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Visions of Community Health and the Social Good in Kenya: Turning Community Health Workers into Entrepreneurs

Edwin Ambani Ameso and Ruth Jane Prince

ABSTRACT

In East Africa, social enterprises that fuse development work with entrepreneurial activities and a language of 'innovation' are becoming prominent. Critical of the NGO/donor model, which they hold as unsustainable, such organizations are funded by corporate investment and philanthropic capital but aim for self-reliance through enlisting local actors to market social services, while providing loans, digital infrastructures and training in entrepreneurship. Based on ethnographic fieldwork in Kenya, this article examines the ethos, ambitions and practices of one such enterprise operating across Africa — Healthy Entrepreneurs. This not-for-profit organization seeks to enable community health workers to become 'health entrepreneurs' by training them in business management and offering them a loan and mobile phone from which they order health commodities online and sell them to rural communities. Focusing on the perspectives, motivations and experiences of local managers and the entrepreneurs themselves, the article explores relations between entrepreneurism, community health work, sustainability and the 'social good', and the frictions surrounding them. The model of turning community health workers into entrepreneurs, which fosters competition while placing the burden of success onto the individual, shifts the ethos of community health work towards a focus on business. However, the moral economies in which community health entrepreneurs are embedded complicates this picture.

INTRODUCTION: A SOCIAL ENTERPRISE MODEL FOR COMMUNITY HEALTH WORK

At a 'cluster meeting' held under a tree at a rural health facility in western Kenya, Mike,[1] a young man in his mid-30s, examined a pile of paper forms placed on a wooden table. Facing him were 10 community health workers, rebranded as 'community health entrepreneurs', dressed in their signature

1. All personal names and locations used have been altered as part of anonymity and confidentiality considerations.

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green shirts and caps. They were waiting to receive the off-prescription medicines and commodities they had ordered, which Mike had transported in the boot of a Toyota. Mike — a graduate from a Kenyan university and the father of two small children — was the local manager of Healthy Entrepreneurs, henceforth HE, a not-for-profit social enterprise founded by a Dutch expatriate in Uganda in 2011. The organization seeks to support primary healthcare by creating alternative infrastructures for delivering health commodities and information to rural populations, and aims to make community health work more 'sustainable' by offering community health workers (henceforth CHWs) an alternative form of income generation (Borst et al, 2019; HE, 2022). In particular, HE seeks to create what it calls 'entrepreneurs' out of some of the volunteer CHWs, by providing the infrastructures to enable them to run small businesses selling off-prescription medicines and other commodities.

As Mike checked through the orders, two of the community health entrepreneurs (CHEs) distributed paracetamol tablets, sanitary pads, condoms, multivitamins, pain-relieving gels and balms and other products, with each individual receiving the items they had ordered. These CHEs were a group of eight women and two men, aged between 30 and 60, who had received a two-day training from HE on business management, health information, and on using the organization's digital platform. Mike had recruited them from a pool of CHWs who were attached to the county government's 'community units';[2] they continued to serve as CHWs, linking rural households to healthcare facilities, offering health information and reporting vital events, among other duties. To become a CHE, they were required to raise 4,000 Kenyan shillings (Ksh) — circa US$ 40 — and attend the training. Along with the distinctive green T-shirts and caps, received for free as part of HE's attempts to, in Mike's words, motivate and incentivize them, the organization issued the CHEs with smartphones and a starter pack with healthcare products and off-prescription medicine worth US$ 70, on credit. It also offered the CHEs a start-up loan of Ksh 8,400 (c. US$ 84) to be repaid in instalments of Ksh 700 (c. US$ 7). For the credit extended to CHEs, the organization expected repayment within the first year.

At monthly cluster meetings like the one Mike organized under the tree, the CHEs receive the products they have ordered online from digital platforms, usually on credit.[3] The organization buys these medicines and commodities wholesale and delivers them to CHEs who sell them to 'community

2. The county governments are the 47 semi-autonomous political and legal entities which act as administrative units under Kenya's 2010 Constitution that ushered in a devolved system of governance. A community unit refers to the lowest level of health service delivery which is provided by trained volunteer CHWs and includes basic health promotion and disease-prevention services (Aridi et al., 2014).
3. Payment is via Mpesa, Kenya's mobile money payment platform, run by the telecommunications giant Safaricom.

members', choosing a price that they find suitable and using the small profit to pay off the loan and order more goods. Their earnings are supposed to supplement the Ksh 2,000 (c. US$ 20) they receive (or should receive) monthly from the county government as community health workers, providing, in Mike's opinion, a more sustainable income.

At the time of our research (2018–20), Healthy Entrepreneurs was operating in eight countries across the African continent, with start-up funding from the Dutch government, the Gates Foundation and corporate investors. In Kenya, it was present in six counties of the western region (Kisumu, Homa Bay, Siaya, Vihiga, Kisii and Kakamega), focusing on rural and remote, 'hard-to-reach' communities where, according to HE, people experience limited access to health facilities and a perennial shortage of health commodities, including off-prescription drugs (HE, 2019).[4] As explained to us by its Kenya-based staff, and as outlined on its website, HE promises to stimulate social development by introducing CHE programmes centred around social marketing, social franchising and micro-entrepreneurship to achieve social goals, among them improved community health (Borst et al., 2019). It targets rural populations by training selected CHWs as micro-entrepreneurs who sell affordable health products and off-prescription medicines, while providing information and other services (HE, 2019). These activities are in addition to the routine community health work they do, which is supported by county governments.

HE is managed by staff deeply motivated by concerns about how to do development in what they perceive as a more sustainable way. They are critical of dominant models of financing and organizing community health work. In Kenya, as in many African countries, CHWs are volunteers and are supposed to receive a US$ 20–30 minimum monthly stipend from county governments, NGOs, or donor-funded projects. HE argues this model is unsustainable, given that CHWs receive their monthly stipends either irregularly or not at all. Instead, HE aims to create a network of these community health 'entrepreneurs', expanding rural communities' access to health products and services while developing alternative forms of income for community health workers. The organization therefore recruits selectively from an existing pool of CHWs, training them in entrepreneurship, including accounts management and how to run a small business.

During the past decade, social enterprises involving new models of community health work have become prominent in many countries in the Global South, alongside arguments that they offer more sustainable ways of organizing primary healthcare (e.g. Bärnreuther, 2023; Gandhi and Raina, 2018). Following trends in development more broadly, such organizations

4. In 2023, HE stated its aim to expand into other Kenyan counties and to create 3,500 community health entrepreneurs (Challenge Fund, 2024). Liaising with focal persons within the county Ministries of Health, HE has ventured into Marsabit, Kilifi and Nakuru counties (HE, 2021, 2022).

introduce what they call 'market-driven solutions' into development and global health (Dolan, 2012; Huang, 2020; Kar, 2017; Schwittay, 2011), promoting themselves as sustainable ventures combining business principles with 'a passion for social impact' (Macassa, 2021: 1). Making use of emerging financial, technical and digital infrastructure and promoting a language of 'disruption', they argue that models of entrepreneurship, self-help and social enterprise are key to driving the innovative social change that has been lacking in state-centred or NGO-driven development (Irani, 2019). In the social entrepreneurship literature, 'social business' describes an organization that runs commercial operations to address societal problems (Santos et al., 2015). As the language of sustainable development has become central to the social business model, the idea of the flexible entrepreneur — a bottom-of-the-pyramid figure who can 'adapt fluidly to multiple economic activities, embody risk-taking subjectivities, and move easily across social and spatial boundaries' (Huang, 2020: 33) — has become highly valued (see Hisrich et al., 2017; Lombard and Strydom, 2011; Praszkier and Nowak, 2012). An 'ethos of innovation and entrepreneurship … has colonised philanthropy, development projects, [and] government policies' (Irani, 2019: 1), including, increasingly, global health and primary healthcare (Bärnreuther, 2023). Like other social enterprises, HE aims to instil market participation at the bottom of the pyramid, to harness the power of 'social connectivity' and to offer the promise of social mobility (Elyachar, 2012).[5] This model is supposed to empower CHWs, releasing them from dependence on NGOs and the erratic governmental monthly stipend.

