



SAFE WATER AND AIDS PROJECT (SWAP)



CONTINENT

Africa



COUNTRY

Kenya



HEALTH FOCUS

Primary health care, HIV



AREAS OF INTEREST

Community health workers,
Community mobilization



HEALTH SYSTEM FOCUS

Health workforce

SAFE WATER AND AIDS PROJECT (SWAP), KENYA

A network of trained community health promoters, primarily drawn from vulnerable community groups, who earn an income conducting door-to-door sales and provide education to improve health and increase access to health and hygiene products for their communities.

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BL	Baseline (survey)
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CDC	Centre for Disease Control and Prevention
CHP	Community health promoter
CHW	Community health worker
DIV	Development Innovation Ventures
HIV	Human immunodeficiency virus
ITN	Insecticide-treated bed net
KNBS	Kenya National Bureau of Statistics
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Nongovernmental organization
P&G	Procter and Gamble
PSK	Populations Services Kenya
STI	Sexually transmitted infection
SWAK	Society for Women and AIDS in Kenya
SWAP	Safe Water and AIDS Project
TB	Tuberculosis
UN	United Nations
USAID	United States Agency for International Development
US\$	United States dollars

CASE INTRODUCTION

The Safe Water and AIDS Project (SWAP) is a community health network that utilizes best practices from public health, business and research. It prioritizes economic and social empowerment for marginalized community members and resource-poor communities in rural Western Kenya. SWAP identifies, recruits and trains community health promoters (CHPs), whose role is to go door-to-door in their local communities, educating households and promoting good health practices. In addition, CHPs are able to generate their own income through the sale of health products, and become economically self-sustaining. CHPs are recruited and trained at no cost to themselves and are then given products on credit at wholesale prices to sell in their communities at retail. A CHP can earn a profit of up to US\$ 110 per month, depending on the number of households visited.

SWAP sets up Jamii (meaning 'community') Centres, which operate as central business hubs for the CHPs of a given area. These Jamii Centres are usually set up at the local government health facility and are run by a SWAP project officer. CHPs visit the Jamii Centre on a weekly basis to reconcile stock and data, take their profits and get new stock. The project officer at the Jamii Centre provides ongoing mentoring and training to the CHPs. Additional training is provided in targeted subjects by external partners. In 2007, SWAP established its research department, which conducts studies on the impact and effectiveness

of products and methods, and provides an avenue of revenue generation.

The SWAP case study demonstrates how marginalised patient groups can play a valuable role in extending care to remote communities through community health promoter platforms. Engaging and equipping these patients with knowledge and skills can result in gender empowerment, and the altering of engrained societal perceptions of illness and disease. It also shows how health programmes in developing countries can improve the socioeconomic wellbeing of communities by incorporating entrepreneurial income generating opportunities as part of service delivery.

Our initial focus was on safe water, providing safe water systems for the community members. We also train the community health promoters on behavioural change and health promotion in general, and they do door-to-door sales and health promotion. So they will really check in the home: Is the pregnant mother going to the clinic? Are the children immunized? Is there safe water in the home? Do they practise hand-washing? Do they sleep under a mosquito net? And all these other primary health issues. A lot of them are really vulnerable women – that is widows, people living with HIV from very poor backgrounds – who are now economically empowered. So they make an income while they improve health. (Alie Eleveld, Founder, SWAP)

1. INNOVATION PROFILE AT A GLANCE

Organization Details

Organization name	Safe Water and AIDS Project (SWAP)
Founding year	2005
Founder name (Nationality)	Alie Eleveld (Dutch, resident in East Africa for 30+ years)
Current head of organization	Alie Eleveld
Organizational structure	Nongovernmental organization
Size	45 full time employees, 200 active community health promoters

