

INNOVATOR CASE STUDY



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From Project Delivery to Business Model Transformation in Colombia

The Global Health Innovation Grants (GHIG) program focuses on fostering the growth and scale of health-focused innovations and social entrepreneurs in low- and middle-income countries (LMICs) through one-year grants. Since 2016, liH has worked with grantees to identify metrics that align with their project objectives and activities. Analyzing this data, liH provides an assessment of the portfolio in each cohort, as well as over time, to identify areas for improvement for the program. *This case study is one of six from the GHIG9 grantee cohort.*



1. Company and Innovation Overview

Bive (Fundación Vive con Bienestar) is a Colombian social business that connects rural, underserved, and indigenous communities to timely, affordable, and high-quality health services. Its traditional business streams have included connecting people to a vast network of private healthcare providers (via a family membership card) and running rural health brigades with providers in that network. For most of its history, its core strengths were not technological. They were community trust, a network of local health workers, and established relationships with health providers. More recently, through a partnership with [Pegasi](#) and as part of GHIG9, Bive has begun using artificial intelligence (AI) for efficient population health management (for example, data organization and eligibility identification) combined with automated voice calls, to extend its community-based outreach model in cervical cancer screening.



Industry/ Sector	Community health; preventive care; population health management
Geographic Focus	Rural Colombia, including underserved, indigenous and Afro- American communities
Year Founded	2012

Business Type	Nonprofit
Headquarters	Manizales, Caldas, Colombia
AI Innovation	AI- and data-supported outreach and population health management, developed with Pegasi, to identify, contact, and follow people eligible for cancer screening in low- connectivity settings.

This case study examines the cervical cancer project and what it suggests for how Bive might develop its model going forward.

Bive built its reach through local health workers, community trust, and long-standing provider relationships. Under GHIG9, it implemented **Pegasi's AI tool, adding data-supported eligibility identification and automated outreach to its existing model.**



2. Problem Definition and Context

In rural Colombia, young people are *eligible* for cervical cancer screening and human papillomavirus (HPV) vaccination through the health system, but not all of them are successfully *reached*. Their names may appear in databases without the benefit of outreach or an effective vaccination appointment.¹ Because adults are not eligible for HPV vaccination, the challenge is ensuring that eligible young people receive the vaccine in time—a gap Bive has worked to address for more than a decade.

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Bive's foundational challenge has always been equitable access to preventive health services. Colombia's rural, Afro-American, and indigenous communities face persistent disparities in healthcare access: geography, cost, and weak connections to the formal health system make preventive services harder to reach, and too many treatable conditions go undetected for years.^{2,3} To address this, Bive has spent years building trust-based community relationships and empowering local health workers—solutions that go beyond what software alone can achieve.

That method rests on a clear principle: Bive aims to complement and strengthen the existing health

Map of Colombia Showing Bive's Current Areas of Activity



system, not to replace it or compete with it. Rather than constructing a parallel delivery infrastructure, it connects people to the services that are already supposed to reach them. Its relationships with local hospitals, providers, and community associations are the operating backbone of that work, cultivated over years of consistent presence and long before any AI tool entered the picture.



3. The Solution

The pathway is straightforward. Local providers share population databases, which Bive/Pegasi's AI processes to identify women eligible for screening. Given patchy connectivity and limited smartphone experience in rural Colombia, Bive uses automated voice calls to reach women, then connects those who accept to community health workers (CHWs) for in-person follow-up. CHWs translate digital outreach into trusted, in-person



A community health worker from Bive (right) with a beneficiary of the project. Photo credit: Bive.

connections. In Amagá (an administrative region of Antioquia, Colombia), for instance, after a CHW explained HPV prevention in relatable terms, a teenager who had refused the vaccine earlier changed her mind and received it. In the indigenous municipality, a CHW from the community built trust that enabled women to participate in screening—demonstrating that personal connection is key to impact.

A 26-year-old woman who attended an education session had never understood the importance of regular screening. Afterward, she explained that “this exam can help detect changes early” and resolved to schedule her first appointment.