Critiques of this model of entrepreneurial development are manifold (e.g. Dolan, 2012; Dolan et al., 2012; Huang, 2017, 2020; Irani, 2019; Kar, 2017; Lazar, 2004; Schwittay, 2011) and make a number of points. Development is outsourced to the entrepreneur (often female, marginalized and poor) who is made responsible, through her entrepreneurship and empowerment, for development outcomes. The focus on entrepreneurship assumes that independence, empowerment and success can be achieved through developing business acumen, asserting new moral repertoires of the social good and the moral individual while ignoring pre-existing hierarchies and the social relations in which people are embedded. Such social enterprises often involve competing goals, such as promoting women's empowerment while tightly controlling their activities and monitoring them. Moreover, as Huang's ethnography demonstrates for iAgents in Bangladesh, the entrepreneurship model is not stable but in transition, may be only partially translated, and is often contested, both because the targeted communities approach social enterprises within older models of development patronage and because market models exploit existing moral orders of sociality (see also Bärnreuther, 2023). The entrepreneurs themselves must therefore navigate competing

5. This ideology has been critiqued for creating what has been called 'poverty capitalism'.

logics and conflicting roles, leading to unresolved tensions and contradictions. While the model may indeed empower some individuals, it also creates new fissures between those who succeed and those who don't — between the deserving and undeserving poor (Dolan, 2012). Finally, entrepreneurs are vulnerable to the precarity of their markets, hence, 'anticipated futures may be short-lived' (ibid.: 7).

Drawing on ethnographic research conducted in Kenya between 2018 and 2020, this article explores the model of turning community health workers into entrepreneurs, which fosters competition while placing the burden of success onto the individual, and which produces infrastructures of health service delivery that run parallel to (while piggybacking on) the government health system. Cognizant of the critiques of the entrepreneurship model, as outlined above, we address the question of why managers and the health entrepreneurs themselves embraced it. Thus, we examine the values and beliefs that undergird the social enterprise model and people's commitment to it, the arguments they make, and the solutions they seek, while exploring the tensions and contradictions that emerged and how these were negotiated. In so doing, we highlight the often-ambivalent perspectives, motivations and experiences of members of HE's staff, as well as the health entrepreneurs themselves, concerning the relations and frictions between entrepreneurism, community health work, sustainability and the nebulous concept of the social good. While HE shifts the ethos of community health work from a focus on service to a focus on business, the moral economies in which community health entrepreneurs are embedded complicates this picture.

Below, we discuss our research and methods and introduce the Kenyan context. We then examine the ethos, ideology and practices of HE's social enterprise approach to community health work; its conceptions of the social good and entrepreneurship; its approaches to sustainability; and its social business model, including tensions between for-profit and not-for-profit goals, approaches to audit and measures of success. We explore the views of community health entrepreneurs themselves, and the frictions that emerge. Finally, we discuss the limitations of the entrepreneurial approach to community health work. While recognizing that CHW programmes have been beset with multiple challenges, we explain why we are critical of the turn towards a social enterprise model of delivering primary healthcare, in Kenya and beyond, and how it subverts much of the ethos of community health work as it has been understood since the 1970s.

METHODS

Our introduction to HE was through Onyango, a community health worker whom the first author, Edwin Ameso, shadowed as he made routine household visits over several months. Edwin was curious about the green shirts

that several CHWs, Onyango included, often wore, which bore both Ministry of Health inscriptions and the HE logo and slogan. Onyango explained that he had been recruited by Healthy Entrepreneurs in 2018 to become a CHE, and offered to take Edwin along to the next meeting.

The material we present here proceeds from this entry point and is based on ethnographic fieldwork in Kisumu, Homa Bay, Kakamega and Siaya counties from 2018 to 2020 as part of our larger project exploring the Kenyan government's attempts to expand citizens' access to healthcare under its universal health coverage (UHC) agenda. During the time of our fieldwork, HE operated in rural western Kenya, with its modest headquarters and administration in Homa Bay and Kisumu counties respectively, and with plans to expand into neighbouring counties.

We conducted observations, interviews and informal conversations with members of HE's on-the-ground staff, whom we also accompanied on field trips and to HE cluster meetings. We also conducted group discussions, informal observations and interviews with CHEs. Edwin spent four months following CHWs who doubled up as CHEs in their everyday work, and conducted household visits to the CHEs after initial invitations. He carried out six interviews with HE field officers delivering, documenting and taking payments for product orders made by CHEs, and further interviews with the HE project coordinator in the region. Accompanying HEs allowed for observation of the HE supply chain and the digital technology used, as well as interactions between local managers and CHEs. Meanwhile, the second author, Ruth Prince, focused mainly on a smaller non-communicable disease project that the organization was piloting in a neighbouring county, interviewing the managers, pharmacist and tele-doctor, attending cluster group meetings at the local market between CHEs and a group of 15 elderly persons with hypertension and diabetes, as well as following the CHEs in their daily work. Together, we conducted group discussions with community health workers and with CHEs. Conversations and group discussions with health entrepreneurs as well as with community health workers who were not CHEs gave us insights into diverse perspectives, experiences and disagreements. Interviews with managers and various cadres of health workers, pharmacists and field officers were opportunities for frank discussions about the organization, its objectives, limitations and challenges, and its vision of community health work.

This research formed part of a larger research project on the Kenyan government's experiments with universal health coverage, defined by the World Health Organization (WHO) as ensuring that 'everyone has access to the health services they need without financial hardship' (WHO, 2010; see also Prince, 2017; Prince and Neumark, 2022). We conducted research in government bureaucracies, NGOs, health insurance offices; with health workers, in hospitals and clinics; and with patients and their families as they negotiated

access to healthcare (Ameso, 2022; Ameso and Prince, 2022; Muinde and Prince, 2023; Prince, 2022, 2023, 2024).[6]

INNOVATIVE SOLUTIONS TO PRIMARY HEALTHCARE IN KENYA?

Since the 1970s, community health workers have been recognized as crucial building blocks strengthening primary healthcare systems, offering a bridge between health centre and community, particularly in rural and remote areas, and acting as agents of health education, disease prevention and development (Chen et al., 2021; Frankel and Doggett, 1992; Masis et al., 2021; Warren et al., 2021).[7] However, structural and administrative constraints hamper the development of robust national CHW programmes (Frankel and Doggett, 1992; Wintrup, 2023). Community health work faces multiple challenges deriving from, among other issues, poor financing and remuneration for community health workers (conceived of as 'volunteers') and an often-romanticized perception of a holistic community. Tensions concerning remuneration, support structures and integration are reflected in community health work and programmes in several countries (see, e.g., Aseyo et al., 2018; Brunie et al., 2014; Dil et al., 2012; Lusambili et al., 2021; Maes, 2017). Moreover, CHW programmes are often embedded in patriarchal, gendered and authoritative, top-down governance structures. Critics have argued that CHWs, as volunteers, are exploited for their free labour by promoting an ideology of self-sacrifice and the virtues of having a 'community spirit'. The recent turn towards expanding healthcare access and services under the UHC umbrella has revived interest in community health work, with CHWs promoted as having the capacity to reach rural communities (Aseyo et al., 2018; Saint-Firmin et al., 2021; Wintrup, 2022). However, these programmes are often pursued without incorporating lessons learned from past failures and successes (Wintrup, 2023).

From 2017 to 2022, the Kenyan government actively pursued a UHC agenda. Policies included improving access to primary healthcare and experimenting with various health-financing models. From December 2018, public healthcare was offered for free in four Kenyan counties, for one year, as part of a UHC pilot funded in part by the World Bank. Reforms of the parastatal National Hospital Insurance Fund, to expand membership and services covered, were also pursued (Muinde and Prince, 2023; Prince, 2017,

6. Edwin conducted 12 months of PhD fieldwork from February 2019 to February 2020, while Ruth conducted six months of fieldwork. Research was funded by a European Research Council grant no. 759820, PI Ruth Prince (EU Horizon 2020), and Anthropology of Human Security in Africa (ANTHUSIA), EU grant no. 764546.

7. Community health work programmes are a crucial component of the principles of primary healthcare articulated in WHO's 1978 Alma-Ata Declaration. Through CHWs, these programmes seek to provide health promotion, disease prevention and healthcare services at practicable costs (see Frankel and Doggett, 1992).

2022, 2023) and continue today. These moves have taken place amidst a reduction in donor funding for global health after the 2008–09 financial crises. International organizations as well as governments are encouraging 'alternative financing' for health systems, looking particularly to corporate investors and private–public partnerships. Entrepreneurship is promoted as one such financing mechanism. This terrain offers fertile ground for organizations like Healthy Entrepreneurs, which raise funds from philanthropic and corporate investors, with the aim of becoming self-sufficient.

It is important to understand initiatives such as Healthy Entrepreneurs in the context of Kenya's health system. The 2010 Kenyan Constitution devolved some aspects of management and delivery of healthcare services to the 47 county governments, retaining policy and regulatory functions at the national level (Masaba et al., 2020; Moses et al., 2021). Within the devolved system, CHWs constitute the basic tier of care — reporting on morbidities and mortalities, connecting pregnant women and infants to clinics, and offering health information through household visits. Rebranded 'volunteers' in 2018 and 'community health promoters' in 2023,[8] these CHWs receive a monthly stipend and a national health insurance cover administered by county governments but primarily financed by NGOs and other development partners (Ameso, 2022; Ameso and Prince, 2022).[9] These monthly remunerations to CHWs have been erratic, despite recent efforts of county governments to earmark funds for community health services (Abuya et al., 2021; Koon et al., 2013).