Innovation Value

Value proposition	A community health worker model prioritising economic and social empowerment for marginalised community members and resource-poor communities in rural Kenya that utilizes the best practices from public health, business and research.
Beneficiaries	<p>Direct beneficiaries: Unemployed women living with HIV and marginalised community members (Community Health Promoters)</p> <p>Indirect beneficiaries:</p> <ul style="list-style-type: none"> • Communities living in low-income rural settings • Vulnerable population groups (orphans, widows) • Kenyan Provincial Ministry of Health
Key components	<ul style="list-style-type: none"> • Social and economic empowerment platform for marginalised HIV positive women • Training programme in community health and education • Community business centres supplying health products • Public health research centre

Operational Details

Main income streams	<p>Diversified funding portfolio:</p> <ul style="list-style-type: none"> • Grant funding • Revenue from sales of health products • Income from research studies
Annual expenditure	US\$ 700 000
Cost considerations	CHPs are recruited and trained at no cost to themselves and are then given products on credit at wholesale prices to sell in their communities at retail. After they pay back SWAP for the products and get new stock, the CHP keeps the profit. For the household, health promotion is free and costs vary by product.

Scale and Transferability

Scope of operations	Western Kenya, with operations and research in 6 counties (Kakamega, Kisumu, Homa Bay, Siaya, Vihiga, Nairobi)
Local engagement	SWAP engages with local community leaders to facilitate ongoing support for CHPs. They go through traditional community channels when entering a new area and work with the country Ministry of Health to align strategies. Regular business mentoring is provided to CHPs and their feedback is integrated into programme improvement.

Sustainability	<ul style="list-style-type: none"> • Diversified funding streams for activities, especially generating revenue through research • Partnerships with key organizations to contribute in kind and support the organization in refining its own business sustainability • 3. Memorandum of Understanding with the Ministry of Health in support of SWAP's work and frame interactions with the government
Scalability	<p>For the SWAP model to be scaled in a new country or location, the following minimum conditions are needed:</p> <ul style="list-style-type: none"> • a supportive local ministry of health; • initial funding for start-up costs; • avenues for community engagement.

2. CHALLENGES

Kenya has a high prevalence of communicable diseases, which places a major burden on the health system as well as the economy at large. The human immunodeficiency virus (HIV) is the leading cause of mortality in the country, at 14.8% (WHO, 2015). There is a high prevalence of tuberculosis (TB) infection, as well as a co-infection rate of 45% for TB and HIV (KNBS & ICF Macro, 2010). Eighty-three percent of those infected do not know their HIV status, and only 35% of those in need of antiretroviral therapy (ART) are accessing treatment (Kenya AIDS Indicator Survey, 2009). Vulnerable groups include AIDS orphans, pregnant women and rural populations living in areas with a high burden of disease. Girls and young women are particularly vulnerable to infection and the negative social consequences of infection.

Western Kenya is especially marked by a high burden of disease and poor health outcomes. It has the highest rates of infant and child mortality in the country. For every 1 000 live births, 95 infants die before age 1, compared to the national rate of 59 deaths per 1 000 live births (KNBS, 2010). Under-five mortality is 149 deaths per 1 000 live births, while the national rate is 84 deaths per 1 000 live births (Patel et al., 2012). It also has the highest HIV prevalence at 15.1%, compared to the 6% national rate in Kenya.

Poor health is exacerbated by poor water quality and inadequate sanitation. Diarrhoeal disease

remains one of the major causes of childhood morbidity and mortality in Kenya, particularly in areas where there are shortages of safe drinking water, adequate sanitation, malnutrition and pollution of food sources (World Health Organization, 2009). In a recent survey, the two-week period prevalence of diarrhoea was 16.2% for children under five years of age (Patel et al., 2012). Diarrhoea counts for over 16% of deaths under five years (Shaheed & Bruce, 2011). In the Western region, only 6% of the population has access to piped water and 5% have access to electricity (KNBS, 2010). Water is often collected daily from rivers and ponds where livestock drink and families wash clothes and bathe. The use of carefully selected and properly used public health products (e.g. bed nets, household water treatment, hygiene products) has the potential to be a cost-effective way to improve the overall health and productivity of communities. Awareness, demand, supply, and use of these technologies, however, are typically low, especially among low-income, rural communities, where market penetration for many of these products has been slow or non-existent.