Screening and follow-up care are delivered by existing health providers. A woman who arrives for a Pap smear or an HPV test receives the service through the same facility she would use for any other covered benefit; if the result is positive, she enters the standard clinical pathway for diagnosis, referral, and treatment. Bive’s role is to track attendance and follow-up, closing the loop between outreach and outcome without duplicating clinical work.

The clinical service was already part of the health system’s covered benefits. The gap was not formal entitlement, but actual uptake. HPV vaccination

and Pap smears are covered by Colombia’s compulsory health insurance plan. Bive does not require payment for services the system already covers. Its budget covers the connective tissue: outreach, data management, CHW deployment, and the Pegasi technology that moves a woman from a database entry to accessing a diagnostic test or a clinic visit.

In Supía (an administrative region of Caldas, Colombia), a woman in her mid-forties had never been screened, largely because she had never understood its importance or received guidance. After the project’s educational activities, she was screened for the first time. The results ruled out cervical cancer lesions but identified a vaginal infection requiring treatment; the project team connected her to the local hospital. The episode makes the abstract pathway concrete: education, screening, diagnosis, and care help the patient navigate the health system.

Technology helps identify whom to reach; Bive’s community infrastructure determines whether outreach becomes care.

Bive sees the cervical-cancer project as a model with broader applicability to other preventive and chronic-care priorities. The GHIG9 project tested the model for one condition, in four municipalities, over approximately 18 months.



4. Challenges Faced

Implementing the AI-supported outreach came with several challenges. At the data level of the health system, Bive found that health providers have multiple fragmented databases, incomplete patient information, manual processing of large patient datasets, and low capacity to risk-profile the community. On the operational level, **internet coverage was inconsistent**, and many residents had limited smartphone familiarity, making digital-first channels unreliable; automated voice calls



Meeting of Bive and public hospital staff in Supía (Caldas, Colombia) to establish a public-private partnership for the project. Photo credit: Bive.

were designed partly in response, using the mobile network. Communities that had built relationships with Bive over years were not automatically receptive to an **unfamiliar digital channel**, and Bive's CHWs had to bridge the gap. At the provider level, **health staff required training** to use AI tools in their workflows (in this case, the Pegasi platform), and their readiness to integrate new tools varied across the four municipalities.

The more consequential finding concerned **ownership**, not performance. In the four municipalities, participating **providers relied on Bive to operate the outreach** process, rather than integrating the AI tool into their own routines. They handed over their population databases, and Bive's CHWs, operating the Pegasi system, ran identification, contact, and follow-through. The delegation made the project possible: providers could participate without disrupting their routines. But it also meant the **outreach capacity remained tethered to Bive's presence**, and use of the tool did not continue in the same form after Bive's field team withdrew. That strength may also have masked an adoption gap: the ease with which providers could delegate meant there was little immediate pressure on them to build the tool into their own routines.

The takeaway was not that providers had to run AI tools themselves, but that a temporary project

had not yet become something they would adopt as routine or pay for as a service. That gap pushed Bive to define how to create an economically and operationally sustainable model and who its clients should be.

The Model at a Glance

Setting	4 municipalities
Partnership	Bive + Pegasi
Outreach	Manizales, Colombia
Clinical Delivery	Screening, vaccination, referral, and treatment through existing public providers

Project Scope at a Glance

Focus	Cervical cancer screening
Municipalities	4 administrative regions of Colombia
Duration	Approximately 18 months
Cost	Approximately \$3 per patient managed
Beneficiaries	2,807 women 1,889 children and adolescents

Bive's model improves community trust in health systems and the inclusion of diverse population groups.

An evaluation performed by Universidad de Caldas showed:

- Improvement in attitudes toward the safety of the HPV vaccine from 63.5% to 95.9%.
- HPV vaccination increased from 28.5% to 87.6% in girls aged 9–13.
- Pap smear screening increased from 67.2% to 97.9% among women in the participating community.

One participating community was indigenous (in Caldas, Colombia). Bive worked with a woman leader from this community who had the role of a CHW, culturally adapting the interventions and strengthening community trust. 11.3% of women participating in the project identified themselves as indigenous.



