Interview with Liz Jarman (Living Goods)

Ashley Hopkinson

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Ashley Hopkinson: Can you start by introducing yourself and talk about the challenge and the problem that Living Goods set out to solve? How do you see the organization working towards solving that?

Liz Jarman: I'm Liz Jarman, CEO of Living Goods. Great to be here with you. I think it's an interesting question, because whilst I think it's still a problem we're trying to solve, I think we've evolved a lot in how we're trying to solve it. But the basic premise of why we exist is because there is still a lack of access to basic healthcare around the world. Half the world still doesn't have it. 5 million children still die of treatable and preventable diseases, and we know that in Sub-Saharan Africa, where we work, those primary healthcare systems are struggling. The struggle has to do with lack of health workers, skilled health workers, affordable drugs, lots of stock-outs, counterfeits even, long distances to go to health facilities, and long wait times.

So really, we are about how do you make sure there is access to that healthcare, and that's where community health workers come in. We very much think that community health workers can dramatically expand access to healthcare and save millions of lives. There's evidence all over the place. They can do it far faster, and less costly than facility-based care.

We started 15 years ago, and you had to really make this point. I think right now there is more buy-in that community health workers are a route to solve that problem, but I think it's now less if you need them, but how is that really working? And I think they remain underfunded. The potential of community health workers is not fully realized, and so I think what we're about is how do you really ensure that community health workers can reach their full potential. How can they reach their full potential? And we've been doing that for 15 years, and I think we've learned a lot, and got some things right and got some things wrong along the way.

Ashley Hopkinson: You're working in the field where you're serving a large population, you're engaging with them through community health workers, but by and large, who would you say benefits from your work, and how do they benefit?

Liz Jarman: One of our first values is to put families first, so I think the first people that benefit from our work are those families that are not getting access to healthcare, and now have access to healthcare. I think it starts in the communities, it starts with one family at a time, and I think it's really important to always remember that. And that's what truly grounds us.

Access to healthcare, to those individual women, those families, those children, is so critical. But of course, for me, then it's the health system. For me, community health workers form the bedrock, if you like, the foundation of any health system, and make that health system, the term being used now is resilient. I think we all recognize the need for a resilient health system during the pandemic, during COVID, and there's going to be future pandemics, so really building that resilience, not just for today, but for the future. More and more this is also resilience to the climate crisis, climate issues as well.The benefit to the whole health system is huge in terms of having a strong community health, if you like, foundation. So there are two elements which obviously support a wider government.

I think then there's a bit in the middle. There's the community health workers themselves. We very much believe they should be a professionalized cadre, that they should be equipped and able to do their roles with dignity, that they are paid, that they have the knowledge.

One thing about Living Goods is we truly believe digital and data is powerful, that they are well supervised as well. For me it is then the actual people doing the work, the hard work, those community health workers benefit from being able to do their job well, and being treated with respect, and that they have a job, and they are paid for it, and they are building skills which will develop them, potentially if they want to, to do more outside of just being a community health worker.

So I think there's so many layers, starting at the health system, and then those community health workers, and of course overall, that the governments, the countries have that strength in terms of providing health to their citizens.

Ashley Hopkinson: There are a lot of wonderful health organizations, and I think they're all necessary because they're answering different pockets of needs in our communities. What would you say makes the work of Living Goods distinctive in this space, particularly in the health sector?

Liz Jarman: I love the radical collaboration we have, and I think we all do bring different things, and we try and work in different places so we're not overlapping, and we can learn from each other. But I think for us, we have real deep experience from working at quite a high scale across multiple countries. We're in Kenya, Uganda, Burkina Faso. I would say we're a very locally rooted organization, and a learning organization as well.

There's probably four things [that make us distinctive in the health space]. I touched on it earlier, but our deep digital and data experience goes back to 2014. It's actually when I joined the organization, so I've been there for 10 years, and we created an app on a smartphone for community health workers. I think we were one of the first ever to do it over 10 years ago. I was skeptical whether this would ever take off, I'll be honest. Obviously, I became a big convert. But I think because we have been doing it for 10 years, we know what it takes to scale, and it's not easy to digitize, but the benefits really outweigh the complexity of digitizing community health workers.