In light of these health challenges, ensuring access to and utilization of health services is a vital component of improving health outcomes in Kenya. Although utilization of health services among the population is increasing, access to quality health care is still limited for a large number of people.

3. INNOVATION IN INTERVENTION AND IMPLEMENTATION

3.1. A HOLISTIC EMPOWERMENT PLATFORM FOR MARGINALISED WOMEN LIVING WITH HIV

I think what makes our work innovative is the combination of health and economic improvement, which really complement each other. It makes an income for the women who are vulnerable: women living with HIV, widows... They become self-reliant while they also adopt healthy practices themselves. It has reduced stigma and discrimination for people living with HIV, who have become useful members of society. (Alie Eleveld, Founder, SWAP)

SWAP seeks to uplift and empower women living with HIV/AIDS in Western Kenya. This has led the organization to establish a community-health network comprised of community-health promoters (CHPs). The role of the CHP is to go door-to-door in their local communities, educating households and promoting good health practices. In addition, CHPs are able to generate their own income through the sale of health promotion products, and become economically self-sustaining. A CHP can earn a profit of up to US\$ 110 per month, depending on the number of households visited.

CHPs are directly identified and recruited by SWAP from the communities in which they live. They are usually vulnerable women with few prospects for status or income, drawn from Community Units, HIV support groups and widow groups, home-based care groups, orphan support groups, as well as any other community self-help groups that show interest in SWAP's work.

These CHPs receive training in community health and business practices. The training and products are centred around 6 key principles for better family health: 1) Prevent diarrhoea; 2) Prevent malaria; 3) Eat nutritious food; 4) Plan your family; 5) Immunise your children; and 6) Prevent the spread of HIV and prevent mother-to-child transmission. This training takes place over two weeks when they first join SWAP and is then

supplemented with refresher training and mentorship opportunities. More specifically, they are trained on aspects of behavioural change, health promotion, maternal and child health care, business management, social marketing, stock management, record keeping and mobile phone technologies.

The CHPs are further trained on the package of health products they would be selling in their local community. The basket of products includes products to prevent the main causes of morbidity and mortality, such as diarrhoeal illness, malaria, HIV, malnutrition and respiratory infection. There is a strong focus on safe water collection, treatment, purification and storage, as well as hygiene and nutritional products. These products are sold at full cost recovery wholesale prices to the CHPs, who then sell them door-to-door in their communities at retail price. CHPs are able to retain all the profits generated from product sales.

In addition, SWAP also supports the training of Ministry of Health (MOH) employed community health workers. These CHWs work in close collaboration with the SWAP CHPs to best serve the health needs in their local community.

3.2. COMMUNITY BUSINESS CENTRES

SWAP sets up Jamii (meaning 'community') Centres, which operate as central business hubs for the CHPs of a given area. These act as central distribution centres for the health products, but also play a role in the ongoing training and support of the CHPs. The Jamii Centres are usually set up at the local government health facility and are run by a SWAP project officer.

CHPs visit the Jamii Centre on a weekly basis to reconcile stock and data, take their profits and get new stock. The project officer at the Jamii Centre provides ongoing mentoring and training to the CHPs. Additional training is provided in targeted subjects by external partners. For example, SWAP staff were recently trained on Village Savings and Loans by CARE Kenya; Sales by Nicole Grable

from George Washington; and Interpersonal Communication by PSK. The training programme also aims to improve a CHP's ability to facilitate social behavioural change and build capacity for interpersonal communication. This is to promote an understanding of how and why people change behaviour, and to enable more effective health education and community engagement. Currently SWAP has 11 Jamii Centres.

