Handbook for Case Studies, Promising and Best Practices from the Global Fund Round 7 HIV Program

[Non-Government Component]
OUR VISION

CARE Kenya’s work aims at achieving the overall vision of CARE International:
“A world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security”

CARE does this by addressing the underlying causes of poverty, building capacity for self-reliance, working in partnership with all stakeholders at community and national levels, programming based on sound analysis, innovation, research and learning and by addressing all forms of injustice at all levels.

OUR MISSION

CARE’s Mission is to serve individuals and families in the poorest communities in the world. Drawing strength from our global diversity, resources and experience, we promote innovative solutions and are advocates for global responsibility.

We facilitate lasting change by:
• Strengthening capacity for self-help
• Providing economic opportunity
• Delivering relief in emergencies
• Influencing policy decisions at all levels
• Addressing discrimination in all its forms

Guided by the aspirations of local communities, we pursue our mission with both excellence and compassion; the people whom we serve deserve nothing less.

CARE KENYA’S PROGRAMMATIC GOAL 2013-2018

Empowering women and girls to be self-reliant, have a sustainable, high quality of life and that their rights are fully realized.

CARE intervenes in three critical areas [domains of change], informed by a theory of change and supported by pathways to realizing these changes including:

• Human conditions [access and control] – ensuring that women and girls have equitable access to and control of productive assets, basic services, opportunities and benefits
• Social positions [transformed practices] – ensuring that socio-cultural practices and processes promote women and girls’ well-being and equality
• Responsive institutions [enabling environment] – ensuring that institutions at local and national level have policies and practices in place that enhance equitable development and resilience of women and girls.
CARE Kenya’s work aims at achieving the overall vision of CARE International (CARE) which is a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security.

True to this vision, CARE Kenya took the challenge in 2007 to seek the mandate of the Country Coordinating Mechanism of the Global Fund in Kenya (now known as the Kenya Coordinating Mechanism (KCM) to support the fight against HIV, one of the biggest epidemics known in Kenya and globally.

HIV has the capacity to degrade human dignity. It has the capacity to erode humaneness in individuals due to ignorance, judgmental attitudes and stigma. It has the capacity to test tolerance and win against any community or nation. However, with partnerships such as the one offered by KCM, the Global Fund (GFATM), the communities affected by HIV, the advocates of rights protection, we will see the end of AIDS.

CARE seeks a world of hope. It is our determination and commitment to changing the tide of the epidemic that ignited our resolve to seek this partnership. It is the hope for performance of grants in Kenya that gave us the resolve to try, do it well and accomplished successfully. We set out to bring this hope in many underserved communities in Kenya in 35 counties and represented by if not all, most of all ethnic compositions, races, and diverse age and sex specific categories.

We employed nationally approved standards and guidelines and continuously reflecting on policy and practice, workable models, innovations, promising practices so as to deliver high impact interventions across the continuum of HIV prevention, care and treatment support.

In this journey, a number of promising and best practices were identified and partners learned from one another, but also from other implementers, with CARE facilitating implementation support through provision of disbursements, technical quality improvements, cross learning, reflections and scale up where feasible. On grants management and capacity improvement of sub recipients, CARE in line with the program objectives, sought to strengthen the capacity of implementers for optimal performance.

Besides technical quality, strengthening the capacity of organizational systems including grants and financial management, program planning, monitoring and
evaluation, use of strategic information to inform programming investments, decisions and improvements were done. Organizations oversight organs (boards) and management bodies were engaged proactively and within a culture of performance based funding to refocus institutional policies, procedures and practices to enhance accountability and performance.

As the program comes to an end, CARE has documented these Case Studies and Practices which demonstrate a few of the strategies adopted by the program in service delivery. The practices are replicable and we encourage those managing and implementing similar programs to utilise these in HIV scale up efforts, within a context of diminishing resources but with more evidence for epidemic control in Kenya and globally.

We are therefore very optimistic that, as you read this handbook you will come across practices that are applicable in your programming.

Bogdan Dumitru
Country Director
CARE Kenya
These Case Studies, Promising and Best Practices are a culmination of five years of management and implementation of the Global Fund Round 7 HIV program by CARE International in Kenya (CARE) together with its 54 implementing partners [Sub-Recipients]. This handbook was as a result of both ongoing participatory field interactions and a purposive end term qualitative review of the program.

It complements the program’s end term evaluation findings and human interest stories published as part of documenting accomplishments realised by the program.

We acknowledge all the CARE [Principal Recipient] staff and those of the sub-recipients who at different times during implementation, used innovative ways, developed models and with support of management of CARE, sharpened these to realise the impacts at a personal, communal and national level as reflected in program progress reports and as evidenced from quantitative and qualitative processes used in this knowledge management process.

Special thanks first go to partner organisations whose triumphs have been documented in this handbook. Our gratitude also goes to the county governments and previously developed levels of government [districts and provincial] who have continued to offer support and leadership in the control of the epidemic.

Special appreciation goes to the following CARE staff who played a critical role in this process including the design, execution, identification, analysis and compilation of these Practices and Case Studies namely Rosemary M. Mbaluka, Emmanuel Wamalwa, Elizabeth Githinji, Marline Jumbe-Kumbe, Joyce Waititu, Juster Thuranira, Catherine Karugu, Isaac Maina, Peris Karanja, Wycliffe Omondi, Roseline Nthenge, Paul Omondi, Kaima Ruiga, John Mathigu, Pamela Agum, Jacinta Nyithya, Martin Mwaura, Jesse Nyoro, Victor Bett, Jackie Mutai, Benson Ogogo and Edna Musyoka.

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Our appreciation goes to the KCM and Government of Kenya agencies such as NACC, NASCOP and the parent Ministry of Health, the HIV ICC, current and previous leadership of NACC since the design and implementation support of this program, the chairs and co-chairs of the KCM [current and previous 2007-2014]; all for their leadership over the Global Fund programs in Kenya without which these impacts would not have been realized.
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ACRONYMS
OPERATIONAL DEFINITION OF TERMS

**Best Practice:** This has been defined as “knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts (WHO, 2008). It refers to the process of gathering and applying knowledge about what is working and what is not working in different situations and contexts through feedback, learning and reflection. The documentation of best practices includes the identification and contextualization of both lessons learned, the continued process of learning, feedback, reflection, analysis and re-strategizing on what works, how and why.

**Disability:** The United Nations Convention on the Rights of Persons with Disabilities defines disability as ‘those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (United Nations Enable, 2006).

**Intellectual Disability** – This refers to a lower than average ability to process new or complex information, learn new skills, and cope independently. It involves limitations in intellectual functioning and adaptive behavior (OSHI, 2005).

**Discrimination:** The unjust or prejudicial treatment of people living with HIV that denies them social participation leading to infringement of their human rights.

**Hard to reach areas:** These are places that are underserved with infrastructure (road networks, telecommunication, electricity and health facilities) and experience hot and dry climatic conditions.

**Empowerment:** The process of obtaining knowledge and skills to access basic opportunities by marginalised individuals or group, either directly by those people, or through the help of others. It also includes actively thwarting attempts to deny those opportunities, encouraging and developing the skills for self-sufficiency, with focus on eliminating the future need for charity or welfare by the individuals or groups.

**Integration:** “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.” (WHO, 2008)¹ The aim of integrated health services is for individuals in the target group to receive all appropriate interventions at a ‘one-stop-shop’.

**Human readers:** These are individuals trained to carry out actual individualized support to people with intellectual disability. This support includes

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home-based HIV interventions and education that is individualized and based on Augmentative and Alternative Communication (AAC) formats for their understanding.

They are specially trained on the special needs of persons with intellectual disability (PWID) and skills of communicating (reading their spoken and unspoken language), interpreting and providing a two way feedback between the service provider and the PWID.

**Key populations:** These are defined groups who due to specific higher-risk behaviour are at an increased risk of HIV irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviour that increase their vulnerability to HIV. These key populations includes: men who have sex with men (MSMs), Injecting Drug Users (IDUs), prisoners and people in other closed settings, sex workers and transgender people. People in prisons and other closed settings are included because of the often high levels of incarceration of the other groups and the increased risk behaviours and lack of HIV services in these settings (World Health Organization, 2014). Long distance truck drivers and fisher folk are also regarded as key populations in this context.

**Stigma:** A mark of disgrace associated with being HIV positive leading to social exclusion.

**Peer education:** This involves utilizing the individuals belonging to a given age group, setting, socio-cultural environment to effect change among other members of the same cohort. This strategy was used throughout the program to effect change at the individual level and modified the people’s knowledge, attitudes, beliefs and behaviors. This strategy effected change at the group and societal levels as it modified norms and stimulated collective action that led to changes in HIV knowledge and behavior.
CHAPTER 1:
INTRODUCTION

1.1 CARE INTERNATIONAL IN KENYA [CARE]

CARE is a humanitarian non-governmental organisation (NGO) which has since 1968 been working in close collaboration with multiple stakeholders to help enhance social justice and alleviate poverty in Kenya. In Kenya, CARE has been operational since 1968 and targets approximately 2 million people per year. Our current programmatic focus is geared towards empowering women and girls to be self-reliant, have a sustainable, high quality of life and their rights are fully realized [2013/14-2018/19]; while engaging institutions for enabling policy and accountability and with communities for transformational practices that enhance women and girls access to and control over productive assets and benefits – as well as engaging men and boys. CARE intervenes in three critical areas:

(i) **Human conditions** – ensuring that women and girls have equitable access to and control of productive assets, basic services, opportunities and benefits.

(ii) **Social positions** – ensuring that socio-cultural practices and processes promote women and girls’ well-being and equality, and

(iii) **Responsive institutions** – ensuring that institutions at local and national levels have policies and practices in place that enhance equitable development and resilience of women and girls.

We undertake program interventions by collaborating with national and county governments, communities and development partners to implement programs that highly impact women and girls while targeting relevant stakeholders. Our programs focus on health, livelihoods improvements and financial inclusion supported by our strategic directions of quality partnerships, advocacy and policy, organizational evolution and knowledge management. CAREs stakeholders include the Government of Kenya (GoK), the private sector, local and international non-governmental organisations, community-based organisations (CBOs) communities, target and impact groups.

In Kenya, HIV and AIDS has generated historic achievements and averted millions of new infections and AIDS-related deaths through scaling-up of treatment, prevention and care. The current adult prevalence rate is 5.6 per cent [KAIS 2012] down from 7.2 per cent when this program was designed [KAIS 2007].

An estimated 1,192,000 million Kenyans aged between 15 and 64 years were HIV infected at the time of KAIS 2012 and 104,000 new adult and child infections occur every year (NACC, 2013). As a result, 29 per cent of adult mortality, 24 per cent of all morbidity, 20 per cent of maternal mortality and 15 per cent of under-5 mortality is HIV related. This is adversely affecting and consequently threatening gains in life expectancy and other development and health outcomes achieved over the past decade.
1.2 OVERVIEW OF THE GLOBAL FUND ROUND 7 HIV PROGRAM [2009-2014]

In 2009, the Kenya Coordinating Mechanism (KCM) appointed CARE International in Kenya (hereafter referred to as CARE) as the non-state Principle Recipient for a five-year Global Fund Round 7 HIV Program (hereafter referred to as the GFR7, or the Program).

In order to deliver this program, CARE worked closely with various stakeholders and partners including the Ministry of Health (MoH) - the National AIDS Control Council (NACC) and the National AIDS and Sexually Transmitted Infections Control Program (NASCOP), the Kenya Coordinating Mechanism (KCM) of the Global Fund Programs, local and international NGOs, other Civil Society organizations (CSOs), network groups for People Living with HIV (PLHIV) and the UNAIDS.

The GFR7 HIV Program was chiefly implemented through sub-contracted organizations commonly referred to as Sub-Recipients (SRs). The program primarily focused on extending HIV prevention to marginalised and underserved populations, linkage to care and treatment and enhancement of optimal adherence and retention through treatment literacy. This was meant to complement national efforts to decentralize access to Anti-Retroviral Therapy (ART) thus increasing access as visualised in the Kenya National AIDS Strategic Plan (KNASP) II.

1.3 PROGRAM GOAL

The program was designed to improve the quality of life for people living with HIV and reduce new infections through formulating and implementing strategies that increase uptake of prevention and treatment services.

1.4 PROGRAM OBJECTIVES

Specifically, the program aimed:
1. To scale up and maintain PLHIVs on ART
2. To increase access to HIV testing and counseling (HCT) services
3. To increase uptake of HIV prevention and treatment services
4. To strengthen institutional capacity of HIV program implementers to effectively monitor the program

1.5 PROGRAM IMPLEMENTATION STRATEGIES

The strategies employed to ensure attainment of the above objectives include:
- Promoting access to HIV testing and counselling for men and women aged 15 to 49
- Sensitization of youth, persons with various forms of disability, persons in the formal and informal workplace and key populations on HIV prevention
- HIV prevention, care and treatment literacy for behaviour change targeting PLHIV and their treatment buddies
- Promoting peer education
- Regular support supervision, technical oversight and effective use of strategic
information for evidence-based service delivery

1.6 THE PROGRAM’S TARGET POPULATION

The primary beneficiaries for the program included:
- The general population targeting men and women of the reproductive age of 15-49 for HCT
- Persons living with HIV, irrespective of gender or age, together with their treatment buddies. Areas of high HIV burden were particularly targeted
- Youth in and out of school of both genders aged 10–35 years
- Key populations including sex workers, long distance truck drivers, injecting drug users, prison inmates, men who have sex with men and fisher folk
- Persons with various forms of disability including intellectual disability, physical disability, visual impairment, hearing impairment and multiple disability
- Persons in both the formal and informal workplaces

1.7 GFR7 HIV PROGRAM PERFORMANCE

The performance-based funding model as principled by the Global Fund is to ensure utmost accountability, efficiency and effectiveness. It means that funding is dependent upon proven results measured against time-bound targets. Performance-based funding promotes accountability and provides an incentive for recipients to use their funding as efficiently as possible. Depending on the results, a grant is given one of the five possible ratings, that is, an A1, A2, B1, B2 and a C, with the A1 being the highest and C the lowest in the grant rating methodology. The rating determines how much of the remaining funding can be accessed.

CARE and her partners successfully implemented the GFR7 HIV Program; posting a remarkable performance. The program attained an A1 rating of more than 100%, five times consistently during Phase II up to the grant closure. Such a tremendous performance is attributable to the active engagement of strategic partners including the MoH (NACC and NASCOP), KCM, HIV ICC, SRs, sound financial accountability and risk mitigation systems coupled with an effective grants management and oversight mechanisms. Moreover, robust and functional M&E systems with quick response to challenges during implementation all explain this exemplary performance.

1.8 RATIONALE FOR THE DOCUMENTATION OF CASE STUDIES, PROMISING AND BEST PRACTICES

The Best Practices included in here are evidence of quality, impact, refined processes in the management and implementation of the Global Fund Round 7 HIV grant. These Practices and Case Studies represent the thousands of others which have not been featured here, but not any less impactful. Therefore, as the program drew to a close, CARE sought
to document the pillars that informed the outstanding success – especially considering the previous grants in Kenya had not performed to expectation.

Further, CARE was the first non-state Principal Recipient. CARE therefore sought to establish what could have been done better, and any lessons learned beyond the standard program evaluation findings. This handbook, hence, documents organizational experiences both at CARE and at Sub Recipient partner organizations in the delivery of the non-government component of Global Fund Round 7 HIV program.

Specifically, this handbook:
- Documents systems, policies and procedures that can be attributed to the success of the program
- Brings out innovative strategies in effective grants management
- Generates information on unique models and approaches that can inform scale up of HIV programming

1.9 METHODOLOGY USED IN THE COMPILATION OF THIS HANDBOOK

The information used to develop the Best and Promising Practices was sourced from an in-depth desk review and primary data collection through structured interviews, key informant interviews, in-depth interviews and focus group discussions with the PR’s and SRs’ staff as well as program beneficiaries.

In depth desk reviews were done through an objective and systematic process. Documents reviewed include: the project proposal, periodic progress reports, feedback reports, evaluation reports (mid-term and end term), program review meeting reports, capacity assessment reports, field visit reports, program policy documents, case studies, audit reports, exchange visit reports and documented success stories. The Best Practices generated by the program were based on a standard definition and a critical analysis of what constitutes a best practice (WHO, 2008). Critical parameters that informed this collection include:
- Effectiveness - The practice must work and achieve results that are measurable
- Cost efficiency - The proposed practices must produce results with a reasonable level of resources and time
- Relevance - The practice must address the priority health problems
- Replicability - The proposed practice, as carried out, must be replicable elsewhere in the region
- Ethical soundness - The practice must respect the current rules of ethics for dealing with human populations
- Sustainability - The practice must be implementable over a long period of time without any massive injection of additional resources

The following chapters outline selected Best and Promising Practices in CARE’s GFR7 HIV programming, compiled from the existing literature and interviews.
CHAPTER 2:
INTEGRATING HIV TESTING AND COUNSELLING (HTC) SERVICES IN HEALTH SERVICE DELIVERY

2.1 INTRODUCTION

Between 2009, at the beginning of the GFR7 HIV program, and 2014, at its close, Kenya made significant improvements in HTC coverage, rising from 34.3 per cent in 2007 (KAIS, 2007) to 71.3 per cent (KAIS, 2012). This rise is attributable to various factors and initiatives, including interventions from the nationally implemented GFR7 HIV program (ETE report, 2014). HTC is a key entry point to HIV prevention, treatment, care and support. The critical role of HTC in the HIV prevention and treatment continuum continues to be pronounced with the advent of ART as prevention, HIV prevention, positive living as well as the continued strengthening of various structural, biomedical and behavioral interventions to PLHIVs. Under the GFR7 HIV program, 17 Civil Society Organizations (CSOs) implemented HTC interventions.

Two CSOs, namely Community Health Africa Trust (CHAT) and Family Health Options Kenya (FHOK) integrated HTC into other health programs including Sexual Reproductive Health (SRH), basic curative services, maternal and child health (MCH) services and linkages to care and treatment. Integration of services has been found to be more responsive in addressing the unmet needs of people living in poverty, those experiencing poor access to healthcare, gender inequality and socially marginalized1.

2.2 IMPLEMENTATION OF THE PRACTICE

The partners worked closely with Community Owned Resource Persons (CORPs) and community opinion leaders, including chiefs, religious leaders, women and youth group leaders in mobilizing community members for HTC services. The mobilisers used a door-to-door approach in the mobilization and Information, Education and Communication (IEC) materials for messaging and aggressive demand creation.

