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- Action in the Community Environment (ACE) Africa
- Africa Focus NGO
- Beacon of Hope (BOH)
- Catholic Diocese of Homa Bay - ASUMBI
- Community Asset Building and Development Action (CABDA)
- Community Livelihood Development Forum (COLIDEF)
- Community Research in Environment and Development Initiatives (CREADIS)
- Church World Service (CWS)
- Child Welfare Society of Kenya (CWSK)
- Family Health Options Kenya (FHOK)
- Franciscan Sisters of the Immaculate Conception of the Holy Mother of God (SFIC)
- Handicap International (HI)
- Homeless Children International (HCI)
- Health NGOs Network (HENNET)
- Health Education Africa Resource Team (HEART)
- HelpAge International (HAI)
- Homeless Children International
- Hope Valley Family Institute (HVFI)
- HOPE Worldwide Kenya (HWWK)
- Kenya Basic Support Foundation
- Kenya HIV Business Council (KHBC)
- Kenya Network and Women with AIDS (KENWA)
- Kisumu Urban Apostolate Programmes (KUAP) - Pandipieri
- Kolanya Girls Boarding Primary School
- Makindu Children's Centre (MCC)
- Migori Community-Based Orphans HIV/AIDS Centre (MICOBA)
- Mothers’ Rural Care for AIDS Orphans (MORCAO)
- Nazareth Hospital
- Neighbors in Action (NIA)
- The Omari Project
- Rafiki wa Maendeleo (RWM)
- Rural AIDS Prevention and Development Organization (RAPADO)
- Raphaelites – Red Hill Place
- Reachout Centre Trust
- Ripples International
- Franciscan Sisters of the Immaculate Conception of the Holy Mother of God (SFIC)
- St. Camillus Dala Kiye Children Welfare Home
- St. Mary's Medical Center, Kapsova
- Tesia Isanga Organisation
- Tropial Institute of Community Health and Development (TICH)
- Tuungane (Impact Research and Development Organization – Impact RDO)
- Twana Twitu
- Wajir South Development Association (WASDA)
- WEM Integrated Health Services (WEMIHS)
- Women and Youth Against AIDS and Poverty (WAYAAP)
- Wema Centre Trust
- Youth Action for Rural Development (YARD)
- Student Campaign Against Drugs (SCAD)
- Support for Addictions Prevention and Treatment in Africa (SAPTA)
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>AB</td>
<td>Abstinence and Be Faithful</td>
</tr>
<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APHIA</td>
<td>AIDS, Population and Health Integrated Assistance</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CAP</td>
<td>Capable Partners Program</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
</tr>
<tr>
<td>CSI</td>
<td>Child Status Index</td>
</tr>
<tr>
<td>CWS</td>
<td>Church World Service</td>
</tr>
<tr>
<td>DPO</td>
<td>Disabled Persons Organization</td>
</tr>
<tr>
<td>DQA</td>
<td>Data Quality Audit</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
</tr>
<tr>
<td>FHOK</td>
<td>Family Health Options Kenya</td>
</tr>
<tr>
<td>HAI</td>
<td>HelpAge International</td>
</tr>
<tr>
<td>HI</td>
<td>Handicap International</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIMS</td>
<td>Health Information Management System</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>IDF</td>
<td>Institutional Development Framework</td>
</tr>
<tr>
<td>IS</td>
<td>Institutional Strengthening</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MSC</td>
<td>Most Significant Change</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS STI Control Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>OD</td>
<td>Organizational Development</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PMEP</td>
<td>Performance Monitoring and Evaluation Plan</td>
</tr>
<tr>
<td>PMP</td>
<td>Performance Monitoring Plan</td>
</tr>
<tr>
<td>PWD</td>
<td>People With Disabilities</td>
</tr>
<tr>
<td>RFA</td>
<td>Request for Applications</td>
</tr>
<tr>
<td>RTE</td>
<td>Real-Time Evaluation</td>
</tr>
<tr>
<td>RWM</td>
<td>Rafiki wa Maendeleo</td>
</tr>
<tr>
<td>SAP</td>
<td>Substance Abuse Program</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Capable Partners Program (CAP) is a Leader with Associates Cooperative Agreement awarded to AED by USAID/Washington. CAP works across various sectors—health, environment, agriculture, micro-enterprise, education, information technology, gender, conflict mitigation, business development, etc.—to strengthen the organizational and technical capacities of non-governmental organizations (NGOs), NGO networks and intermediary support organizations.