We have 60 staff now, from software engineers, to infrastructure, to data management experts, predictive analytics, all doing this work. And whilst there are some great technical organizations that build the platforms like MEDIC, ONA, Dimagi, to name a few. We don't see ourselves as a technology organization, but we know how to scale, and we know how you optimize that technology to really drive health outcomes ultimately. I think I always say there's a bit of a myth that you put a phone in the hands of a community health worker, you have an app, and it's a bit like downloading WhatsApp, and off you go. If only it was that simple. It's not. What should the app look like? How do you consistently have that across countries? How's the data back end work, et cetera. There's a lot that goes behind it, and we've been doing it for years, and we know the pitfalls and we know how to get the most out of it. So that's the first thing, the digital, and then how you use the data.

I think the other one is a term that is performance management approaches. In the public sector it's not a term used a lot. I come from the private sector, so I am used to it. It links to the technology, and that technology should not be just a data collection tool. Often that's what governments want, and that's fine originally, but it's much more. I think data should be collected passively, like secondary. It's a tool to allow community health workers to perform the best they can, whether that's when they're triaging a sick child and there's a workflow guiding them through that, or whether it's reminding them what to say to a pregnant woman at certain stages of her pregnancy, or how to talk about family planning, depending on where the woman is in her needs, or sending reminders if you need a top-up of your family planning, or you've treated a child for malaria and you want to check.

It is really making the quality of your work much better, but I think it's also allowing supervisors, and we're a real believer that you need strong supervision, supervisors of community health workers to see how community health workers are doing. And maybe they're not doing well because they've got knowledge gaps, maybe they've moved away, maybe someone's sick in their family, but you know that and you can try and address that. And in the same way, we've had supervisors ourselves, managers who coach and mentor you and hold you to account, and they don't just send you on a training course. I think it's about that as well. So, for me it's our deep

knowledge, and data, and digital, and also how you use that data to drive performance, and ultimately, health outcomes.

And then I think probably a third area for me is about meaningful government partnerships. I think this is probably the one area we've evolved a lot and learned a lot. We started off as a bit more of a social enterprise. In fact, we were selling products. We then moved to recognize that we needed to be better at health system strengthening, and now I think we've learned a lot about how to build those deep, lasting, government-led partnerships. What we do now is only scale where there is co-financing from the government. We've learned about how you get that deep commitment from the government. How do you align to have multi-year, long-term relationships with the government, but there's skin in the game, so they gradually invest more as we reduce. We're in it for the long game, 5 to 10 years, or whatever it takes, and we recognize that you have to support on the ground, very much hands-on, as well as at the national levels.

Kenya is a good example. It's probably where we've learned and where I think our expertise is really coming through. Next year more than 7,000 community health workers in Kenya will be supported in this way. Health in Kenya has devolved to the counties. It's a county system and there's forty-seven counties. We have contracts with five counties so far, where they commit to financing. It is a very high return on investment for us, because about 50% of my Kenya program costs are paid for by the government, but that's not the main driver. I think the biggest thing is not just because it's efficient for us and our investors, but actually, it means there's deep government buy-in, there is skills development, there's lasting ownership. And I think we didn't have that when we've done things in the past.

When I talk about co-financing, co-implementation, we are still very hands-on. So pick one of those counties in Kenya, Kisumu, it has 3000 community health workers. Some entire countries almost have that, so it's a big county. But even with this co-implementation model, we have over 30 staff based there, which will reduce over five years, but it's still very much hands-on.

Ashley Hopkinson: This might be specific to Kenya, because you have the deep roots there, and the co-financing and co-implementation is already happening. But I wonder if you could share an example from your work that illustrates the impact of the work.

Liz Jarman: That was actually the next area I was going to say is really important to us. It translates to durable impact, and that's really important. First of all, I think we have invested in external evaluations. We've had partners fund that, so we have actually done two RCTs [randomized control trials].

It happened to have been in Uganda, but I think it helped us. We got the results in 2014 for the first one. We showed an amazing 27% reduction in child mortality, and that was at a relatively small

scale. We were quite small then. We wanted to prove that it was working. There were about 500 community health workers. We learned a lot, but then we went, "Oh my goodness, this is working. Let's see if it can work elsewhere." So then we took that model to Kenya. We actually then, several years later, did a much bigger RCT, with 4,500 community health workers, supporting 3.6 million people. So this is now at scale.