A public address system was used for audience mobilisation for an enhanced uptake of HTC services. Mobile HTC outreaches were integrated with MCH services, family planning, cervical cancer screening, STI screening and treatment. These services were conducted at designated areas including market places, schools, church compounds and community watering points. These were culturally sensitive, socially acceptable within the host community and without any breach of ethics.

The CSOs utilized qualified HTC counsellors drawn from both the health facilities and the community. These counsellors who were accredited by NASCOP adhered to the national HTC guidelines and reporting tools in HTC service delivery. The CSOs worked very closely with the MoH.

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Sub-County AIDS and STI Coordinators and the Kenya Medical Supplies Agency (KEMSA) in acquisition of HTC test kits. To ensure quality assurance in HTC service provision, HTC counsellors were expected to undertake Proficiency Testing (PT). Further, HTC was overseen by certified counsellor supervisors with the technical oversight support from the County AIDS and STI Coordinators (CASCOs). After HTC, all consented clients were directed to other service delivery points for MCH, family planning, cervical cancer screening, STI screening and treatment and basic curative services. These were provided by clinical officers and nurses within the same outreach sites.

### 2.3 KEY ACHIEVEMENTS

Through the integrated approach to service delivery:
- 48,941 [Males: 25,317 and Females: 23,624] were reached with HTC services alongside other health services. It is important to note that this strategy yielded highly especially in reaching men. As Kenya’s HTC practitioners explore strategies that can reach men better, given their low response rates in all the other HTC strategies, including Provider Initiated Counseling and Testing (PITC) and stand-alone Voluntary Counselling and Testing (VCT)
- Women accessed free Human Papilloma Virus (HPV) screening, MCH and family planning services. Those suspected to have cervical cancer after screening were referred to the FHOK health facilities for further follow-up and management
- HIV positive clients were successfully referred and linked to care, treatment and support services

Overall, services leveraged on each other’s resources to ensure synergistic mobilization of communities. Recipients to program interventions benefited from multiple health services within the same time and place, saving them time and cost.

### 2.4 LESSONS LEARNED

- Integrating HTC service provision with other health services is a cost effective strategy as the service providers cut operational costs and the beneficiaries receive services on the same day in a one-stop shop.
- Integrated services in the context of outreaches are an effective strategy in reaching men, as well as women with HTC services. HTC uptake among men in Kenya continues to be low. Overall, the proportion of women who had ever been tested for HIV almost doubled from 2007 to 2012, nearly reaching the universal goal of 80 per cent. Although testing among men more than doubled; from 24.9 per cent in KAIS 2007 to 62.5 per cent in KAIS 2012, it however still remains lower than women at 40.9 per cent and 79.8 per cent from the two surveys. Clearly, these are off the 80 per cent mark as also revealed from the KNASP III end term review findings. Clearly, there is still more to be done.
The mobile approach to HTC enabled the program to reach more men (401,318) than women (359,989) between the ages of 15 and 49 years. This approach then becomes critical in upscaling HTC among male population which remains low as KAIS 2012 found out.

2.5 CONCLUSION

There is need for programs to integrate health service provision to the targeted populations in all settings during outreaches. A ‘one-stop shop’ with a comprehensive service package is more cost effective and provides a better platform for uptake of quality health services especially to the marginalized and underserved populations. Where integration is not possible within the implementing partner organizations, effective linkages, partnerships and inter-agency collaborations can add great value, improve cost-efficiencies with better value for money in heath programming.

2.6 A CASE STUDY OF THE CAMEL MOBILE CLINIC EXPERIENCE: AN INTEGRATED APPROACH TO HEALTH SERVICE DELIVERY IN HARD TO REACH LOCATIONS

2.6.1 INTRODUCTION AND JUSTIFICATION

Community Health Africa Trust (CHAT) is a registered CBO implementing mobile HTC services in Laikipia and Samburu counties. The counties are vast, acutely underserved with infrastructure and experience hot and dry climatic conditions. CHAT targets hard to reach nomadic populations who are underserved and marginalized using camel caravans to enhance access to HTC and integrated health services.

THE PROBLEM

The communities served by CHAT are predominantly nomadic; moving with their livestock in response to changing rainfall patterns and in search of pasture. Poor road infrastructure in Laikipia and Samburu makes access to most of the interior parts of these counties difficult in the provision of basic health care and other essential services to the rural populations. This situation is exacerbated by limited health facilities that are many kilometres away from target communities, low HTC uptake, high stigma, poor linkage to care, poor adherence and hence low viral suppression among PLHIVs.
In these communities, men unlike women have traditionally been the main beneficiaries of health education programs, including HIV prevention education and services.

This is attributable to the unequal power relations between men and women as dictated by culture and social constructs surrounding gender. Women are regarded as men’s property and have to seek permission to access health related services. These communities also have very poor maternal and child health outcomes, low FP uptake and poor SRH practices among women and girls.

2.6.2 STEPS UNDERTAKEN TO ADDRESS THE PROBLEM

To address the challenges experienced by the target communities, CHAT initiated integrated camel mobile clinics that are conducted quarterly to address multiple health needs of the population. The services included HTC, treatment and support groups for those testing HIV positive, basic curatives, ante-natal and post-natal services, immunization and family planning. Up to nine camels were used as the local means of transport since they can navigate the harsh terrain which has little or no road infrastructure.

The team in the camel mobile clinic comprises a nurse, a community based HTC counsellor, a community mobilizer, local CORPs and up to four camel handlers. The clinic takes one month as it moves from one location to another. Medical supplies and HTC kits are carried by the camels that are able to bear large volumes of supplies.

The CORPs from the various geographical locations mobilize community members in advance to enable them to access the integrated health services. For accessibility and acceptability, the medical camps are set strategically mostly at community service points such as watering points and near manyattas (households).

The CHAT team works closely with the provincial administration and local community leaders in ensuring security during the camel caravan clinic days. Through the integrated mobile camel clinic, CHAT has been able to bring health services closer to the target nomadic population.

CHAT has also ensured that women and men receive the best possible exposure to information, HIV testing, counselling and treatment services. In light of the widespread and chronic poverty of the target population, CHAT believes that it is necessary to focus on prevention and link those infected to care and treatment services.

2.6.3 KEY ACHIEVEMENTS

- 11,917 (Males: 5,408 and Females 6,509) have been able to uptake HTC services out of which 2,659 were couples
- The model has promoted the development of a strong community support network for PLHIV, including formation of
support groups that has contributed to reduction in stigma
- Community members are able to access comprehensive health services both preventive and curative

2.6.4 CHALLENGES AND HOW THEY WERE OVERCOME

Staff burn out that was occasioned by long periods out in the field with limited communication with family members and friends. Occasionally satellite phones were used by the staff to communicate with their families back home.

2.6.5 SUSTAINABILITY PLANS

- The community support network will continue to support PLHIV in the community with the use of community-based HTC counsellors
- It is anticipated that the national and county government will continue to support CHAT with HIV test kits and family planning commodities. The Community Based HTC counsellors and Community Based Distributors (CBDs) for family planning commodities will work hand in hand with community-based HTC counsellors

2.6.6 LESSONS LEARNED

- Integrated health service delivery models are more cost effective in provision of HTC services as compared to parallel health service delivery and stand-alone HCT services. For example, GFR7 Program data shows that it cost KSh419 to reach a client with an integrated package of health services using the camel caravan approach by CHAT as compared to KSh863 used to reach a client with HTC services by Wajir South Development Agency (WASDA) within hard to reach areas of Wajir South. However, scientific methods of evaluating this cost effectiveness are recommended.
- Use of community resource persons sustains continuum of service delivery even after phase out of programs.
- Integrated model creates a platform for scale up and sustained response.

2.6.7 CONCLUSION

The model can be replicated in regions with nomadic and pastoral populations with weak infrastructure (poor road network and geographically sparse health facilities) as services are brought closer to where there is the greatest need.
1.1 INTRODUCTION

The Kenya AIDS Strategic Framework (KASF) IV 2014/15-2018/19 points out the need to focus prevention efforts to key populations because they are disproportionately at a higher risk of HIV transmission and acquisition when compared to the general population. The high risk populations in the context of GFR7 HIV Program include sex workers and their clients (both male and female), IDUs, MSMs, long distance truck drivers, prison inmates and fisher folk. These populations have the highest risk of not only transmitting and acquiring HIV, but also STIs due to increased frequency of high-risk sex (unprotected anal and vaginal sex, multiple and concurrent partners) and drug-related HIV risky behaviours such as sharing of sharps and needles as well as flash bleeding.

Key populations continue to experience barriers in accessing health services despite efforts and investments made by subsequent programs. Key populations account for one third of new HIV infections in Kenya, estimated at about 166,000 per year (KMoT, 2008 and 2008/09 KDHS).¹ According to the behavioural and biological survey (2010-11) on HIV and STIs among key populations, including MSMs, female sex workers (FSWs) and IDUs conducted in Kenya, HIV prevalence among MSMs was 18.2 per cent, FSWs was 29.3 per cent and IDUs reported 18.7 per cent ² all significantly higher than the prevalence evidenced in the general population.

GFR7 HIV Program partnered with nine organizations to deliver interventions to key populations in Nairobi, Coast, Eastern, Nyanza, Rift Valley and Central regions of Kenya targeting Sex Workers and their clients, IDUs, MSMs, long distance truck drivers, prison inmates and fisher folks. Organizations that undertook this work include BHESP, CHAT, Foundation of People Living with HIV/ AIDS in Kenya (FOPHAK), GOAL Kenya, Hope Valley Family Institute (HVFI), Hope World Wide Kenya (HWWK), Kenya AIDS NGO Consortium (KANCO), MERLIN and Neighbours in Action Kenya (NIAK).

1.2 IMPLEMENTATION

Given their elusive nature, the snowballing approach was used to mobilize key populations for outreach sessions and for Peer Education Training (PET). The sessions lasted between four and eight hours a day for five days targeting 25 participants segregated by the various key population categories.

Each trained peer educator was expected to reach 10 peers with HIV prevention information. In this strategy, the program effectively facilitated a package of information tailored to the various key populations on HIV prevention, care

and treatment. The package included information on HIV prevention, HTC with an emphasis on repeat testing after every three months since key populations are a high risk group to HIV, - correct and consistent condom use, Voluntary Male Medical Circumcision (VMMC), gender-based violence and sexual reproductive health services (STI screening and treatment, family planning and cervical cancer screening for the women), ART and prevention with positives (PwP, alcohol and substance abuse, pre-exposure and post exposure prophylaxis, prevention of mother to child transmission (PMTCT) for those who are HIV positive and human rights information.

This package of prevention information was further strengthened by provision of HTC services to enable recipients make informed decisions based on the outcome of their HIV test results. Key populations were made aware of the various referral sites within their locations. Those who were HIV positive were referred and linked to health facilities for HIV treatment, care and support. For those who were HIV negative, behavioral interventions were provided to enable them to overcome various vulnerabilities exposing them to risks of HIV infection, progression and transmission.

1.3 ACHIEVEMENTS

- The program reached 39,712 (18,200 males, 21,512 females) key populations with HIV prevention education and related services [condoms, referrals and linkages to other care services for those infected]
- The GF program developed a key population’s documentary that has been approved by NACC for production and distribution as a reference BCC tool. This documentary continues to reach various categories of key populations with prevention and safer sex education
- Increased usage of new sterile needles and syringes by IDUs was confirmed by the GFR7 HIV end term evaluation implemented by CARE
- Increased ability to negotiate and use condoms correctly and consistently by sex workers and MSMs

1.4 LESSONS LEARNED

- The peer to peer approach in reaching key populations with HIV prevention, as well as information on treatment and care is effective in key programming as it ensures sustainability
- Failure to facilitate provision of comprehensive health services targeting female IDUs, HIV BCC information, condom use and ART services could be a barrier to female IDUs accessing HIV prevention services. It is important to facilitate provision of SRH services too

1.5 CONCLUSION

Programs implementing interventions targeting key populations should be encouraged to adopt the peer to peer model for HIV information and behavior change. Such programs should focus on a comprehensive health package while
working with female key populations because of their unique SRH needs when compared to their male counterparts.

1.6 A CASE STUDY OF MENTOR SISTERS IN SEX WORK: A PEER TO PEER APPROACH

1.6.1 INTRODUCTION AND JUSTIFICATION

Sex workers (SWs) in Kenya are often subjected to violence, both in their personal lives and at work. This violence is a manifestation of stigma and discrimination, further demonstrated by the fact that sex workers typically receive less protection and support but instead face disapproval and discrimination. Sex work occurs in complex environments dominated by power structures within family, community, workplace and the state. Within this context, SWs experience human rights violations including physical violence, emotional abuse, rape, and extortion.

Bar Hostess Empowerment and Support Program (BHESP), an organization for and by all women working in bars and sex workers in Kenya, was founded to advocate for SWs’ rights and recognition and to reach them with HIV prevention, treatment and care information through 24 peer-led groups where some of the members were beneficiaries of the peer educators trainings and HIV prevention outreaches.

1.6.2 THE PROBLEM

Bar Hostess Kambi Moto, a Korogocho-based group is one of the groups initiated by BHESP. The members have been playing the role of mentor sisters to new and younger female sex workers aged between 10 and 17 years. The group members in the course of their work established that new and younger sex workers had little or no information on HIV prevention and SRH services, negotiation skills for standard pricing and condom use, correct condom use, substance and drug abuse and how to send ‘distress signals’ to their peers. The older sex workers who had been in the trade for more than five years knew and understood all the dangers associated with their work felt the need to empower
their young sisters with information to protect them from contracting HIV and STIs, unplanned pregnancies, negotiate for condom use and protect themselves from both physical and sexual abuses.

1.6.3 STEPS UNDERTAKEN TO ADDRESS THE PROBLEM

BHESP identified and selected popular “opinion leaders” amongst the sex workers for peer education training in order to use the peer to peer approach in reaching out to other sex workers to improve knowledge, skills, and attitudes that reduce the risk of acquiring or transmitting HIV and STIs.

Selection of the peer educators was done in a manner to promote acceptance by the sex workers and reach the target population effectively. The selected sex workers were then trained as peer educators and called mentor sisters and tasked with reaching out to younger sex workers with HIV prevention, treatment and care information.

In empowering the younger sisters with information, the mentor sisters meet weekly at a place and time of their choice. The young sex workers are taken through HTC, prevention of HIV infection, SRH information and services, physical protection and pricing issues. They are encouraged to undertake HTC services to confirm their HIV status to enable those who are HIV positive to enroll for treatment, care and support services and also protect their clients from HIV and STI infections.

Those found to be negative are encouraged to continue accessing HTC services quarterly. There is also emphasis on correct and consistent condom use since it plays the dual role of protecting them against contracting HIV and STIs and avoiding unplanned pregnancies.

The young sex workers are also informed of the importance of accessing post exposure prophylaxis (PEP) within 72 hours following a condom burst or even rape. They are also reminded to charge a standard fee based on their base to facilitate a bargaining power within the group. On protection issues, they are informed on how to trigger the distress alert for others to come to their aid.

Apart from mentoring younger sex workers, the mentor sisters also distribute condoms at the hotspots directly to fellow female sex workers or feed the dispensers in the brothels or bars and mobilize other sex workers to be peer educators.

Each older sex worker is assigned young ones to continue mentoring them and ensuring that they are follow the instructions they were given. Their attitude is that a more informed sex worker will result in reduced risky behaviour, greater regard for personal safety while conducting sex work and increased avenues for support and protection.

1.6.4 KEY ACHIEVEMENTS

- There is increased awareness of HIV prevention, SRH and protection services among the younger and older sex workers.
workers as there is continuous peer to peer education before setting off for business

- Sex workers responded better to thwart physical and sexual abuse from clients. They alerted their colleagues based on the distress signal system who came to their aid. Through the BHESP paralegal system, some perpetrators of violence have been prosecuted and sentenced

- Sex workers were able to practice safer sex despite challenges in uninterrupted condom supply. With better negotiating power, they were able to factor in condom costs when pricing thus militated against the unavailability and cost of female condoms as well as the time to time stock out of male condoms. The end term evaluation report records that sex workers who were beneficiaries of the program practiced safer sex as compared to none-beneficiaries as demonstrated by 81per cent reporting to have used a condom with their last client as compared to 61per cent reported in KAIS 2012

1.6.5 KEY CHALLENGES AND HOW THEY WERE OVERCOME

Despite the female sex workers being informed on HIV protective measures such as consistent and correct condom use, their clients still took advantage of them and refused to use condoms. They were encouraged to use designated work stations to guarantee their safety and quickly seek support from their mentor sisters in case of distress.

1.6.6 CONTINUITY OF THESE INTERVENTIONS

The mentor sister system continues to reach out to new, young and naïve sex workers and empowers them with information that will enable them to protect themselves and their clients from HIV and STIs.

1.6.7 LESSONS LEARNED

- Sex workers can stand for their rights and are key players in contributing to the reduction of new HIV infections if supported with commodities (condoms and lubricants) for their trade and provided with PEP in case of a condom burst and/or rape
- Use of recognized sex workers as peer leaders in reaching out to other sex workers with HIV prevention and treatment information is effective and sustainable
CHAPTER 4:
PROMOTING UPTAKE OF HCT AND PREVENTION SERVICES AMONG PEOPLE WITH DISABILITIES

1.1 INTRODUCTION

The Kenya AIDS Strategic Framework (KASF) IV 2014/15 - 2018/19 identified Persons with Disabilities (PWDs) as a vulnerable group to HIV infection. PWDs are particularly vulnerable to HIV infection in certain contexts and often bridge new HIV infections across populations. PWDs that are infected need special care taking into account their unique physical and psychological needs. PWDs who are not HIV positive also need HIV information and services tailored to them and sensitive to their unique needs.

The GFR7 HIV Program’s focus on PWDs was driven by the glaring gap in access to HIV information by this group, accessibility of HTC services, language, physical, social and cultural barriers with weak skills among health service providers to facilitate effective access to health services. The needs for PWDs to acquire skills for provision of HIV services is acknowledged but very few have been supported to attain the competence necessary for provision of quality services. This limitation arises from assumptions of the supposed sexual inactivity of PWDs and public health policies that have remained indifferent to their diverse conditions (CARE Minimum Standard Guidelines, 2010).

