
Kevin Lee	2014	Asia	A Single Drop For Safe Water	Community Hygiene & Development	https://www.ashoka.org/en-il/fellow/kevin-lee
Bénédicte Défontaines	2013	Europe	Réseau mémoire Aloïs	General Healthcare & Cognitive degradation	https://www.ashoka.org/en/fellow/benedicte-defontaines
Lisa Brown	2013	North America	Workman Arts	Mental Health	https://www.ashoka.org/en/fellow/lisa-brown
Lobe Cissokho	2013	Africa	Mutuelle de Santé Oyofal Paj de	General Healthcare	https://www.ashoka.org/en/fellow/lobe-cissokho
Mary Delano	2013	South America	México Tierra de Amaranto	Malnutrition	https://www.ashoka.org/en/fellow/mary-delano
Charlie Howard	2012	North America	MAC-UK	Mental Health	https://www.ashoka.org/en/fellow/charlie-howard
Jason F. Mclennan	2012	North America	International Living Building Institute	Green Building	https://www.ashoka.org/en/fellow/jason-mclennan
Latha Anantha	2012	Asia	River Research Centre	Envrionmental sustainability	https://www.ashoka.org/en/fellow/latha-anantha
Martin Guzman	2012	South America	Proyecto Lumen	Eye Care	https://www.ashoka.org/en/fellow/martin-guzman
Mohamed Zaazoue	2012	Africa	Healthy Egyptians	Preventive medicine & healthcare quality improvement	https://www.ashoka.org/en/fellow/mohamed-zaazoue
Nattaya Boonpakdee	2012	Asia	Women's Health Advocacy Foundation	Sexual Health & Youth care	https://www.ashoka.org/en/fellow/nattaya-boonpakdee
Simon Kabore	2012	Africa	Network Access to Essential	Healthcare quality improvement	https://www.ashoka.org/en-bd/fellow/simon-kabore
Partap Chauhan	2012	Asia	Jiva Ayurveda	General Healthcare	https://www.ashoka.org/en/fellow/partap-chauhan
Suresh Kumar	2012	Asia	Institute of Palliative Medicine	Palliative Care	https://www.ashoka.org/en/fellow/suresh-kumar
Zoe Finch Totten	2012	North America	The Full Yield	Healthy Lifestyle	https://www.ashoka.org/en/fellow/zoe-finch-totten
Sehnaz Layikel	2012	Europe	RUSIHAK - Human Rights in Mental Health Initiative	Mental Health	https://www.ashoka.org/en-sg/fellow/sehnaz-layikel
Asher Hasan	2011	North America	Naya Jeevan	Health insurance	https://www.ashoka.org/en/fellow/asher-hasan
Catalina Escobar	2011	South America	The Juan Felipe Gómez Escobar	Infant & child care	https://www.ashoka.org/en/fellow/catalina-escobar
Gary Cohen	2011	North America	Health Care Without Harm	Environmentally-friendly Healthcare	https://www.ashoka.org/en/fellow/gary-cohen
Josh Nesbit	2011	North America	Medic Mobile	General Healthcare	https://www.ashoka.org/en/fellow/josh-nesbit
Kristin Groos Richmond	2011	North America	Revolution Foods	Malnutrition	https://www.ashoka.org/en/fellow/kristin-richmond
Nimit Tienudom	2011	Asia	AIDS Access Foundation	HIV/AIDS	https://www.ashoka.org/en/fellow/nimit-tienudom
Robert Master	2011	North America	Commonwealth Care Alliance	HIV, Disabilities & General Healthcare	https://www.ashoka.org/en/fellow/robert-master
Roberto Kikawa	2011	South America	Centro de Integracao de Educacao e Saude - CIES	General Healthcare	https://www.ashoka.org/en/fellow/roberto-kikawa
Ana Lucia Villela	2010	South America	Projecto Criança e Consumo	Consumerism & Children development	https://www.ashoka.org/en/fellow/ana-lucia-villela