We've just got the results. It's not yet published, but should be soon, which has shown a 30% reduction, so almost slightly better, in fact. For us, evaluations aren't actually just about, "Hey, look how good we are. We've got something that works, which is important." It is trying to unpack what it is that makes a difference. Not just for us, but for others. But it also allows us to course correct as well if things aren't going well. We are an organization that looks at the midline review and says, "Okay, what's working? What's not working? Then do we need to adjust anything?" So I think we've got these studies to show it's working, but I think what we've also done is really try to codify what it is that has enabled those results. And when we're supporting governments, how do we make sure that that is front of mind? How when we talk to others who want to do similar things, can we really pull that out. So that's your big, fancy evaluations.

Another example in Kenya, because you talked about Kenya, was we have real time data there, or thereabouts, which is able to show the number of pregnancies registered, the number of sick kids that have been assessed and treated. You have this real impact. And we've been doing it now for eight years in Kenya, and the counties have seen some of the health indicators come down. For me, an evidence of impact in a slightly, shall we say, less scientific way, is when the Kenyan government wanted to create an electronic community health information system, so they recognized Living Goods as a partner that had been doing this already, and they asked us to be support and spearhead the design and implementation. What they've created is based on the app that we had worked with from 2014.

Right now, for me, this is a demonstration of this journey for eight years, where President Ruto was committed, and it's now happening, nationwide scale-up of digitizing all 100,000 community health workers in Kenya, paying them, and equipping them. That's also a demonstration of impact when there is investment at that level, something's going right as well.

Ashley Hopkinson: How does Living Goods measure success, and what is the evidence that you're making the progress?

Liz Jarman: It's an interesting one. I think there's a couple of things we think. We always think that impact equals the impact per CHW, so she is delivering the results, and there's lots of ways to measure that, times the number of CHWs, but also the length of time.

And there's always a bit of compromise on some of that as well. If you're doing direct service delivery, you can get a very high impact per CHW, but your reach isn't going to be as far, and is it going to be as durable? Is it going to last once you've gone? So we try to think of those three factors in how we think about impact.

In terms of our theory of change, we're still very much focused on measuring RMNCH [Reproductive, Maternal, Newborn, and Child Health], so health outcomes at a country level. Even if we're not everywhere in the country, if we could try and work where the greatest need is, then hopefully that will help. And also have an amplifying effect that others can learn from us, even if we're not supporting directly, then we want to see some of those health indicators, sub-national, nationally move. And those RCTs obviously help to show where we want to get to, but we're not always going to do big RCTs every time. So we've actually created something called High Impact Health Touches.

We wanted to find a way to capture a composite proxy of all the work a community health worker does. There's 11 or 12 components, and they're really based on proven, real-world effectiveness, that these interventions do lead to saving lives and reducing health burden. We can track the data, and it represents at least 80% of what a CHW does.

For example, these 11 components are like doing a malaria diagnostic, referring immunization, registering a pregnancy, doing a PNC visit, postnatal visit. So they are activities a community health worker does that we can track and will save lives. We have a way of setting a target of what that should be, but we also use the Live Save tool, the list tool, which came out of Johns Hopkins School of Public Health. It is quite widely used. But you can take those individual components, and you can model the number of lives saved.

One of the things it does is it allows us to see how well the community health worker is doing in different programs, different countries. Some people really want convincing on the return of investment. We've even done studies to show what are the hits for per $100 invested.

It's one data point, and again, the impact per CHW that you then have to say how many, and over a period of time. For us, it is about professionalizing and digitizing community health workers, and actually moving the dial on health outcomes. To have it durable, and lasting, and scaled, then the next outcome that we really try and measure, which is much harder, is if there is increased ownership and investment in community health by governments. That's where we start to try and look at a number of system change indicators, and they are very specific per country. We're trying to now look at a more scorecard approach at a country level.

We've used something called a name tool, which looks at 10 pillars behind a community health system, and the four levels of functionality. Where are they on a journey? And we do that if we're

working sub-nationally. We're also starting to think about what that might look like at a country level or nationally. How do we move some of those? It's interesting, in our theory of change, we also said an ultimate outcome is that countries we work in, but also countries other partners are working in, so recognizing everybody is doing this, whether it's Muso in Mali, or Last Mile Health in Liberia, or whoever, that there's this cohort of countries that have high impact durable community health systems, and there's this body of evidence coming which is really starting to recognize the importance of professionalizing, digitize, and importantly, these countries are inspiring other governments to invest. We're starting to see that with the global fund commitments, USAID is talking more and more, the government of Kenya, Burkina Faso, where we work, and I think the Community Health Impact Coalition, is also the coalition we work with. They have a great scorecard to measure that. So I think there's, again, you've got measurements at a community health level system, and then you've almost got global movement measures as well, which I think is important to keep, to get into the detail, but step back as well.