1.2 IMPLEMENTATION OF THE PRACTICE

Under the GFR7 HIV Program, CARE worked with four Sub Recipients to reach PWDs including: the Kenya Society for the Mentally Handicapped (KSMH), the Kenya Union of the Blind (KUB), the United Disability Empowerment in Kenya (UDEK) and the Organization for Assisting Hearing Impaired Persons (OAHIP) in targeting male and female PWDs with comprehensive HIV prevention packages, including HTC and referral services for further treatment, care and support.

Those targeted were PWDs with different forms of disabilities including, physical, mental, hearing impairment, visual impairment and those with multiple forms of disabilities. Partnerships and networks with key institutions such as organizations working with PWDs, relevant Government of Kenya (GoK) ministries, education institutions, families, care givers, community leaders, Community Health Workers (CHWs), among others, were used to reach these vulnerable populations. The multi-stakeholder approach ensured that all the various forms of disability were covered and PWDs who may have been secluded were reached and helped to build follow-up support systems and forge referral linkages.

The approaches used by the program included: HIV prevention sessions for PWDs, training of health care workers in basic sign language to support HTC services for the hearing impaired persons, development and airing of radio programs where content is developed and adopted to plain language that is relevant to
persons with mild, moderate, severe and profound mental disabilities, development and distribution of IEC materials for visually impaired individuals, home based outreach events for the mentally challenged (that involves identification of PWD, assessment, identification of appropriate human readers, development and implementation of individualized intervention strategies), establishment of resource centers and reaching out to PWDs through a peer to peer approach.

These strategies aimed at providing access to quality information on HIV prevention, counselling and testing, care and treatment and referral services. CARE prepared minimum standard guidelines that guided content delivery. Information was packaged in mediums, formats and styles that were accessible to each group with disability, by type. These were then presented in structured three to four hour sessions depending on concentration and understanding. In some cases the sessions targeted specific disability such as hearing impaired, visually impaired and mentally challenged while others had mixed disabilities.

Efforts were made to address access and communication needs of each disability by type. Services were pro – PWD and took the community outreach approach so that such services are taken closer to the PWDs doorsteps thereby enabling them to overcome service accessibility barriers.

1.3 KEY ACHIEVEMENTS

Through outreach events, 20,469 (9,722 Males and 10,747 Females) PWDs from 18 counties (Nairobi, Kiambu, Mombasa, Kisumu, Kakamega, Nyeri, Kericho, Meru, Busia, Nandi, Migori, Kirinyaga, Embu, Machakos, Bungoma, Nakuru, Kitui and Muran’ga) were reached. To support the uptake of HTC services among persons with hearing impairment, a total 427 (204 male and 223 female) health care workers were trained in basic sign language. Peer educators have been able to continue undertaking sensitization training to their peers as a result of the intervention and have also had access to HIV testing, counselling and treatment services in local health centres.

Through the program, there was an increased access to information on HIV prevention, care and support. The health workers trained in basic sign language are able to communicate and to offer HIV counselling and testing services to clients with hearing impairment. CARE was part of a sub-committee of the HTC Working Group at NASCOP charged with the responsibility of seeing how the HTC guidelines can incorporate HTC for PWDs during a review process that NASCOP was undertaking on the guidelines.

This opportunity brought to the table CARE and its partners’ experience on BCC and HTC for PWDs, including training of health workers in sign language, approach to reaching PWID, production of IEC materials.
targeting PWD such as braille material, production of minimum standards to guide BCC among PWDs and the production of a documentary on PWDs all of which proved very important in informing the necessary revisions to the HTC guidelines.

1.4 LESSONS LEARNED

- PWD learning institutions, family members, human readers and regional networks for PWD and health care workers play a critical role in mobilization and reaching out to PWD

- Use of organizations working with PWD facilitates ownership, acceptability and sustainability of program interventions

- Combining male and female PWDs impedes effective delivery of sensitive topics such as breast, cervical and prostate cancer and other reproductive health issues

- The five days allocated for health care workers training to enable them to have capacity to reach the hearing impaired persons with HCT services was inadequate to effectively transfer this skill to functional use. Future programs should consider training health workers for a longer period of time so as to allow adequate time for theoretical and practical components of the training. This should be coupled with refresher training and on-site mentorship to enhance proficiency in functional skills to increase access to HIV and health services to persons with hearing impairment

1.5 CONCLUSION

Through the intervention, the PWDs have been able to improve their knowledge of HIV as well as have access to HIV prevention, care and treatment services. For similar interventions in future, there is need to continue this integrated approach in creating awareness and integrating other health related aspects that affect PWDs, including reproductive health, screening for non-communicable diseases (including various forms of cancers) as well as Tuberculosis.

The sensitisation of the health care workers on the needs of the PWDs should be prioritised by the government so as to ensure access to HIV prevention, care and treatment and sexual and reproductive health services as a basic human right.
1.6 A CASE STUDY OF A COMBINED APPROACH IN PROMOTING UPTAKE OF HTC SERVICES AMONG THE HEARING IMPAIRED

1.6.1 INTRODUCTION

OAHIP works to empower people with hearing impairment with vital information on HIV prevention, focusing on the importance of HTC, behavior change, treatment and care and other health related services. In support of this strategy, OAHIP, with the support of the GFR7 HIV Program embarked on a national campaign to build capacities of health care workers in sign language in order for them to effectively serve the hearing impaired segment of the population. The objectives of fighting HIV through strengthening communication skills by training in sign language was aimed at equipping strategic facilitators, including social and health workers, with skills to offer quality services to hearing impaired persons.

1.6.2 IMPLEMENTATION OF THE PRACTICE

Through GFR7 grant, OAHIP had three broad areas of intervention, namely: sensitization of PWD on HIV prevention, care and treatment, peer educators training and training of health care workers in sign language. For the sensitization events, OAHIP worked closely with the relevant ministries, heads of learning institutions and civil society organisations dealing with people with disability for mobilization.

The mobilization process deliberately responded to gender gaps in reaching out to PWDs to ensure that women and men, girls and boys, had access to HIV-related information and services. The sensitization sessions were held in places accessible to PWDs. The sessions were facilitated by health care workers with skills to communicate effectively with PWDs and knowledgeable about HIV and disability. Support towards this was also received from sign language interpreters. Training of the peer educators took five days after which they were expected to reach 10 other peers with HIV information as well as link them to the HTC counsellors for HTC services.

OAHIP developed a sign language training manual that was used to train health care workers to enhance delivery of HTC services in sign language. Mobilization and training was done by OAHIP in collaboration with the Medical Officers of Health including county and sub county AIDS and STI Control Coordinators (CASCOS). OAHIP conducted refresher sessions with the beneficiaries for support and quality assurance. The program targeted health workers and HTC counsellors attached to government health facilities, private health facilities and civil society organisations.

1.6.3 KEY ACHIEVEMENTS

Four hundred and twenty seven, (204 males and 223 females) health care workers, were trained in basic sign language to support
uptake of HTC services for the hearing impaired. After the training, OAHIP conducted a rapid assessment towards the end of 2012. The assessment revealed that some of the healthcare workers were pursuing advanced training in sign language on their own because of the interest they developed from the initial basic training supported by the project.

As a result of the trainings undertaken, most health facilities that benefited have contact persons providing services to hearing impaired clients. Training of health care workers in basic sign language has reduced language barriers enabling the hearing impaired clients to easily access HTC and other HIV services in health facilities. Some health facilities with counsellors who acquired the sign language skills have reported increases in the number of HIV persons seeking HTC services.

OAHIP trained 252 (123 males, 129 females) peer educators who played a critical role in identifying, sensitizing and referring people with hearing impairment to trained health workers for HTC services. The peer educators further reached 2,444 (1,272 males, 1,172 females) other peers with HIV prevention messages and 8,164 (4,018 males, 4,146 females) total PWDs were reached during outreaches events.

1.6.4 CHALLENGES AND HOW THEY WERE OVERCOME

- The five-day period allocated for training of health workers was inadequate in comparison to the scope of the training curriculum. However to mitigate against this, the project offered refresher sessions and follow-up for support. Participants were issued with reference materials and were also referred to relevant institutions of higher learning.

- Due to the fact that OAHIP was not offering HTC services, there were situations where PWDs were sensitized on HTC but could not access the services. In such situations, the clients were referred to facilities with health care workers trained in sign language.

- Constant transfer of health workers trained in sign language hindered continued service delivery to PWD in some health facilities, especially those that had initiated disability friendly services. This can be mitigated by closely liaising with County health authorities on joint planning to facilitate sustainability.

1.6.5 LESSONS LEARNED

- Working closely with the Ministry of Health at all levels made implementation of the PWDs interventions much easier, especially identification, training and follow-up of the health care workers, as well as providing support supervision and mentorship.

- Mastery of sign language requires more time to understand and practise for effective communication with people with hearing impairment. The limited time within which training had to be conducted limited integration of services or provision of comprehensive services and training.
1.6.6 CONCLUSION

- The initiative by OAHIP in support of hearing impaired persons has been sustained through collaboration and networking with stakeholders to ensure more service providers acquire the necessary skills to support PWDs in Kenya. This initiative and practice can be scaled up in both private and public health facilities in all counties to promote PWDs’ access to HIV and reproductive health services.

- Civil society organizations should ensure effective collaboration and linkage with mainstream health care service delivery structures, systems and personnel to effect maximum benefit to populations served with HIV and all other health services.

1.7 A CASE STUDY OF USING HUMAN READERS TO PROVIDE INDIVIDUALIZED SUPPORTIVE SENSITIZATION ON HIV TO PEOPLE WITH INTELLECTUAL DISABILITY

1.7.1 INTRODUCTION

This case study illustrates the unique approach used by the Kenya Society for the Mentally Handicapped (KSMH) to conduct outreach activities for People with Intellectual Disability (PWID) on counselling and testing. KSMH was established in 1971 as a lobby group advocating for the rights of persons with intellectual disabilities in Kenya. Its mandate is to promote the visibility, acceptance, inclusion and equity for PWID and their families.

In addition, KSMH is involved in promoting the mainstreaming of the socioeconomic development needs of the people with mental disability in the country. With regard to HIV, KSMH seeks to enhance supported access to HIV services for this much marginalized population category.

1.7.2 THE PROBLEM

More than 20 types of intellectual disorders have been identified; of which about 10 are common in Kenya as experienced by KSMH’s interactions with this population category. Persons with intellectual disability are faced with many challenges both congenital and acquired; with the most outstanding being their inability to develop basic social life skills and rational decision making.

All these factors lead to poor judgment in situations requiring rational thinking on matters as important as their sexuality and reproductive health. This problem is particularly worse for women and girls who are already socially disempowered by gender inequalities.

By virtue of their condition, PWIDs are more exposed to the risk of HIV infection than the rest of the general population. Their inability to make independent and informed decisions makes them highly vulnerable and exposes them to the risk of sexual abuse and exploitation, which
increases the probability of infection and re-infection with STIs and HIV.

A false belief exists within society that PWIDs are not sexually active leading to the rise in their abuse and infection without commensurate interventions and outreach services. The common forms of sexual abuse and exploitation involving PWIDs within the family set up are rape and incest. This is usually concealed due to the shame, taboo and stigma attached to mental disability.

PWIDs are usually regarded as a burden to their families and society and are confined to their homes and institutions which deny them important access to HIV services. Their families, care-givers and host communities also lack the necessary skills for the identification and provision of HIV intervention services.

Where services are offered, there is a lack of an individualized approach in delivery of HIV prevention, care and treatment services for this particular population. Consequently, cases of HIV infection among PWIDs are discovered too late for timely linkages to care and treatment.

Factors influencing progression of HIV to AIDS among PWIDs include:

i. Often times community members cover up cases of sexual violation that expose PWID to HIV infections and re-infections

ii. Poor reporting channels for identification and reporting of PWIDs in need of HIV prevention interventions

iii. Lack of resources to enhance the role of PWID supportive institutions in coordinating the provision of HIV services to PWIDs

iv. Limited social support and interventions either directly to the affected PWID or through their guardians

v. PWID’s inability to voluntarily and independently access HIV services due to the nature of their disabilities

vi. PWID’s poor compliance to ART since they depend fully on the support of others who may lack proper skills to provide adherence support or are too pre-occupied with other socioeconomic activities thereby lacking commitment for quality support to PWID

1.7.3 IMPLEMENTATION OF THE PRACTICE

KSMH has been providing supported identification and individualized HIV services for persons with intellectual disability. The focus has been Nairobi County, Kiambu County (specifically Thika sub-county) and Muranga County (specifically Maragwa sub-county) where the organization has experienced an increased demand for services among PWID.

Under Global Fund Round 7 Program, KSMH supported PWID to access information on HIV prevention and treatment. KSMH also aimed at increasing the uptake of HIV prevention and treatment services including HTC, among persons with intellectual disability through behavior change communication using mass media
and community outreaches. Under mass media, the organization developed and aired radio programs on HIV prevention and treatment and developed and distributed IEC materials on ART. The radio programs targeted PWID, care givers, human readers, family members, teachers, community members and the potential abusers of PWID and focused on issues related to intellectual disability such as sexuality, stigma reduction and HIV prevention, care and treatment interventions for PWID.

Under community outreach, KSMH conducted outreach activities to sensitize PWID on counseling and testing for HIV prevention. Considering the challenges of working with PWIDs, KSMH worked through an approach known as Supported Access to Counselling and Testing (SACT) for PWID. The approach appreciates the inability of PWID to make informed decisions, hence the need for support.

The approach works with people who are specially trained on the special needs of PWID and skills of communicating (reading their spoken and unspoken language), interpreting and providing a two way feedback between the service provider and the PWID and vice-versa. Technically known as Human Readers, they are expected to support them to access various services, including counselling and testing for HIV and related services such as supported uptake and consistent use of ART.

Those selected to provide this support must be friendly and empathetic members of the family, relatives or guardians proven by KSMH and the local provincial administration to be responsible and capable of protecting the rights of the PWID and willing to provide them with satisfactory all round support at the time they are charged with the role of providing care to them. Key steps to sensitize and provide Supported Access to Counselling and Testing (SACT) to PWID include:

a) Identification of PWIDs in the areas of focus

Identification of PWIDs is the first step towards supporting the PWID, not only with regard to HIV but also for purposes of assessing their types of needs as KSMH’s target population to form a basis for planning appropriate interventions. Identification and development of a register of PWID draws both from the existing records as well as from newly discovered cases.

For purposes of this project, proactive identification methods were used including partnering with the local provincial administration, who have knowledge of homesteads in the area, including those with PWID, collaboration with local churches, identification and collaboration with community mobilizers and social workers attached to different CSOs and FBOs in the target sub counties.

Help Desk: A help desk at KSMH offices supports the identification process. Run by trained project and administration staff, the desk develops an inventory of information that includes, among others,
the numbers of PWIDs per sub country, their exact location within the sub-county, area chief and assistant chiefs under whose jurisdiction a PWID falls, a list and contact details of friendly family members or givers and the trained human reader(s) to work for each PWID. The help desk becomes the central port of call for all information on PWIDs. It receives calls-in by Kenyans with information on PWID and calls back for more information to enable follow-through with reported cases.

**Rescues:** Where PWIDs are abused physically or sexually, KSMH is compelled to conduct rescues through the involvement of the provincial administration for security reasons because abusers of PWID often resist KSMH’s access and sometimes turn violent. Other cases involve family members who out of ignorance or deliberate stubbornness take legal action to prevent KSMH reaching out to PWID. The provincial administration also assists in making follow-ups and ensuring that the family takes responsibility for the welfare of the PWID.

**b) Training of Trainers (TOTs)**
The strategy involves training of TOTs on individualized provision of supported access to counselling and testing for HIV prevention and communication to acquire feedback from PWIDs and their Human Readers.

The training includes, among other things, underlying principles of mental disability and how to identify a PWID; basics on personality disorders and the different types of PWID; how to set the climate for engagement with a PWID and personalities necessary for befriending a PWID; how to overcome violent and restless PWIDs; building teams for working with mentally challenged persons; basic skills necessary for communicating effectively with a PWID – seeking, giving and understanding feedback signals; how to identify a suitable human reader – considering the home situation and family dynamics and the reader’s association with the PWID; the role of the human reader – to support the PWID in accessing HCT and follow-up for ART; social economic circumstances of PWIDs in Kenya; law and PWIDs – gaps and inconsistencies; seeking consent from PWIDs; HCT for PWIDs, referral and follow-up support.

The TOTs are empowered to, in turn, identify and train human readers to carry out actual individualized support and to replicate the knowledge and skills imparted to them to others in the sub counties. These trainers directly engage the human readers throughout the project’s intervention period.

**c) Assessment of PWID for Type and Degree of Intellectual Handicap**
This process is done on the second visit to PWID in their home. TOTs identify and train suitable human readers for each of the PWIDs identified as most at risk. The training takes four half day sessions on the methods of sensitizing the PWID for counselling and testing for HIV/AIDS and ART and referral. KSMH and its team of project officers take responsibility to
provide follow-up through the human reader.

d) Supported Sensitization of PWID on Counselling and Testing

This is the final and most important part of the process. It is conducted by the human reader who uses verbal communication, reinforced with communication aids (IEC), largely pictorials to sensitize the PWID. Non-verbal communication such as gesticulation and sign language is used for PWIDs who can hear and those with added handicaps such as deafness. For PWID with mild intellectual conditions, visual aids such as videos are used to reinforce the messages given. For PWIDs who can read printed matter with significant comprehension, the facilitator and human readers use printed IEC material, encourage self-reading and through question and answer method, assess their understanding and internalization of the messages.

The facilitators encourage PWIDs who can write to communicate their feedback by writing or tracing their thoughts on paper – crude art. Drawing or tracing ideas on paper has been proven to work very effectively for traumatized people – and most PWID live a life of trauma caused by their condition or abuse or both. After sensitization sessions, the human reader on case by case basis refers the PWID for CT. The success of this process is assessed based on the:

- Number of PWIDs sensitized and provided with supported access to counselling and testing for HIV/AIDS prevention
- Number of PWIDs and their human readers sensitized and provided with supported access to counselling and testing for HIV/AIDS prevention
- Number of PWIDs and their families sensitized and provided with supported access to counselling and testing for HIV/AIDS prevention

1.7.4 ACHIEVEMENTS

Up to 1,091 PWID were sensitized on HIV prevention and treatment in facilitating adherence to ART, 28,174 IEC materials were developed and distributed. KSMH also developed and aired 58 radio programs. The project has reached out to the most vulnerable members of society who are most often forgotten, hence empowering them with knowledge and skills on HIV and SRH.