During our fieldwork, CHWs were becoming more vocal in pointing out the challenges facing them in delivering community health. In several counties, CHWs had started organizing themselves, forming WhatsApp groups to meet and protest in the regional capital, Kisumu. They argued that the monthly stipend of US$ 20 is not commensurate with their workloads, claiming it treats them as 'volunteers' and forces them to seek alternative forms of income to make ends meet, while they are expected to spend many hours providing care in their communities. They voiced these concerns in several group discussions we organized with CHWs. In the words of one of their leaders, Rose:

> They [government] pay us nothing and they are calling us community health workers! And you know a community health worker has a family, has children and would like her children to attend school, just like any other child in the community. You know, your money is your money, however little it is …. But when you are planning that if I work by the end of the month I'll get 2,500 [shillings], and nothing comes, sometimes the work becomes very

8. The efforts by the nation state to rebrand community health workers as 'health promoters' reframes the pre-Yaoundé Conference concept of community health work. However, the 1980s CHWs conference in Yaoundé was aimed at highlighting the indispensable role that these lay workers have in achieving primary healthcare goals (Frankel and Doggett, 1992).
9. Historically, NGOs and other development partners have developed CHW programmes providing services in 'vertical', disease-specific programmes while engaging with governments in 'horizontal' CHW programmes (Hodgins et al., 2021).

> difficult. Because you are a mother, you are a father, when you go back home the children need food, they need education, they need clothing. So you know … they put us in a situation … we are just like beggars in the community. And you know the people at the community level know us as 'doctors' [persons with social status and economic means]. [Would] a doctor borrow something from a client? It's so painful! … Our children cannot even get a good education. That's why they are using the [term] 'Volunteer'. The government does not want [the term] 'Worker'. So you know if you say the 'V', in Kenyan law, somebody cannot … should not volunteer for more than three months. When somebody has helped you for three months, he or she should be put on payroll.[10]

Poor and asymmetrical remuneration of CHWs, alongside questions of motivation, have provided opportunities for organizations like HE, which advocate social enterprise as an avenue for community health work in Kenya. HE regards itself as a 'partner' working with county governments to deliver healthcare, and markets itself not as an alternative to CHW work but as an opportunity for CHWs to generate supplementary income. As such, it works with CHWs who are already integrated into the county government health system. As Bärnreuther (2023) argues, while promising 'innovative' models of financing through the market, it is notable that entrepreneurship models and social enterprises continue to rely on the state (see also Irani, 2019; Rudnyckyj and Schwittay, 2014). The Kenyan state provides the infrastructure of community health units and covers their basic stipend, while HE offers opportunities to make alternative incomes while doing community health work.

In 2018, when we commenced our research, HE had approximately 1,000 CHEs in Kenya, distributed in several counties and organized into 'clusters'; they were visited regularly by managers such as Mike, who deliver the commodities, check record-keeping, and address technical and other issues (HE, 2022). The system is held together by a digital infrastructure, which monitors the entrepreneurs' activities, success score and credit rating, as well as creating an end-to-end supply chain for products delivered to the CHEs on-site through local distribution hubs. CHEs place orders for the commodities they sell on their smartphones through an online platform maintained by HE. In 2019, they could order off-prescription medicines, albendazole, vitamin A, paracetamol, oral rehydration salts and zinc tablets, and products such as mosquito repellents, skin care creams, children's toothpaste and nappy creams.[11] Their smartphones contained a health information application, which CHEs used to advise household members about primary healthcare, and a free communication application designed in India, called Kaizala, as well as WhatsApp. HE had designed an online health and vital statistics questionnaire for CHEs to fill out when visiting

10. Focus group discussion (FGD), Community Health Workers' Group 2, Kisumu county, 31 January 2020.
11. Other products are analgesics, female hygiene products, modern contraceptives, other vitamins and soaps (Borst et al., 2019). Antimalarials were initially included, until the county governments intervened.

households. CHEs could also refer patients to the organization's tele-doctor, with patients being charged a fee of US$ 1–3 for such phone consultations.

HE is just one example of a social enterprise entering the field of healthcare, in collaboration with the Kenyan government. Other examples of market-based social enterprises in healthcare in Kenya are Living Goods (founded in 2007 by US citizen and private equity investor Chuck Slaughter), Access Afya (founded in 2012 by US citizen Melissa Menke and private investor Duncan Goldie-Scot), and PharmAccess (founded in 2001 by Dutch citizen Joep Lange) (Dohmen et al., 2022; McKague et al., 2014). Indeed, Kenya (and East Africa more generally) has become a hotspot of similar experiments that seek to increase access to healthcare for citizens by fostering entrepreneurship alongside digital innovations (Neumark, 2023; Neumark and Prince, 2021). Financial and digital technology companies, partnering with Kenya's mobile communications giant, Safaricom, offer digital platforms for innovative forms of health financing, insurance and mobile health, forming hybrids between business, NGOs and social enterprises, and blurring boundaries between for-profit and not-for-profit ventures (ibid.; see also Al Dahdah, 2022; Prince, 2024). Development and healthcare as fields of experimentation nurtured in Kenya's 'Silicon Savannah' are embracing the language of Silicon Valley with its models of financial inclusion through digital technology, and of investment and innovation, where the riskiness of experimentation is positively valued (Donovan and Park, 2019).[12] At a country level, HE signals the growing visibility of private ventures in the public healthcare system. Public healthcare delivery becomes increasingly commodified as the organization seeks out markets and approaches citizens as consumers.

It is important to note that Healthy Entrepreneurs operates in a context where healthcare is already highly monetized (Wafula et al., 2022). From 1989, under structural adjustment policies imposed by the International Monetary Fund, the Kenyan government introduced user fees into all health facilities. In 2004 user fees were abolished at clinics but retained at hospitals, where patients must pay for most medical services and commodities (exceptions are global health programmes funding HIV/AIDS, tuberculosis and malaria services). Due to stockouts in public health facilities and long waiting times, patients are often forced (or may prefer) to use private laboratories, clinics and chemists. Alongside the public healthcare system is a thriving private healthcare terrain (Prince, 2023), which ranges from top-end corporate hospitals to small private clinics and pharmacies, often owned and run by health workers on government payrolls. A culture of entrepreneurship among Kenyan health workers has prevailed since 1978, when the government allowed state-employed doctors to simultaneously work in

12. See Ameso (2024) on the use of medical drones in public health systems in Ghana and Malawi.

the private sector. However, community health work has, until recently, remained firmly within the public health sector.

Entrepreneurship in Community Health Work

HE describes itself as a 'social impact and social investment' organization aimed at introducing entrepreneurship and business practices into community health work (see Lokman and Chahine, 2021). As such, it is deeply committed to improving primary healthcare delivery. Mike explained HE's emphasis on providing a social good in the following terms:

> HE is designed to engage with community health volunteers as entrepreneurs who can earn from their community health services. Some of these people in remote areas cannot access hospitals for quality care. Even those who go to the hospitals do not find the drugs necessary to treat their ailments. They go home when they are still sick. So, HE is trying to make sure that people do not spend on transport to access these far-off hospitals for nothing. The people can quickly go to the CHEs to get the drugs they need. In underserved sub-counties, a majority of people live in poverty and cannot afford medication. With the lack of health products and information, many people remain unreached by essential and quality medications.[13]

During our fieldwork in 2018 and 2020, HE was developing new projects including piloting a project on non-communicable diseases (NCDs), which focused on older people with hypertension and diabetes. The project trained selected CHEs in taking blood pressure and blood glucose readings, equipped them with blood pressure machines and glucometers, and encouraged them to link patients with the HE tele-doctor for consultations and prescriptions, while delivering the pharmaceuticals prescribed — all at prices cheaper than the cost of transport and drugs at government clinics. Mary, the young manager of the NCD project (who worked in a small rural market town), explained that it helped elderly persons, who could save on transport to government clinics where they often wait for hours to find that medicines are out of stock. Now, she explained, a CHE could visit them at home, give them information, take their blood pressure or glucose reading, and link them to the tele-doctor, all for a consultation fee of Ksh 200–300 (c. US$ 2–3) plus the cost of each pharmaceutical (Ksh 80–250, c. US$ 1–3).