Ashley Hopkinson: I want to know what you've learned, what teachable lessons can be taken from the work that you're doing, that maybe others could use? One of the things that comes to mind is that you chose to do the digital app. Why did you decide to do that in place of other strategies? Or you've got the co-financing and the co-implementation. How is that working? What insights and lessons can you share that you've learned along this journey in doing this work?

Liz Jarman: They're the great ones that actually come to mind. We truly believe that digital and data does drive performance, and is a key enabler of lasting results. We've got the evidence now to show that it's worth the investment, and you can see the governments coming along. But I think what I would say to others is, it's worth the investment, but it's not easy to do.

It's not just about putting a phone in the hands of a community health worker. There's a lot that goes behind it. How do you have this performance management approach that I talked about earlier? So one example is, I've talked to others who look at you, going, "Wow, we don't do that." And it is how we set targets. And I know the first time we talked to our government partners about, "Let's set the targets for the community health workers." And they go, "What? You set targets?" And because there is still a bit of a mindset they're volunteers, even though things are slowly moving, there's a bit of a mindset of "why should you set targets?"

But we have very robust tools, where we look at the disease, the published disease burden. We look at the population, we look at results that have been achieved to date, and we do use terms, like in the private sector, market share. What market share of the disease should community health workers be addressing, and therefore, how many pregnancies should they be registering? How many women who have unmet family planning needs should they be engaging with? How

many sick children they should be assessing. It just gives you a sense, and you can create this high impact health touch measure as well to monitor.

I think there are some things we've done which feel a bit scary, but it's like, what are the targets they should be hitting? Even if the community health workers don't know it themselves, what does good look like, so we can really ensure they're reaching their full potential. Then, using this huge amount of data that is passively collected from the tool to deep dive when things don't look great.

I'll give you an example of what we're doing in Uganda right now. We did this new market share analysis of family planning. We've been doing family planning for two or three years. We get pretty good results, but we suddenly looked at the market and the needs, and where the communities have actually come, there's much more appetite for it. And we said, "We're not capturing enough. There are unmet needs that we are not addressing, so let's set higher targets and then figure out how we get there." We've improved this year by doing that by 20%. We wanted to get even better. By deep diving, using the analysis, you are able to find a statistic like we've just got, 42% of all referrals in Uganda are not being completed.

So then you can get into, "Okay, what are the issues behind that? What's the quick fixes? What is going to take time? What might need policy change? What might be needed much longer term? What can we do now?" And I think that getting that mindset of what is it going to take to move the dial on some of these health indicators, and how do you use that data really effectively, I think is an area we've really spent a lot of time doing, and why I think we've got some of those high results that the RCT were showing.

I touched on this earlier, I think hand-in-hand with that is another subject matter that people, other partners, but also governments, don't particularly like discussing. This is the broader performance management of a community health worker. It goes back to what I was saying before about this mindset that they're volunteers. If they are being professionalized, they are being paid, we should respect them and treat them as such. And of course, if there is a community health worker not delivering, you want to support, you want to find out why, you want to help them.

I've had a number of conversations with government to say, if we've done everything we can, and that community health worker is not serving her community effectively, there are families that aren't being supported. So if we've done everything to identify the issues, supported her, or maybe she's just not around, then we have to have the conversation about replacing her. It's no different than a staff member in our team. We hate doing that, but sometimes you have to go down that route. I do think that's another area that we should be willing to tackle and have those difficult conversations.

I think upskilling supervisors and having that mindset on setting targets, and supporting, and coaching, and mentoring is important. It's quite unusual in the public health system, and I think something that hopefully others could learn from as well.

Ashley Hopkinson: How would you say, as an organization, Living Goods is working toward systems change in the field?

Liz Jarman: First of all, it is that government partnership. It's recognizing that how we do it, is by partnering at every level. [We do this with the] co-implementation, co-financing, on the ground partnership with a view that we want to walk away, but that it's going to take time. It could be 5 or 10 years, and we'll reduce over time, and they take more ownership. That partnership definitely, I think, leads to systems change.