1.7.5 CHALLENGES AND HOW THEY WERE OVERCOME

- The project experienced hostility from family members during visits therefore denying access to PWID. This is resolved by involving the provincial administration to provide security since abusers of PWID often resist access and sometimes turn violent as well as sensitization of communities of PWID rights and tailor made services for this group
- People with disability, especially those with intellectual disability, experience strong social stigma and
discrimination from society, friends and families which hinder them from accessing health services. The project focuses on sensitizing and empowering the community and family members to embrace and support PWID to access health services.

- Currently, policy guidelines and the law exclude and classify PWID as persons of “unsound mind” leading to national and HIV programs that do not recognize supported consent for PWIDs. KSMH used trained human readers or care givers who receive and interpret information on behalf of PWIDs and provide feedback in provision of HIV counselling, testing and ART services.

- The Supported Access to Counselling and Testing (SACT) approach used by KSMH tends to be costly because of the various steps to be taken before the actual sensitisation of the PWID occurs, including identification, training of TOTs, identification and training of human readers, conducting of repeat sensitisation sessions and the need for communication aids and IEC materials. Under GFR7 HIV Program CARE and KSMH overcame this challenge by reviewing the budgetary provisions and allowing for flexibility beyond unit costs determined for other forms of sensitisation targeted to able bodied people.

1.7.6 LESSONS LEARNED

- Comparative to other populations and controlling for other confounders, working with PWID is more costly and requires adequate time, planning, adequate resources and patience to offer personalized support for effective uptake of services by the population. Furthermore, this differs from person to person (with intellectual disability) and so program interventions should have room for flexibility to accommodate the diverse special needs.

- While working with PWID it is important to undertake audience segmentation and to understand that each individual uses his or her own unique augmentative or alternative mode of communication and therefore each PWID requires an individual human reader who comprehends this unique method of communication.

- When designing and implementing an intervention for PWID it is paramount to consider and put into practice the rights of PWID to participate in all decision making processes, the right to support and the right to engage in all aspect of life.

- There is need for the government to put in place policy guidelines for informing interventions targeting People with Disability (PWD) in general and those with intellectual disability (PWID) in particular, to ensure that their fundamental human rights, especially their right to good health, are met. This should begin by generating proper statistics on this population to support planning and implementation.
CHAPTER 5:
USE OF RELIGIOUS STRUCTURES IN FIGHTING STIGMA AND BREAKING BARRIERS AMONG THE MUSLIM COMMUNITY

1.1 INTRODUCTION

In Kenya more than 1.4 million adults were living with HIV (KAIS, 2007). The prevalence rate was higher in urban areas but the greatest burden of the disease was in the rural areas.

In 2012, national HIV prevalence was estimated to be 5.6 per cent among Kenyans aged between 15 and 64 years, significantly lower than the HIV prevalence estimate in 2007, which was reported at 7.2 per cent (excluding the North Eastern region).

The KAIS 2007 report indicated that the north eastern region had the lowest prevalence rate of 0.8 per cent. In addition, the North Eastern region showed significant change in HIV prevalence for provinces where HIV prevalence increased significantly from 2003 to 2007. The prevalence has been low in the region but, stigma and discrimination remain very high.

HIV infection has been growing steadily in the North Eastern region due to many factors including cultural, religious and economic. This increase is attributed to socio-cultural practices such as wife inheritance, early marriages and female genital mutilation, marrying off young girls to older men, polygamy, ease of acquiring divorce (the region has the highest divorce rate in the country), the issue of serial polygamy - that is marrying and divorcing several women or vice versa - is a unique social cultural phenomenon that is an emerging risk factor in this region), rape and revenge rape, inter clan conflict that is common in the area, male dominated leadership evidenced in decision making and male control of resources.

In addition women and girls bear the burden of HIV/AIDS where they provide uncompensated Home Based Care; take care of extended family members, including the sick, and have no rights for their own sexual and reproductive health needs. For instance, women are required to seek their husbands’ approval before they can get tested to know their HIV status.

The region also experiences high levels of illiteracy, denial of existence of HIV/AIDS – with majority attributing the HIV and AIDS to curses and punishment by Allah (God) because of “sins”. Most people still believe that HIV and AIDS is a myth and that it is a “disease for others” or the mathemadhu (non-Somalis) and Kaffirs (non-believers).

There are still people who argue that HIV/AIDS is God’s will on umma (humanity) and a curse for humanity’s sins and this is used to justify ill treatment and neglect of PLHIV.

HIV related stigma, whether measured by stigmatizing attitudes, fear of or perceived stigma, or enacted stigma negatively impacts the quality of life of people living with HIV. Stigma and discrimination act as impediments to uptake of HIV testing,
treatment and care and to adherence to
treatment. This was depicted in the KAIS
2007 report which indicated that the
North Eastern region had the lowest levels
of HIV testing (7.0 per cent) compared to
all other provinces.

Stigma associated with sinful behavior
is frequently assumed to interfere with
access to care for those infected. There
is also a high level of lack of disclosure
amongst the PLHIV, with some consciously
or unconsciously continuing to spread
the virus – fearing to come clean about
their status for fear of retribution by
the society. Tied to stigmatization is
discrimination which affects women and
girls more as they are not empowered to
make free choices on matters of sexuality
and reproductive health.

The region has low levels of HIV/AIDS
awareness and lack of community-based
HIV/AIDS prevention, treatment, care and
support programs for PLHIV and stigma
reduction programs. Stigma associated
with HIV and AIDS prevents PLHIV to seek
treatment and other necessary support
from the few CCC in the county hospitals
due to fear of isolation and discrimination.

The region also suffers inadequate health
infrastructure and is religiously sensitive
to HIV and AIDS services. Community
members in some cases have advocated
for social exclusion of PLHIV. The stigma
surrounding HIV has played a key role
in preventing community members from
engaging in HIV services.

In order to address these gaps, appropriate
and timely interventions are necessary to
establish and strengthen the community
capacity and social transformation for an
AIDS free society, a society that is fully
informed on HIV and AIDS.

This is being achieved through building
support structures at the community level
using religious leaders and strengthening
community systems to prevent new
infections, and improving the quality of
life of people infected and affected by HIV
and AIDS.

This is being done by the Supreme
Council of Muslims (SUPKEM), Wajir South
Development Association (WASDA) and
Peace and Development Network Trust
(PEACENET).

Figure 5: A Heroine Exemplifying Changing Attitudes Towards HIV
1.2 IMPLEMENTATION OF THE PRACTICE

The fight against the epidemic needs a holistic and multi-sectorial approach to overcome the unique barriers to HIV interventions. Religious leaders led by Muslim organizations such as SUPKEM, WASDA and PEACENET, who are partners in the GFR7 Program worked hard to change these perceptions and the negative attitudes.

The service delivery areas implemented by SUPKEM were Mobile HIV testing and counselling through the door-to-door approach targeting both male and female from the ages of 15 to 49 years; airing of radio programs focusing on behaviour change among the youth and the role of religious leaders and parents in advocating for the change in the society; Youth Outreach Events targeting the young people from the age of 10 to 35 years; youth sporting events that involved both male and female; development and distribution of IEC materials on ART in the form of posters, fliers and brochures which were printed in Arabic, Somali, Borana, English and Swahili languages.

The sensitization of people living with HIV and AIDS and their family members on ART adherence was to enhance disclosure among the target group, fighting of stigma, denial and discrimination amongst the muslim community which was the target population.

The organization partners with Muslim leaders in the campaigns against HIV and AIDS and enhances promotion of abstinence from sex outside marriage.

During sensitization and radio sessions, the sub-county AIDS and STI coordinators, Imams or Sheikhs, are present to provide the religious aspect of HIV prevention, treatment and care among the Muslim community, while the SCASCO presents the medical aspect of HIV prevention and treatment.

Peer education training targeted the youth through a five-day training session on the basic HIV and AIDS sensitization and reproductive health, among other topics, in the approved curriculum.

To select peer educators in a manner that will recognize the Islamic context and the Muslim way of life, SUPKEM ensures the success of the peer-education program is undertaken from those who excel and demonstrate aptitude as Peer Educators (PEs).

SUPKEM also identifies and selects popular opinion leaders who ably represent different segments of the Muslim community fabric with a predisposition to special populations requiring sustained HIV prevention interventions.

1.3 KEY ACHIEVEMENTS

One of the greatest achievements of the project was strengthening of OPAHA (Organization of People Affected by HIV and AIDS) which is an institution that
advocates and lobbies for the rights of PLHIV. Through the GFR7 HIV Program it was possible for OPAHA to bring PLHIV together in Wajir County under one umbrella body and conduct sensitization sessions.

WASDA has reached out to PLHIV in Habaswein and Bute who were highly stigmatized and never had the opportunity to integrate.

Through efforts by OPAHA the said PLWHAs were de-stigmatized and united to form post-test clubs where they learned and accepted their current status followed by disclosure to partners and family members.

1.4 KEY CHALLENGES AND HOW THEY WERE OVERCOME

- Due to the vastness of the regions and limited health facilities, follow up and linkage to care and treatment was a challenge

- Low literacy levels have affected awareness of the HIV pandemic because some health workers are non-Somali speakers and encounter language barriers

1.5 LESSONS LEARNED

- Involvement of Muslim religious leaders in program activities helped build trust, support and knowledge of HIV between program staff and the community

- Most of the PLHIV are scattered in rural areas which creates logistical challenges in reaching them to sensitize them on HTC and ART programs

1.6 CONCLUSION

Involvement of Muslim religious leaders in the implementation of HIV programs in North Eastern or in Muslim communities where there are high levels of stigma and discrimination is very critical if the trend of new infections is to be reversed and PLHIV initiated and retained on HIV care and treatment. Muslim leaders are important in HIV programming because they command respect and influence community decisions.

Their involvement enables community members access the HIV services available in the community, thereby reducing new infections and getting those living with HIV on treatment and care. The use of community religious leaders is cost effective and also sustainable because they continue educating the community even after the program ends.
CHAPTER 6:
REACHING OUT TO ADOLESCENTS THROUGH SCHOOL HEALTH CLUBS

1.1 INTRODUCTION

Studies in Kenya have shown that among the youth in school, sexual activity is most frequent in the upper primary and secondary classes. KASF IV prioritizes adolescents and young girls as a vulnerable population that needs to be reached. A study by the National Council for Population and Development (NCPD) in 2007 found that 52 per cent of unmarried youth aged between 15 and 19 years had begun sexual activity. According to the 2008-09 Kenya Demographic and Health Survey (KDHS), the government has put in a lot of effort in prioritizing adolescent and youth issues with a view to promoting and harnessing the health and dynamism of this vulnerable yet critical age cohort.

Although early childbearing among teenage girls is an impediment to their education, 3 per cent gave birth at the age 19. These statistics imply that this age group could be in danger and therefore the need for urgent intervention. Establishing school health clubs was identified as an effective way of facilitating the provision of relevant HIV and AIDS information to those who are still in school. Through joint efforts by the Ministries of Education and Health and other partners, the government has developed policy and guidelines to promote school health and to a larger extent, community health. These documents complement other existing health, and HIV and AIDS strategic documents.

One of the Global Fund Round 7 Program strategies for reducing cases of new HIV infections and increasing uptake of HIV prevention services among the youth in school is through school health clubs. This was achieved through formation and maintenance of 57 school health clubs. The school health club intervention was implemented by Zinduka Afrika, Kitui Integrated Creative Arts and Business Appraisal (KICABA), Maji na Ufanisi, Action Aid Kenya, World Relief Kenya (WRK) and Food for the Hungry Kenya. The objective of school health club activities through the GFR7 funding aims to sensitize club members on HIV and AIDS, enhance life skills and values, equip club members with skills for health promotion; and promote HIV prevention and health activities in schools.

1.2 IMPLEMENTATION OF THE PRACTICE

During the implementation of the program, strategies were employed to support the establishment and orientation of existing school health clubs to undertake HIV prevention, hygiene and other health activities among club members, peers, school populations and the community where the schools are based. The focus of the intervention included, supporting establishment and management of 57 school health clubs which involved, engagement and sensitization of school management and key stakeholders for ownership, training of patrons in HIV and AIDS and imparting knowledge to the adolescent boys and girls on behaviour change and HIV prevention. Deliberate effort was made for each of the school health clubs to engage female and male patrons who supported their day to day running.
The patron was charged with the responsibility of integrating HIV prevention and support in the already established health clubs for sustainability or formation of new clubs where they were nonexistent. The program trained all the patrons to equip them with knowledge and skills in HIV prevention among the youth in school and also on effective management of the health clubs. The clubs targeted young people (both male and female adolescents) in primary and secondary schools. The mobilization and recruitment of club members was done by both patrons and peers who were already members.

Each club had 30 members who were trained to reach out to other youths in schools. The vibrant and dynamic nature of the youth calls for use of innovative facilitation methods and techniques. The participants were allowed to initiate and participate in facilitation methods that respond to their energy and creativity that were tailored to behavior change outcomes and those the youth can adopt and use during their own interaction periods. The facilitation methods and techniques are anchored on the equal participation of boys and girls.

The patrons also invited equally trained and knowledgeable persons from the community, school or health facilities to facilitate school health clubs sessions and held regular meetings during the school calendar to discuss specific topics on Sexual Reproductive Health, behaviour change, delayed sexual debut, HIV prevention, provision of psychosocial support for young adults living with HIV and other life skills. Alongside the structured meetings, school health clubs organized other activities including reciting poems, debates, songs, skits and interclass or inter school competitions for purposes of disseminating HIV prevention messages.

The maintenance of school health club activities entails organization and provision of guidance and support to the health clubs to hold regular sessions on a monthly basis to discuss subjects of interest, including, but not limited to, Sexual Reproductive Health, HIV and AIDS, life skills and values and reaching out to other youths in schools.

1.3 KEY ACHIEVEMENTS

The school health clubs have been beneficial to both members and peers. The program reached 4,980 (2,229 males, 2,751 females) club members from the 57 health clubs with education on adolescent health, including HIV prevention. These further reached out to 9,311 (4,435 males, 4,876 females). The club members have been empowered and have demonstrated ability to confront Sexual and Reproductive Health issues affecting them and to approach their patrons and teachers for support and further guidance. Some of the adolescents living with HIV have been able to disclose their status to teachers who have been very supportive in terms of referral to care, treatment and adherence to ART.

Girls have been empowered to resist sexual molestation from boys and older men and exhibit confidence in reporting sexual harassment cases. The head teachers have
reported a reduction in dropout cases due to pregnancy and overall improvement in performance since the inception of this initiative and more sexually active youth are seeking HIV testing as a result of increased knowledge.

1.4 CHALLENGES AND HOW THEY WERE OVERCOME

- Constant transfer of school health club patrons negatively affected capacity retention for the already trained patrons. This was redeemed by building the capacity of at least two school health club patrons per school and sensitization of all teachers during GFR7 close out period to enhance sustainability.
- Tight school curriculum within the education calendar at times constrained time for health club activities. The mitigation measures included engaging school managers in development of joint work plans in tandem with the school calendars.

1.5 LESSONS LEARNED

- Use of students who have demonstrated remarkable change in behavior as peer educators and role models was a very effective way of influencing the behavior of other students and reaching out to them with Sexual Reproductive Health, HIV prevention and treatment messages.
- Training peer educators on life skills and supporting forums of exchanging messages and health education (including inter club competitions, information corners providing IEC materials for youth in school to discuss in after-class sessions) was an instrumental approach in disseminating HIV prevention information.

1.6 CONCLUSION

School health clubs are imperative entry points for behavior change communication that protects young people from HIV infection. This approach promotes constructive learning processes, skills and confidence building among adolescents in order to take up more active roles in HIV prevention and treatment agenda. It is therefore critical for the government and other development agencies targeting adolescents to consider using the school health club approach as an effective intervention in targeting this vulnerable group.

1.7 A CASE STUDY OF USING SCHOOL HEALTH CLUBS AS AN AVENUE FOR HIV PREVENTION

1.7.1 INTRODUCTION

World Relief Kenya works towards building the capacity of communities, families and individuals to lead lives of fidelity among married couples and abstinence among the non-married, embracing orphans and vulnerable children, persons infected with and affected by HIV and AIDS as well as offering comprehensive/holistic services to enhance social, physical and economic development to the youth.

1.7.2 IMPLEMENTATION OF THE PRACTICE

During the implementation of Global Fund
Round 7 HIV Program, World Relief Kenya (WRK) established 20 school health clubs in Teso and Loitoktok. The establishment of the clubs was done in consultation with the Ministry of Education and the school’s administrations. To ensure that teachers were adequately equipped with HIV information, two teachers from each of the schools were trained as patrons. The training was done for three days using the choose life curriculum, paving way for formation and maintenance of the clubs.

Each of the clubs formed has 30 members who have been trained to reach out to other youths in schools. Health clubs hold regular meetings during the school calendar to discuss specific topics on Sexual Reproductive Health, behaviour change, delayed sexual debut, HIV prevention, provision of psychosocial support for young adults living with HIV and other life skills. Alongside the structured meetings, school health clubs organize other activities including reciting poems, debates, songs, essay writing competitions, skits, interclass/school competition for purposes of disseminating HIV prevention messages. Interschool competition provided a forum to share information in form of debates, artwork, songs role plays narratives among others.

1.7.3 KEY ACHIEVEMENTS

As a result of the interventions, club members have developed ability to openly and freely discuss issues that touch on their life, especially messages on life choices, HIV and AIDS and behavior change with teachers and peers. The existence of the clubs played a major role, providing a platform for health club members to congregate and share health information. WRK school health clubs were more popular with adolescent girls who composed of 61.4 per cent as compared to boys who consisted of 38.6 per cent, which is a significant achievement given the vulnerability levels of girls in the two areas of operation.

1.7.4 CHALLENGES AND HOW THEY WERE OVERCOME

Transfer of SHC patrons who had been trained in facilitating the SHC sessions left a gap. To mitigate this gap and ensure continuity of the SHCs program after Global Fund Round 7 HIV Program, all teachers from the 20 schools were trained in HIV prevention, treatment and SRH with special focus on adolescents.