This work, to provide especially rural populations with needed medicines and health information, is one part of HE's social mission. The other part is to encourage entrepreneurship as a set of skills and capacities among community health workers, and to stimulate what it calls 'market participation'. HE's vision of community health work thus re-imagines CHWs as both development agents and entrepreneurial citizens, who can produce change in their communities. However, only some CHWs are selected by the organization. Instead of the skill set usually associated with community health

13. Key informant interview (KII), Healthy Entrepreneurs local manager, Seme (Kisumu county), 20 January 2020.

work, such as interest, empathy, 'having heart' and rootedness in the local community, alongside (increasingly) numeracy and literacy (Aseyo et al., 2018; Maes, 2017), HE selects CHEs from among 'the more successful and active' CHWs, according to Mike, based on their entrepreneurial skills: 'We aim to instil business skills and develop business skills and entrepreneurship, making them into CHEs that approach their work as a potential market'.[14] Healthy Entrepreneurs places particular emphasis on numeracy and 'business orientation'. Mike believed that CHEs were, in his words, 'motivated' by the entrepreneurial model with its promise of both livelihood and possible future social mobility. As he explained:

> We need those in the remote areas to access care … and we can only be successful if we engage the CHWs fully, making them know they are valued. … They will work if they are motivated, and that is why we want to get them away from the handouts that they are receiving from the government. Handouts mean that people are doctoring data. They do not do the work from their hearts. Having CHEs work and earn from selling over-the-counter drugs is a sustainable model. The project motivates the CHWs because most are attached to health facilities and are unpaid. If you are not empowered, you will not be able to work because you also have your family, and you will be wondering what they will eat.[15]

Although the CHWs we interviewed talked about the importance of 'having the heart' for community health work, it is significant that neither Mary nor Mike mentioned this quality as being a criterion for selection. Instead, Mary talked about how 'productive' the CHEs should be, and how the organization measured success in terms of how 'active' the CHEs were in repaying loans and placing orders. Describing the NCD programme, where CHEs are further selected out of a pool to be trained in NCD management, Mary stated that: 'We select the top performing ones for the NCD project. It is these CHEs who are most active and consistent in repaying their loans and ordering new supplies that are proving to be able to run this as their own small business'.[16] Thus it is successful CHEs who are selected to engage with HE's non-communicable disease project, which aims to reach markets of elderly rural citizens. They are seen as capable, able to cope with the financial model and also to generate returns for themselves and investors taking a risk with the new project.

The Business Model

Situated ambivalently as neither charity nor business, social enterprises must walk a fine line between achieving a social mission and making a profit (Lokman and Chahine, 2021; Neumark, 2022; Prince and Neumark, 2022;

14. KII, Healthy Entrepreneurs local manager, Kisumu central (Kisumu county), 10 February 2020.
15. KII, Healthy Entrepreneurs local manager, Kombewa (Kisumu county), 31 January 2020.
16. KII, Healthy Entrepreneurs project lead, Kisumu county, 20 February 2020.

Santos et al., 2015). Like other social enterprises working in development and health, Healthy Entrepreneurs seeks to move beyond what it regards as the failures of NGOs, donors and the state to produce sustainable development.[17] Mary told us, 'We see this funding model and ethos of entrepreneurship or social impact and investment as a whole new world, which is sustainable. We have learnt from the NGO model, which has not been sustainable'. She explained that when NGOs leave, or project funding cycles end, the interventions also cease, because people rely on what Mike termed 'handouts'. Asked to elucidate this further, Mike said: 'If you think you are getting handouts, then you wait for those handouts, and when they cease to come, you stop working. There are no more incentives'.[18]

The ability to generate revenue is central to creating social enterprises as service providers (Munoz et al., 2014). Mary described HE as a social enterprise which fosters private enterprise to promote what she described as social goods. She explained HE's business model in the following terms:

> We run a business model … [this is] the basis of our organization. It is the basis of our ambition to expand HE and its revenue generation model. We get investment from these private investors because we tell them, we demonstrate that we can use the money as a loan, which we can repay with interest. … The business model is both financial, bringing in investors, and technical, using information technology for quality control. We have financial investors … through the Dutch Ministry of Foreign Affairs, also the Gates Foundation, which brings in investors. One-half of our organizational ethos is commercial; it is to make a profit. Although we plough any profits back into the organization.[19]

Mike described HE's model as 'to get investor money, or loans, which are paid back with interest. Investors put money into HE, on the basis that they will get returns'.[20] In other words, HE as a social enterprise pursues speculative capital investments, promising in return financial and social value, and legitimation for socially responsible funding (Irani, 2019; Neumark, 2022).

While HE relied on donor, philanthropic and investor capital to sustain its operations during the period of our fieldwork, its ultimate aim was to become independent of this external funding. Mary emphasized that sustainability means that HE's operational costs would be met through the profits CHEs earn by selling off-prescription drugs and other non-pharmaceutical commodities. As Mike told Edwin,

> We want to see if they [CHEs] are making profits. For albendazole [an antihelminthic or deworming medicine], we sell to them at Ksh 10, and we encourage them to sell it from Ksh 15–40, so if you find someone who is very poor, you sell it at 15 shillings, but if they have money, you sell it at 40 shillings. With the monitoring, our products are of high quality and,

17. Irani (2019) alludes to the new face of social enterprises as social business hybrids making an opportunity out of the innumerable shortcomings of development, particularly in the provision of social goods.
18. KII, Healthy Entrepreneurs project lead and local manager, Homa Bay county, 13 March 2020.
19. KII, Healthy Entrepreneurs project lead, Homa Bay county, 7 March 2020.
20. KII, Healthy Entrepreneurs local manager, Kisumu county, 20 February 2020.

> just as they profit, we also make a small profit. As an organization, with our warehouses, we procure large quantities of products as we get more county governments to partner with us. In addition, with more and more CHWs joining and managing to make a profit, it is an attractive call to investors, but also it means that the organization can survive without them.[21]

Mary explained that HE 'needs to talk a language of business on the one hand and a language of social value on the other'. She continued, 'We are not-for-profit but for-profit at the same time. Unlike NGOs, which are not-for-profit, we see being for-profit as being more sustainable'.[22] Like other social enterprises that are committed to a social good, HE seeks to ensure that fees charged for services and medicines are affordable for rural communities. The organization insists that any profit is ploughed back into the organization, which creates tensions with its model of seeking corporate investors who want evidence of the market value of their investment.

A language of market expansion infused much of HE's ideology (see Roy et al., 2022). For Mary, the NCD project had 'great potential'. In Uganda, when a similar project focusing on NCDs had been trialled, 'the market grew and sales shot up'. She explained:

> The profit margin is double that of the rest of our sales. So, we see potential in the NCD project as CHEs can earn from it. By screening for NCDs and setting up these community groups focused on NCDs, you are opening a market for other products too, not just for the NCD medicines, so you, or the CHEs, are reaching a larger market, or creating one for their other products. This NCDs project is another reason why the CHEs like this programme.[23]

Mary explained that HE encouraged autonomy and economic risk-taking among the CHEs enrolled in the NCDs project. However, for HE to become independent of investor funding, she suggested, the business model would have to be scaled up: both HE and the CHEs would have to improve their performance. One of the challenges facing the success of the business model, Mary acknowledged, was that the CHEs were themselves embedded in the communities they served, among households with very low incomes. As the CHEs explained in group discussions, they found it hard to refuse to give medicines and other products to elderly people either on credit or at low prices, because these people often could not afford to buy them. Both Mike and Mary recognized that these pressures created considerable attrition, with some CHEs dropping out or being unable to repay their loans. For Mike, this failure was due to a lack of business acumen, and the solution was further training. This emphasis on training in business skills as the route to success overlooks the complex economic and social landscapes that the entrepreneurs are embedded in and have to navigate, as well as the often-limited economic value in circulation.

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21. KII, Healthy Entrepreneurs local manager, Kisumu county, 31 January 2020.
22. KII, Healthy Entrepreneurs project lead, Homa Bay county, 21 March 2020.
23. KII, Healthy Entrepreneurs project lead, Homa Bay county, 7 March 2020.

Measures of Success and Impact

Mary explained that HE was concerned to assess the sustainability of its programmes in terms of their impact:

> We look at outcomes differently from the donor world, which looks at numbers of CHWs trained. For example, if 2,000 CHWs are trained, the donors take this as a measure of success. The investment world sees this [success] in terms of revenue. We measure success in terms of the performance of CHEs, whether they are repaying their debts and how much profit they make for themselves. Revenue is a measurement of the performance of the CHW, thus of the quality of the work. We want well-performing CHWs. So, we measure in terms of economic impact.[24]

This demonstrates that technologies of audit are an important part of HE's work and form an ethico-moral framework in which the market is valued as a driver of development and social good, considered necessary for producing social impact (see Murray et al., 2022; Scherz, 2014). The emphasis on such technologies parallels a focus on results-based financing (RBF) in global health and development interventions.[25] Such technologies allow HE to remain profitable and financially valuable to investors (Poveda et al., 2019). Addressing community health concerns is thus deeply intertwined with the financial as well as the social values that form the organization's core ethos. Social impact was measured by the performance of CHEs, which, in term, was measured not by their impacts on community health or the quality of care they offered (which are difficult to assess through numbers), but by the revenue they made. Added to this are hard-to-measure considerations of the 'time saved' by members of the community who use CHEs rather than spending time and money getting to healthcare facilities. Asked to explain how the organization conceptualized social impact, Mary replied: 'This is the basic impact we focus on: the cost and time saved. We calculate that about 50 per cent of health costs are spent on transport, so we see that this is our intervention. Our business has an impact in terms of costs saved and time saved. This is the social impact measurement'.[26] Although Mary was optimistic about HE's potential to create a more sustainable model of community health work, after two years of working with CHEs, she was not naïve about the challenges such a programme faced. Although she had been trained in the language of business, Mary described herself as 'more of a social value person' than a 'business person'.

