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BUILDING COMMUNITY CAPACITY IN HIV/AIDS RESPONSE: THE CASE OF MAANISHA PROJECT

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ABBREVIATIONS

AEO	Agricultural Extension Officer
AIDS	Acquired Immune Deficiency Syndrome
AMPATH	Academic Model for Prevention and Treatment of HIV/AIDS
AMREF	African Medical and Research Foundation
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CACC	Constituency AIDS Control Committee
CBS	Central Bureau of Statistics
CCC	Comprehensive Care Centre
CHW	Community Health Worker
CSO	Civil Socitey Organisation
CSW	Commercial Sex Worker
DDO	District Development Officer
DfID	Department for International Development
DHS	Demographic and Health Survey
DTC	District Technical Committee
FBO	Faith Based Organisation
GAC	Grants Approval Committee
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
GOK	Government of Kenya
HBC	Home Based Care
HEDC	Health & Economics Development Consortium Group
HIV	Human Immuno Deficiency Virus
IDU	Injecting Drug Users
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
MARP	Most At-Risk Population
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NGO	Non-Governmental Organisation

NHSSP	National Health Sector Strategic Plan 1
ODSS	Organisational Development and Systems Strengthening
PLHIV	People Living with HIV
PSO	Private Sector Organisation
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
TOWA	Total War on AIDS
TRC	Technical Review Committee
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
USD	United States Dollar
VCT	Voluntary Counselling and Testing
WAFNET	Women Action Forum for Networking
WB	World Bank
WHO	World Health Organisation

ABSTRACT

This case study documents the experiences drawn from AMREF's Maanisha programme in Kenya which works with various stakeholders for a co-ordinated and participatory HIV/AIDS response. The programme applies a twin approach of provision of capacity building and grant making. The study highlights the lessons learnt in contributing to a co-ordinated, harmonised, participatory and vibrant response to HIV/AIDS in Kenya. It draws a number of recommendations for future policy and practices based on the programme's experience.

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4.1 | INTRODUCTION

By the end of 2007, close to 33 million people were living with HIV globally (UNAIDS, 2008). During the year, a total of 2.7 million people were newly infected with HIV and the AIDS epidemic had killed 2.1 million people. Over two-thirds of people living with HIV (PLHIV) are from sub-Saharan Africa. The region accounts for almost three-quarters of all AIDS-related deaths globally. In sub-Saharan Africa the epidemic is characterised by marked gender inequalities with 59% of PLHIV being female.

Since its formation in 1999, Kenya's National AIDS Control Council (NACC) has co-ordinated the country's HIV/AIDS response. It has led in the formulation and implementation of two national AIDS strategic plans for the periods 2000-2005 and 2005-2010. The current strategic plan provides the overall direction for HIV/AIDS programming in Kenya and advocates for a multi-sectoral and comprehensive approach encompassing prevention, care, treatment and support, and socio-economic mitigation (NACC, 2005). Through NACC's leadership, Kenya's HIV/AIDS response has evolved in both geographic and conceptual terms. Conceptually, the country has progressed from managing HIV and AIDS as a medical problem, to recognising the public health significance of the epidemic, and today applies a social model to HIV/AIDS programming. Key stakeholders in Kenya recognise that the pandemic has enormous negative social and economic effects and can only be effectively addressed through a multi-sectoral response based on partnerships among stakeholders. This shift has led to considerable changes in HIV/AIDS programming including a shift from largely health facility-based activities to a greater balance between health facility and community-based interventions. There is greater involvement of communities including beneficiaries, civil society and private sector. However, gaps abound regarding optimal approaches for co-ordinating and harmonising the response while fostering genuine involvement and empowerment of communities.

4.2 | LITERATURE REVIEW

Kenya has been grappling with the HIV/AIDS pandemic for the last three decades. The country is among the high HIV and AIDS burden nations with prevalence above 5% since 1990. For instance, the prevalence of HIV among adults aged 15-49 years has risen from 5.3% in 1990 to 7.4% in 2007 translating to more than 1.4 million PLHIV (NASCOP MOH, 2008). In addition, the epidemic is marked by considerable gender and geographic disparities. Five females are infected with HIV for every three males infected in the 15-64 years age bracket (*Ibid).* This feminisation of HIV is an established pattern since the 1990s and has been attributed to interplay of physiological susceptibility and power relations (Longfield et al, 2002).

Out of the country's eight administrative provinces, two have prevalence well above the national average with Nyanza province leading at 15.3% followed by Nairobi at 9% (NASCOP MOH, 2008). In 2006, 140,000 people died due to AIDS leaving a cumulative total of 1.1 million orphans aged 0-17 years in Kenya (NACC, 2007). Worse still there are about 150,000 children aged 0-14 years living with HIV. The country has witnessed a decline in life expectancy from 61.9 years in the period 1979-1989 to 56.6 years in the period 1989-1999, and to 50.5 years in 2006 (CBS, 2002; NACC, 2007). The low life expectancy is largely attributed to the interplay between HIV/AIDS and poverty. Poverty is prevalent, with over half of the population (56%) surviving on less than 1US$ a day (CBS, et al., 2004).

An assessment undertaken by AMREF (2004) in the Lake Victoria Basin region of Kenya and baseline assessment undertaken one year later (AMREF, 2005) revealed that the country's HIV/AIDS response was hampered by constraints in five areas namely:

- Co-ordination
- Communities' capacity
- Participation of communities in HIV/AIDS mitigation
- Availability of resources to communities
- Challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most-at-risk[1] categories of Kenya's population.

These findings corroborate those found in other assessments of Kenya's past national response to HIV/AIDS *(Delion et al, 2004)*.

In the last decade, the fight against HIV/AIDS in Kenya has gotten more funds and commitment from the government, Global Fund to fight Tuberculosis, AIDS and Malaria (GFTAM), the World Bank, bilateral donors, and private sector foundations. However, the increase in the number of actors at both country and local levels has resulted in vertical and piecemeal interventions that are

1. Most-at-risk populations include people living with HIV, widows, youth, sex workers, men who have sex with men, injecting drug users, and people with disabilities.

unsustainable. The efforts require greater co-ordination among partners to ensure that resources are not wasted and actions are not duplicated – thus the need for application of the "Three Ones" principles[2] . Although Kenya is a signatory to the principle, findings from the assessment undertaken by AMREF revealed that a third of CSOs were not following the national guidelines in HIV/AIDS implementation (AMREF, 2004). Further, many rarely reported to NACC nor used the harmonised HIV/AIDS indicators stipulated in the national monitoring and evaluation framework. The co-ordination of HIV/AIDS response in Nyanza and Western provinces was weak with district NACC structures citing duplication of roles, inadequacy of resources to facilitate co-ordination, and low monitoring and evaluation capacity.