3.3. COMMUNITY OUTREACH FOR VULNERABLE POPULATION GROUPS

SWAP conducts a series of other activities in response to the needs of the local community:

- They offer support for vulnerable members of local communities in helping start-up businesses for widows, rebuilding houses, covering school fees and basic requirements for orphans, as well as assisting with hospital and funeral contributions for individual emergencies. CHPs bring forward cases they encounter in their communities and wherever possible, SWAP tries to share costs and involve the communities in delivering support.
- Community health education workshops cover a range of topics and target audiences. SWAP conducted training and refreshers for 1 153 community members on topics relating to HIV prevention, sexually transmitted infections (STIs), condom promotion, basic business skills and safe water use in 2014 (SWAP, 2015).
- Emergency support activities (surveillance, training, logistics support, testing of water sources to identify outbreak areas, distribution of supplies, etc.) are done in collaboration with the MOH and partners, such as the Red Cross, in response to extreme weather conditions (draughts and flooding) and disease outbreaks. In 2015, SWAP was active in cholera response efforts and research.

3.4. PUBLIC HEALTH RESEARCH CENTRE

In 2007, SWAP established its research department, which conducts studies on the impact

and effectiveness of products and methods. Research activities include baseline, surveillance and feasibility studies, and the collection of both quantitative and qualitative data to evaluate the health and economic impact of the distribution model and products. Since 2007, they have published 28 articles in peer-reviewed journals and use the results of these studies to adapt their model and guide decision-making on approaches and products to use. *"I'm a very strong believer in research. I feel that it should not be in some paper somewhere, it should really be on the ground. So we are trying to pick up the practical experience and lessons learnt, and we try to implement it. So we keep on changing our programmes."* (Alie Eleveld, Founder, SWAP)

SWAP also has a water laboratory at its head office in Kisumu where samples are tested and studies on sample quality assurance, sample coding and water testing are conducted. The water laboratory is used for training of staff and students, and opened to partner organizations and individuals who wish to test their water quality. The SWAP Laboratory can be used to analyse approximately 60 to 70 water samples in a day (SWAP, 2015).

These studies allow SWAP to trial new methods and approaches to improving community care with funding from research partners. They can then implement new practices based on these findings. The findings of the research are also shared with the MOH to help influence policies and interventions at a country level. SWAP has visiting researchers that join them from partner institutions to conduct research. Grants for research provide an additional source of revenue.

Not only does the research department provide an evidence base to inform implementation, it does so in a financially sustainable way as new methods of implementation are tested through funded research. This means that when a new approach, product or activity is initiated, it has been piloted with full cost recovery first.

4. ORGANIZATION AND PEOPLE

SWAP's vision is of a healthy and empowered community where everyone enjoys a high quality of life. It aims to achieve this by increasing income from environment-friendly and health-orientated micro-enterprises and improving the health status of vulnerable communities.

SWAP's founder, Alie Eleveld, is a public health specialist. She has a deep passion to support and uplift women and vulnerable communities. Originally trained as a public health nurse, Eleveld realised the need to go beyond traditional health approaches and address the social, economic and environmental factors responsible for wellbeing. A Dutch national, Eleveld has lived and worked in East Africa for over 30 years, doing work in HIV, water and sanitation, public health community programmes and research. *"I saw that women living with HIV, if they are economically empowered and if they can improve their own health, could live productive lives. So we started introducing safe water systems to these women and they were saying, 'Gosh, this is really helping our families. We have less diarrhoea in the home, I feel much stronger now. Why can't I also sell this to our neighbours?'"* (Alie Eleveld, Founder, SWAP) This led to the development of a community sales model to provide access to health products and income generation

opportunities for vulnerable individuals. In 2005, she founded the Safe Water and AIDS Project, a nongovernmental organization operating out of Kisumu in Western Kenya.

Originally operating with only four employees based in a community centre in Kisumu, SWAP was first known as SWAK (the Society for Women and AIDS in Kenya). It targeted HIV support groups, introducing them to safe water systems and micro-entrepreneurship. In 2006, it registered independently as an NGO and expanded the basket of products sold, as well as initiating its micro-financing programme.