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24. KII, Healthy Entrepreneurs project lead, Homa Bay county, 7 March 2020.
25. RBF refers to financial mechanisms that are being promoted by international development agencies and stakeholders to link incentives to improved health outcomes, especially in low- and middle-income countries (see James et al., 2020: Oxman and Fretheim, 2008).
26. KII, Healthy Entrepreneurs project lead, Homa Bay county, 7 March 2020.

Seeing as 'Community Health Entrepreneurs'

What perspectives do community health entrepreneurs themselves offer on the relations and tensions between community health work and the business model advocated by Healthy Entrepreneurs? And how do their experiences compare to those CHWs who were not chosen by the organization? As noted above, community health workers we interviewed expressed deep frustration with the remuneration they received, often unreliably, from the county government. As frontline health workers, they knew they were indispensable in primary healthcare, yet they received little recognition from the government. The following excerpts from group discussions underline their frustrations:

> Without us [community health workers], they cannot even know how many antenatal mothers [there are] in the community. They cannot know how many people have defaulted from taking their drugs, how many people have defaulted from going to the mother's clinic. They cannot know. It is us [community health workers], because we are staying with these people. So we know how many deaths have taken place, which areas cholera has just dropped today, which things are happening …. It is the community health volunteers that know them, because they [the government officials] just come, they sit here at the hospital, but with us, we are in the community.

> Without our work, the hospital cannot move. Even right now if you go back to the village and say that we are not going to do anything concerning latrines, concerning health, concerning anything, things will get worse.[27]

A community health entrepreneur and CHW explained that the monthly stipend from the government 'rarely comes'. In this situation, people appreciated the opportunities that HE offered for making a living: 'Having HE around has really motivated us to continue serving our communities. We are encouraged to go see the sick and we know that in these remote areas, with these medicines and small things we sell, at least we can have food on the table'.[28] Another stated, 'This entrepreneurship was helping us, at the same time they were helping the community …. Because the drug that a client could buy at 150 [shillings], he or she will get from us at 100 shillings, this person has saved 50 shillings'. She explained that after being recruited by Healthy Entrepreneurs: 'We never even care for the stipend from the government, we were living a good life … because at the end of the day, when we come … from the market, we'll come back home with salt, sugar, milk and even meat, we can put meat on our table, not [like before] every day [only] *omena*, everyday [only] vegetables'.[29]

The CHEs reported that the households they visited also appreciated being able to buy items such as ibuprofen, cough syrups and bedbug treatments. Some CHEs were able to make up to Ksh 3,000 (US$ 30) a month;

27. FGD, Community Health Workers, Kombewa (Kisumu county), 31 January 2020.
28. FGD, Community Health Entrepreneurs, Kisumu county, 1 February 2020.
29. Ibid. *Omena* are small fish, a local staple, highly nutritious and cheap, but associated with poverty.

one reported a lucky month when his earnings reached Ksh 8,000 (partly because he owned a motorbike). Being able to set prices according to what people would pay was also an asset. However, the good sales they experienced initially were partly the result of the county government allowing CHEs to sell malaria tests and drugs. After two months, this policy was reversed, and CHEs were back to selling 'pampers [nappies], cough syrup and medicine for bedbugs'.[30]

Other CHEs faced setbacks, reporting that it was difficult to ensure a profit, as they gave out goods on credit or at low prices, especially to neighbours, family members and vulnerable households they visited. These dilemmas illustrate how they navigate these exchanges within particular social relations and moral economies.[31] As one CHE told Ruth:

> I know very well that this person, I don't want to leave her to die and she cannot get this 100 [shillings] for the antimalarial drug. I'll just give her, if she will bring [something for me later] I'll appreciate, if she doesn't, I'll not go for it. … But when I go to your house, like you Ruth. I just look at you and know Ruth is working somewhere [i.e. is earning money]. And if I know the drug is 250 at the chemists, I'll start with, 'just give me 250'. Yah, that's the same price at the chemists, then remove 20 shillings and give me 230. … That is why, when I go to somebody who is capable, instead of selling that bedbug drug at 130, I'll sell it at 200 when somebody has got the money.[32]

Giving away the items they hoped to sell, or providing them at lower prices than expected, was economically challenging for CHEs, leading to anxieties about being able to pay back debts. However, CHEs also reported that recipients often tried to compensate them by bringing food as payment in kind, such as maize from their gardens — 'One *gorogoro* [one tin of maize], even two *gorogoro*'.

CHE1: Someone doesn't have money, so instead [she says] 'take my maize and give me drugs', or 'take my bananas and give me drugs, or take my beans…'.
CHE2: Even beans, you can take those beans to the market and you recover the money.
CHE1: Or you can use it at home.
CHE3: So somebody cannot die and you have medicine, you exchange the things in the community.[33]

CHEs reported facing hostility from some local businesses, such as the small private chemists and shops selling pharmaceuticals that are common in every marketplace and village: 'They see that we can be taking some customers away from the pharmacies or from chemists'.[34]

While the CHEs we talked to were fairly satisfied with HE's support and the opportunities it gave them, we should underline that they belonged to a group of more successful CHEs. The organization reported that some

30. FGD, Community Health Workers, Kombewa, 20 January 2020.
31. Ibid. See Roitman (1995) and Shipton (2007) for a discussion of the social constitution of forms of credit and debt in Cameroon and Kenya, respectively.
32. FGD, Community Health Entrepreneurs, Kombewa, 20 January 2020.
33. FGD, Community Health Entrepreneurs, Kombewa, 13 January 2020.
34. Ibid.

CHEs were unable to pay back their loan, or were facing ongoing difficulties. Moreover, many community health workers could not join HE's training because they could not raise the initial funds. Healthy Entrepreneurs' recruitment strategy therefore appears to target those who were already better-off economically than others. This led to some tensions between CHWs and CHEs, although these were only referred to obliquely in our conversations.

During some of the group discussions, we became aware that not all participants were CHWs or CHEs, and that the CHEs who organized the meetings with us had, in fact, invited other people to join, to allow them to receive the compensation we offered for 'transport'. This experience underlines how CHWs and CHEs position themselves as brokers, making opportunities available to others. Individual CHEs expressed some ambivalence about their CHE work: they were glad that it brought opportunities for income generation, but felt that it added to the burden of their daily CHW work. Moreover, they were unsure how to deal with the tensions it created with other CHWs who could not become 'health entrepreneurs', as well as with neighbours, family and friends. Perhaps this brokerage was an attempt to defuse these tensions.

'DISRUPTING' COMMUNITY HEALTH WORK

While doing research, we became rather sceptical of the approach of HE, and thus initiated several discussions with both managers and CHEs during which we relayed, in a respectful way, our concerns and critique. We also discussed the health entrepreneur model with members of county government health teams, who were in charge of managing county-level health services; some were critical of the encroachment of entrepreneurship into community health work. Our critiques were not new to HE's local managers, who engaged in lively discussions with us, acknowledging our concerns but also maintaining their view that entrepreneurship and social enterprise were indeed more sustainable approaches; they had little faith in the government's capacity or will to implement a more sustainable community health strategy. Below, we outline five main criticisms concerning the entrepreneurship model, which we raised during these discussions.

First, the HE business model is selective and competitive. Only some CHWs manage to get through the training, or indeed raise the necessary funds of Ksh 4,000 (c. US$ 40) to begin training; and of those who trained, not all become successful CHEs, able to pay back debts and make a living. HE itself documents that many CHWs do not succeed in becoming CHEs and that those who succeed in getting enrolled as CHEs find it difficult to pay back their loans or to create a sustainable income from selling commodities. This is because HE's model of success is based on developing a particular form of 'entrepreneurship' among people who live in

communities where livelihoods are insecure. CHEs live amongst and must sell their commodities to people who have low and unstable incomes, and who often rely on credit from neighbours, digital lenders or CHWs to get essential services. They have to craft 'clients' out of family, neighbours and members of the communities in which they live. Whether such a business model is sustainable remains questionable; HE's assessment as well as our interviews suggest that many CHEs do not manage to sustain their business.