On the other hand, the capacities of communities to mount an effective response were weak (AMREF, 2004). In Kenya, organised communities such as local CSOs have tried to address local needs including those that have arisen as a result of HIV infections. While the emergence of these groupings ought to provide the continuity and long-term commitment required for sustainable development, many CSOs did not have the organisational and technical capacities needed for designing, implementing, and monitoring effective HIV and AIDS interventions. For instance, among 70 CSOs surveyed, only 20% had elected leaders, 15% had annual plans to guide implementation, 53% had financial procedures in place, 22% used finances efficiently, and 68% had a constitution *(Ibid)*. The CSOs lacked systems of tracking their performance and resource utilisation, a situation that made it difficult to assess the efficiency and effectiveness of community interventions. Without adequate organisational capacity, the CSOs could not efficiently use any technical skills they possessed. These co-ordination and harmonisation gaps had also been recognised as key challenges during implementation of the World Bank-supported Kenya HIV/AIDS Disaster Response Project that was part of the Multi-Country AIDS Programme (Delion *et al,* 2004). Effective HIV/AIDS programming calls for adequate co-ordination by NACC at all levels coupled with participation and empowerment of communities.

Equally, linkages between the CSOs and government structures were very weak and were characterised by a palpable disconnect between what the CSOs were doing and what the formal health system desired (AMREF, 2004). It was difficult for CSOs to implement HIV and AIDS interventions in line with government policies and guidelines simply because they did not have the information. For example, while Kenya's Ministry of Health curriculum on home and community-based care training recommends a training duration of 11 days, many CSOs conducted such courses for a period of about three days (AMREF, 2004). Further,

2. On 25 April 2004, UNAIDS, and other stakeholders co-hosted a Consultation on Harmonization of International AIDS Funding and formally endorsed the "Three Ones" principles, which call for the following components as it relates of HIV and AIDS Programming: (a) One agreed AIDS action framework that provides the basis for co-ordinating the work of all partners; (b) One national AIDS co-ordinating authority, with a broad-based multi-sectoral mandate; (c) One agreed country-level monitoring and evaluation system.

the CSOs did not know what support to expect from district NACC and Ministry of Health structures because the structures rarely involved the CSOs in local review and planning processes. Notably, the relationship between NACC structures and the CSOs was characterised by mistrust. These weaknesses worsened the co-ordination and capacity gaps described earlier. In order to promote sustainable health development, communities should be proactive participants in any health system designed to serve them (AMREF, 2007b).

Further, massive funding gaps among CSOs in Kenya undermined effective HIV/AIDS responses (Delion *et al,* 2004; AMREF, 2004). This is partly attributable to prevailing high levels of poverty leading to the inability of households to cope with the effects of the epidemic and over-reliance on external social support structures.

Finally, the assessment found that poor people in Kenya are most affected by HIV and AIDS. They are more vulnerable to other issues such as traditional and cultural practices, gender inequalities, violation of human and legal rights and high-risk sexual practices that perpetuate the spread of HIV and worsen its impact (AMREF, 2004). Subsets of the population that are more vulnerable to infection and severe negative social impact if infected or affected include widows, orphans, sex workers, men who have sex with men, adolescents and the youth, people with disabilities, and mobile populations such as long distance truck drivers and fisher folk. For example, the assessment by AMREF (2005) revealed that 50% of widows undergo sexual cleansing, a high risk sexual practice in western Kenya. Much remains to be done to reach these groups with interventions that go beyond awareness creation to addressing the myriad of cross-cutting issues that hinder behaviour change and limit their quality of life.

4.2.1 | PAST EXPERIENCES IN HIV/AIDS PROGRAMMING

Many of the HIV/AIDS initiatives in sub-Saharan Africa have highlighted the feasibility of holistic HIV/AIDS responses and the value of linkages between beneficiary structures and the formal health systems. For example, the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) in Kenya which began in 2001 has shown that a comprehensive approach to care and treatment that takes cognisance of the nutritional, psychosocial, and other needs of those infected and affected is feasible in resource-poor settings (AMREF, 2006). The programme reaches tens of thousands of PLHIV with treatment, care, support, and socio-economic impact mitigation interventions in Kenya. It has established and maintained strong linkages between community support structures for PLHIV and health facilities for purposes of patient monitoring and referral. Similarly, the Kitovu Mobile AIDS Homecare Programme in Uganda implemented since 1987 has shown that linkages between communities and health systems are essential for successful implementation of home and community-based care programmes with such linkages enabling transfer of skills and effective referral *(Ibid)*.

Other projects such as the Kisumu Urban Apostolate Programme in Kenya have also highlighted the value of ensuring that a strong referral system is an integral part of community HIV/AIDS response. A traditional healer's project implemented by AMREF in Standerton, South Africa has shown that it is possible to develop strong and sustainable linkages between formal health systems and traditional healers. The project has helped traditional healers get organised with effective governance. It has enabled previously hard-to-reach populations to access counselling and testing services, behaviour change communication, and home and community-based care for those infected with HIV and tuberculosis (AMREF, 2006). The project has highlighted the challenge of providing financial incentives to community-based care providers, a policy level debate that has remained unresolved in several African countries.

Previous projects have demonstrated that it is possible for poor and marginalised communities to play a key role in an HIV/AIDS response. For instance, the Kisumu Urban Apostolate Programme trains and supports home and community-based care workers to visit and provide care to PLHIV in poor parts of Kisumu city in Nyanza province, while also mobilising, organising, and training communities to provide care and support services for themselves (AMREF, 2006). In addition, the Luwero Orphans and Vulnerable Children Support Project in Luwero district of Uganda demonstrated that it is possible to strengthen the capacity

of communities to take care of orphans, thus helping them to realise their full potential. The project has since 2001 reached 1,800 orphans with formal education, vocational skills, and legal support on an annual budget of USD 220,000 *(Ibid)*. In the process of supporting income-generating initiatives the project has shown that loan-based income-generating schemes for poor families caring for large numbers of orphans is often difficult to sustain.