The Kenya Small Grants and Institutional Strengthening Program II (hereafter called CAP Kenya) was an associate award under the CAP leader award. The program was implemented from December 31, 2005 through December 31, 2010. Funded by USAID/Kenya under the President’s Emergency Plan for AIDS Relief (PEPFAR), CAP Kenya was a response to the continuing challenges Kenya faced in the prevention, care and treatment of the people affected and infected with HIV and AIDS. Through this award, CAP Kenya contributed directly toward the PEPFAR goals for Kenya of providing comprehensive HIV/AIDS support and services in prevention care and treatment by managing grant funding to, improving the quality of services provided by, and enhancing the organizational systems of its local partner organizations.

1.1—AWARD HISTORY AND FINANCIAL SUMMARY

Table 1 shows the award history through eight modifications. The total estimated cost of the project was $25,298,744. Modification 1 amended the scope of work to include prevention programs with substance abusing populations; modification 4 added activities to expand participation of people with disabilities in development; and modification 7 added specific activities related to care of and support for OVC.

Table 1: Award History

<table>
<thead>
<tr>
<th>Modification</th>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>December 30, 2005</td>
<td>TEC $9,000,000; obligation $2,842,500</td>
</tr>
<tr>
<td>Modification 1</td>
<td>April 3, 2006</td>
<td>Incremental funding $380,000 (for prevention programs with substance abusing populations)</td>
</tr>
<tr>
<td>Modification 2</td>
<td>February 13, 2007</td>
<td>Incremental funding $4,805,000</td>
</tr>
<tr>
<td>Modification 3</td>
<td>August 6, 2007</td>
<td>TEC increased to $25,000,000; completion date extended to 12/30/09; incremental $5,420,000 (total obligation $13,447,500)</td>
</tr>
<tr>
<td>Modification 4</td>
<td>September 29, 2008</td>
<td>TEC increased to $25,298,744; incremental funding $298,744; period of performance extended to 31/03/10 (for the expanding participation with people with disabilities grant to Handicap International)</td>
</tr>
<tr>
<td>Modification 5</td>
<td>October 24, 2008</td>
<td>Incremental funding $2,090,000</td>
</tr>
<tr>
<td>Modification 6</td>
<td>December 16, 2008</td>
<td>Incremental funding $7,900,000</td>
</tr>
<tr>
<td>Modification 7</td>
<td>September 17, 2009</td>
<td>Updated Program description approved</td>
</tr>
<tr>
<td>Modification 8</td>
<td>December 18, 2009</td>
<td>Incremental funding $1,562,500; period of performance extended to 12/30/2010</td>
</tr>
</tbody>
</table>
2. GOAL AND OBJECTIVES

CAP Kenya was designed to manage grant funding to NGOs, community-based organizations (CBOs) and faith-based organizations (FBOs) working in communities across Kenya to provide services to those infected and affected by HIV/AIDS, particularly orphans and vulnerable children (OVC), their caregivers, and people abusing substances. Beyond managing the grants, the program provided organizational and technical assistance to improve the capacities of organizations to expand and improve the quality of services to beneficiaries. These activities contributed directly to the PEPFAR goals for Kenya and are consistent with the USAID/Kenya Strategic Objective, “to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services.”

Figure 1 shows the Results Framework on which this project was based.

Figure 1: CAP Kenya Results Framework
3. INSTITUTIONAL STRENGTHENING STRATEGY AND APPROACHES

CAP Kenya utilized an integrated approach to IS that addressed the grantees’ capacity through four key functional areas:

1) the provision of grants;
2) organizational development;
3) program technical capacity; and
4) financial and risk management.

The functional areas separately and collectively contributed towards the successful achievement of the CAP Kenya overall goal of strengthening grantees’ capacity to deliver better quality HIV and AIDS services to their target communities. The four interventions are described in further details in the following pages.

3.1—GRANTS

CAP Kenya provided grants directly to selected organizations and indirectly to subgrantees through umbrella organizations to enable them to carry out their core function of delivering HIV and AIDS services to vulnerable groups. Through technical assistance and training, CAP Kenya assisted organizations in expanding and scaling up their existing activities and effectively using grant funding to achieve their goals.

3.1.1—DIRECT GRANTS

Over the course of the period of performance of the project, CAP Kenya managed grants to a total of 48 organizations. CAP Kenya selected grantees through a competitive selection process. In 2006, thirteen grantees were from a pool initially short-listed by USAID Kenya from an open-universe request for applications (RFA). The remaining grantees were selected in a series of closed-universe RFAs issued by CAP Kenya, and grants were awarded according to the timescale in Table 2. A more detailed description of the funding cycles is provided in Annex 1.