1.7.5 LESSONS LEARNED

- The peer sessions in clubs helped both girls and boys to share appropriate information on HIV prevention and also helped the students to build their confidence and self-esteem to interact with their peers more freely.
- Patrons review meetings enabled progress updates and facilitation of joint planning sessions that support the schools to integrate club activities with their calendars
- Inter-school competitions provided a unique forum for entertainment and information sharing in the form of debates, artwork, songs, role plays and narratives
CHAPTER 7:
FROM PAPER TO PAPER-LESS: EMBRACING INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) FOR EFFECTIVE PROGRAM MONITORING AND EVALUATION (M&E)

1.1 INTRODUCTION

The GFR7 was implemented with a total of 54 SRs who were the direct implementers of the program. CARE was therefore expected to demonstrate performance of the program through periodic progress reports, both programmatic and financial, in a timely manner to the Global Fund (GF) with the primary sources of data being the SRs. The periodic program progress reports received were reviewed and validated before aggregation for overall programmatic reporting. Such programmatic and financial reports submitted would then be used by the PR to generate numerous reports for different audiences including: the PR to support programmatic decisions and revisions to strategy, SRs, the Local Fund Agent (LFA), the County Coordinating Mechanism (CCM), CARE headquarters in Canada and other key stakeholders.

Each SR implemented a multiplicity of Service Delivery Areas (SDAs) which subsequently informed Key Performance Indicators (KPIs) of the program. Programmatic data was disaggregated by age, gender and target population category while financial data was reported per implementing entity, budget category and programmatic interventions given that the GFR7 HIV grant was performance based where programmatic results have to be reflective and in sync with financial investment.

1.2 THE PROBLEM

The program had Ms-Excel based database and an indicator tracking matrix which supported consolidation of Strategic Information (SI) from all the SRs on the various SDAs. Financial reporting was also done using excel reporting formats by the SRs and further reported in CARE’s financial system.

The database system hence presented a manual reporting mechanism which did not adequately provide for comparative reporting between programmatic results and funds utilization as per the expectation of a performance-based funding model.

This significantly affected work flow and made tracking of programmatic performance to specific financial performance complex. Further, this presented an additional time lag challenge in reporting for programmatic performance and financial utilization, again negating the principles of performance-based funding.

1.3 IMPLEMENTATION OF THE PRACTICE

In cognizant of the existing potential for utilization of ICT for Decision-Making (ICT4D), reporting, indicator tracking, having a harmonized electronic and real-time data management system, improved data and information access, retrieval, utilization and archival; CARE sought to develop and operationalize a web-based data capture and reporting platform (M&E Online) to respond to this enormous challenge to facilitate efficient data management and address reporting compliance gaps previously experienced during grant implementation in Phase I.

The development of the online data capture
and reporting platform was highly rigorous from system designing, training of both the PR and SRs program, grants and M&E staff on the system, further enhancement of the application based on feedback during and after the training, conduction of a needs assessment to establish the infrastructure and technical capacity gaps of the SRs for the platform to be fully operational, establishment of an eligibility criteria of the SRs to take part in the pilot based on findings from the needs assessment, conducting a refresher training after the system’s refinement, further enhancement of the application based on ongoing feedback to the software developers, full roll-out and closer follow-up of the SRs to ensure that the web-based platform was fully utilized.

Moreover, there was continuous technical assistance to users who had operational challenges. This guaranteed optimal operationalization of the M&E Online.

1.4 KEY ACHIEVEMENTS

i. Undoubtedly, the M&E Online facilitated the achievement of the Program Objective to Strengthen Institutional Capacity to Effectively Implement and Monitor the Program. Beyond the GFR7 HIV grant, a majority of the SRs embraced online data capture and reporting given the rich experience they got from the M&E Online and its obvious and evident benefits.

ii. The M&E Online was a very robust web-based system with considerable levels of success as it served as an effective platform for data-back-up, complementing the already existing paper-based reporting system.

iii. The platform’s inbuilt data-back-up feature with restricted user rights and access had no match, more so in view of the seven-year document retention policy as per the Global Fund’s grant requirements.

iv. The PR’s reporting requirements were highly voluminous and hence doing an archival search of the paper-based reports was exceedingly simplified as characterized by the platform’s ability in swifter data access and retrieval - for both historical and current data. Data processing and analysis was also greatly simplified through computations as opposed to manual tallies with the paper-based system.

v. There was a significant improvement in reporting compliance by the SRs in terms of timeliness and completeness; from zero for the period ending September 2011 to 73.1 per cent for the period ending March 2014.

vi. It facilitated an online and offline data capture. This was particularly essential for data transmission from the SRs’ various service delivery points where there was intermittent, or lack of, internet connectivity.

vii. The dashboard, in the home page, gave a snapshot of programmatic performance at a glance.
viii. An inbuilt audit trail function for tracking user logs helped safeguard against data corruption and mutilation.

ix. Trouble shooting on user challenges significantly shortened turn-around as a result of its real-time feature.

x. Enabled different levels of reports review at PR and SR level. This helped generate valid and reliable data. The provision for real-time feedback between the PR and SRs expedited decision-making.

xi. Facilitated for error checks, flagging, querying and data validation at the various levels of reports review, which warranted high quality data generation and reporting.

xii. Allowed for concurrent comparative review of programmatic and financial performance across implementing entities and KPIs. This feature impressively underscored the performance-based funding mechanism.

xiii. The M&E Online allowed for exporting of the reports to Ms-Excel and other platforms for data manipulation. Unquestionably, its inter-operational nature helped satisfy the various reporting needs for each implementing entity and the PR.

xiv. It highly complemented the Excel-based Data Base Management System (DBMS) by the principle of Double Data Entry where data is entered not once, but twice, in the M&E Online and in the Excel based data base. Data triangulation would then be conducted and any discrepant data emanating from the hard reports, excel-based data base and the M&E Online would call for a thorough DQA; either on-site or off-site (see figure 1 below).

As a result, this yielded more than 90 percent consistency between the different data sets and highly amplified the level of confidence in the information in terms of reliability and validity.

1.5 LESSONS LEARNED

i. Refinement of the M&E Online to capture county, sub-county and constituency level SI for comparative analyses of the disease burden would have considerably added reporting value. This possibility could have informed the implementation strategy and response as per the National HIV Prevention Revolution Roadmap (2013), tailored for each implementing partner, target population and geography - Knowing your Burden, Knowing your Response

ii. The M&E Online presented an opportunity to further explore interoperability with other digital reporting applications, including Mobile Telephony and Personal Digital Assistants (PDAs). A function in use of biometrics with the M&E Online could have helped address the perennial challenge of double reporting as often characterized by most manual and paper-based systems

1.6 CONCLUSION

The M&E Online improves efficiency and ensures quality reporting in a multi-level program where there are various service delivery points with only one reporting hub. This ICT innovation streamlines program M&E particularly for programs that are keen to demonstrate results, value for money and for program models that call for timely and real-time programmatic decision-making.
CHAPTER 8:
IMPROVING AND SUSTAINING GRANTS PERFORMANCE: USE OF COMPREHENSIVE FINANCIAL MANAGEMENT TRACKING TOOL

1.1 INTRODUCTION

CARE developed a Comprehensive Financial Management Tool to address systemic issues – particularly poor budget management and reporting challenges by SRs due to poor grants financial management, low funds absorption, ineligible costs occasioned by budget overruns and poor programmatic achievements preceded by delayed accountability by SRs.

During implementation, the program experienced many incidences of budget overruns, low funds absorption, late and incomplete reporting by SRs. Based on SR assessment as well as re-evaluation of existing financial reporting tools, CARE attributed the underperformance to two main factors.

First, for the SRs with regional program implementation (several regions), staff at the field level lacked a tool to track utilization of financial advances against program line budgets. The organizations lacked systematic mechanisms to reference support documents to aid liquidation of records coming from the field offices to SR head offices. The financial documents sent to head offices for serialization during monthly reporting overwhelmed the finance staff, resulting in late and incomplete reporting.

There were no systematic advance and liquidation procedures between field and head offices. Liquidation of advances from the field was done manually. Concerned head offices, therefore, had to wait for submission of support documents from the field to commence the preparation of monthly reports, arrange support documentation and make copies for certification.

This led to voluminous documentation and increased the workload for staff and, consequently, incomplete, inaccurate, and late reporting. Second, staff whose advances covered more than one SDA lacked a tool to analyze advance utilization per SDA. Savings on SDAs were at times spent on other SDAs, leading to budget overruns. The SR financial reporting tool also was deficient in:

- Provisions for comparison between budget utilization and Program achievement
- Tracking of SR disbursement utilization against program achievement or funds burn rate
- Poor payment approval track mechanism between payments, budgets, and disbursement liquidation. As a consequence, SRs realized that they had incurred budget overruns, too late
- The financial reporting tool was labor intensive with minimal formulas making it prone to manipulation

1.2 IMPLEMENTATION PRACTICE

CARE developed a comprehensive Financial Management tool to address the limitations of the existing reporting tool
that adversely affected the performance of SRs. CARE initially tested the tool with its own staff - Global Fund program staff - followed by a pre-test with a select number of SRs to determine the tool’s usability, reliability and areas of improvement. After the pre-test, the tool was refined and disseminated to all SRs for adoption.

Thereafter the tool was rolled to all partners and its use resulted to an overall improvement in financial management. Generally addressing the gaps noted above lead to the overall improvement of financial management in GFR7 HIV Program and adoption by a number of SRs in their other programs

1.3 KEY FEATURES OF THE TOOL

The tool had the following unique features and user ability that underlay its usefulness:
- It was automated using formulas and password protection increasing user efficiency while controlling data entry to minimize manipulation
- It reduced considerably, manual data entry and deficiencies such as typing errors, time input, data manipulation, and staff fatigue
- Compared data on percentage of program achievement against burn rate per SDA
- Provided current funds balance per SDA addressing the problem of budget overruns
- Indicated the number of targets being funded by a disbursement
- Gave amounts being requested as advance by field staff against the expected cost for the given number of targets
- Compared monthly expenditure versus approved budget
- Comparison between cumulative expenditure and budget and disbursement to date
- Assisted SRs to determine additional funds requirements and seek approval for pre-financing and to carry out additional work or target reallocation
- It provided for daily capture of advances and expenditure into the financial reporting sheet that was eventually submitted to CARE at the end of the month
- Financial reporting was linked to a payment approval form that showed a person approving such payment, the effect of the advance/payment on the monthly budget and cumulative actuals against budget and disbursements, and crucially, whether the amount requested was within the approved ceiling
- The system was referred to by most SRs as a “talking tool” owing to the fact that it informed the user what needed to be done or printed when processing advances, upon receipt of disbursement from CARE, liquidation
as well as when submitting the end of month financial report

- The tool had a hyperlinked check list that saved the user time previously spent navigating through a large number of work sheets

- An advance liquidation component was developed for use by field staff for SRs with field/regional offices. The component was used for daily expenditure reporting. This supported an efficient financial program cycle because of the following features: the tool alerted the user where and what information was missing and would block generation of document serial numbers until all information was inputted

1.4 ROLLING OUT OF THE TOOL TO SRs

In order to enhance the understanding of the tool, CARE conducted trainings at the quarterly program review meetings, at SRs’ head offices and at the field level. The sessions brought together both program (field and headquarter staff) and finance teams at partner level in order to explain the operationalization of the tool and its benefits.

This was intended to enhance teamwork between the teams, acceptance and buy-in of the tool. CARE supported the SRs to incorporate all past data to ensure that the document captured past and current financial information using the tool.

SR feedback was used to continuously improve and refine the tool right from its introduction to the end of the program. The tool became popular with users as it evidently addressed most of their challenges in reporting and accountability and integrity issues. As one SR user quips:

“…..This tool ought to have been provided from the word go. As a field officer, I now know how to track my advances, explain variance and which documents to support my liquidation as well how to present and code them. I am now an all-round field person with good understanding of finance……”

FHK Field Officer, Isiolo

Following the feedback and improvements made to the tool, CARE issued it to the rest of the SRs, providing individualized guidance and support in utilization. Henceforth, CARE continued receiving positive feedback on the tool’s usability, performance, and benefits.

“…..Even if CARE would give us an option of not to use the tool, I would still use it due to the benefits it has brought to me as an accountant…”

Accountant, Young Women Campaign Against AIDS, Nairobi

1.5 KEY ACHIEVEMENTS

i. The tool enabled program and finance staff to keep track of expenditures and program activities under various service delivery areas (SDA), thereby, reducing under-spending or over-spending on the budget or unintended costs that
led to questioned or disallowed costs and demands for pay back.

ii. Payment approval tool enabled the SRs to detect and address potential budget overruns before they occurred.

iii. Incomplete reporting reduced significantly. Sub Recipients achieved this by:
   (a) Ensuring fund balances were fully reconciled against cash at hand, in bank and outstanding imprest
   (b) Fully reconciled bank statements
   (c) Detailed variance and explanations and all other required reports
   (d) Reduced missing receipts and support documents

iv. Improvement in timely reporting by all the SRs that implemented this tool.

v. CARE’s turnaround time for approval of SR financial reports also improved due to well-documented and referenced documentation resulting in shorter review periods.

vi. Some SRs replicated it in non-GF programs.

1.6 LESSONS LEARNED

- It’s important to collect and incorporate Staff (both finance and program) inputs at tool development stage.
- Pretesting tools is a useful step in their development and refinement. Seeking feedback from potential users also creates ownership and enhances their adoption.
- Staff or user training on use of new tools is very important and determines the quality of outputs intended to be generated through use of the tool. This training is as critical to the field staff as to the headquarter staff.

1.7 CONCLUSION

Development of tools that are relevant to program and financial reporting is important in program design. The illustration of the challenges faced with a poor reporting tool demonstrates that a good reporting tool is important to ensure the success of a program.

Prior to the development of the tool, the program had challenges achieving its programmatic results coupled with low funds absorption. Therefore, programs need to give adequate time to development of reporting tools to ensure program success.

1.8 A CASE STUDY OF PERFORMANCE TURNAROUND IMPROVEMENTS AS A RESULT OF THE COMPREHENSIVE FINANCIAL MANAGEMENT TRACKING TOOL

1.8.1 INTRODUCTION

Women Fighting AIDS in Kenya (WOFAK) is a national non-governmental organization founded and registered in Kenya in 1994 by a group of women most of whom had tested positive to HIV. The founding group had in mind an entity that would provide them with a forum for mutual support and empowerment.

Since inception, WOFAK has made tremendous achievements, contributing
significantly to national efforts aimed at HIV prevention and to providing comprehensive care and support to women, youth, and children living with and affected by HIV and AIDS, enabling them to lead better and quality lives.

WOFAK started working with CARE from 2009 on the GFR7 HIV Program on HIV and AIDS. It was mandated to carry out sensitization of PLHIV and families on ART, community outreach events for youth and peer educators training. Implementation was multi-regional given that these activates were being implemented in Kisumu, Siaya and Homabay counties.

### 1.8.2 STATUS OF WOFAK BEFORE THE UPTAKE OF TOOL

- Before introduction of comprehensive financial management tools, WOFAK had significant performance gaps as demonstrated below; the organization consistently failed to meet the contractual timeline for the submission of monthly reports. Out of twelve reporting months, the SR reported late in ten months.

  - Despite late reporting, the support documents were never sequentially arranged making it difficult for CARE staff to review. CARE on numerous occasions called the SR to its offices to rearrange its monthly reports. Further, WOFAK failed to account for all bank withdrawals, this being because of some receipts and other support documents missing at the field level. On many occasions, it took time for WOFAK to get receipts from the field, revise reports and have them submitted to CARE. See **TABLE 1**.

  - Late reporting by WOFAK and long turnaround time for report liquidation led to delayed disbursements. The SR would get funds either in the first or second month of the quarter for which it was to implement the program due to delayed disbursements. This meant that staff and other resources would stay idle for the one or two months and then implement the activities for the entire quarter within one month. This greatly compromised the quality of the program. **TABLE 2** gives an analysis of delays in funds disbursement before implementation of the comprehensive financial management tool.

<table>
<thead>
<tr>
<th>Month</th>
<th>Date Reported by WOFAK</th>
<th>Date Report Liquidated by CARE</th>
<th>Turn Around time (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-11</td>
<td>17-Jan-12</td>
<td>30-Apr-12</td>
<td>104</td>
</tr>
<tr>
<td>Jan-12</td>
<td>14-Feb-12</td>
<td>30-Apr-12</td>
<td>76</td>
</tr>
<tr>
<td>Feb-12</td>
<td>12-Mar-12</td>
<td>30-Apr-12</td>
<td>49</td>
</tr>
<tr>
<td>Mar-12</td>
<td>11-Apr-12</td>
<td>30-Apr-12</td>
<td>19</td>
</tr>
<tr>
<td>Apr-12</td>
<td>23-May-12</td>
<td>29-Jun-12</td>
<td>37</td>
</tr>
<tr>
<td>May-12</td>
<td>18-Jun-12</td>
<td>29-Jun-12</td>
<td>11</td>
</tr>
<tr>
<td>Jul-12</td>
<td>13-Aug-12</td>
<td>19-Nov-12</td>
<td>98</td>
</tr>
<tr>
<td>Aug-12</td>
<td>7-Sep-12</td>
<td>19-Nov-12</td>
<td>73</td>
</tr>
<tr>
<td>Sep-12</td>
<td>15-Oct-12</td>
<td>19-Nov-12</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period Covered by Disbursement</th>
<th>Date before which the SR ought to have received Fund</th>
<th>Actual Date Funds Received</th>
<th>Implementation Delay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2011 - Jan 2012</td>
<td>1-Nov-11</td>
<td>7-Dec-11</td>
<td>36</td>
</tr>
<tr>
<td>Feb 2012 - Jun 2012</td>
<td>1-Feb-12</td>
<td>15-May-12</td>
<td>104</td>
</tr>
<tr>
<td>Jul 2012 - Sep 2012</td>
<td>1-Jul-12</td>
<td>11-Sep-12</td>
<td>72</td>
</tr>
<tr>
<td>Oct 2012 - Dec 2012</td>
<td>1-Oct-12</td>
<td>21-Nov-12</td>
<td>51</td>
</tr>
<tr>
<td>Jan 2013 - Mar 2013</td>
<td>1-Jan-13</td>
<td>11-Feb-13</td>
<td>41</td>
</tr>
</tbody>
</table>
WOFAK had difficulties in tracking its budget. TABLE 3 gives an analysis of actual expenditure against budget as at December 31, 2012.