Earlier work has emphasized the vital role of involving beneficiaries in design and implementation of interventions targeting them. For instance, the Zanokhanyo Youth Centre in Peddie, South Africa has been operational since 2001 and has shown that youth-friendly sexual and reproductive health services provided by youths are more attractive than similar services provided by less youthful health care workers. The centre provides young people with sexual and reproductive health information, life skills training, and peer education. It is led by a steering committee whose membership includes peer educators and youth representatives (AMREF, 2006). Similarly the International Centre for Reproductive Health in Mombasa, Kenya has successfully reached female sex workers with preventive interventions by engaging and training them as peer educators *(Ibid)*. But the same project has also shown that negotiating powers among female sex workers remains low in the context of transactional sex, seriously increasing the risk of HIV infection to themselves and their clients.

It has been established that the spread of the virus is fuelled by poverty, precarious health conditions, illiteracy, the inferior social status of women, as well as other socio-cultural, structural and environmental factors (Ricardo, 1997a). Although such cross-cutting issues continue to worsen the spread of HIV and impact of AIDS, previous work has revealed that it is possible to address these issues. For example, the Comprehensive Community-Based Rehabilitation in Tanzania Legal Aid Services in Dar es Salaam has helped widows and orphans to safeguard their rights and social security. Their interventions have included provision of legal representation and educating society on legal and human rights. Similar observations have also been made by AIDSCAP and Family Health International in HIV/AIDS prevention and control projects implemented in Latin America and Caribbean Countries (Ricardo, 1997b). In Kenya, the pioneering work of POLICY Project and Kenya National Commission on Human Rights based on the realisation of the continuing trend of violation of women's right to property ownership and inheritance rights in the face of HIV and AIDS continue to register encouraging results. This initiative works with the custodians of culture to address women's property ownership and inheritance rights among communities living in the Lake Victoria Region (Nyongo, 2005).

Elsewhere, the United Nations Population Fund (UNFPA) has reported that when culture is considered in the design of a reproductive health intervention, significant success can be realised (UNFPA, 2008). This is because culture conditions people's perception and behaviour which are both central to the way HIV prevention and treatment efforts are perceived. Indeed, stigma and discrimination are both rooted in culture and tradition and worsen after HIV infection. Interventions that respect, protect and fulfil human rights in the context of HIV and AIDS are not only consistent with emerging good practice but also likely to register wider community participation and ownership (Peterson, 2004). Participation and involvement of the most-at-risk populations form the core of Maanisha response.

While the previous programming experiences described in this section highlight a number of best practices worth incorporating into HIV/AIDS programming, they do leave several issues unresolved. First, they do not demonstrate successful approaches for building on the work of pre-existing CSOs and PSOs that provide care to a considerable proportion of the population and form the bedrock for community level sustainability. Leveraging civil society energies in the HIV/AIDS response is a potentially powerful approach considering the sheer durability of CSOs. While there have been past attempts at providing grants and building the capacities of the organisations, successful experiences at combining comprehensive capacity building and provision of grants to CSOs and PSOs into one coherent and effective process remain scarce.

Second, past experiences have failed to demonstrate effective mechanisms for superimposing co-ordination and harmonisation mechanisms into prevention, treatment, care, and support interventions. Fostering better co-ordination has the potential to optimise benefits from other interventions by creating local support networks among stakeholders, reducing duplication, and enhancing shared learning of best practices.

Third, despite the significant role played by cross-cutting issues in worsening the spread and impact of HIV, past experiences on how to comprehensively mainstream the issues remain scarce with most efforts being piecemeal. Fourth, past experiences have largely focused on technology transfer with transient attempts at strengthening organisations, a situation that has hampered the utility of transferred technology and grossly limited the effectiveness of aid. Moreover, there are no past experiences that show how a programme can combine capacity building of CSOs, comprehensive mainstreaming of crosscutting issues, strengthening of co-ordination mechanisms, improvement

in the quality of life of the infected and affected people, and policy influencing through documentation of best practices in one project. While it may be argued that combining them can be a prodigious task that could jeopardise success, it is probably one of the best approaches for fast tracking social and health development in Africa, where isolated magic bullets have failed to deliver significant gains, and are unlikely to do so in future.

4.3 | THE MAANISHA HIV/AIDS RESPONSE

Project Description

Maanisha project is a community-based HIV/AIDS programme of AMREF in Kenya. It aims at sustained reduction in the incidence of HIV, AIDS and sexually transmitted infections. Maanisha is a Swahili word which means "giving meaning to". The project aims at giving meaning to HIV/AIDS interventions in Kenya. AMREF with support from the Swedish International Development Co-operation Agency (Sida) implemented "Maanisha Phase I" in the Lake Victoria region covering Nyanza and Western Provinces from January 2004 to September 2007. Based on the successful implementation of the first phase, the programme has been scaled up to cover 82 districts in Nyanza, Western, Rift Valley and Eastern provinces.

Maanisha's conceptual framework was premised on the fact that the complexity of the HIV/AIDS epidemic requires innovative strategies that draw from state-of-the-art biomedical and public health interventions that incorporate broad-based socio-economic and cultural initiatives.

AMREF implements the project in partnership with NACC, Ministry of Health (MOH), CSOs and a few PSOs. The programme is currently funded by Sida and the UK Department for International Development (DFID). About 60% of Maanisha's budget goes to grant making targeting CSOs and PSOs. The programme focuses on addressing the needs of vulnerable categories of people, in line with the Kenya National HIV/AIDS Strategic Plan for the period 2005/2006 to 2009/2010, and on narrowing the gap between the community and the rest of the health system, in line with current National Health Sector Strategic Plan (NHSSP). Specific target groups include: PLHIV; caregivers; widows; orphans; injecting drug users; sex workers; men who have sex with men; adolescents and youth; people with disabilities and mobile populations.