Eleveld currently operates as the Country Director for SWAP and is focusing on building the capacity of a competent management team. There are now 45 employees on the payroll, as well as visiting researchers, volunteers and over 200 CHPs. SWAP's stated values are compassion, integrity, partnership, teamwork and responsiveness. *"We work together, help one another to change the lives of our people in the community. So SWAP is doing a lot in terms of improving life standards, especially for the people employed in it. It's a good organization to work in."* (SWAP Jamii Centre Project Officer)

5. COST CONSIDERATIONS

SWAP has been successful in having a diverse portfolio of income streams, consisting of: 1) donor funding; 2) income from product sales and 3) research department and water laboratory income. Donor funding has increased from US\$ 50 000 in their first year (2005) to just over US\$ 900 000 in 2014. It makes up the majority of the revenue. SWAP utilizes a partnership with Procter and Gamble (P&G), running a P&G sub-distribution centre where they sell P&G products to traders in the surrounding areas. This brings in additional revenue as well as qualifying SWAP for bonuses

and discounts on products. This revenue is put towards administrative costs to reduce donor reliance.

Primary costs are incurred from programme expenses, direct costs from rent and running the offices and from salaries. CHPs are not paid directly by SWAP, but rather earn their own income based on revenue from the sales they conduct. Excluding set-up and training costs, which vary by centre, the annual running cost of a Jamii Centre is US\$ 4 000.

6. OUTPUTS AND OUTCOMES

6.1. IMPACT ON HEALTH CARE DELIVERY

In 2014, 45 different health products were distributed by the trained community health promoters, including 25 411 bottles of Waterguard (chlorine solution), 73 630 mosquito nets, 111 083 sanitary pads and 236 516 bottles of detergent. In addition to the income-generating benefits of the model, the impact of improved access to health-related products and education on the local communities is identified in a number of multi-year studies. A survey done in 2014 in SWAP's intervention area showed mosquito net use up to 93%, hand washing up to 59%, with soap and clean drinking water treatment up to 54% in the targeted households around the Jamii Centres.

A two-year research project in 60 villages, which included bi-weekly home visits to assess product use, was conducted (specifically uptake of Waterguard, insecticide-treated bed nets (ITNs), and micronutrient Sprinkles) (Harris et al., 2012). A total of 60 villages were randomly assigned to intervention and comparison groups. Following a baseline survey (BL), a multifaceted intervention – comprising social marketing of these products, home visits by SWAP CHPs, product promotions, and modelling of water treatment and safe storage – was implemented in intervention villages. Comparison villages received only social marketing of Waterguard and ITNs. At baseline, <3% of households had been visited by a SWAP vendor. After the first year, more intervention than comparison households had been visited by a SWAP vendor (39% versus 9%, $P < 0.0001$), and purchased Waterguard (14% versus 2%, $P < 0.0001$), Sprinkles (36% versus 6%, $P < 0.0001$), or ITNs (3% versus 1%, $P < 0.04$) from that vendor (Harris et al., 2012).

In a qualitative study on the scaling potential of improved cook stoves, women reported the need for less firewood, fuel cost savings, reduced smoke, improved cooking efficiency, reduced eye irritation, lung congestion and coughing (Person et al., 2012). *“With the old cook stove you would have difficulty breathing and cough a lot as a result of too much smoke. One gets itchy eyes that turn*

red.” “With the old cook stove I could use fuel worth KES 70 a week and now I only spend KES 30 worth of firewood a week.” (Cook stove purchasers in Person et al., 2012).

6.2. COMMUNITY AND BENEFICIARIES

The beneficiaries of SWAP are two-fold. Firstly, the women living with HIV/AIDs who work as CHPs become economically independent. Secondly, households in local communities gain health education and products to encourage the prevention of disease and greater wellbeing.

Many CHPs have been drawn from HIV support groups, whose members have previously been stigmatised. With SWAP enabling these individuals to become economically active, their status in society, as well as their self-esteem shifts. *“[The CHPs] are recognised by the leaders, which is really huge because in the past the leaders would really shun these women and they would think, ‘Well, they are dying anyway.’ But now they are inviting them to come give health talks at the community meetings. So it's that self-esteem and reduced stigma and discrimination that are also part of it.”* (Alie Eleveld, Founder, SWAP)

One positive example of this is Rose, a CHP who was recruited from an HIV support group. She now practises healthy behaviours and educates other members of her community to do the same. She offers counselling for those who are HIV positive and encourages people to get tested. Rose has become financially secure, and has managed to educate her two children and expand into new income-generating activities with the product sale profits. She is a role model in her community, recognised by the leaders and actively showing people that it is possible to be a valuable member of society despite living with HIV.