### 1.8.3 FACTORS THAT CONTRIBUTED TO GAPS IN PERFORMANCE

CARE carried out an assessment of the financial management systems and established the following gaps:

i. The advance request only listed the planned activities and their cost. However, these were not compared against the approved budget. Therefore, the signatories to the payments would not tell the effect of the payment on the budget.

ii. Liquidations from the field level did not give a comparison of actual cost against expenditure.

iii. Expenditures in the liquidation form were a summation of related costs that were in batches. However, there was no listing of receipts per batch and their amounts. Confirming the accuracy of the amounts being liquidated required manual summation per batch. This made review of reports lengthy, tedious and time consuming. This led to reviewer fatigue and rendered them vulnerable to errors of omission and commission.

iv. Further, receipts were not referenced. This meant that should the sum total of all receipts in any batch fail to match with the one in the liquidation, it would be difficult for one to establish which document was missing or erroneously reported. Also, document safety and retrieval was very difficult.

v. Liquidation was done using Microsoft Word and manual summation with a high probability of erroneous summation.

vi. Use of Multiple Petty Cash forms. The cashier would advance petty cash to the field officer, who, from the petty cash given by the cashier, would make payments and issue another petty cash form to the vendor. This caused confusion during the review because it would be difficult to distinguish between the main petty cash form from the cashier and sub-petty cash form issued by the field officer. This was attributed to transactions with service providers who lacked receipts.

vii. The SR lacked a policy on how soon the field officer would submit liquidation documents to the Accounts Assistant. Field officers did not understand their roles in handling finances and how this affected program implementation.

<table>
<thead>
<tr>
<th>Indicators/ Milestones</th>
<th>Cumulative Approved Budget</th>
<th>Cumulative Expenditure</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitization of PLWHAs and families on ART</td>
<td>1,676,400</td>
<td>2,216,807</td>
<td>(540,407)</td>
</tr>
<tr>
<td>Community outreach events for youth</td>
<td>1,666,560</td>
<td>2,174,082</td>
<td>(507,522)</td>
</tr>
<tr>
<td>Peer Educators training</td>
<td>1,966,500</td>
<td>1,917,900</td>
<td>48,600</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>306,500</td>
<td>318,500</td>
<td>(12,000)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>2,175,600</td>
<td>2,030,560</td>
<td>145,040</td>
</tr>
<tr>
<td>Planning &amp; Admin</td>
<td>442,500</td>
<td>502,319</td>
<td>(59,819)</td>
</tr>
<tr>
<td>World AIDS Day</td>
<td>61,740</td>
<td>60,870</td>
<td>870</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8,295,800</td>
<td>9,221,038</td>
<td>(925,238)</td>
</tr>
</tbody>
</table>
viii. Liquidations in the field were prepared by Accounts Assistants and approved by program coordinators. Nevertheless, the coordinators did not understand what exactly they had to review in the liquidation form before approval.

ix. The accountant at the head office had to wait for the support documents from the field to start developing the financial report. Typing each receipt in the financial report made it too bulky and very difficult to locate errors.

1.8.4 STRATEGY TO ROLL OUT THE TOOL

CARE met WOFAK’s Executive Director and Accountant at the Head Office and made them appreciate the existing financial management gaps and how each contributed to non-compliance with the Global Fund program. It was agreed that CARE would go to the field and carry out capacity building for staff in each region. The accountant at the WOFAK headquarters was taken through the new financial tracking tool and guided on how to use it as well as what to expect from the field.

1.8.5 KEY ACHIEVEMENTS

WOFAK submitted sequentially arranged support documents; enhancing efficiency of financial review by CARE. All bank withdrawals were fully accounted for as liquidated expenditure, while cash at hand was fully listed as an outstanding imprest.

The report was consistently complete. This reduced the turnaround time from the time reports were received from WOFAK to the time they were finally keyed in the Financial System at CARE. See TABLE 4 (next page)

- Improved reporting by WOFAK and the resultant reduction of turnaround time in report liquidation enhanced efficiency in disbursement processing as shown in the next page.
As shown in the graph, for all quarterly disbursements after the uptake of the tool (From April 2013) WOFAK received funds before the commencement of the implementation period.

- Budget tracking by WOFAK also improved. As at the end of program activity implementation (March 2014), as shown in **TABLE 5**, WOFAK budget variance was Ksh9 8,180 only.

<table>
<thead>
<tr>
<th>Month</th>
<th>DATE Reported</th>
<th>Liquidated</th>
<th>Turn Around time (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting prior to new reporting template</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-11</td>
<td>17-Jan-12</td>
<td>30-Apr-12</td>
<td>104</td>
</tr>
<tr>
<td>Jan-12</td>
<td>14-Feb-12</td>
<td>30-Apr-12</td>
<td>76</td>
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<tr>
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<td>12-Mar-12</td>
<td>30-Apr-12</td>
<td>49</td>
</tr>
<tr>
<td>Mar-12</td>
<td>11-Apr-12</td>
<td>30-Apr-12</td>
<td>19</td>
</tr>
<tr>
<td>Apr-12</td>
<td>23-May-12</td>
<td>29-Jun-12</td>
<td>37</td>
</tr>
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<td>May-12</td>
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<td>11</td>
</tr>
<tr>
<td>Jul-12</td>
<td>13-Aug-12</td>
<td>19-Nov-12</td>
<td>98</td>
</tr>
<tr>
<td>Aug-12</td>
<td>7-Sep-12</td>
<td>19-Nov-12</td>
<td>73</td>
</tr>
<tr>
<td>Sep-12</td>
<td>15-Oct-12</td>
<td>19-Nov-12</td>
<td>35</td>
</tr>
</tbody>
</table>

| Reporting after adoption of new reporting tool |
| Nov-12      | 10-Dec-12     | 31-Dec-12  | 21                      |
| Dec-12      | 27-Jan-13     | 31-Jan-13  | 4                       |
| Feb-13      | 19-Mar-13     | 28-Mar-13  | 9                       |

**Table 5**

<table>
<thead>
<tr>
<th>Indicators/ Milestones</th>
<th>Approved Budget in Ksh</th>
<th>Expenditure</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Outreach Events</td>
<td>4,442,567</td>
<td>4,442,567</td>
<td>0</td>
</tr>
<tr>
<td>Community meetings</td>
<td>4,572,278</td>
<td>4,572,278</td>
<td>0</td>
</tr>
<tr>
<td>Peer Education Training</td>
<td>1,942,050</td>
<td>1,942,050</td>
<td>0</td>
</tr>
<tr>
<td>World AIDS Day</td>
<td>91,740</td>
<td>91,740</td>
<td>0</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>538,550</td>
<td>536,550</td>
<td>2,000</td>
</tr>
<tr>
<td>Human Resources</td>
<td>3,929,640</td>
<td>3,832,600</td>
<td>97,040</td>
</tr>
<tr>
<td>Planning and Administration</td>
<td>958,602</td>
<td>959,462</td>
<td>(860)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>16,475,427</strong></td>
<td><strong>16,377,247</strong></td>
<td><strong>98,180</strong></td>
</tr>
</tbody>
</table>

Graph 1
CHAPTER 9:
HOLISTIC, CONTINUOUS AND INNOVATIVE APPROACHES TO SUB RECIPIENTS SYSTEMS STRENGTHENING

1.1 INTRODUCTION

In order to realize the assurance of the capacity of SR’s for implementing the grant, CARE commissioned an independent baseline capacity assessment of potential partners to determine the following: legal and contractual status, governance and risk management processes, program management capacity, financial management and reporting, monitoring and evaluation and Human Resource technical capacity.

The assessment identified the following gaps at SR level:

- Weak SR governance and management; poorly functioning boards and oversight functions
- Weak financial systems; limited electronic financial management tools and, poor internal operating environments, including the complete absence of financial operating policies and guidelines
- Weak monitoring and evaluation capacity; weaknesses in data collection and storage including the absolute absence of M&E systems
- Lax organizational culture and practices among CSOs and SRs that resulted in poor management oversight
- Weak human resource capacity; weak competencies in both programmatic and financial management processes.
- Conflict of interest, including founder member syndrome, where the founder was the institution’s executive director and, therefore, bearing undue influence over management and board decisions

1.2 IMPLEMENTATION OF PRACTICE

Following the assessment, CARE provided the following mitigating processes and systems:

- The development of key policy documents to guide the planning, implementation and management of the GF grant, including grants operations manual and an accounting manual for SRs
- M&E framework, including the development of reporting tools and an M&E manual for the program
- The provision of a holistic capacity building approach to improve not only the internal operating environment for the grant but also the quality of implementation.

1.3 CAPACITY BUILDING

The program continued to facilitate capacity building at partner and CARE level in order to enhance the abilities and capacities to enable the effective and efficient implementation of measurable and sustainable results. Routine field supportive visits were enhanced during the period, for both program and effective grants management.

Program review meetings offered an opportunity for sharing of best practices and identifying challenges while seeking a participatory process for mitigation. As a value add to program activities, gender and sexual reproductive health training
was planned with the objective of ensuring that all determinants of HIV at individual and community level were considered for effective programming. At institutional level, the drive to aid organizations improve their institutional governance, financial and program M&E systems capacities was implemented through individualized technical assistance for organizations using the organizational development model (systematic change process), and supporting them in forming sound policies, organizational structures and effective methods of management and financial control.

1.4 HAVING ALL INCLUSIVE CAPACITY BUILDING AT THE FIELD LEVEL

In order to enhance the understanding and application of the performance-based model, CARE intensified field visits jointly undertaken by Program and Grants Officers (Portfolio Managers) as part of the program’s capacity building efforts where focus was on all inclusive capacity building sessions.

These sessions brought together both program (field and HQ staff) and finance teams at partner level in order to explain the operationalization of program processes while enhancing support and team work between the teams. This generated the timely, qualitative, and accountable implementation methods that led to the success of the program.

The capacity building initiatives at the field level also included working with SRs and training facilitators on minimum standard guidelines, strategies to ensure that participants provided accurate data in the participant’s lists, financial controls in paying allowances to beneficiaries as well as activity documentation and reporting.

At the field level, youth group leaders and youth resource center coordinators were trained in leadership skills, group management, their roles before, during and after youth group events, building and sustaining group excellent performance, community inclusiveness, gender mainstreaming strategies and developing and managing income generating activities to ensure sustainability of GF interventions on HIV and AIDS beyond the program.

Some of the compliance issues included missing Local Purchase Orders (LPO’s), missing minutes of procurement committee meetings by SRs as well as lack of receipt books or invoice and quotation forms by vendors. In order to enhance accountability and therefore compliance, through field visits, CARE supported the development of procurement tools. These included LPO’s, quotation forms and cash receipt acknowledgement notes.
1.5 ENHANCING THE INTERNAL OPERATING ENVIRONMENT FOR ACCOUNTABILITY

1.5.1 GOVERNANCE TRAINING

Having identified weaknesses in governance and oversight at both baseline and midterm assessments, and recognizing the importance of good oversight in grants management as a fundamental pillar in the performance-based model, there was need to support the implementing partners in improving their capacity of oversight instruments to reinforce a common understanding of transparency, accountability and good governance. This was to ensure ethical practices and identify strong practices that contribute to the effectiveness, permanence and efficiency of the organization.

To support this process CARE sought to provide technical assistance to the organizations by providing training to board members of twenty (20) organizations. The technical assistance included an initial organizational assessment that would contribute to the actualization of the training action plans. This assessment noted the following key gaps at organizational level:

- That competencies of some directors was wanting, and their roles, responsibilities and functions as directors were not fully understood
- That there was often no distinction between governance and management and many board members meddled in day to day management functions
- That many directors of boards had very limited or no understanding of their statutory, contractual or common law duties or attendant liabilities
- That in many cases the board members were not clear of the mandate, vision, values and mission of their institutions

The training, therefore, covered the following fundamental issues:

- Guidelines on the Global Fund Program on contract, implementing plans, minimum standards
- Concepts, principles and codes of corporate governance; the 21 principles of corporate governance in Kenya, including the board duties and strategy, its responsibility in financial accountability and risk management processes
- Policy, legal and regulatory framework of CSOs operations in Kenya, including the provisions of the Public Benefits Organization Act No. 18 of 2013
- Duties and liabilities of directors; statutory, contractual and common law duties
- Evaluating and assessing governance in CSOs; the process of assessment and evaluation including board members involvement in governance assessments; individual directors; board committees to be assessed; issues that the evaluation may uncover; how the board should act on the results; the value of acting on the board evaluation.

At the conclusion of the session, each board member was tasked with the responsibility
of performing an assessment of gaps within his or her institution and developing an action plan to mitigate gaps and identify opportunities for strengthening organizational functions. The action plans derived short, medium and long-term intervention timelines which the implementing partners would uptake and implement as they strengthened internal capacity to deliver organizational goals.

1.5.2 STRENGTHENING INSTRUMENTS OF ACCOUNTABILITY

A strong internal operating environment that harnesses accountability is founded on the availability and utilization of policies to guide all functional components within an organization. Capacity assessments demonstrated a lack of these instruments for a number of implementing partners as well as a gap in capacity to enable the development of the same internally. CARE therefore commissioned a technical assistance program to Sub Recipients to undertake a review of existing systems, identify gaps within the system, including internal controls, and work the boards and management organs to develop and strengthen harmonized procedures for governance, management, human resources, monitoring and evaluation, financial and operational systems, train/orient board and management staff on the systems.

1.5.3 ENGAGING PROGRAM QUALITY THROUGH FORMAL TRAINING (GENDER, SRH, BCC)

Gender considerations in the context of HIV and AIDS prevention, treatment and care are a critical component to the success of HIV and AIDS programs where adequately assessing and identifying factors that impede or enhance intervention activities among different target groups, promotes the achievement of program objectives.

While gender and SRH integration training were not considered interventions in the grant proposal, continued community engagement and assessment of staff capacity at both PR and SR levels, demonstrated the need for enhanced quality in these processes.

CARE, through efficient and effective program implementation, was able to realize significant savings from its operations which supported gender and SRH training for PR and SR staff and included community resource persons who were an integral part of the implementation delivery teams at community level.

The gender and SRH training aimed at integrating gender in decision-making and implementation of the program. The end of training evaluation analysis found that 100 per cent of interviewed SRs found this intervention relevant and lauded its practicability.
1.5.4 KEY ACHIEVEMENTS FROM THE PRACTICE

i. There was growth and consistency of performance as shown in TABLE 6.

**Grant Ratings:** A1-Above 100%, Exceeds Expectations; A2- 90% - 100%, Meets Expectations; B1-60% - 89%, Adequate; B2- 30% - 59%, Inadequate but potential demonstrated; C-Below 30%, Unacceptable [Source: Global Fund Grant Management Letters]

ii. As reflected in the End Term Evaluation, there were positive changes in SR risk rating profiles for governance and M&E capacities when compared to midterm and end term findings where SRs governance improved from 42 per cent to 46 per cent.

iii. The impact of the PR’s institutional strengthening also led to improvement of processes on standardizing reporting tools, data recording, segregation and reporting. The processes led to improved reporting by SRs, data was more accurate as it was disaggregated by age and the correct information fed into the national M&E system. As per the ETE report on M&E, the capacities of SRs improved from 19 per cent to 54 per cent for the low risk SRs.

iv. Impact on Monitoring and Evaluation Processes (Timeliness, Completeness, Data, Quality). Document review and feedback from SR interviews during ETE showed that in Phase II there was a more systematic approach towards disaggregation of data by age groups. The SRs used the M&E training and interaction with PR to improve their data capture for all age groups. Other changes included disaggregation for the different MARPs categories.

v. The ETE analysis also demonstrated the reduction in the data flow process by different SRs which resulted in improved reporting timelines as per graph 2 in the next page.

vi. There was an improvement of data quality based on Global Fund appraisals over the course of the grants as shown in TABLE 7 in the next page.

vii. Governance interventions led to the development of action plans to improve governance oversight mechanisms. For the SRs whose uptake of governance interventions was high, there were

---

**Table 6**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Overall Rating</th>
<th>Program Performance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-Apr-09</td>
<td>30-Sep-09</td>
<td>B2¹</td>
<td>18%</td>
</tr>
<tr>
<td>01-Oct-09</td>
<td>31-Mar-10</td>
<td>B2</td>
<td>50%</td>
</tr>
<tr>
<td>01-Apr-10</td>
<td>30-Sep-10</td>
<td>A2</td>
<td>93%</td>
</tr>
<tr>
<td>01-Oct-10</td>
<td>31-Mar-11</td>
<td>A2</td>
<td>183%</td>
</tr>
<tr>
<td>01-Apr-11</td>
<td>30-Jun-11</td>
<td>A1</td>
<td>118%</td>
</tr>
<tr>
<td>01-Jul-11</td>
<td>31-Dec-11</td>
<td>C</td>
<td>16%</td>
</tr>
<tr>
<td>01-Jan-12</td>
<td>30-Jun-12</td>
<td>A1</td>
<td>102%</td>
</tr>
<tr>
<td>01-Jul-12</td>
<td>31-Dec-12</td>
<td>A1</td>
<td>105%</td>
</tr>
<tr>
<td>01-Jan-13</td>
<td>29-Jun-13</td>
<td>A1</td>
<td>114%</td>
</tr>
<tr>
<td>30-Jun-13</td>
<td>31-Dec-13</td>
<td>A1</td>
<td>105%</td>
</tr>
<tr>
<td>01-Jan-14</td>
<td>31-Mar-14</td>
<td>A1</td>
<td>107%</td>
</tr>
</tbody>
</table>
significant changes. For example, SRs like MDM and KICABA which were yellow rated at baseline and midterm assessments demonstrated marked improvement in the delivery of their respective performance targets (Ref: case study)

viii. Capacity building initiatives provided at SR level, including formal and informal trainings and the support to systems enhancement, effectively realized significant reductions in the incidence of disallowed costs as demonstrated in Graph 3.

ix. Impact on Program Efficiency (More Results for Less Shillings): The program over-achieved its targets by utilizing less money for activities in most indicators as shown in Table 8.