Second, the HE programme creates tensions in the communities the CHEs live and work in. Tensions exist between CHEs and those CHWs who do not get selected, or with those who cannot pay back their debts and drop out of the organization. The process of selection, and the ensuing difference in opportunities for income generation between CHEs and other CHWs, risks creating envy and divisions among the CHWs themselves. Such frictions are not new, however; they are part of the everyday landscape that many CHWs are used to dealing with, where NGOs continue to offer new projects and there is competition to access them. HE thus simply adds another layer to a dense forest of healthcare actors competing for space in the Kenyan public healthcare system. However, where HE differs from other projects is its clear focus on competition and individual success, measured by how well the CHEs can run their business. The programme also creates conflicts with other health workers, notably pharmacists and nurses who often run chemists or small shops in rural or semi-urban markets, where they sell similar commodities to those that HE sells. During fieldwork, Edwin became aware of the threats that CHEs experience and the fears of participation that accompany the threats, especially from senior cadres of health workers (who run small businesses on the side, as they too try to generate income beyond their government salaries). Far from being remote, out-of-the-way places, the villages and small market towns where CHEs operated were already thriving healthcare markets, well-connected to circuits of pharmaceuticals (see Whyte et al., 2003). CHEs must navigate, then, between different actors and organizations that are already present and that sell healthcare services and commodities, as well as juggling their roles as entrepreneurs, and the expectations of neighbours, family members and the communities in which they live.

Third, as became clear in our group discussions and interviews with CHEs, the entrepreneurship model of community health work burdens CHEs with even more tasks and with often conflicting duties, as their entrepreneur work simply adds to (and maybe takes time away from) their work for the government as CHWs. In Kenya, some county governments were initially hesitant to welcome the HE model, as they feared it would divert CHWs away from community care. County health officials we interviewed in Kisumu voiced such concerns, arguing that the entrepreneurship model had a negative effect on the delivery of primary healthcare and the voluntary nature of community health work. Instead of building up community health work and integrating it into existing health system structures, they

worried that HE piggybacks on existing structures, while expecting CHEs to do additional work to gain an income.[35]

Our critique of the business model of community health work does not imply that we idealize the 1970s' model of community health work. There is much diversity in these programmes, across countries, cultures, funding models and health systems, and an extensive literature analyses their various successes and failures. While there are examples of programmes that have been sustainably financed by national governments, for example in Ethiopia (Maes, 2017) and in Mali (Saint-Firmin et al., 2021), adequate remuneration remains a major challenge, owing to the reluctance of governments to finance them. In many cases, CHWs are expected to work largely voluntarily with little compensation. Community health worker programmes can also be accused of being patriarchal and exploitative, as they use low-income, often female volunteers (Bärnreuther, 2023) — although such programmes may offer opportunities for women to widen their social networks outside of the household (Nading, 2014). Community health work has also been undermined by the often-simplified imagination of what a community is, overlooking divisions, power structures and hierarchies. Community health work is thus a complex and often contradictory endeavour, the realities of which may be far from the ideal described in the 1978 Alma Ata Declaration. Our argument, however, is that these 'failures', complexities and challenges do not justify giving up on the model of state-organized CHW programmes, where community health workers are properly remunerated and integrated into PHC systems, as the state has geographical, political and temporal continuity which NGOs and social enterprises cannot offer.

The visibility and success of organizations such as HE indicates the degree to which Kenya's public health system is being transformed in the direction of social enterprise and entrepreneurship. At the same time, it is clear that HE depends on its partnerships with county governments for credibility, as well as for access to pools of already-trained CHWs and thus to new bottom-of-the-pyramid markets. The existing infrastructure of the public health system enables HE to scale up its operations. Does this mean that the precarity of community health workers is being normalized, allowing the Kenyan state to further divest itself from responsibility for their livelihoods while outsourcing the provision of services? The ambiguity expressed by some county health officials concerning the operations of Healthy Entrepreneurs suggests this question remains open.

A fourth criticism of the HE model is that it claims to offer services that it does not actually provide. Earlier in this article, we quoted Mike, who claimed that HE ensures that 'essential and quality medicines' are made available to people in rural areas who otherwise would not have access to these drugs, or who would have to make lengthy journeys to health

35. KII, Health Management Team member, Kisumu county, 29 January 2020.

facilities to receive them. However, the county governments in Kenya have not allowed HE to distribute prescription drugs.[36] Apart from the pilot NCD project described above, available in just one county, CHEs distributed non-prescription medicines only — products that are already widely available in local shops, pharmacies and market stores — as well as non-medical commodities.

Finally, the insertion of entrepreneurship into community health work fundamentally changes the latter's ethos: it represents an approach to community health work that is no longer grounded in willingness to serve but in the capacity to earn, eroding values based on volunteerism, interest and empathy. This is underlined in the blurring of boundaries between community work for-profit and not-for-profit (Bärnreuther, 2023; Maes, 2017; Neumark and Prince, 2021; Scherz, 2014). This reproduces inequalities, tensions and hierarchies among community health workers, as those who do not qualify or survive the rigours of entrepreneurship feel excluded, while those who participate face the dilemma of approaching community members as potential consumers. Since the pool of customers is tied to neighbourliness and kinship relations, navigating and negotiating the supply of health commodities as a business is complicated and fraught with uncertainties and risk.

While it is true, as we explained above, that healthcare in Kenya is already commercialized, and monetary exchanges, both formal and informal, pervade much of the public healthcare system (and 'traditional' medicine too), community health work itself has been fenced off from commercial exchanges, at least formally. By contrast, HE offers a model of community health work that has as its core market exchange, itemizing and selling particular commodities. While this work is conceived as taking place alongside and in addition to ongoing primary healthcare, it presents a stark contrast to an ideology of community health work and primary healthcare as non-commoditized services. The success of CHEs is assessed on the balance of their accounting books, their ability to pay back loans and to make a profit. In the process, the ethos of community health work as a public good is traded off for health as a commodity and health work as a business venture, where rural communities become a market pool to be profited from.

Although HE staff and managers did not agree with all our critiques, they listened to them. They also pointed out that the organization and its staff are not uncritical of its programmes and are keen to improve them. In the course of our conversations with Mary, she admitted that 'there are many questions, and we are still not sure what are the answers, and whether we

36. The two exceptions to this have been: a trial project in Siaya county, which had CHEs distributing malaria tests and antimalarial medicines (the county government prohibited this practice in 2019); and HE's pilot NCD project, described above, which was allowed because the tele-doctor prescribed the medicines that were distributed (this project was ongoing in 2020, but facing problems of financial viability).

have found the right solution'. HE local managers such as Mary, Mike, the tele-doctor and the pharmacist often discussed with CHEs the challenges they face selling products to people in their neighbourhoods who cannot afford to pay. Refusing to sell on credit is, CHEs told us, 'not neighbourly', and a risk most CHEs cannot afford to take. This model makes it hard for the CHEs to make a profit and pay back their loan, especially when 'clients' are relatives, neighbours and friends. Mike, too, was aware of such delicate issues:

> We have had cases where people default, but we always tell the CHEs that this is their business and they have learnt about business skills. They also know the people well, so they must do their due diligence. We advise them to consider the economic aspects in their communities often but also avoid anything that will ruin their relationships with their neighbours, who are essentially their customers and clients.[37]

However, as Mike's words underline, the challenges faced by CHEs in making a viable business did not, for most HE staff, undermine their faith in the social business model of development.

Why, despite all the tensions we have outlined, does faith in the social business model of development remain strong among HE staff, and why is it embraced by the health entrepreneurs? One reason is that, for some people — both for the managers and staff employed by HE, and for the successful CHEs — it has delivered (some) material gains. A positive experience of income generation may contrast with their experiences of NGO-led development, where opportunities come and go, and of the Kenyan state, which is experienced as unreliable and extractive. CHEs and others are thus open to trying out new strategies to make livelihoods. More broadly, the focus on fostering independence and self-development speaks to an important orientation that has long been encouraged in post-independence Kenya, even if such goals remain hard to reach (Lockwood, 2023; Neumark, 2017; Prince, 2015; Smith, 2008).

CONCLUSION

In this article we have offered insights into how and why notions and practices of social enterprise based on a conception of the 'social good' are making inroads into African public healthcare systems. We have also underlined the ways they are being modified and translated by actors on the ground. Following the frictions surrounding Healthy Entrepreneurs, we have explored how values placed on market mechanisms and business models in driving sustainable development are contextualized and translated in the context of fragmented health systems, rural communities and local moral economies, by managers and by CHEs themselves.