For me, [SWAP] is a body that changes lives. In areas where we have worked, people have given testimonies that, ‘before I was not treating water, I had these diarrhoeal cases here and there. But since I started working with SWAP, it's changed my behaviour from not having safe water to now

consuming water which is safe.' And for CHPs, their living standards have also changed. (SWAP Jamii Centre Project Officer)

6.3. ORGANIZATIONAL MILESTONES

SWAP recently celebrated its 10th anniversary. Looking back over the decade, the following were identified as significant milestones:

- In 2006, SWAP officially registered as an NGO.
- In 2007, SWAP established its research department with support from CDC Atlanta. The first research project was a nutritional study in collaboration with Gain Foundation and CDC. The water laboratory was established to support this research.
- In 2010, in collaboration with P&G, SWAP launched its first Jamii Centre in Nyakwere. Since then another 9 have been built and another 11 planned with secured funding.
- In 2010, SWAP worked with P&G to change its distribution model from working with groups to recruiting and training individual CHPs to

promote health and do door-to-door sales, with an aim of improving the health and development of the community by increasing access to health products and related information.

- In 2011 and 2014, SWAP was a finalist in the UN Water for Life Best Practices Award.
- In 2014, SWAP became winner of the 'Crystal of Hope Award', which granted them €100 000. These funds were put towards the procurement of two new vehicles and a point-of-sale software package, to help with tracking sales and move away from manual stock management. Although SWAP has been using mobile phone technology to support the process for tracking stock and debts, one of their challenges was not being able to afford integrated software to facilitate this management prior to the award.
- In 2014, SWAP also received a USAID/DIV grant of 1 million US\$ over three years, allowing them to expand their operations and build another 18 Jamii Centres over the period.

7. SUSTAINABILITY

Sustainability of Jamii Centres

SWAP aims to achieve sustainability of each Jamii Centre within three years of set-up. SWAP has two Jamii Centres nearing sustainability. Influencing factors that have enabled this include being based at a health centre in a remote area (accessed by many people, but because of the remoteness there is not much sales competition), being in an area with a supportive government and having very active project officers who are well networked and committed. Challenges to sustainability include competition from other suppliers of products, CHPs being engaged in other activities that compromise their work with SWAP, drop-outs of CHPs from Jamii Centres, defaulting and debt management, low levels of engagement and commitment in some communities, and corruption. Default may happen for a range of reasons, but is often a result of sickness, household expenses such as school fees being due, or emergencies such as funeral expenses. Another

challenge has been corruption of project officers, either through under-banking or not fully accounting for stock variance. This has always led to summary dismissals.

Products in the SWAP basket include fast moving consumer goods (soap, hygiene products, water purifying treatment, etc.) as well as larger one-time investment products (such as cooking stoves and ceramic filters). This means there is sufficient recurring demand for product sales to be a sustainable source of income for the CHPs, as they will not sell themselves out of work.

To further mitigate risk and increase internal sustainability, SWAP is currently piloting the use of a loan and saving structure, instead of credit for providing products to CHPs. They are trialling different approaches at individual Jamii Centres to identify what might work best in the longer term.

I think the greatest challenge is in stock management and stock movement, so if we then get losses for whatever reason and the stock doesn't come back, then it is such a headache for SWAP ... So what we are trying to do [with the pilot studies] is to shift that burden from ourselves to the community health workers. We are trying to give them loans, so they have a kitty and from that they can have their own savings, and in the long run plough it back into getting the goods themselves. (Chrispin Owaga, Former-Deputy Country Director, SWAP)