Table 7

<table>
<thead>
<tr>
<th>GF Management letter number and period</th>
<th>M&amp;E data accuracy concerns noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUDR 2 (Oct 2009 – March 2010)</td>
<td>Poor data quality of reported results due to lack of adequate documentation</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>Variances between CARE reported program results and those verified by LFA</td>
</tr>
<tr>
<td>2012: Onsite Data Verification (OSDV)</td>
<td>Disaggregation of results by correct age categories – Need for revision of reporting templates to disaggregate results</td>
</tr>
<tr>
<td></td>
<td>Standardization of reporting tools – use of new reporting tool by all SRs</td>
</tr>
<tr>
<td></td>
<td>Enforce confidentiality of data for program documents, especially MARPs documentation</td>
</tr>
<tr>
<td></td>
<td>Enforcement of document retention policy to be communicated to SRs</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>No data issues – over 99% data accuracy</td>
</tr>
<tr>
<td>July – Dec 2012</td>
<td>There were zero data quality issues</td>
</tr>
<tr>
<td>Jan – June 2013</td>
<td>There were zero data quality issues</td>
</tr>
<tr>
<td>July – Dec 2013</td>
<td>No Data issues – over 99% data accuracy</td>
</tr>
<tr>
<td>Jan – March 2014</td>
<td>No data issues – over 99% data accuracy</td>
</tr>
</tbody>
</table>

Table 8. Program and Finance Performance vs GF Rating

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Overall Rating</th>
<th>Program Performance (% age)</th>
<th>Finance Performance (% age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-Apr-09</td>
<td>30-Sep-09</td>
<td>B2²</td>
<td>18%</td>
<td>24%</td>
</tr>
<tr>
<td>01-Oct-09</td>
<td>31-Mar-10</td>
<td>B1</td>
<td>50%</td>
<td>39%</td>
</tr>
<tr>
<td>01-Apr-10</td>
<td>30-Sep-10</td>
<td>A2</td>
<td>93%</td>
<td>60%</td>
</tr>
<tr>
<td>01-Oct-10</td>
<td>31-Mar-11</td>
<td>A2</td>
<td>183%</td>
<td>73%</td>
</tr>
<tr>
<td>01-Apr-11</td>
<td>30-Jun-11</td>
<td>A1</td>
<td>118%</td>
<td>58%</td>
</tr>
<tr>
<td>01-Jul-11</td>
<td>31-Dec-11</td>
<td>C</td>
<td>16%</td>
<td>39%</td>
</tr>
<tr>
<td>01-Jan-12</td>
<td>30-Jun-12</td>
<td>A1</td>
<td>102%</td>
<td>88%</td>
</tr>
<tr>
<td>01-Jul-12</td>
<td>31-Dec-12</td>
<td>A1</td>
<td>105%</td>
<td>89%</td>
</tr>
<tr>
<td>01-Jan-13</td>
<td>29-Jun-13</td>
<td>A1</td>
<td>114%</td>
<td>86%</td>
</tr>
<tr>
<td>30-Jun-13</td>
<td>31-Dec-13</td>
<td>A1</td>
<td>105%</td>
<td>91%</td>
</tr>
<tr>
<td>01-Jan-14</td>
<td>31-Mar-14</td>
<td>A1</td>
<td>107%</td>
<td>90%</td>
</tr>
</tbody>
</table>
This outcome is attributed to efficiencies as a result of the use of innovative strategies and integrated approaches in implementation of program work.

Cumulatively the program realized savings of approximately KSh24 million. CARE consequently developed a concept note for additional scope of work at community level for the period between January and March 2014.

1.6  A CASE STUDY OF A SR WHOSE INSTITUTIONAL CAPACITY WAS SUCCESSFULLY STRENGTHENED

1.6.1  INTRODUCTION

Nyarami is an acronym for three civil society organisations named Nyayomo, Rapado and Midacon, which teamed up to form a community-based voluntary counselling and testing service provider in August 2003 in response to a growing need for the services in Migori County. Nyarami started working with CARE from 2009 on the GFR7 HIV Program on HIV and AIDS.

A baseline capacity assessment conducted revealed that Nyarami had weak institutional capacity, scoring poorly in financial accountability, ability to absorb allocated funds, past program performance, accuracy and timeliness of reporting and validity of the reports provided by the organisation.

It did not have sound financial systems, internal control systems or a qualified accounting officer. It was declared a medium risk organisation, meaning it had areas that needed improvement before contracting or could be contracted with preconditions and provided with at most three months to respond to the issues raised in the capacity assessment.

The audit recommended capacity building interventions aimed at providing the organisational capacity to implement and manage the intended programs. The recommended actions included training of finance staff, skills on work plan development and on GF-related monitoring and evaluation and plans for strengthening financial management as pre-conditions to contracting.

Nyarami was contracted conditionally to start implementing while at the same time executing the recommended capacity building recommendations as the program progressed. It was advised to recruit four key staff comprising a program manager, program officer, accounts officer and an M&E officer. Once this condition was met, the organisation was formally contracted and awarded minimal program targets.

For the first three months of implementation, CARE provided consistent technical assistance, coaching and mentoring to Nyarami in both program and financial management and reporting. By the end of the first semester of implementation, Nyarami had achieved all the allocated targets and effectively accounted for the KSh7.8 million it was allocated in the first two disbursements, returning efficient management, good
absorption/burn rate and effective liquidation devoid of questioned or disallowed costs that were common to other organisations at the time.

This was confirmed during the first quarterly program review meeting in December, 2009 where Nyarami was hailed by CARE for exemplary performance. This was attributed to the recruitment of qualified staff, fiscal discipline in the management of funds and focused support from CARE. These included development of reporting tools - both financial and program - training of staff - both finance and program - field support visits, support for cross learning among the partners and development and training on use of M&E online.

Confident that it was on the right path, CARE allocated Nyarami one more service delivery area, and additional targets in other SDAs. This translated into additional funding amounting to KSh7,257,788. The funding rationale was that each target had a fixed amount of money for its implementation.

Hence, the more the targets, the bigger the budget the organisation received. By the end of Phase 1 in June, 2011, Nyarami had received seven disbursements on schedule, totalling up to KSh22,368,788 and successfully reported on schedule. It also became the first organisation to submit timely and complete reports to CARE.

In the same period, Nyarami participated in the LFA conducted onsite data verification and mid-term program evaluation. Both processes declared the organisation the best in terms of data management, utilisation and reporting. They found no errors or discrepancies in its data.

As a result of its success, CARE organised exchange visits for 12 other SRs to learn from it, particularly in the areas of fiscal discipline, exemplary M&E systems and reporting. After the visit, Nyarami received encouraging feedback that some of the SRs that visited, had adopted some of its data management tools and had joined the group of SRs returning timely reports.

Nyarami was appointed by CARE to attend a National Monitoring and Evaluation Systems Strengthening (MESST) workshop hosted by the Ministry of Finance (Government PR) as a representative of GFR7 HIV Program SRs.

Due to its outstanding performance, Nyarami’s targets increased in Phase II as well as the cumulative budget of about KSh28 million and a further KSh4 million towards the end of the phase, totalling up to a program budget of KSh32 million through 15 disbursements in five years. During the period, Nyarami retained A1s by the GF rating system, greatly contributing to CARE’s consistent A1 program ratings over the period.

Compared to other stakeholders in Migori County, Nyarami is rated highly due to its performance in the HIV and AIDS field. The stakeholders in the sector hold quarterly
and bi-annual progress review meetings which Nyarami attends. When the devolved governance system came into place in 2013, Migori County established a Health Committee and to date Nyarami retains the chair’s seat.

Acknowledging its enhanced capacity and programming record with GFR7, two other donors approached the organisation for new partnerships. Planned Parenthood Federation of America (PPFA) came on board in January 2013 as well as Omega Foundation (OF). They continue to support the organisation’s expansion of programs into other areas while scaling up its success in promotion of uptake of HTC and treatment and care services for PLHIV.

PPFA is supporting provision of quality reproductive health information and services program for women and youth with a grant of about KSh45million which will run for two years while a KSh23 million grant by USAID’s Fanikisha Program supports OVCs, HIV prevention, care and treatment that is running for two years. There is increased demand for the services offered by Nyarami because of its current strengthened capacity in mobilisation strategy and interventions that were carried out successfully.

The outstanding achievements by Nyarami in GFR7 HIV Program are not without some challenges. The good work Nyarami is doing is not clearly documented for systematic internal learning and sharing with other programs.

Documentation is largely project-based because it is donor-driven. This means institutional memory may be lost as soon as projects close out. Performance assessment for the governing body as well as the management is lacking and the only attempts ever made have been non-structured and haphazard. There also lacks a clear staff development system. Transition, exist and sustainability strategies for programs are lacking, which leads to uncertainty and high staff turn over every time a project approaches its end. Nyarami experienced insurmountable challenges trying to get tax exemption for airing radio programs, despite the combined efforts with seeking the same from the Kenya Revenue Authority.

1.6.2 LESSONS LEARNED

Capacity building interventions for sub granting implementation is vital to ensure program success. However, lead organizations need to understand the capacities and operating dynamics of the organization.

Developing tailor-made interventions yields greater results than having generic capacity building programs. Nyarami illustrates that employing a dual strategy of individualized support with generic interventions does yield greater results.

1.7 CASE STUDY OF THE TRANSFORMATION OF A HIGH RISK SUB RECIPIENT TO A LOW
**RISK AND WELL PERFORMING SR**

### 1.7.1 INTRODUCTION

Kitui Integrated Creative Arts and Business Appraisal (KICABA) is a local non-governmental organisation based in Kitui County. Established as a self-help Group-cum-CBO in 2002, it was registered in 2008. Its goal is poverty reduction among the poor through an integrated approach. The Baseline Capacity Assessment report identified the following as its weaknesses: weak governance and accountability systems, especially with lack of clear separation between the board and secretariat; members of the board got part time contracts as staff of the organization and, inadequate capacity of the program staff to monitor and report appropriately. The assessment rated KICABA as a high-risk organization, which meant it had major areas that needed improvement.

These presented accountability risks to the program and could only be considered for funding if these areas were addressed. Inability to respond or address these issues would lead to late or non-contracting and the organization needed at most six months to address the deficiencies.

The organisation was contracted by CARE with the following pre-conditions: submission of a document detailing the separation of roles between the board and management, submission of samples of cash book, petty cash book and payroll summary to support the submitted financial manual and submission of a Monitoring and Evaluation plan as per the grant agreement. Despite these measures, KICABA started experiencing significant challenges in conducting and reporting on program activities and accounting for funds and resources given it by CARE and work fell behind schedule.

Despite the apparent clear separation of board and management responsibilities, the line between the two organs continued to be blurred. Technical staff lacked capacity to implement HIV program activities and there was no human resource policy governing recruitment of staff. Despite a finance manual having been developed, it was not operationalised as KICABA incurred questioned and disallowed costs, provided late, incomplete and inaccurate reports and insufficient support documentation for both program and finance.

CARE carried out an audit and based on the findings, KICABA was suspended from the program to allow for capacity building to address the ensuing problems.

“….It was a painful decision for the board to take but also a wakeup call for the board and management to the fact that things had to be done right, not only for GFR7 HIV Program but for any donor funds that came on board….”

*KICABA’s Board Secretary.*

During the period when activities were suspended, CARE focused, and embarked,
on an intensive organisational and institutional capacity-building program for KICABA. It started by providing support for the professional recruitment of new and qualified staff.

This first step was necessary so that the SR hired personnel to participate in other institutional capacity development interventions alongside the board. The action was followed by re-mapping of program activities that KICABA was carrying out in a vast geographical area without the equipment to facilitate them.

The third action was the engagement of a consultant to support KICABA in the development of optimum policies, systems and procedures that would enable it to work effectively and efficiently and deliver on its mission and particularly on the GFR7 HIV Program. CARE hired a consultant to conduct a re-assessment of the organisation’s capacity. Its report and that of the initial capacity assessment informed the development of a capacity building plan for the SR.

The consultant instituted an intensive capacity development initiative that looked at the whole organisation, starting with a review of its vision, mission and goals, principles and values. Then it supported the development of policies, systems and procedures, including human resources, finance, monitoring and evaluation and board policies.

The consultant also supported KICABA to develop operations and accounting manuals and financial management tools, among them budget tracking tools, budget templates and payment vouchers. Finally, the consultant came up with a basic board operations manual and performance appraisal tools and recommended board renewal and training.

Satisfied with the results of the consultancy, CARE lifted the suspension and resumed disbursement of funds to the SR. CARE recommended board training on governance at a workshop organised for all SRs.

Following resumption of funding and activities, the following changes were observed in KICABA’s processes:
- The board understood its role and performed its oversight of the program with utmost dedication. The chairman started meeting key organisational staff once every week to evaluate and determine whether they were on the right track and whether there were challenges and areas where staff needed capacity building. According to staff, the board took the organisation’s activities much more seriously than before and, role conflicts with management became a thing of the past
- KICABA displayed competence and professionalism in the way it conducted business, courtesy of the new team of qualified and experienced staff
- KICABA became strict and on schedule with program delivery; never late in meeting its targets and, indeed, at some
point requesting additional workload

- Programmatic and financial reporting improved tremendously in terms of timeliness, completeness, quality and integrity of both data and financial accountability. From reporting as late as on the 20th of the month, KICABA began reporting on or before the due date and this became its culture throughout Phase II of the program.

- KICABA operationalized and strictly enforced the newly developed internal control systems. These included management of program advances by ensuring that project advance requests were based on a clear activity plan and budget.

- Every advance was issued against an approved advance request form and liquidation of the same was done within 24 hours of completion of the activity, ensuring that no additional advance was given before the previous one was fully accounted for; and complete failure to account for advances was penalised by recovering the unaccounted for amounts from the staff pay cheque.

- KICABA also started conducting timely and consistent monthly bank reconciliations. This practice enabled the accountant to discover a bank error where KSh50,000 had been deducted from its GFR7 account. With the accurate monthly records, she successfully petitioned the bank for a refund. This led to KICABA’s appreciation of the importance of consistent monthly reconciliations.

- KICABA strengthened accountability procedures in the field by enforcing proper signing of participants’ payment forms and ensuring that adequate personal details were given to support activities. This minimised cases of payment forms signed by an individual being presented for accounting at KICABA or CARE, thus effectively addressing incidents of questionable payments and disallowed costs experienced in Phase I.

- KICABA established a good filing and information management system, resulting in improved presentation of reports; better archiving of important program and financial documents as contractually obligated as well as good organisational practice. This significantly addressed the challenge of misplacement or loss of documents which was common before the training.

- KICABA gradually shifted from a project mind set to program/and organisational approach to programming.

- Its work planning and budgeting improved drastically. Budgets were arranged in clearly itemised budget lines, with sufficient detail and notes the organisation followed and adhered to the PR guidelines on GFR7 budgeting standards throughout Phase II.

- KICABA’s systems, policies and procedures built with CARE’s support have since been replicated in all its...
other programs and some of the youth groups the organisation is supporting have also adopted some of them in simplified form. The strong monitoring and control systems have convinced Barclays Bank to provide support to two of these youth groups.

- After CARE trained KICABA's board on governance, it came up with internal deadlines on when activities should be done, reviewed, corrected and reports submitted to CARE.

- CARE capacity building interventions therefore made KICABA's questioned and disallowed costs a thing of the past because the supporting documentation was sufficient, there was accountability of funds and monies were spent within the budget lines, hence no budget overruns. KICABA appreciates CARE's stringent enforcement of standards, accountability and compliance.

Here below is the accountant's comment:

“…Before this support, I used to find CARE’s document verification unnecessarily tedious and its demands for accountability appeared outrageous. But, following the capacity building interventions and increased interaction with CARE, I appreciated the value of that level of verification and the importance of compliance. I now enjoy accounts and no longer view CARE as a prefect and the tormentor of Phase I, but a worthy friend and a partner to keep....”

Through CAREs capacity building intervention and the close relationship the two organisations forged through the program, there were mutual benefits where each contributed to the other’s achievement of its objectives. KICABA scored an A1 rating for three consecutive times, hence contributing to CARE's A1 rating for 5 consecutive reporting periods, thereby fully meeting its obligations to the donor.

As a whole KICABA got both its organisational and institutional capacity strengthened. Today, it stands out as an emerging NGO, known in the whole of Kitui County for its services to the community. The accountant’s parting words make a good closure to this case study.

1.8 A CASE STUDY OF AN ORGANIZATION THAT TURNED AROUND ITS CAPACITY AND PROGRAM PERFORMANCE: THANKS TO CARE’S INTERVENTIONS

1.8.1 INTRODUCTION

Mothers Delight Moments (MDM) was formed in March 1998. It was formally registered as an NGO on December 9, 1999, with activities in the informal settlements of Nairobi’s Eastlands and Kisauni in Mombasa.

Its current physical address is New Nyali in Mombasa. In 2007/2008, MDM submitted a proposal to the KCM to be part of the
GFR7 Program for HIV and AIDS. MDM was selected to carry out activities in Mombasa.

The organisational capacity assessment carried out on MDM at baseline found that the SR had: weak governance system – board members doubled up as staff with no segregation of roles between Board and secretariat; there were ad-hoc board meetings; the HR manual and the SRs organogram were not aligned and there was weak maintenance of finance records in the branch office in Mombasa.

The assessment rated MDM as a high-risk organization, which meant that the organisation had major areas that needed improvement which presented accountability risks to the program and could only be considered for funding if these areas were addressed. Inability to respond or address these issues would lead to late or non-contracting and the organization needed at most six months to address the issues.

The assessment recommended some pre-conditions for contracting including a plan for developing a Financial Management Manual, and addressing the governance issues including separation of the roles and responsibilities of the board and secretariat. The organization was contracted with these pre-conditions, and was additionally required to demonstrate ability to implement allocated targets and capacity to effectively utilize funds vis-à-vis its documented low absorptive capacity.

CARE advised them to set up basic governance structures, systems and procedures and recruit key staff namely, a program manager, accountant and two field officers as a condition for signing a contract for a GFR7 grant. MDM reviewed its constitution and came up with clear and distinct roles for the board, a five-year strategic plan and basic organisational policies and procedures.

On receipt of these documents, CARE formally contracted MDM in October of 2009 to: implement activities in sensitization of youth in school and out of school on HIV prevention through community outreach events; sensitization of people living with HIV and their family members or buddies on adherence to treatment and care and training of peer educators for HIV prevention.

Upon contracting in September 2009, MDM was able to implement program activities but as soon as work started, the low institutional capacity diagnosed by the earlier assessment became apparent, leading to discontinuation of its implementation. Following the suspension of program implementation, the PR instituted an investigative audit on the organization which was carried out by CARE internal audit and compliance unit and involved review of financial and administrative systems to establish areas of risk exposure and make appropriate recommendations.

The audit determined that a total of KSh361,521 was questionable and the
SR was required to refund the amount to CARE. The audit also noted other financial and administrative systems inadequacies and provided recommendations to address the weaknesses.