And of course when I say on the ground, we're supporting the supervisors, we're supporting the supervisor managers, we're supporting the program lead in that county. But for that to be successful, you'd also need what we call a really strong enabling environment. New policies are an important example. [In Kenya] there wasn't a policy to allow community health workers to treat pneumonia with amoxicillin, whilst that was very much approved everywhere else, and in almost all other countries in Sub-Saharan Africa. It's one of the leading causes of child deaths.

And so, it took us five years, but we were able to do a project using the digital tools to show how this could be managed and get the policy changed. Interestingly enough though, the policy has changed, and we just assumed it would roll out, but there's real reluctance, so now we're also having to do more evidence based work in other counties to build and show that digital tools allow there to be more controls in place than without them. The enabling environment could be very practical policies like that.

For us to professionalize community health workers, it is digitizing, it is supervising, it is compensation, it is having access to tools and knowledge. We call it DESSC, digital, equipping, supply, supervised and compensated. It is also about ensuring, in the countries we work in, that that is recognized. In Uganda this year, for the first time ever, that was actually in a policy. And for me, a win is when the government officials start telling me about DESSC, "Have you heard of DESSC? We're really believers in that." It's like, "Yes, get in there." Kenya, it happened a long time ago, and now it's being funded by the government, and Burkina Faso, there's actually a policy review underway that we are helping the government to do..

I think it's really important that it's not just about policy. It is then what that policy cost, financed, actually materialized. And I think that's an interesting one in Uganda right now. We ask, how do we keep that moving forward so it's realized like it has been realized in Kenya? But then in Kenya, how do you hold them to account so that it's done and you're getting the health outcomes. So it's a

journey, and that may include us seconding staff to government. It's working in coalitions, it's doing return on investment case studies if needed. There's a lot on policy change and financing.

As I said earlier, I do think working in coalitions is so important. I banned the word competition in Living Goods. I think we should all work together, we should advocate together. We're much stronger. There's partnerships like Sheik. In Kenya, there's one called CHU for UHC. It makes a huge difference, and we definitely shouldn't be duplicating, we shouldn't be competing. So, for me, coalitions really help drive systems change as well.

And I think purely investing in community health workers, as I've shared already, helps build a strong foundation to a resilient health system. The digital tools create that strong foundation, and evidence, and data for decision making at every level, but I think it also empowers community health workers to have a whole load of skills. They're doing dignified work, they've got digital tools, they feel enabled, empowered to do the work they're doing. If the CHWs go on to use their skills in other ways in their communities, or other for me, I think it's broader development and economic push in the country as well.

One thing we are bad at, and we're going to really push to get better, is we're a bunch of doers and we're not very good at documenting what we do. We get stuff done, but when somebody says, "Well, what do you do? It's like, "Yeah, good question." And actually, you asked about guidance to others. We've had quite a few partners and even other governments say, "Can you come and give us some advice, and help with this?" And of course we want to do that. We're thinking, "How do we do that really well?" And it starts with having something documented. We recognize that there is a role to play in documenting what's working, creating potentially some global goods that can be used by others, and then offering some advisory services, whether that's paid or not. It's an area we're figuring out, because I think you have a responsibility when you've learned a lot, to actually be able to pass on that knowledge and not just keep it to yourself, or those directly you're working with, the wider field. That, I think, has a broader change role as well.

Ashley Hopkinson: What would you say is needed from other partners or people in this space to advance systems change?

Liz Jarman: One of the lessons we learned is truly listening to what problems the governments are trying to solve for, and not just come with your solution. “This is what works, now you need to do it.” I think you have to have more of a co-creation mindset about “this is the problem they're trying to solve for, you've got some great evidence, so have other people. How do we bring that together?” It is really important to have evidence-based interventions, and work with that. Governments don't always know what they don't know, so you need to bring some of that evidence, and also to really listen and co-create, have that co-financing element. So, I think there's

co-creation and co-financing, which obviously requires enhanced domestic funding or institutional funding.

I love the collaboration we have with many partners, but I think there could be even more, so I do think it's so imperative that there's no duplication, there's no competition, that you are really recognizing each other's strengths and you're coming together. And it doesn't help, the way some of it is funded. I do think we're quite fortunate, Living Goods, that we're not reliant on a lot of the big restricted institutional funding. We know that that's where a lot of the money is and it does force very different types of partnerships too. We're trying to find that right balance [with our partnerships].