Sustainability of the organization

SWAP has found that sustainability of the model as a whole is more challenging than sustainability of the individual Jamii Centres. *"We wanted to spread the sustainability from the [Jamii] centre level back to the office level, which means catering for all overhead and model costs and everything that comes with it. That's why we have a margin for the CHWs and a margin for SWAP. So that has to be taken into consideration, and I think it will be for a longer period of time [before reaching sustainability]."* (SWAP Financial Officer)

SWAP is undertaking a number of activities to try to increase the sustainability of the model as a whole. These include pursuing opportunities for marketing and sale of research, water laboratory and testing services, as well as training activities (SWAP, 2014). Although they do not foresee a viable move away from donor funding completely, in order to diversify donor risk SWAP has actively sought to increase the number of donors and grants. They have increased from a single donor in 2005 to 17 different donors and research grant sources in 2014.

Partnerships supporting financial sustainability

Partnerships have been an important element of SWAP's operating model. SWAP received

technical support from P&G to develop, commercialise and professionalise their business model. This was especially valuable as most of the core staff came from a public health, not business, background. *"I'm a public health specialist ... We were thinking health not business, but Procter & Gamble mentored us, and are still mentoring us, saying 'You need to do this better, this needs to become sustainable...'"* (Alie Eleveld, Founder, SWAP) With P&G, SWAP may become a learning lab to test the reception of products into the Kenyan market. SWAP currently uses its water laboratory to test products from P&G, which provides sustainable income.

In 2014, SWAP signed an MOU with the MOH in Siaya, Kisumu and Kakamega County, and with Marindi Health Facility in Homa Bay County. In addition to being supportive of the project, these local ministries of health have also provided land on which to build new Jamii Centres, attached to health facilities. The SWAP model links in effectively with the public sector community strategy. The Kenyan MOH identifies the community-based approach as the mechanism through which households and communities strengthen their role in health and health-related development by increasing their knowledge, skills and participation (Ministry of Health, Republic of Kenya, 2007).

Another key partner is CDC Atlanta, represented on the Board. They have provided technical support to establish the research department and water lab, and linked SWAP to various donors, universities and research institutions. They have also provided human resource experts on epidemiology, data management and lab, research design and methodologies. SWAP is board member of HENNET, a National Health NGO Network with 90 members, stimulating the linkages between health NGOs, private sector and the MOH.

8. SCALABILITY

SWAP currently operates in four counties in Western Kenya, with research in another two. These four counties had an approximate population of 4.5 million in the last census, when Kenya's population was 38.5 million (KBS, 2010). Leveraging existing resources and partnerships, SWAP is currently expanding operations within these four geographical regions and expects to have 18 newly funded Jamii Centres operational with trained CHPs within the next two years. Before significant expansion of the whole model to new areas is feasible, SWAP would benefit from improving its business efficiency in revenue collection, stock management, and monitoring and evaluation, which could be facilitated by the incorporation of modern technologies. The steps discussed above for increasing sustainability would be a good starting point.

A valuable innovation in implementation used by SWAP, which could be scaled to other projects and regions, is its use of research to build partnerships, generate revenue and iteratively inform and improve the implementation of the solution. Usually organizations struggle to dedicate personnel to focused research efforts. The approach taken by SWAP, where partnerships with research bodies, universities and visiting researchers are used to grow a strong research department, is a strategy for integrating this function in a sustainable way.

For the SWAP model to be scaled in a new country or location, the following minimum conditions are needed: 1) a supportive local ministry of health; 2) initial funding for start-up costs; and 3) avenues for community engagement.

9. KEY LESSONS

9.1. IMPLEMENTATION LESSONS

Building workforce and culture

The people who work within an organization shape its success. SWAP has seen how this can occur – both positively and negatively – and emphasizes the importance of selecting good people. Having a good recruitment structure in place is valuable; as is investing in staff improvement. SWAP has found it difficult to compete with the private sector in attracting good talent as the salary differential is high, but has found that creating an opportunity for growth, exposure, satisfying work and continuing education can help compensate for this. The leadership team also reflected on how important it is to build an environment that reflects the values of the organization. One of the ways this has taken shape for SWAP is its zero tolerance stance on corruption.