37. KII, Healthy Entrepreneurs local manager, Kisumu county, 13 March 2020.

Following Ong and Collier (2007), we can approach the social enterprise model as a 'global assemblage' of ideas and values concerning entrepreneurship, development and the social good, that move around the globe as they are embraced by various actors and organizations. Yet these ideas and values do not move seamlessly. Anna Tsing argues that global or universal concepts and ideas are always engaged in 'sticky locations', which give them traction but also shape their trajectories and how these unfold.

> Engaged universals travel across difference and are charged and changed by their travels. Through friction, universals become practically effective. Yet they can never fulfil their promises of universality. Even in transcending localities, they don't take over the world. They are limited by the practical necessity of mobilizing adherents …. All universals are engaged when considered as practical projects accomplished in a heterogenous world. (Tsing, 2004: 8)

As 'engaged universals', models of social enterprise and entrepreneurship are slowed down by the frictions they encounter in particular locales (ibid.).

Healthy Entrepreneurs engages community health workers in multiple ways, including by offering training in new digital and business skills, creating new connections and opportunities, and providing health information services. Healthy Entrepreneurs articulates an ideology and set of practices aimed at incentivizing and organizing rural citizens to participate in the realm of healthcare as customers and clients, and to approach community healthcare services as part of a healthcare market. HE promises investors potential returns through their capital flows as CHEs are envisioned as agents of change, improving health, but also instilling entrepreneurial cultures in rural communities (Huang, 2020). This model is supposed to empower CHEs. Irani (2019) describes how entrepreneurial experiments in sustainable development are aimed at being replicable and low-cost, promising to create stable and reliable economic infrastructures to extract value at the bottom of the pyramid. In this model, community health entrepreneurs must provide services at their own financial risk, taking out loans in order to finance their businesses. Thus, the model offloads risks and responsibilities onto CHEs, who must 'translate between market-based moral repertoires, and local notions of sociality and ethical personhood' (Huang, 2017: 614), making them into ambiguous figures of health work and development in their own communities.

The values that Healthy Entrepreneurs nurtures differ from older visions of community health work, which promoted notions of community, altruism, solidarity and 'having heart', as many of the CHWs we spoke to reminisce. These older values are being substituted with market-oriented ideals of healthcare as a commodity to be bought and sold. Our research shows, however, that these substitutions are partial and that they are, in the day-to-day interactions that community health workers engage in, continually contested. While Healthy Entrepreneurs' focus on entrepreneurship reshapes the ethos of community health work towards a business-oriented model, the

moral economies in which CHEs are embedded complicate this. Thus, some health entrepreneurs ended up selling medicines and other products to elderly people either on credit or at low prices, because the elderly often could not afford to buy them; they also felt under pressure from family and friends to 'lend them' goods. Moreover, the entrepreneur's business did not necessarily entail commodification of community health work but was part of a give-and-take of making livelihoods in rural communities. Thus, if they are unable to pay money for the goods they buy from health entrepreneurs, people will endeavour to offer something 'in kind', such as a sack of beans or maize from their own gardens. The fact that the work of health entrepreneurs, like that of CHWs, takes place within ongoing relationships (of extending credit and incurring debt) with neighbours, family and others, suggests that, although forms of entrepreneurial self-making may become a normalized part of community health work and primary healthcare, such global 'models-in-motion' (Huang, 2017: 604) unfold in local contexts where other moral economies are at work.

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REFERENCES

Abuya, T. et al. (2021) 'Incentive Preference for Community Health Volunteers in Kenya: Findings from a Discrete Choice Experiment', *BMJ Open* 2(11): e048059.

Al Dahdah, M. (2022) 'Between Philanthropy and Big Business: The Rise of mHealth in the Global Health Market', *Development and Change* 53(2): 376–95.

Ameso, E.A. (2022) 'Navigating Care: Realities of Health Insurance and Social Protection in Kenya'. PhD dissertation, Aarhus University and University of Oslo.

Ameso, E.A. (2024) 'Digital Entanglements: Medical Drones in African Healthcare Systems', *Global Public Health* 19(1): 2405987.

Ameso, E.A. and R.J. Prince (2022) 'Striking Health Workers: Precarity and Healthcare in Neoliberal Kenya', *Anthropology Today* 38(4): 11–14.

Aridi, O.J., A.S. Chapman, A.M. Wagah and J. Negin (2014) 'A Comparative Study of a NGO-sponsored CHW Programme versus a Ministry of Health-sponsored CHW Programme in Rural Kenya', *Human Resources for Health* 12: 64.

Aseyo, R.E. et al. (2018) 'Realities and Experiences of Community Health Volunteers as Agents of Behaviour Change: Evidence from an Informal Urban Settlement in Kenya', *Human Resources for Health* 16: 53.

Bärnreuther, S. (2023) 'Disrupting Healthcare? Entrepreneurship as an "Innovative" Financing Mechanism in India's Primary Care Sector', *Social Science & Medicine* 319: 115314.

Borst, A.J.R., T. Hoesktra, D. Muhangi, I. Jonker and O.M. Kok (2019) 'Reaching Rural Communities through "Healthy Entrepreneurs": A Cross-sectional Exploration of Community Health Entrepreneurship's Role in Sexual and Reproductive Health', *Health Policy and Planning* 34(9): 676–83.

Brunie, A. et al. (2014) 'Keeping Community Health Workers in Uganda Motivated: Key Challenges, Facilitators, and Preferred Program Inputs', *Global Health Science and Practice* 2(1): 103–16.

Challenge Fund (2024) 'Selection Kenya: Healthy Entrepreneurs'. Challenge Fund for Youth Employment. https://fundforyouthemployment.nl/kenya-selection-healthy-entrepreneurs/

Chen, N., M. Raghavan and J. Albert (2021) 'The Community Health Systems Reform Cycle: Strengthening the Integration of Community Health Worker Programs through an Institutional Reform Perspective', *Global Health Science and Practice* 9(1): S32–S46.

Dil, Y., D. Strachan, S. Cairncross, A.S. Korkor and Z. Hill (2012) 'Motivations and Challenges of Community-based Surveillance Volunteers in the Northern Region of Ghana', *Journal of Community Health* 37(6): 1192–98.

Dohmen, P. et al. (2022) 'Implementing Value-based Healthcare Using a Digital Health Exchange Platform to Improve Pregnancy and Childbirth Outcomes in Urban and Rural Kenya', *Frontiers in Public Health* 10: 1040094.

Dolan, C. (2012) 'The New Face of Development: The "Bottom of the Pyramid" Entrepreneurs', *Anthropology Today* 28(4): 3–7.

Dolan, C., M. Johnstone-Louis and L. Scott (2012) 'Shampoo, Saris and SIM Cards: Seeking Entrepreneurial Futures at the Bottom of the Pyramid', *Gender & Development* 20(1): 33–47.

Donovan, P.K. and E. Park (2019) 'Perpetual Debt in the Silicon Savannah', *Boston Review* 20 September. www.bostonreview.net/articles/perpetual-debt-silicon-savannah/

Elyachar, J. (2012) 'Next Practices: Knowledge, Infrastructure, and Public Goods at the Bottom of the Pyramid', *Public Culture* 24 (1(66)): 109–29.

Frankel, S. and M. Doggett (1992) *The Community Health Worker: Effective Programmes for Developing Countries*. Oxford: Oxford University Press.

Gandhi, T. and R. Raina (2018) 'Social Entrepreneurship: The Need, Relevance, Facets and Constraints', *Journal Global Entrepreneurship Research* 8: 9.

HE (2019) 'Annual Report 2019'. Healthy Entrepreneurs. www.healthyentrepreneurs.nl/wp-content/uploads/2020/12/Annual-Report-2019_final.pdf

HE (2021) 'Annual Report'. Healthy Entrepreneurs. www.healthyentrepreneurs.nl/our-concept/

HE (2022) 'Annual Report'. Healthy Entrepreneurs. www.healthyentrepreneurs.nl/our-concept/

Hisrich, R.D., M.P. Peters and D.A. Shepherd (2017) *Entrepreneurship* (10th edn). New York: McGraw-Hill Education.

Hodgins, S. et al. (2021) 'Community Health Workers at the Dawn of a New Era. Introduction: Tensions Confronting Large-scale CHW Programmes', *Health Research Policy Systems* 19(3): 109.

Huang, J.Q. (2017) 'The Ambiguous Figures of Social Enterprise: Gendered Flexibility and Relational Work among the iAgents of Bangladesh', *American Ethnologist* 44(4): 603–16.

Huang, J.Q. (2020) *To Be an Entrepreneur: Social Enterprise and Disruptive Development in Bangladesh*. Ithaca, NY and London: Cornell University Press.

Irani, L. (2019) *Chasing Innovation: Making Entrepreneurial Citizens in Modern India*. Princeton, NJ: Princeton University Press.