Table 2: Timescale for Grant Awards

<table>
<thead>
<tr>
<th>Date of Grant Award</th>
<th>No. of New Grantees</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2006</td>
<td>13</td>
</tr>
<tr>
<td>April 2006</td>
<td>7</td>
</tr>
<tr>
<td>November 2006</td>
<td>2</td>
</tr>
<tr>
<td>February 2007</td>
<td>23</td>
</tr>
<tr>
<td>April 2008</td>
<td>2</td>
</tr>
<tr>
<td>March 2009</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total No. of Grantees</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>
Grant funding was targeted at community-level service delivery programs addressing the following PEPFAR areas:

- orphans and children vulnerable to HIV/AIDS
- other prevention activities
- abstinence and be faithful (AB) programs
- other/policy analysis and system strengthening
- counseling and testing
- palliative care: basic health care and support
- strategic information (surveillance, health information management system (HIMS) and M&E)

Funding was typically obligated annually to grantees for a 12-month period. Successive obligations were based on a review of performance and funding availability. In order to help grantees implement and manage their grants in an AED- and USAID-compliant manner, CAP Kenya developed the comprehensive CAP Kenya Grants Management Manual, which is included as Annex 2.

3.1.2—Umbrella Grants

Out of the 48 grants, CAP awarded three to umbrella organizations—Handicap International (HI), Church World Service (CWS) and Help Age International (HAI)—which managed subgrants to 14 other organizations. The main goal was to build these umbrella organizations’ capacity to manage grants in compliance with AED and USAID requirements, as well as to strengthen the capacities of the subgrantees. CAP Kenya achieved this by:

- training umbrella grantee staff to use and adapt tools and approaches;
- holding regular meetings between CAP Kenya and umbrella grantees for program planning and review;
- conducting joint monitoring visits to the programs; and
- participating in umbrella grantees’ partners’ forums.

3.2—Organizational Development

Organizational development (OD) focuses on supporting grantee organizations to improve their organizational capacities and sustainability. CAP Kenya used the Institutional Development Framework (IDF) and other assessment tools described in section 4.1 to assess organizational competencies and capacity gaps, and to subsequently guide the development of organizational improvement plans. CAP Kenya trained and worked intensively with the grantees to support them in achieving the objectives set out in their plans.

3.3—Program and Technical Capacity

CAP Kenya’s support in technical and program management was designed to enable grantees to plan and deliver quality programs and become recognized leaders in the fields of HIV and AIDS prevention, care and support. CAP Kenya provided technical assistance to grantees through one-on-one support, training, peer exposure visits, comprehensive feedback on quarterly narrative reports, grantees’ quarterly forums and regular dissemination of electronic technical resources.
3.4—Financial and Risk Management

Financial and risk-management interventions built the capability of grantees to manage and effectively report on how they spent funds. CAP Kenya provided training in activity-based budgeting and grants management to equip grantees with the skills to manage funding in compliance with USAID requirements. Through consistent training and TA provision, CAP Kenya placed special emphasis on building grantee capacity in budgeting and financial reporting, internal controls, risk management, compliance with grant requirements and standards, and general accounting.

4. Institutional Strengthening Processes and Tools

The CAP Kenya institutional strengthening (IS) process was designed to bring about organizational self-awareness as well as to increase and sustain improved effectiveness and overall organizational health. The fundamental elements of this approach are shown in Table 3 below. CAP Kenya’s aim was to work with grantees to achieve the standards described under each element.

Table 3: Elements of the IS Approach

<table>
<thead>
<tr>
<th>Management Systems</th>
<th>People</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizational policies that provide a solid framework or operation</td>
<td>• Effectiveness of the individuals in terms of capacity and abilities</td>
<td>• Transparency in governance</td>
</tr>
<tr>
<td>• Clear and actionable operational plan and budgets</td>
<td>• Intergroup relations/team work and effectiveness of the organization as a whole</td>
<td>• Focused mission/strategic plans that builds off of the strengths of the organization and responds to needs within their contexts</td>
</tr>
<tr>
<td>• Financial management and M&amp;E systems that prepare and enable them to manage large grants</td>
<td>• Results-based management systems established to ensure everyone understands and is able to identify their roles in achieving overall objectives (collective responsibility)</td>
<td>• Positioned to join with peers to carry out campaigns for long-term sustainable change</td>
</tr>
</tbody>
</table>

To achieve these objectives, CAP Kenya’s approach involved a series of interrelated steps:

1) baseline assessments, which lead to the creation of needs-based improvement plans;
2) implementation of OD interventions and technical assistance; and
3) monitoring and evaluation of grantee progress.

CAP Kenya also continually monitored the institutional strengthening process itself to constantly apply learning and improve its approaches to working with the grantees. For detailed information on the institutional strengthening interventions CAP Kenta employed with each grantee, see Annex 3.
4.1—Institutional Strengthening Tools

The IS process started with baseline assessments and continued with analyses of capacity needs using various institutional strengthening tools: the IDF, management questionnaires, rapid organizational assessments, the HIV and AIDS Technical Assessment, substance abuse program (SAP) technical assessments, data quality audits (DQA), monthly financial reports and financial audits.