With CARE’s support the organization was able to recruit competent staff who benefited from all technical trainings organised by the PR as well as quarterly review meetings that brought together all the partners in this program, providing MDM with an opportunity to learn and share experiences with the others.

Key trainings attended by staff included grants management workshops, implementers program review workshops, work plan and budget development workshops, cross learning visits among SRs, ToT training on ART and BCC component, training (design M&E and reporting training for SRs, Monitoring and Evaluation systems strengthening workshops, governance training for SRs’ board members and data platform refresher training, among others). CARE also set out to mentor staff and board members on management and organisational leadership.

Further, CARE outsourced a consultant to assist MDM develop policies and procedures and set up systems, including finance, operations accounting and human resources manuals, M&E policy, budget tracking tool and finance reporting template for financial reporting. CARE purchased and trained the accountant in using quick books. After the above process MDM was fully equipped with functional systems, policies and procedures and new staff. This marked the beginning of its turnaround.

MDM not only resumed full implementation of activities but, also became one of the leading partners in terms of work planning and budgeting, data and knowledge management, program innovation and use of data in decision-making.

MDM’s monthly reporting improved in terms of timeliness, accuracy and quality of report presentation and support documents. For instance, reports were submitted before due date and were enriched with comprehensive case studies, human interest stories and lessons learned.

As a result of this improved performance, CARE identified MDM as a learning organisation and an example of one of the few outfits that had started the GFR7 without the capacity to implement programs but had emerged as one of those leading in responsiveness and application of capacity provided.

Consequently, whenever targets were available from other partners or from savings at PR level, MDM was among the first organizations to be considered for additional work.

That is how, in Phase II, MDM got targets in a new service delivery area – Most at Risk Populations (MARPs), in which it again excelled. Overall, MDM achieved A1 rating consecutive times, being one of the SRs that contributed to similar rating by
the program at CARE.

MDM also stands out as one of the 24 SRs that successfully and smoothly closed out their programs in June, 2014 with very successful community close-out forums and broad stakeholder participation. Besides, the SR participated actively in GFR7 End of Program Evaluation and the documentation of knowledge, both led by consultants commissioned by CARE. Thus, MDM successfully went through a complete program cycle despite initial challenges.

Despite these many successes, however, the MDM board and management feel there are areas the PR could have done better or differently and suggests that at the beginning of the program, CARE’s capacity building approach was overwhelmed by the sheer demands of program start up and especially of GFR7 magnitude – in terms of the numbers and level of partners involved and geographical spread.

The first half of year one of the program was thus very challenging for SRs and the PR alike. However, by the second half of it, things changed dramatically and the program’s management got onto a smooth stretch to the end.

From 2011 CARE’s team was restructured to adopt a portfolio management structure described in detail in the chapter below. This significantly strengthened grant oversight and support to the SRs. The resultant changes brought about significant improvement in terms of accountability, grants management and reporting compliance by MDM.

There was prompt decision-making and quicker turn around in feedback. The improved leadership largely contributed to seamless funds disbursements for MDM. From May, 2012 to the end of the program (March, 2014), MDM’s institutional capacity improved tremendously which led to better implementation and performance by the SR.
1.1 INTRODUCTION

Prior to grant signing of Global Fund Round 7 implementation the number of implementing organizations increased from 34 to 54.

The increase affected CARE’s capacity to manage the grant management processes as the program cycle processes that harness efficiency and effectiveness were undermined because no commensurate administrative costs were added to CARE to meet the required increase of SR support.

Consequently, the first program performance rating in 2009 generated a B2 rating based on the Global Fund rating matrix. The period 2010 also saw the initiation of the Global Fund Office of Inspector General (OIG) audit process for Kenya, whose report outlined the following gaps under the CARE component:

- Low absorption capacity of SRs;

- Delays in the submission of reports by the SRs

- Delays in the review of these reports by the PR

- Concerns about the quality and accuracy of the reports received from SRs and the risks of misreporting on some indicators, which led to the omission of some reports by the Local Fund Agent (LFA).

- Delayed disbursements to SRs pending resolution of incomplete reports and information on expenditures; and

- Delays in obtaining tax exemption status.

- Delay of more than eight months in the appointment of a monitoring and evaluation expert.

While fundamentally, some of these concerns emanated from a poor SR selection process that CARE did not participate in, they were exacerbated by the lack of adequate human resource capacity at CARE level in that:

i. There were only two (2) Grants Officers (GOs) and Eight (8) Program Officers (POs) to provide support to 54 Sub Recipients implementing in multiple locations across the county. The program team had more staff and able to provide support to an average of 6 to 7 SRs while the Grants team shared 27 SRs per each officer. The staffing imbalance led to coopting of 2 Grants Accountants to support the Grants officers enabling the workload to be shared among 13 to 14 SRs per officer. However, there was still an imbalance because the program team was able to support less number of SRs than the grants component. The imbalance of program and grants component resulted to the following:

a) It took long to review and liquidate financial reports due to huge workload

b) Because of delayed liquidations, it took long for SRs to receive their disbursements given that...
they had to wait until cumulated liquated expenditure hit a 90% threshold set by CARE. This would lead to idle human resources at SRs level during the period of delayed disbursements. The SRs also had to accelerate program activities to cover up for wasted time due to delayed disbursement risking putting program quality in jeopardy.

Grants Officers (GOs) took more time doing desk review, resulting in reduced field level support, verification and capacity building visits to SRs at field level.

This therefore meant that:
- Instead of field visits being supportive to improve program performance, they became more verification and investigative visits reactive to signals of high risk. Therefore, whenever sub-recipients were informed about planned visits, they became suspicious of the visit intentions. This resulted in mistrust between the PR and SR instead of building partnership relationships.
- Minimal support visits by CARE teams made SR underperform in financial reporting in terms of timeliness as well as quality of report and presentation of support documents. This further resulted to even further delays in review processes.
- Given that there was minimal capacity building of SRs on internal controls and contract adherence mechanisms, there were high incidences of disallowed costs which the SRs would probably have avoided had it received capacity building by CARE staff.

- Lack of full program and institutional support by CARE, due to the low staffing levels also resulted to low absorption capacity of SRs.

1.2 IMPLEMENTATION OF THE PRACTICE

Due to lack of adequate human resource capacity, CARE rationalized the program human resource needs and created a portfolio management structure that would adequately support the grants management cycle. This structure considered the level of effort requirements of respective staff for the complementary processes of program and grants. CARE made a request to the Global Fund for new staff structure whose features were as follows:

I. Grants Officers (GO) were paired with Program Officers (PO) and were allocated a portfolio of five organizations to support and supervise.

II. The office arrangement was made such that the Grants and Programs officer managing the same portfolio sat together, with their desks next to or facing each other.

III. Each of the two Grants Coordinators (GC) was paired with a Program Quality Coordinator (PQC) to share an office and coordinate the management of four portfolios.
IV. Each portfolio was allocated an M&E officer with close oversight of the M&E Coordinator.

V. A position of Grants Manager (GM) was created to work closely with the Programs Manager (PM) and to supervise the programs and grants teams respectively.

VI. A position of Senior Program Manager was created to offer overall oversight to the program.

VII. Overall the program received oversight and support from the Health sector headed by the Health Program Director and staffed with M&E, Grants Management and Program Quality personnel.

On a monthly basis:

a. Both the Grants and Programs Officer managing the same portfolio would decide on which SRs reports to start reviewing given that the clearance of the finance report would not proceed without the summary of program review report duly signed by the PO. Therefore, the Grants Officer would review the Finance report while the PO would concurrently review the program report of the same SR. They reviewed 100% of reports and support documents.

b. The reviewed program and finance reports would then proceed to GC and PQC who would agree on modalities and priority of financial and programs review. Sharing the office made this easy. Sampling support documents to be reviewed per SR was done at this level.

c. From coordination level, all programs files would proceed to the Programs and Grants Managers for approval. The dully approved Summary of Program review report was then attached to the Financial Files. Sampling was done at this level.

d. From coordination level, the financial files with a copy of duly reviewed programs summary report moved to the management level where files liquidating KSh400,000 and below were approved by Grants Manager/Programs Manager, between KSh401,000 and KSh800,000 by Senior Programs Managers, between KSh800,000 and KSh2 million by Health Program Director while any amount beyond KSh2 million was approved by the Country Director.

Figure 8: Capacity Building Session for CARE’s GFR7 Program Staff
This distribution of authority helped reduce file review bottlenecks.

Quarterly Program Reviews: These were at 2 levels:

i. PR internal review were held prior to the joint PR and SR program review meetings to review portfolio performance, funds utilization, reporting compliance, challenges faced and how they were resolved, portfolio work plan as well as financial projection for the subsequent period and plans for support supervision

ii. Joint quarterly review brought together at M&E, Programs and Finance staff from each SR and the PR staff. There was also a portfolio self-review session whereby all SRs within a portfolio would have their own session together with their respective GO and PO and discuss key performance highlights, challenges faced, lessons learned, cross cutting issues and issues specific to the SRs as well as way forward.

1.3 KEY ACHIEVEMENTS

The portfolio management structure supported the complementary roles required from a performance-based program where resources are disbursed based on result.

With the pairing of a grants officer with a program officer, the program was able to; effectively offer holistic support to individual implementing partners; quickly identifying performance challenges, supporting capacity building identification and follow up needs, ensuring timely verification process and therefore disbursement process, enhancing program quality initiatives, ensuring data quality, flow and retention, identifying risk factors.

The portfolio structure also introduced management and coordination positions in order to reduce supervision demands on the management team.

1.4 LESSONS LEARNED

- **Matching resource requirements to expected program outputs:** It is important to understand the scope of work of a program and determine the human and technical capacity requirements to avoid delays in restructuring of program components. Donor funding often times is restrictive and inadequate and therefore it is important to secure all the available resources from the start of the program in order to ensure program success.

- **Planning and implementation:** Resources not planned properly fail to yield quality results. CARE instituted work planning and ensured reports were received on time, reviewed within the stipulated time. This allowed teams, more time in the field to provide support to organizations and improve on program quality. The planning strategies employed by CARE during implementation
led to the program achieving A1 Global Fund ratings in program and financial reporting due to high funds absorption, minimal errors in program reporting, and high program results achievement.

1.5 CONCLUSION

To achieve quality programming, programs must be clear and aware of the resource needs to ensure support to implementation is met.

This is especially important for sub-granting components that require external parties to meet the program results. If the implementation is to be carried out by grass roots and community based organizations then it is imperative that a well-structured support structure is in place to provide support.

Key areas to focus on to ensure support to organizations in a sub-granting model include:

- Determine and select organizations based on scope of work, competencies to implement the program and ability to account for funds allocated.

- Identify the human resource capacity required to support an upcoming program. By doing so, enough resources are allocated at the start of the program and therefore reducing the complications of requesting for budget modifications that is often difficult with many donors.
CHAPTER 11: EFFECTIVE, ROBUST AND TIMELY RISK MANAGEMENT

1.1 INTRODUCTION

CARE, prior to the start of implementation, and with technical assistance outsourced and paid for by UNAIDS Technical Assistance Facility (TSF) jointly with consultants, conducted capacity assessment of organizations at baseline and midterm (supported by The Global Fund) to determine the capability of the pre-selected and continuity of sub-recipients to manage funds and implement programs effectively.

The comprehensive assessment considered the following aspects of the SRs legal and contractual status, Program management, annual income, financial management and reporting, and governance and risk management, monitoring and evaluation capacity and technical capacity for proposed areas of implementation.

In governance and risk management, the assessment sought to identify the membership and functioning of the board and/or the management committee of these organizations, and the extent to which the oversight body was able to manage risk and ensure accountability.

The findings of the assessment categorized sub recipients as low, medium, and high risk. Risk was a major factor and CARE had high incidences of unsettled advances mainly due to fraud and misappropriation of funds by end of phase 1 of the program.

The baseline assessment provided a good basis for assessing risk that was evident as 26% (14 of SRs) were dropped due to accountability and performance reasons by end of phase 1 were either in the medium risk or in high risk category.

By the end of phase 1 the program realized unsettled advances of USD.193,839 primarily occasioned by fraudulent reporting.

Additionally, most SRs were unable to fully utilize the disbursed funds resulting in low burn rates. This was attributed primarily to delayed start of the implementation process including, inadequate staffing capacity at SR level resulting in poor quality of reports and consequently delayed response to questioned costs. Response measures meant that other well performing organizations had to implement additional workload within stringent deadlines.

Equally, the administrative workload of the PR in contract revisions to effect additional commitments to those organizations taking on new workload as well as revising contracts of those organizations that were losing workload was substantial, and often undermined focus on sustaining program follow ups.

It became apparent that a strong internal operating environment with rigorous internal management processes could not harness risk management, rather it was critical to integrate risk management to staff responsibility through risk analysis and mitigation and CARE needed to take an active role in addressing the issue.
1.2 IMPLEMENTATION OF RISK MANAGEMENT PRACTICE

For effective risk mitigation in the program, CARE believed training was crucial to equip the program staff with the requisite skills for assessing risks in the program and using the risk assessment data for decision-making.

Some of these decisions included development of a risk register, determination of SRs for internal audit, reallocation of targets from high to low risk SRs as well as suspension and termination of contracts for culpable SRs.

It also culminated in the creation of a risk management committee charged with the responsibility of identifying and mitigating against any potential risk drivers in the program. In order to adequately address risk in the program, CARE implemented the following strategies:

1.3 DEVELOPMENT OF A RISK MANAGEMENT FRAMEWORK

The program developed a risk management framework for operationalization of grant processes. It utilized the following key processes in risk management:

- Risk identification: focused on documenting the risk and potential triggers and assigning ownership for the risk and storing this information in a risk register.

- Risk qualification: prioritized the risks by assessing and combining their probability of occurrence and potential impact to the program.

- Risk quantification: determined the quantitative impact to the program.

- Risk response: giving attention to significance and cost of the risk element.

ADOPTION OF A RISK MANAGEMENT SOFTWARE

CARE acquired risk analysis software called TeamMate to ascertain probability, distribution, cost estimates, and sensitivity of risks assigned to the GF program. The system gives various management reports for effective decision making by management. The tools on the software enabled the program to perform complex and concurrent analyses to determine which risks were severe and required immediate attention and action. This represented the more costly consequences for the program and organization or those that had external, uncontrollable influences or impact that needed to be documented and considered for mitigation. The timely identification of these risks for the program helped to minimize the impact of the risk and reaction to the program.

1.4 ESTABLISHMENT OF A GF PROGRAM RISK MANAGEMENT COMMITTEE

Programs that manifest high risks and are of high impact to the country office
are given due attention by management through the risk management committee. The committee for this program comprised of country office senior management, GF program management, and grants coordination teams. The members were trained in effective risk management process. This team met on a regular basis to make; key administrative risk management decisions; decisions on disbursement and audit where risk is deemed probable; to sensitize the grants and program staff on potential indicators for high risk organizations and recommend possible mitigation measures. It also sensitized implementing partners on risk avoidance during program review and director level forums of engagement.

1.5 SUPPORT FROM THE INTERNAL AUDIT AND COMPLIANCE UNIT

The ability of the department to carry out continuous operational audits and examinations of internal check controls supported the risk management processes for the grant. It supported performance measures, result evaluation, and management decisions on remedial actions. Internal audit of the programs involves giving assurance on funds reported regarding implementation of the project activities implemented directly by CARE or through sub recipients.

1.6 CONDUCTED RISK MANAGEMENT TRAINING FOR STAFF

CARE hired a consultant to provide risk management training to all GF program and grants staff. The training was crucial in supporting staff to identify and assess risks under the program and using risk assessment information in decision-making.

1.7 KEY ACHIEVEMENTS

The formation of a risk management committee ensured that outstanding fund balances did not age beyond ninety days (3 months) and funds absorption by Sub Recipients remained high.

Due to the scrutiny of the review, aged balances were critically reviewed and management measures instituted to clear balances including issuing demand letters for SRs to account for the balances.

The committee on a number of occasions provided for suspension, corrective actions, termination, relocation, or increase of work for sub recipients using savings
realized. The committee’s role extended to addressing any external challenges like tax exemption delays that had an impact on the program.

Sixty Five (65) internal audits to SRs were conducted with USD.171,740 realized as unsettled advances and USD.74,252 paid by the SRs. USD.97,488 remains outstanding by end of grant closure and therefore a liability to CARE (these costs were not reported to the Global Fund as expenses as they were identified by the PR as ineligible when the PR reviewed reports or undertook audits).

Internal audits increased from nine (9) in phase 1 to forty seven (47) in phase 2, and investigative audits decreased from six (6) in phase 1 to three (3) in phase 2. Reduction in the number of investigative audits from phase 1 to 2 was a result of dropping the non-performing SRs that were of high risk to the program. Unsettled advances significantly reduced during this period.

The automation of the risk management function using the TeamMate software increased scrutiny of supporting information for financial data and close monitoring of high-risk SRs led to a number of SRs discontinued in phase two and CARE reallocating funds from low performing to high performing SRs.

As a result, the high performing and low risk SRs budget allocations increased, poor performing and high-risk SRs allocations reduced. The result of this strategy was higher funds absorption due to performing SRs. Absorption improved from 58% at the end of phase 1 to 98% at end of phase 2. Incidences of disallowed and questioned costs reduced significantly from USD.193,839 in phase 1 to USD.34,572 in phase 2.

1.8 LESSONS LEARNED

It’s important to develop a program risk management plan based on the risks identified at the program level. The plan should anticipate financial controls and oversight weaknesses; and develop specific action plans to address those weaknesses. The plan is conceptualized prior to program inception to reduce risk during implementation.

A team made up of program, finance, M&E, and internal audit (where applicable) and with higher management representation to make decisions should be constituted and mandated with managing the risk plan. By doing so, there is greater ownership and collaboration between different departments in the organization.

1.9 CONCLUSION

Program planning is crucial and training of partner staff is equally important. However, if there is no system to monitor risk drivers in a program it is possible that the drivers could lead to the demise of the program and implementation fail to achieve its goals.

Risk management and mitigation is
important to ensuring program success is not undermined due factors such as fraud, ineligible expenditure and poor accountability.

12 REFERENCES

1. CARE Global Fund program performance reports [Various]

2. CAREs Audit reports

3. CAREs financial management reports [includes advance ageing reports, financial data, audit teammate reports]

4. PR management Letters from the Global Fund


### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune deficiency syndrome</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<tr>
<td>ART</td>
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