The specific objectives of Maanisha are:

- To build the capacity and capabilities of CSOs and private sector organisations to design and implement quality HIV and AIDS interventions
- To promote safer sexual behaviour and practices among at risk and vulnerable groups
- To strengthen facilitation, harmonisation, and co-ordination mechanisms between CSOs and GOK structures
- To support CSOs to increase access to and improve quality of healthcare and referral services for Persons Living with HIV through increased linkages with the MOH

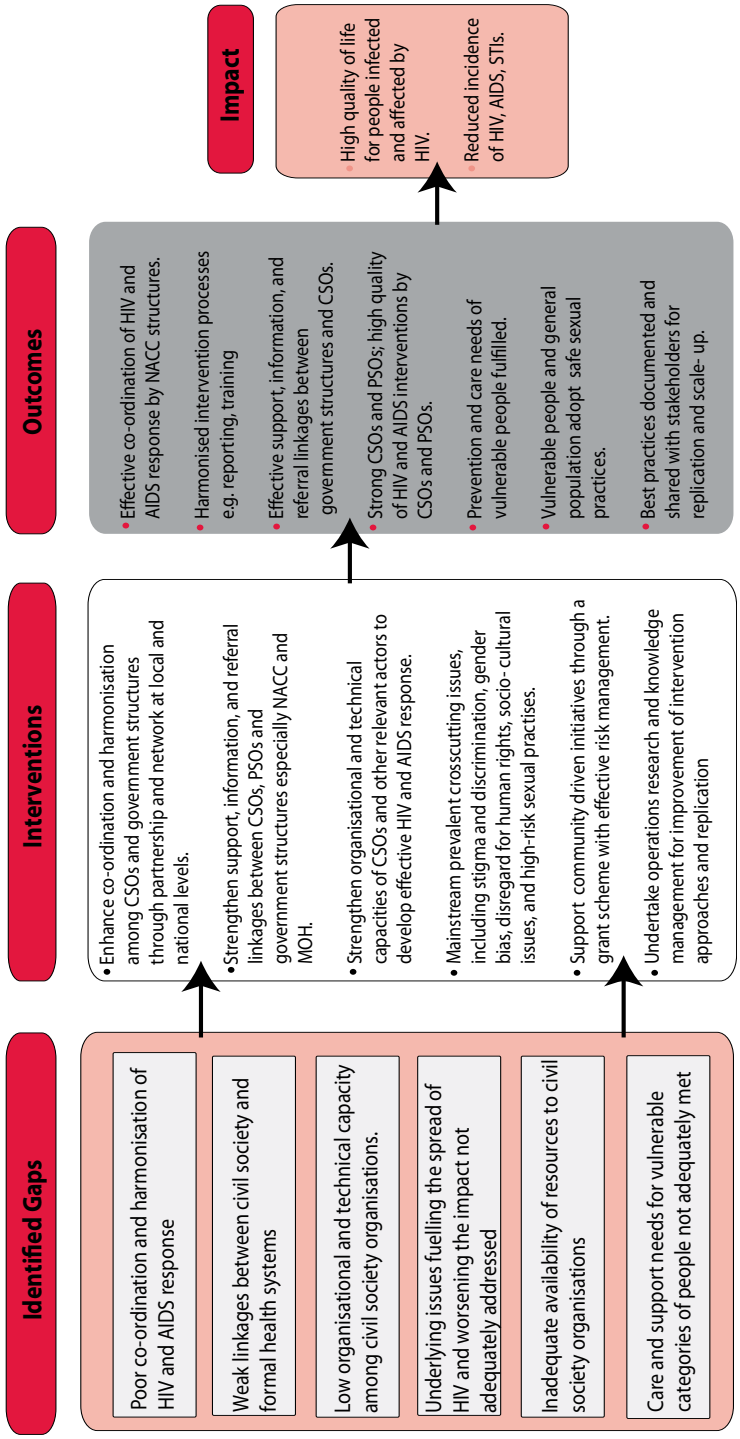
To develop and strengthen a knowledge base for influencing policy and adoption of best practices.

To achieve these, Maanisha has applied the following strategies:

- Development of partnerships with CSOs, private sector organisations, and local and national GOK structures for a comprehensive response to HIV/AIDS
- Capacity building of CSOs, private sector organisations, and other relevant actors
- Mainstreaming of cross-cutting issues, including stigma and discrimination, gender bias, disregard for human rights, socio-cultural issues, and high-risk sexual practices
- Advocating for safe sexual practices and behaviour change
- Provision of support for community-driven initiatives through a grants scheme
- Enhancement of co-ordination and facilitation among CSOs and GOK structures
- Carrying out of operations research and knowledge management for improvement of intervention approaches and possible replication.

In order to inform the implementation strategies, the project conducted a needs assessment and a knowledge, practice and coverage baseline survey in 2004 and 2005 respectively. The needs assessment focused on: the HIV/AIDS service requirements of the communities; capacity and resource needs of CSOs for a sustained and effective response to the HIV/AIDS pandemic; and the training requirements of the providers to meet the needs of vulnerable categories of people. The knowledge, practice and coverage baseline survey provided the benchmarks for the programme.

Fig 4.1: Conceptual framework for the Maanisha Project

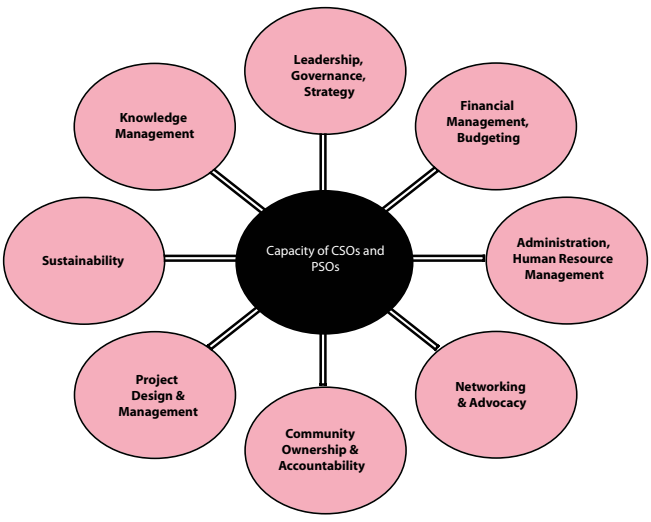


4.3.1 | PROJECT ACTIVITIES

Strengthening capacities of grassroots civil society and private sector organisations

In Kenya, grassroots CSOs and PSOs provide prevention, care and support interventions to a considerable proportion of the country's population. Their work has helped ensure that HIV/AIDS responses are based on actual needs of communities and households, and are accessible and acceptable. During the first two years of implementation, Maanisha has significantly strengthened the capacity of 389 CSOs and PSOs in Nyanza and Western provinces to implement effective HIV/AIDS interventions. The programme has applied a twin approach of grant making and organisational strengthening. The organisational strengthening component has been operationalised using the Organisational Development and Systems Strengthening (ODSS) approach. The approach is implemented by programme staff and Constituency AIDS Control Committees (CACCs) through one-on-one mentoring with the CSOs during which capabilities in eight areas are enhanced: leadership, governance and strategy development; financial management and budgeting; administration and human resources management; networking and advocacy; community ownership and accountability; project design and management which includes enhancing their technical skills in HIV/AIDS programming; sustainability including diversification of resource base; and knowledge management (See Figure 4.2). Maanisha has developed an ODSS manual for CSOs to serve as a guide in application of the approach.