James, N., K. Lawson and Y. Acharya (2020) 'Evidence on Result-based Financing in Maternal and Child Health in Low- and Middle-income Countries: A Systematic Review', *Global Health Research and Policy* (5): 1–15.

Kar, S. (2017) 'Austerity Welfare: Social Security in the Era of Finance', *Anthropology Today* 33: 12–15.

Koon, D.A., J. Goudge and S.A. Norris (2013) 'A Review of Generalist and Specialist Community Health Workers for Delivering Adolescent Health Services in Sub-Saharan Africa', *Human Resources for Health* 11: 54.

Lazar, S. (2004) 'Education for Credit: Development as Citizenship Project in Bolivia', *Critique of Anthropology* 24(3): 301–19.

Lockwood, P. (2023) '"He Who Relies on Relatives and Friends Die Poor". Class Closure and Stratagems of Civility in Peri-urban Kenya', *Journal of the Royal Anthropological Institute* 29(2): 326–46.

Lokman, L. and T. Chahine (2021) 'Business Models for Primary Health Care Delivery in Low- and Middle-income Countries: A Scoping Study of Nine Social Entrepreneurs', *BMC Health Services Research* 21: 211.

Lombard, A. and R. Strydom (2011) 'Community Development through Social Entrepreneurship', *The Social Work Practitioner-Researcher* 23(3): 327–44.

Lusambili, M.A. et al. (2021) 'Community Health Volunteers' Challenges and Preferred Income Generating Activities for Sustainability: A Qualitative Case Study of Rural Kilifi, Kenya', *BMC Health Services Research* 21: 642.

Macassa, G. (2021) 'Social Enterprise, Population Health, and Sustainable Development Goal 3: A Public Health Viewpoint', *Annals of Global Health* 87(1): 52.

Maes, K. (2017) *The Lives of Community Health Workers: Local Labour and Global Health in Urban Ethiopia*. New York: Routledge.

Masaba, B.B. et al. (2020) 'Devolution of Healthcare System in Kenya: Progress and Challenges', *Public Health* 189: 135–40.

Masis, L. et al. (2021) 'Community Health Workers at the Dawn of a New Era: 4. Programme Financing', *Health Research Policy and Systems* 19(3): 107.

McKague, K., M. Menke and A. Arasaratnam (2014) 'Access Afya: Micro-clinic Health Franchise Designed for Scale', in I. Alon (ed.) *Social Franchising*, pp. 61–71. London: Palgrave Macmillan.

Moses, M.W. et al. (2021) 'Performance Assessment of the County Healthcare Systems in Kenya: A Mixed-methods Analysis', *BMJ Global Health* 6: e004707.

Muinde, J.V.S. and R.J. Prince (2023) 'A New Universalism? Universal Health Coverage and Debates about Rights, Solidarity and Inequality in Kenya', *Social Science & Medicine* 319: 115258.

Munoz, S-A., A. Steiner and J. Farmer (2014) 'Processes of Community-led Social Enterprise Development: Learning from the Rural Context', *Community Development Journal* 50(3): 478–93.

Murray, G., M.J. Roy, R. Baker and C. Donaldson (2022) 'How Do Social Enterprises Impact upon Health and Well-being? Some Lessons from Common Health', in M.J. Roy and J. Farmer (eds) *Social Enterprise, Health, and Well-being: Theory, Methods, and Practice*, pp. 191–209. New York: Routledge.

Nading, A.M. (2014) *Mosquito Trails: Ecology, Health, and the Politics of Entanglement*. Oakland, CA: University of California Press.

Neumark, T. (2017) '"A Good Neighbour Is Not One that Gives": Detachment, Ethics, and the Relational Self in Kenya', *Journal of the Royal Anthropological Institute* 23(4): 748–64.

Neumark, T. (2022) 'Leapfrogging the Grid: Off Grid Solar, Self-reliance and the Market in Tanzania', *Social Anthropology* 30(2): 140–60.

Neumark, T. (2023) 'Digital Diagnostics from Tanzania: Beyond Mere Technological Fixing?', *Social Science & Medicine* 319: 115306.
Neumark, T. and R.J. Prince (2021) 'Digital Health in East Africa: Innovation, Experimentation and the Market', *Global Policy* (12): 65–74.
Ong, A. and S. Collier (2007) *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. Oxford: Blackwell Publishing.
Oxman, A.D. and A. Fretheim (2008) 'An Overview of Research on the Effects of Results-based Financing'. Oslo: Norwegian Knowledge Centre for the Health Services. https://fhi.brage.unit.no/fhixmlui/bitstream/handle/11250/2378441/NOKCrapport16_2008.pdf?sequence=1
Poveda, S. et al. (2019) 'Should Social Enterprises Complement or Supplement Public Health Provision?', *Social Enterprise Journal* 15(4): 495–518.
Praszkier, R. and A. Nowak (2012) *Social Entrepreneurship: Theory and Practice*. Cambridge: Cambridge University Press.
Prince, R.J. (2015) 'Seeking Incorporation? Voluntary Labor and the Ambiguities of Work, Identity, and Social Value in Contemporary Kenya', *African Studies Review* 58(2): 85–109.
Prince, R.J. (2017) 'Universal Health Coverage in the Global South: New Models of Healthcare and their Implications for Citizenship, Solidarity and the Public Good', *Michael* 14: 153–72.
Prince, R.J. (2022) 'Beyond Failure: Bureaucratic Labour and the Will to Improve in Kenya's Experiments with Universal Health Care', *Social Anthropology/Anthropologie Sociale* 30(2): 56–80.
Prince, R.J. (2023) 'Private Health Care, Cancer, and the Vulnerable Middle Class in Kenya', *American Ethnologist* 50(4): 595–608.
Prince, R.J. (2024) 'Blurring "Social Justice" with "Market Justice" in Recent Experiments with Healthcare and Social Protection in the Global South', *Global Social Policy* 24(2): 331–35.
Prince, R.J. and T. Neumark (2022) 'Curious Utopias: Dreaming Big Again in the Twenty-first Century?', *Social Anthropology* 30(2): 1–15.
Roitman, J. (1995) 'Review: Queries on Cultural Capitalism', *Cahiers d'Études Africaines*, 35(138/139): 629–45.
Roy, M.J., J. Farmer and M.J. Mandiberg (2022) 'Social Enterprise, Health, and Well-being: A Timely Topic for Uncertain Times?', in M.J. Roy and J. Farmer (eds) *Social Enterprise, Health, and Well-being: Theory, Methods, and Practice*, pp. 1–23. New York: Routledge.
Rudnyckyj, D. and A. Schwittay (2014) 'Afterlives of Development', *PoLAR*, 37: 3–9.
Saint-Firmin, P.P., B. Diakité and K. Ward (2021) 'Community Health Worker Program Sustainability in Africa: Evidence from Costing, Financing, and Geospatial Analyses in Mali', *Global Health: Science and Practice* 9(1): S79–S97.
Santos, F., A.C. Pache and C. Birkholz (2015) 'Making Hybrids Work: Aligning Business Models and Organizational Design for Social Enterprises', *California Management Review* 57(3): 36–58.
Scherz, C. (2014) *Having People, Having Heart: Charity, Sustainable Development and Problems of Dependence in Central Uganda*. Chicago, IL: University of Chicago Press.
Schwittay, A. (2011) 'The Marketization of Poverty', *Current Anthropology* 52(S3): 71–82.
Shipton, P. (2007) *The Nature of Entrustment: Intimacy, Exchange, and the Sacred in Africa*. London and New Haven, CT: Yale University Press.
Smith, J.H. (2008) *Bewitching Development: Witchcraft and the Reinvention of Development in Neoliberal Kenya*. Chicago, IL: University of Chicago Press.
Tsing, A. (2004) *Friction: An Ethnography of Global Connection*. Princeton, NJ: Princeton University Press.
Wafula, F. et al. (2022) 'Healthcare Clinic and Pharmacy Chains in Kenya and Nigeria: A Qualitative Exploration of the Opportunities and Risks they Present for Healthcare Regulatory Systems', *International Journal of Health Planning Management* 37(6): 3329–43.
Warren, C.E. et al. (2021) 'Strength in Diversity: Integrating Community in Primary Health Care to Advance Universal Health Coverage', *Global Health: Science and Practice* 9(1): S1–S5.

Whyte, S., S. van der Geest and A. Hardon (2003) *The Social Lives of Medicines*. Cambridge: Cambridge University Press.
Wintrup, J. (2022) 'Outsourcing Sovereignty: Global Health Partnership and the State in Zambia', *Critical Public Health* 32(5): 608–18.
Wintrup, J. (2023) 'Health by the People, Again? The Lost Lessons of Alma-Ata in a Community Health Worker Programme in Zambia', *Social Science & Medicine* 319: 115257.
WHO (2010) *The World Health Report. Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization.

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