Lastly, I guess it links to the funding and it links to people's passions as well. We've been in places where I talk about community health workers really being able to be professionalized and reach their full potential. They need those four elements, the digital, the equipping, the compensation, and the supervision. Often there's an interest, so they just want to do digital without paying a community health worker.

Ashley Hopkinson: You have to pay people.

Liz Jarman: Well, they'll pay them and digitize them, but there aren't actually any supervisors.Or they don't have access to medicines. And whilst I recognize it's a journey, we use the acronym, DESSC, to try and sound like a table, like four legs of a table. And I say to the teams, often, "You build one leg at a time, although it can be a bit wobbly and it needs fixing, and that's what you're trying to do, you're trying to get those legs in place. Not everything's going to be there from day one." I know other people use different terminology, and it's all essentially the same thing, about professionalizing community health workers, but I think not having short-term funded projects, just one of those legs, is another area that causes all sorts of issues. Something we've pushed very hard for in Kenya. Although a lot of talk is about digitization, it is that they're paid, the supervisor's already there, they've got kits to do the job. But in Uganda, really, the focus is on digitization, and there isn't really a lot of the other stuff happening, even though we're working away behind the scenes, trying to [trying to get the other legs on the desk.]

And when they are digitizing, it's a short-term project for three months, and then people walk away. It's like, "Whoo." It's recognizing that the job isn't done once the policy's written and there's been a few projects. There's a lot. It takes a long time to move this to get to those ultimate health outcomes and system change outcomes.

Ashley Hopkinson: In all your years of experience in this sector, What lessons did you learn from some of the things that you have tried and implemented that did not work or did not meet your expectations? Can you share something?

Liz Jarman: One of our values is being inventive and adaptive, and I think we've had to do that. We're still always trying to find the potential for a game-changing impact and test new things. We have something called learning sites, where we're constantly thinking about what else could happen, and how do you fail fast and learn quickly.

I touched on family planning earlier, about the first time we implemented family planning. It took over a year to get any decent results. We got it really wrong. We thought you'd just talk to a woman, give her her options, and job done. We recognized that you have to visit over numerous times. There's different ways to talk about different things. And so, although we thought we'd learn from experts, there was a lot in the practicality that took time.

We often think about what and how a community health worker would do. What she's doing, like family planning, and then how. We've looked at different supervision models, and we came up with a peer supervision model. But again, when we first did that, we had some perverse incentives, so the peer wasn't supervising in the right way. We didn't get the ratios right. We've got a really good model now, but it was painful to get there.

There's two others that come to mind: co-implementation and co-creation with governments, and signed contracts. I was Kenya's country director when we first tried doing some technical assistant models, and you've noticed I avoid that word. It was terrible, it didn't work. The government wanted it. They wanted to be leading and doing it, and we said, "Yeah, we'll come in and help." But as soon as we left, nothing continued. And that's where we realized you need skin in the game with the co-financing, because then there's real commitment. We started codifying this DESSC element, those four legs of the table, and really thinking about them, and thinking about, "So, okay if they're wobbly, but there needs to be commitment that that is happening." So, codifying that was something that was needed, and we didn't do that at first, we just went in and thought we knew how to improve it.

I can tell you, at the midline, we were not heading towards any mortality reduction. Those early results shared that it's not looking good, and so we went back to basics, and we said, "What are we doing? What's different from what we did before?" When we were at scale, some of those basics had actually drifted. In how important thinking about the four legs was, meant it was really important for us to codify that.

Ashley Hopkinson: That is a good segue into the next question. We talk a lot about funding in this space, and it's necessary, because funding is what's driving the work and raising sufficient funding can be a challenge. Outside of that, what challenges have you faced or you're currently facing, and how are you working to overcome those?

Liz Jarman: When you're not doing direct service delivery, what is good enough? If we were doing it ourselves that impact per CHW will be higher. We have all those DESSC elements, and we've been doing it for years, we're laser focused on it, we don't have lots of other things we have to do and run other health programs. We know if we do it ourselves, we can get really high results. And we know that, as I started off by saying, every single family deserves healthcare, they need the best care.

To be scalable, we do believe governments have to own it. We know that there will be a compromise in that per CHW target, but how much? We're going through that right at the moment. So, right now in Kenya, where the government is owning and leading and delivering, they're hitting about 50% of the performance, if you take those hits as an example, that we can deliver if we do it ourselves in our learning sites. Our learning sites are where we learn, but also our gold standards of what is possible. We're hitting 50%. Is that good enough, or should we be aiming for 60%, or should we be aiming for 70%? That's a challenge for now, “what is good enough”, because you're going to get that impact over far more people over a longer time. There is a compromise, but what compromise? I think that's one.