Fig 4.2: The Organisational Development and Systems Strengthening (ODSS) capacity building framework



To enhance sustainability of the capacity building efforts, Maanisha works with the government's decentralised structures. The programme has trained district development officers (DDOs) and CACCs in ODSS. These government officials whose responsibilities include supervising the implementation of HIV/AIDS activities at the grassroots level apply the ODSS skills during quarterly supervision and mentoring visits to CSOs. In addition to enhancing their capacity to apply ODSS, the programme provides funds to the CACCs to meet transportation costs during visits to CSOs and PSOs.

The programme applies an ODSS scan tool to gauge the level of capacity of CSOs and PSOs in the aforementioned components of ODSS. Programme staff and government officials apply this tool to the CSOs and PSOs at regular intervals. The results are analysed to identify where the CSOs' and PSOs' weaknesses lie and the findings used to determine how to mentor each organisation.

Strengthening co-ordination and harmonisation between government structures and CSOs

Through Maanisha project, AMREF has supported NACC to operationalise the 'Three Ones Principle' in Kenya with considerable improvement in co-ordination and harmonisation of HIV/AIDS programming at the local level. In contributing to an agreed HIV/AIDS action framework, Maanisha has strengthened more than 20 co-ordination fora in Nyanza and Western provinces including district health stakeholders' fora, annual district and provincial joint AIDS review fora led by NACC, grant makers co-ordination fora, a provincial behaviour change and communication consortium, district home and community-based care co-ordination fora, and annual operational planning led by the Ministry of Health. AMREF's support has included provision of funds, technical advice during consultation with government officials, and advocating for greater involvement of CSOs and PSOs in the co-ordination fora. The latter contributed to bridging the gap between the community and the rest of the health system which is also well articulated in the community strategy currently being implemented by the Ministry of Health and other stakeholders in health. Through these fora NACC has rallied stakeholders to undertake programming in line with the national HIV/AIDS strategy while fostering greater synergy and sharing of lessons learnt.

In an effort to enable CSOs recognise NACC as the national co-ordinating agency, AMREF has strengthened the capacity and leadership role of decentralised NACC structures at district and constituency levels to enable them fulfil their mandate. The programme has enhanced the capacity of 56 CACCs and 20 DTCs to confidently and effectively provide support to CSOs and PSOs leading to

vibrant relationships between the two levels of players. Initially, the relationship between CSOs/PSOs and CACCs/DTCs was characterised by mistrust. Further, by actively partnering and working with decentralised NACC structures, AMREF has promoted their visibility and recognition by other stakeholders. The project has further strengthened the capacity of CSOs and PSOs to design and implement programmes in line with the national strategy and policies by training them on specific thematic areas of prevention, treatment, care, support and mitigation. Key trainings have focused on behaviour change and communication, counselling and testing, and home and community-based care.

Finally, in order to help achieve the third "Three Ones" principle, on an agreed monitoring and evaluation framework, AMREF, by strengthening the capacity and authority of decentralised NACC structures, has enhanced their ability to foster application of the co-ordination fora and supervisory visits to CSOs and PSOs. The project has also trained CSOs and PSOs on how to report to NACC using the standard community organisation project-based AIDS reporting forms.

Grants scheme

In order to address the lack of resources, Maanisha has implemented a grant scheme for CSOs and PSOs. The scheme is closely linked to the capacity building component to ensure that supported organisations have the necessary management and technical capacity to utilise the resources and implement effective HIV/AIDS interventions. The scheme consists of the following key elements: demand creation; grants provision; capacity assessment; financial management and systems strengthening; and financial mentoring and monitoring.

Demand creation

In implementing the grant scheme, Maanisha has applied a hybrid approach of 'call for applications' and 'proactive approach'. In the 'call for applications' approach, the programme creates demand among CSOs and PSOs who then submit applications. Demand creation entails working closely with the NACC and Ministry of Health structures at district level to organise dissemination fora for sensitisation and call for applications. Through this approach, the CSOs and PSOs propose need-driven interventions by responding to the call. Before funds are released, a discussion with the eligible CSOs and PSOs is undertaken to help focus the interventions to the Maanisha and Kenya's HIV/AIDS strategy. In the

'proactive approach', the programme actively seeks groups targeting most-at-risk populations.

Grants provision

The project manages the grants through a transparent mechanism involving independent external grant review committees. The implementation team receives, records, and undertakes preliminary review and initial assessment of submitted applications. The team then submits its recommendations to the regional technical review committee. The technical review committee in turn makes recommendations to a national grants approval committee for approval to allow for disbursement of grants to qualifying organisations. The assessment of applications is based on criteria developed and approved by AMREF. The size of the grant per organisation ranges from USD 7,000 to USD 20,000 per year.

Capacity assessment

To effectively manage risk, Maanisha carries out capacity assessment for all prospective CSOs and PSOs before funds are released. Among others, the capacity assessment process checks whether the organisations being funded have a strong grassroots presence and governance structures sufficient to implement the proposed interventions.

Financial management and systems strengthening

As soon as the review process and capacity assessment are finalised, selected CSOs and PSOs are taken through a three-day training to enhance their skills and commitment to the goals and objectives of Maanisha programme and enable them understand the financial management procedures as well as reporting requirements. National guidelines on specific technical areas are provided during the workshop. At the end of the training, the CSOs and PSOs sign contracts and receive their cheques.