5. Business Model and Sustainability

Bive's key asset is community trust, and its next step is to choose among four strategic paths and three buyer types as it aims to offer a bundled population health management service—including data, outreach, coordination, and follow-up—for ongoing purchase by health systems, with initial AI cancer screening costs estimated at USD\$3 per patient managed as a benchmark.

Bive's revenue comes from Bive Membership (an annual membership for access to private providers), rural health brigades co-financed by rural associations, and grant-funded projects. The strategy is to use grants to build lasting services beyond single project cycles.

The GHIG9 project pointed to a fourth revenue stream and clarified four strategic paths.

- **Sell a blended managed service** (technology, outreach, CHWs, coordination, follow-up) to health systems—requiring buyers to value the full package, not just the tool.
- **Train providers to run the AI platform and outreach.** In practice, providers have relied on Bive's team instead.

- **Co-sell a Bive-Pegasi AI screening product.** There's a risk that providers might bypass Bive and contract Pegasi for technology alone, weakening Bive's position.
- **Continue grant-funded outreach,** but this doesn't build diversified, recurring revenue.

The blended managed service best differentiates Bive by combining technology with unique community capabilities.

There are three possible buyer types:

- **Providers:** Hospitals and clinics aiming to boost screening and care continuity.
- **Insurers:** Managing preventive care and financial risk for covered populations.
- **Public entities** (e.g., local/regional health directorates): Meeting cancer-prevention and screening targets.

Bive is exploring demand but hasn't established a stable buyer base. The service aligns with WHO's Global Strategy to end cervical cancer as a public health problem by 2030 (90% of girls vaccinated, 70% of adult women with HPV testing, 90% of women with abnormal lesions receiving treatment) and Colombia's national cancer prevention framework, offering providers and public entities clear outcomes tied to policy goals. Buyers are asked to fund the operational layer that makes these commitments actionable.

Key questions remain: What capacities stay with Bive? How will Pegasi platform access work after grants? Will buyers want Bive-managed or joint Bive-Pegasi services? These factors will determine long-term sustainability.

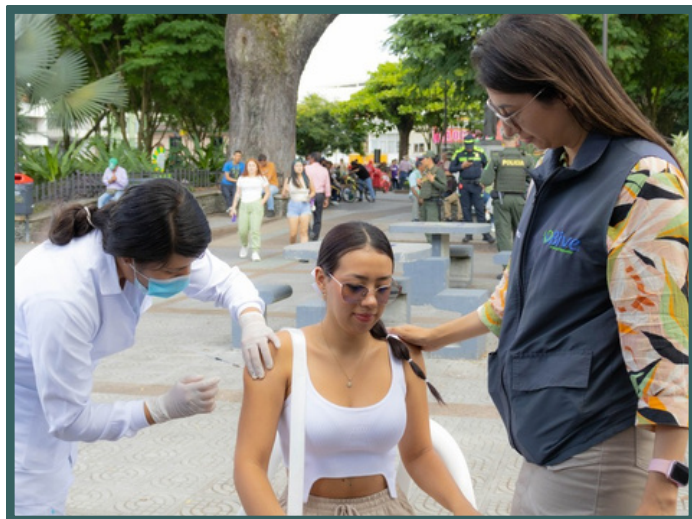


6. Conclusion

The GHIG9 project showed that Bive's strongest asset is its deep community trust and local health worker network—advantages no software can replicate. Bive's core advantage is community trust and connecting people to care, regardless of technology partnerships. The key question is whether health-system buyers will pay for these services beyond funded projects. ★

Sources

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Bive beneficiary receiving the HPV vaccine during a community campaign.
Photo credit: Bive.

Further Reading

1. Instituto de Investigaciones de Salud [Health Research Institute]. Strengthening cervical cancer prevention in Colombia: evidence for the integration of community-based strategies and digital technologies supported by artificial intelligence. Manizales (Colombia): Universidad de Caldas; 2026. Forthcoming.
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AI Disclosure

During the preparation of this case study, the authors used Zoom's built-in AI transcription to transcribe interviews and Claude Opus 4.8 to improve the readability and flow of the manuscript. The editor used Canva AI tools to generate and edit maps. After using these tools, the authors and editor reviewed the content as needed to ensure accurate representation of the information.

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