Barry Zuckerman	2010	North America	National Center for Medical Legal	General Healthcare	https://www.ashoka.org/en/fellow/barry-zuckerman
Michel Nischan	2010	North America	Wholesome Wave	Farmer Wellness	https://www.ashoka.org/en/fellow/michel-nischan
Paula Johns	2010	South America	Adaptare	Tobacco Control	https://www.ashoka.org/en/fellow/paula-johns
Samuel Warrack Goldm:	2010	Asia	D.light	Envrionmental Sustainability	https://www.ashoka.org/en/fellow/samuel-warrack-goldman
Tobias Leenaert	2010	Europe	Ethical Vegetarian Association (EVA)	Healthy Food	https://www.ashoka.org/en/fellow/tobias-leenaert
Victor Berrueta	2010	North America	Grupo Interdisciplinario de Tecnologia Rural Apropiada (GIRA)	Environmental Sustainability	https://www.ashoka.org/en/fellow/victor-berrueta
Arnold Noyek	2009	North America	CISEPO	Healthcare Provider empowerment & otolaryngology	https://www.ashoka.org/en/fellow/arnold-noyek
Jean-François Archamb:	2009	North America	Band of Chefs	Malnutrition	https://www.ashoka.org/en/fellow/jean-francois-archambault
Gregory Van Kirk	2008	Central America	The New Development Solutions Group	General Healthcare	https://www.ashoka.org/en/fellow/gregory-van-kirk
Kiran Bir Sethi	2008	Asia	Riverside School	Child Development	https://www.ashoka.org/en/fellow/kiran-bir-sethi
Molly Barker	2008	North America	Girls on the Run	Women Wellness	https://www.ashoka.org/en/fellow/molly-barker
Rebecca D. Onie	2008	North America	Health Leads	General Healthcare	https://www.ashoka.org/en/fellow/rebecca-onie
Daniel C. Ross	2007	North America	Nuestras Raices	Community Empowerment	https://www.ashoka.org/en/fellow/daniel-ross
Princess Olufemi-Kayod	2007	Africa	Media Concern for Women and	Sexually abused children	https://www.ashoka.org/en/fellow/princess-olufemi-kayode
Jean-Michel Ricard	2006	Europe	SIEL Bleu	Elderly care	https://www.ashoka.org/en-us/fellow/jean-michel-ricard
Ananya Raihan	2004	Asia	D.Net	Rural Empowerment	https://www.ashoka.org/en/fellow/ananya-raihan
Satyan Mishra	2004	Asia	Drishtee	Rural Empowerment	https://www.ashoka.org/en/fellow/satyan-mishra
Jeff Palmer	2003	North America	Coordinated Care Network	General Healthcare	https://www.ashoka.org/en/fellow/jeff-palmer
Renae Griggs	2003	North America	National Police Family Violence Prevention Initiative	Mental Health	https://www.ashoka.org/en/fellow/renae-griggs
Rita Sembuya	2003	Africa	Joyce Fertility Support Center	Infertility	https://www.ashoka.org/en/fellow/rita-sembuya
Zackie Achmat	2003	Africa	Treatment Action Campaign	HIV/AIDS	https://www.ashoka.org/en/fellow/zackie-achmat
David Erickson	2001	North America	Samaritan Inns, Inc.	Drug Addiction	https://www.ashoka.org/en/fellow/david-erickson
Carlos Gómez	1998	North America	Instituto Mexicano de Medicina tradicional Tlahili	Prenatal care, child health & Primary care	https://www.ashoka.org/en/fellow/carlos-vargas-gomez
Albina Ruiz	1996	South America	Ciudad Saludable	Garbage processing	https://www.ashoka.org/en/fellow/albina-ruiz
Indu Harkrishanlal Capo	1992	Asia	CHETNA	Women care & General Healthcare	https://www.ashoka.org/en/fellow/indu-capoor
Teresa Zorrilla Palomar	1990	North America	Health in the Hands of the People	Healthcare Improvement	https://www.ashoka.org/en/fellow/teresa-zorrilla-palomar