Financial mentoring and monitoring

Maanisha programme implementation team provides continuous mentoring and monitoring to CSOs and PSOs during quarterly and ad hoc visits to foster compliance with contractual obligations, utilisation of funds as per approved budget and work plan, and proper maintenance of records. During the first two years of implementation, programme staff have mentored initially weak CSOs and PSOs and witnessed dramatic improvements in financial management capacity and performance. During the visits and review of reports, CSOs and PSOs with persistent challenges in financial management, record keeping, and

documentation are identified and taken through detailed training to enhance their skills and strengthen organisation systems. To guide strengthening of capacity of CSOs and PSOs in financial management, Maanisha has developed and applied a simplified financial management model named the *pot model*

The Pot Model

Maanisha applies a simplified financial system called the 'pot model'. This is a financial management model for lay populations. Key facets of the pot model are financial planning, recording, and reporting. The name of the model is derived from a common household kitchenware used by local communities. The concept of the pot model is based on the financial management principles of accountability, transparency and stewardship. There are two pots that are used in the model. One pot is labelled "Bank" and the other "Cash". "Bank" pot is also called the big pot whereas the "Cash" pot is also known as the small pot. The model demonstrates the figurative flow of funds from outside (donor) into the big pot, and from the big pot into the small pot. The model is made even more user-friendly by a simplified cash analysis book that highlights the place of both big and small pots.

Benefits of the Pot Model

- Financial record keeping (book keeping) is easily done and the records are clear and accessible to the community.
- The model is an excellent tool for financial planning. CSOs are able to undertake accurate financial planning and budgeting.
- Organisations applying the pot model demonstrate excellent financial reporting in terms of timeliness and quality.
- Financial reports perception changes from donor-driven reports to a report for CSO members that is a yardstick for implementation of activities.
- Stakeholders have shown considerable confidence in CSOs supported by Maanisha because of good accountability and transparent practices. This has created visibility for the CSOs and resulted in their involvement in HIV/AIDS stakeholders' fora.
- The model is also contributing to sustainability. CSOs no longe

Behaviour change communication: mainstreaming cross-cutting issues

The Maanisha behaviour change communication strategy aims at adoption of positive sexual behaviour and practices. In implementing the strategy, AMREF recognizes that for individuals to reduce their level of risk or change their behaviour, they first need to understand the basic facts about HIV/AIDS, learn a set of necessary skills, and have access to appropriate services and tools such as counselling, testing and condoms. AMREF also recognizes that individuals are part of the wider community and are influenced by it. Thus, Maanisha's behaviour change and communication strategy involves an integrated and interactive process with communities aimed at developing tailored messages and approaches using diverse communication channels.

Maanisha has stimulated dialogue to broaden the scope of minimising sexual health risks and promoting issues of treatment, care and support to people infected and affected by HIV/AIDS. Following its mid-term evaluation in 2006, the programme has intensified advocacy for safer sexual and reproductive health behaviour with increased focus on the most-at-risk populations (MARPs) including youth, widows, sex workers, men who have sex with men, as well as on the special groups including discordant couples, PLHIV and people with disabilities. The programme in partnership with selected CSOs develops region-specific and appropriate behaviour change and communication approaches and messages for MARPs and other vulnerable populations.

Behaviour change communication approaches are linked to advocacy and mainstreaming of cross-cutting issues, which is a critical aspect of an effective HIV/AIDS response. In Maanisha, advocacy is a process of influencing decision makers and public perceptions about an issue of concern, and mobilising community action to achieve change in among others customary, legislative and policy aspects to address the concern. Like advocacy, the process of mainstreaming cross-cutting issues aims to create an enabling environment for sexual and social behaviour change. The enabling environment is perceived as one where customs, traditions, laws and public policy protect and promote the rights of MARPs and vulnerable groups, support effective programmes, reduce vulnerability to sexually transmitted infections and HIV, and address the consequences of infection. To operationalise these ideals, the programme has developed partnerships with CSOs and PSOs, the custodians of culture and community leaders, including councils of elders and regional networks. For example, the programme has worked with Women Action Forum for Networking that has engaged communities in Nyanza province in HIV/AIDS

education through gender and human rights perspectives (WAFNET, 2007). Similarly, partnership with the Luhya Elders Forum and the Teso Council of Elders has enabled the programme to address women and children property ownership and inheritance rights.

Care and support

Maanisha has helped bridge gaps that exist in the continuum of care and support from the formal health system to the community and vice versa by supporting both levels of care. The programme facilitates meetings between MOH officials and CSOs/PSOs aimed at identifying mechanisms to close existing gaps. For example, in one of the provinces, Maanisha is piloting a community network aimed at bridging the gap between CSOs and local health facilities. The programme has enabled funded CSOs and PSOs to form and develop linkages with support groups where PLHIV go for psychosocial and spiritual support. These support groups are an important part of strengthening the referral system. For example, many of them are today recognised by comprehensive care centres (CCCs) at local health facilities.

Maanisha distributes a community referral tool developed by the Ministry of Health to support groups. In addition, as part of strengthening the referral system, CSOs and PSOs support transportation of clients in need of medical attention to local health facilities.