Engage with local community structures

It is important to engage with all stakeholders throughout the design and implementation of a new programme, especially if it is to connect into the public sector health system. SWAP stressed the importance of collaborating with the MOH as early in the process and as frequently as possible. This helps develop a collective sense of ownership, reduces feelings of competition and helps align strategies for maximum affect. It also makes it easier for the MOH to see the value in the work, as they are continuously updated and engaged throughout the process. They also noted that as a community organization, visibility is important – both locally and internationally. Although there is a time and resource investment to increase visibility, it has corresponding benefits. For SWAP, many new partners, grants and funding opportunities have arisen through intentional efforts to increase international visibility, as well as opportunities in the local community (e.g. the

opportunity to build new centres on government land). On an ongoing basis it is also crucial to stay in touch with the people on the ground (e.g. CHPs). This allows for regular feedback from the front lines of the programme and should be channelled into appropriate changes.

Overcoming donor funding challenges

One of the challenges SWAP faces is navigating the donor community's tight funding restrictions. Not allowing for overhead costs or unforeseen circumstances, as well as expectations of operating on a refund basis, places pressure on recipient organizations. Becoming more sustainable would reduce the reliance on donor funding and open opportunities to be more flexible with funds and try new approaches.

A lot of funds come with restrictions around what the money can be used for. You still want to have the base of human resources that you need to manage the programme. A lot of times the salaries are not captured 100%, so you have to really struggle to fill in the gap and think how are we going to have these expertise and technical skills and at the same time be able to deliver the programme without this being funded 100%. (Chrispin Owaga, Former Deputy Country Director, SWAP)

Addressing the unintended consequences of free-products

Another environmental factor that impacts SWAP's work is the competition with donors handing out free products. Not only does this constrain CHPs' income generating opportunities, it also means that individuals are given products with little information on how to use them effectively. SWAP's emphasis on providing the relevant health information and training to its CHPs creates an understanding within the community on best practices for healthy habits. SWAP's research team found that many women who had received free products were not using them, as they did not know what to do with it. *"We always find that the education component is very important, so we really invest in training these*

women in the hygiene techniques and the health promotion and family health care, so they can all be informed before they go out in the community."

(Alie Eleveld, Founder, SWAP) Engaging organizations that flood the market with free goods to see how an effective collaboration could take place would be an opportunity for SWAP to explore further.

9.2. PERSONAL LESSONS

For founder Eleveld, seeing the impact of SWAP's work is an encouraging and motivating factor. *The thing that gives me joy is really seeing the vulnerable communities now with improved health. We've seen the indicators changing, we've seen them opening bank accounts and being self-reliant, and being invited by the leaders, and that reduced stigma. I think that is really huge. Some of the things we cannot put in graphs or anything like that and are very difficult to document, but the smiles on people's faces when we come ... is lovely to see.*

As an organization that prioritizes working with vulnerable communities, one of SWAP's fundamental beliefs is that everyone has value and can contribute to their communities in meaningful ways. As part of this belief, Eleveld has seen the importance of involving the community in the work they do.

I always believe in involving the community, and having the community own projects is so beneficial. Investing in community-led interventions can really make a bigger impact instead of having everything done top-down, and making decisions for something which sometimes ... may not be culturally accepted or may not work out after you pull out. But if the community owns it and it's led by the community, and it improves their health and makes them self-reliant, I think that's really a win-win situation. ... Work closely with the community, and the Ministry of Health especially. Involve them at all levels. They can become very supportive and it's like a win-win situation for both. (Alie Eleveld, Founder, SWAP)

CASE INSIGHTS

1. Marginalised patient groups can play a valuable role in extending care to remote communities through community health promoter platforms. Engaging and equipping these patients with knowledge and skills can result in gender empowerment, and the altering of engrained societal perceptions of illness and disease.
2. Health programmes in developing countries can improve the socioeconomic wellbeing of communities by incorporating entrepreneurial income generating opportunities as part of service delivery.
3. Diversified funding streams supports the sustainability and longevity of nongovernmental organizations. With good data systems, these organizations are able to generate revenue from commissioned research studies.

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