I think another interesting challenge that we've had to overcome, and we have since overcome it, is when we are still sometimes seen from where we started 15 years ago, having this entrepreneur model. We pivoted because we learned along the way that whilst that can work at a very small scale as a social enterprise, it is not scalable. And in fact, the revenue generated for us was minimal. The revenue generated for the community health workers was not a lot. It adds a huge amount of complexity. And so, we've learned. People come to me and say, "Liz, entrepreneur model." Like McKinsey will say, "Oh yeah, it's the answer to all the problems of funding community health workers. You've done it, you are experts in this." And I go, "Yeah, and we don't think that's the scalable route." So it's an interesting challenge about who we are. Maybe we haven't documented that journey well enough, probably, knowing us.

The other challenge right now is that there is a bit of a view that the job's done. People are talking about community health workers, they recognize the need for them. There are some commitments being made, some money going in, which is wonderful. Of course, we're so excited by that. There's presidential commitments like in Kenya. But as I said to the team, now the hard work really begins. A, there's still not enough money and long-term money, and B, to actually get those health outcomes, to actually get high performing community health workers that feel engaged, that are delivering strongly, that are saving lives in their communities, there's a lot more that needs to happen. And I think a challenge for us is there's a feeling that the job's done, and it's not. I think it's only just starting. Those three are the main ones.

Ashley Hopkinson: What would you say is your vision for Living Goods in the next five years?

Liz Jarman: We're in three countries, and I think every country's in a different place. Kenya's already started professionalizing, or not. There's a journey there. Burkina Faso will start, considering there's a huge amount of political and security unrest there, they're still investing far more of their budget into health than many other African countries. I think maybe even the highest. And we'll be moving to that co-financing model there. I think Uganda is quite behind, so we are looking at how we consolidate to influence much more. So we're on a different journey in all three countries, but ultimately we are moving towards more ownership and health outcomes improving. I'd love to get us to a similar place if there is sustained funding, because we're always there for the long term in other countries.

I think the other thing, and I touched on it earlier, is how do we not have to be everywhere? How can we share our experience, our knowledge for others that want to use it? I think there's a bit of a responsibility there in demonstrating what's worked, and what's not worked.

The other area that we've been learning about is supporting government a lot, and getting the digital tools really optimized. We haven't driven as hard on the innovation side. And again, it's linked to [the idea that the job's not done.] I think there are lots of ways that you can continually innovate and improve the cost-effectiveness. Whether that's telehealth using community health workers, or that's using GIS to map how CHWs work more effectively. Whether that's predictive analytics, or AI, or community-based disease surveillance. Again, thinking about the "what" and the "how". I think there's still more that could amplify CHW's outcomes. It can set up governments to succeed even more so, more cost effectively. There's more that I want as an organization, to be looking at what's happening, what's coming around the corner in five years time, and to continue to be innovative. I think those are probably the two areas.

I hate jargon. I try really hard to avoid it. I haven't used the words "capacity building" or "technical assistance". The other jargon I don't particularly like is "localisation", but that doesn't mean that there's no importance behind that. I do feel we're very grounded and locally rooted. I live in Kenya. All our country directors are now from the continent, and I was a country director. I know they're doing remarkable work, far better than I would ever have been able to do it.

When I became CEO over five years ago, there weren't enough Africans on the board. I wanted advisors who could help me move that, and there's now more than 50%. I think about 60% of my team are Africans, and the rest have deep experience. So, for me, it's not just ticking a box, it's really having that deep knowledge, that deep input into making the work relevant. Of course I am investing a lot in developing more African talent, finding talent, but it takes time. I think that's the other thing that, for me, having a sense of "it's the right thing to do", but doing it in a considered way, and not just getting on a bandwagon. I think we are heading more and more to stronger African leadership, but doing it in a considered way.

Ashley Hopkinson: That's great. Thank you, Liz.

Ashley Hopkinson is an award-winning journalist, newsroom entrepreneur and leader dedicated to excellent storytelling and mission-driven media. She currently manages the Solutions Insights Lab, an initiative of the Solutions Journalism Network. She is based in New Orleans, Louisiana.

** This interview has been edited and condensed.*