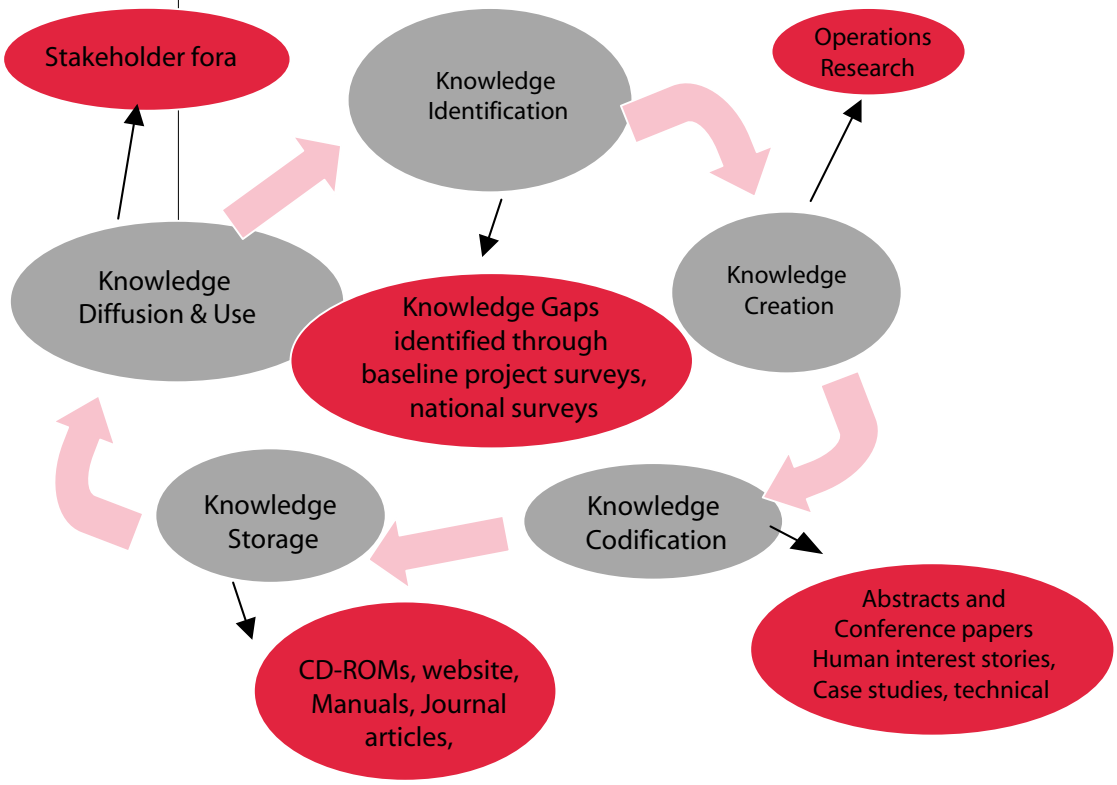
The programme enhances the capacity of communities to provide care and support by funding CSOs and PSOs engaged in provision of home and community-based care, care and support for orphans and vulnerable children, PLHIV and widows. In addition to providing direct care to beneficiaries, these organisations also use some of the funds to train home and community-based caregivers and counsellors to provide services to PLHIV, youth, and other categories of most-at-risk populations and special groups. In Kenya, provision of home and community-based care includes basic clinical care, basic palliative care, nutritional counselling and education, and psychological and emotional support to PLHIV and their families. The funded groups also procure home and community-based care kits and distribute them to caregivers. The programme also funds organisations that provide nutritional support to PLHIV; these organisations offer sustainable means of nutritional support such as seeds for planting to beneficiaries and organise linkages with Agricultural Extension Officers (AEOs). Other funded CSOs support orphans and vulnerable children to access formal education, food and nutrition, medical care and psychosocial support.

Maanisha has supported provision of quality assured services to beneficiaries by encouraging formal health care workers to provide supportive supervision to CSOs and by ensuring that CSOs' and PSOs' trainings are facilitated by MOH personnel. To this end, the programme links the organisations with ministry officials especially district HIV/AIDS co-ordinators and district home and community-based care co-ordinators. Further, the programme facilitates provision of CSOs and PSOs with government approved home and community-based care guidelines, diaries, tally sheets, notebooks, referral forms and other relevant information, education and communication materials, as a means of aligning their activities to the national HIV/AIDS strategy.

Knowledge Management

The programme has identified lessons and best practices for policy influence and practice to inform future HIV/AIDS programming, especially in resource-constrained settings. Key best practices include linkage mechanisms between health facilities and local communities, the ODSS approach to capacity building,

Fig 4.3: Maanisha's knowledge management framework



the Pot Model, approaches for mainstreaming cross-cutting issues, approach to grant making, and Maanisha as a comprehensive HIV and AIDS response model. Knowledge management within Maanisha programme also entails working with CSOs/PSOs and government structures to identify knowledge gaps and finding ways of addressing them, for instance, by undertaking operations research.

In knowledge management, Maanisha has formulated a strategy to guide the processes of knowledge identification, knowledge creation as well as knowledge dissemination in the various national and international fora (Figure 4.3). In addition, Maanisha has generated several knowledge products.

4.3.3 | ACHIEVEMENTS

By June 2008, Maanisha programme had provided grants amounting to USD 4.98 million and strengthened organisational systems and technical capacity for 389 CSOs and PSOs enabling them to design and implement effective HIV/AIDS interventions. Further, the programme strengthened the capacity of 56 CACCs and 20 DTCs to support the CSOs. Based on a mid-term evaluation undertaken by AMREF in 2007, funded organisations demonstrated considerably enhanced capacities including the following: improved governance with all of them having elected leaders and 93% having a constitution; 91% use finances efficiently; all of them provide services in line with national guidelines; and all work with an annual plan.

Qualitative and quantitative data reveal that the Pot Model and ODSS approaches are effective tools for strengthening the organisational capacities of CSOs and PSOs. For example, during the mid-term evaluation, an official of a CSO said the following regarding the Pot Model,

"We demonstrated good financial management through proper book keeping, quality financial reports and involvement of the community in financial matters. This led to additional funding from a new donor, thanks to the Pot Model of financial management"

Thomas Oluoch,
Programme Manager,
Women in Fishing Industry
Programme for Education and Development in Bondo District.

Similarly, a CACC had this to say regarding ODSS,

"Even if Maanisha was to end now, one thing that the project will be remembered for is the ODSS tool. It has given us a framework that enables us to assess CSOs in a standardised manner and plan with them on how to improve. Previously, we had nothing. Everyone worked on their own",

CACC,
Nyanza Province.

In 2006, a quasi-experimental pre and post intervention assessment on four components of ODSS revealed that application of ODSS as an intervention leads to significant improvement in the capacities of CSOs' institutional processes and systems and technical capacity (Table 4.1).

AMREF Case Studies 2009

Table 4.1: Effect of ODSS model on capacity of CSOs and PSOs

Component of ODSS	Sub-component assessed	Comparison group (n=117)		(Intervention group (n= 117)	
		Before (%)	After (%)	Before (%)	After (%)
Leadership and governance	Transparency and accountability	50%	56%	50%	93%
	Regular meetings	33%	27%	33%	93%
Technical capacity	Gender mainstreaming	19%	22%	26%	50%
	Use of national guidelines	13%	14%	14%	50%
Project design and management	Activity development planning 37%	38%	37%	78%	M & E
	procedures	33%	31%	33%	74%
Sustainability	Efforts towards sustainability	23%	23%	22%	29%
	Resource base diversification	21%	21%	21%	24%

(Source: http://www.amref.org/search/poster/)

A client satisfaction survey undertaken in 2007 revealed that majority of CSOs and PSOs (82%) rated ODSS as implemented by Maanisha to be of good to excellent quality (Source: http://www.amref.org/search/poster/). About three-quarters (76%) regarded lead time to receiving grants as adequate.

Through support provided to CSOs and PSOs and enhanced co-ordination of the HIV/AIDS response, the programme has reached and improved the quality of life of 61,335 PLHIV. It has supported 184 CSOs to implement home and community-based care initiatives, distributed 1,796 home and community-based care kits, and trained 4,300 home-based care givers and 330 peer counsellors to provide care to MARPs. The programme has reached and enhanced the quality of life for 43,122 orphans and vulnerable children.

Further, the programme has reached over 400,000 people with social and behaviour change messages through funded CSOs and PSOs. It has distributed more than a million condoms, including 25,000 female condoms. Further, it has strengthened 10 voluntary and counselling centres that have provided services to more than 26,250 clients including those with disabilities.

Maanisha has supported two networks and 328 CSOs to mainstream cross-cutting issues, especially addressing human and legal rights violations, gender inequalities, and socio-cultural issues. As a result of the programme's efforts, many PLHIV, especially women, have reported recovering property they had lost through disinheritance following the deaths of their spouses. Further, the proportion of widows undergoing sexual cleansing fell from 50% in 2005 to 40% in 2007.

Maanisha has strengthened co-ordination and harmonisation of HIV/AIDS response in Nyanza and Western provinces. Today, most stakeholders in the two provinces acknowledge the leadership role of NACC and implement interventions in line with the national guidelines. Notably, anecdotal evidence indicates that the relationship between NACC and CSOs/PSOs is vibrant.

The programme has also made significant progress in terms of sharing lessons and best practices, both locally and internationally. For instance, Maanisha demonstrated how the ODSS approach has been applied to enhance the CSOs' organisational capacities for effective HIV/AIDS programming at the international AIDS Society Conference 2007 in Mexico and later at the International Conference on AIDS and STIs in Dakar, Senegal shared how the global principles on aid effectiveness can be unpacked and applied at the community grassroots level for effective HIV/AIDS response in resource-constrained settings.

4.3.4 | KEY LESSONS LEARNT

The implementation of Maanisha project has brought to the fore several key lessons of value for future HIV/AIDS programming. First, the project has proved that exposing grassroot CSOs to national strategies and standards improves the quality of activities implemented. For this to work there needs to be an effective monitoring and mentoring mechanism that requires adequate programme staff. Second, involvement of government structures in co-ordination of HIV/AIDS efforts and training and mentoring CSOs and PSOs significantly improves the relationship between the two players, enhances sustainability of capacity building efforts, and results in good community response and better co-ordination of interventions. Project experiences have shown that for this to work, government structures need to be supported with capacity enhancement and transportation when visiting CSOs.

Third, grant making to CSOs and PSOs should include a comprehensive capacity building programme to enhance quality of interventions. It should cover capacity assessment prior to disbursement to reduce risk and inform the capacity building process for each CSO and PSO. Further, the following considerations can significantly enhance a grants scheme: involving external oversight committees in reviewing grants applications and processes allows for objectivity, alignment with key programme priorities, and ownership and support from local stakeholders; a 'call for applications' approach is a good way to roll out a grants programme but repeat grants should include a proactive approach to ensure that most-at-risk populations are not left out. It is necessary to have a co-ordination mechanism for sharing information on potential grantees between grant making organisations – this ensures maximisation of resources and non-duplication of efforts.

The mainstreaming of cross-cutting issues within the overall programme framework is an effective way of fostering community behaviour change. Finally, a systematic framework of identification of knowledge gaps in HIV programming, and creation and dissemination of knowledge products serves to promote meaningful replication of the best practices by stakeholders.

4.4 | CONCLUSION

As the HIV/AIDS pandemic continues to ravage Africa, more concerted effort by all stakeholders with the leadership of governments is needed. Key gaps that effective national and regional responses must surmount include poor co-ordination, lack of capacity among the communities, inadequate participation of communities in HIV/AIDS mitigation, limited availability of resources to communities, and challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most-at-risk populations.

There is a lot that new HIV/AIDS programmes could learn and possibly replicate from previous experiences. Governments need to seek new ways of genuinely engaging with and leveraging the work of civil society and the private sector, considering that in many African nations the latter two players provide health care services to more than half the population. Furthermore, governments also need to persistently enhance co-ordination of the HIV/AIDS response by providing credible leadership to multiple stakeholders.

Effective responses must go beyond traditional prevention programming approaches that have not shown optimal benefits; they need to address a myriad of structural issues that are country- and regional-specific, and that fuel the spread of HIV and worsen its impact. Key issues that every programme will need to address include human and legal rights violations, gender inequalities, and prevalent socio-cultural issues. Africa needs to fast track the shift from over-reliance on technology transfer to a balance between technology, local innovation, and enhancement of leadership and organisational capacities at all levels of HIV/AIDS programming. Although holistic programming that addresses all key drivers of HIV infection and impact is never easy for programme managers, it is the way to go if more of Africa's nations are to effectively address HIV/AIDS. There is need to enhance sharing of information and lessons regarding emerging best practices for comprehensive programming and approaches to addressing difficult issues for possible replication.

Maanisha is an evidence-based model of comprehensive HIV/AIDS programming that is replicable in resource-poor settings. The model has brought to the fore key programming practices that have the potential to enhance the effectiveness of a national or local response. It has made considerable achievements by combining a number of HIV/AIDS programming aspects into one initiative. First and foremost, the model brings on board the aspect of strengthening capacities of grassroots CSOs and PSOs though creative adaptation of the ODSS approach. Second, is the aspect of moulding creative partnerships with decentralised NACC and MOH structures complemented with a 'we will walk together'

programming mentality when dealing with grassroots organisations. Third, the model aspect of providing resources through a grants scheme that is enhanced by use of financial management models that are user-friendly for lay populations, seamless integration with capacity building efforts, application of approaches to reach MARPs and involvement of external and independent oversight committees to oversee the process. Fourth, is the aspect of strengthening co-ordination and harmonisation between government structures and CSOs/PSOs; innovative and structural approach to behaviour change; care and support interventions that build on the rights-based approach, especially participation and involvement of beneficiaries. Finally, the model mainstreams the aspect of knowledge management in working with stakeholders in the identification, documentation, sharing and replication of success stories and best practices in HIV/AIDS programming.

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