The IDF is a participatory assessment tool used to appraise the institutional strengths and weaknesses of grantees. The tool provides both an analytic (tabular) and visual (graphic) presentation of results, and quantifies grantee institutional capacities, in six resource areas—oversight and vision, management resources, human resources, financial resources, external resources and technical resources—using rating scores. The tool is also used to reassess the grantees and to provide comparative data that show institutional capacity changes over time. (Further information on the IDF, its elements and constituent capabilities, see http://www.ngoconnect.net/cap-idf.)

The management questionnaire is structured around the elements of the IDF and was used when it was inappropriate to use the IDF. This circumstance arose when the nature of the organization did not fit the typical grantee, for example, when the grantee was one section of a large institution, such as a hospital.

The HIV and AIDS and SAP technical assessments are tools to systematically review grantees ability to implement programs in line with PEPFAR guidance for the appropriate programmatic area. These tools were used at annual intervals, and the results were used to plan technical assistance for the following period. The DQA is a mechanism that CAP Kenya used to ensure that data collected from all grantees were valid, timely and accurate. It was used to assess and improve overall data quality, verify the quality of reported data and assess the underlying data management and reporting systems. Finally, CAP Kenya used other periodic monitoring approaches and tools, such as spot checks and review of reports, to assess capacity needs and growth of grantees.

Table 4 shows the specific tools used to assess the different OD categories.

Table 4: Grantees Capacity Areas and CAP Kenya Assessment Tools

<table>
<thead>
<tr>
<th>Capacity Area</th>
<th>Description</th>
<th>Tool</th>
</tr>
</thead>
</table>
| Institutional Development | Process of organizational change supported by senior management to raise and sustain organizational performance/effectiveness leading to enhanced organizational capacity | • Management questionnaires  
                          |                                                                      | • Institutional Development Framework  
                          |                                                                      | • Rapid organizational assessments  |
| Technical Capacity     | Ability to design and implement programs that utilize best practice and most current technical approaches; capacity to continuously improve the project based on implementation experience | • HIV and AIDS Technical Assessment tool  
<pre><code>                      |                                                                      | • SAP technical assessments  |
</code></pre>
<table>
<thead>
<tr>
<th>Capacity Area</th>
<th>Description</th>
<th>Tool</th>
</tr>
</thead>
</table>
| Program Capacity       | Ability to design and deliver programs and services that are appropriate, cost effective, efficient and meet program objectives and targets | • DQAs  
                          |                                                                               | • Program report review          |
| Financial Management Capacity | Capacity to manage financial resources appropriately, track financial transactions and report on financial status | • Monthly financial reports  
                           |                                                                               | • Spot checks  
                           |                                                                               | • Financial audits |

The results of the participatory assessments provided the basis for developing IS improvement plans and technical assistance packages. The plans defined the interventions that were implemented to address the grantees’ individual needs. See Annex 4 for samples of these tools.

### 4.2—Implementation of Organizational Development

During the implementation of improvement plans, CAP Kenya technical staff and consultants provided one-on-one technical assistance to individual grantees. When appropriate, CAP Kenya conducted trainings that focused on areas of need common to all grantees. Other organizational development activities include peer learning and dissemination of electronic materials.

CAP Kenya also acted as a catalyst for networking and experience sharing between grantees in several ways. First, it conducted partner forums three or four times each year bringing together staff from all the grantee organizations to learn and share experiences. Second, CAP Kenya guided and supported exchange visits between grantees, which were powerful peer learning opportunities that exposed staff members to new ideas and information. Most grantees utilized this opportunity by visiting grantees that worked in their area(s) of interest. Third, CAP Kenya introduced the Founders’ Forum, an innovative group led by founders of the grantee organizations that addressed challenges relating to governance, transition management and succession planning uniquely affecting grantees headed by their original founders.

### 4.3—Monitoring Grantee Progress

At the beginning of each grant agreement, every grantee completed a performance monitoring plan (PMP) that provided a framework for monitoring activities and evaluating change. The PMP was result-oriented and defined indicators for tracking overall outcomes and program objectives. Additionally, grantee quarterly narrative reports were an essential part of performance monitoring and provided information on the progress, achievements and challenges.

CAP Kenya conducted consistent and regular monitoring to track the implementation of grantee projects, assess progress towards achieving set targets, provide technical input in areas of program implementation and challenges, track improvement plans, provide on-site coaching and mentoring, and assess the status and impact of IS interventions.

For grantees that underwent an initial IDF assessment and a subsequent reassessment, CAP Kenya used the Most Significant Change (MSC) technique—a participatory monitoring and evaluation method that works by collecting stories about the impact of the work—to augment
quantitative data. MSC explored the same organizational development domains as those that are analyzed during the assessments: oversight/vision, management resources, human resources, financial resources, external resources and technical capacity.

Data quality assessments focused on the capacity of grantees to collect relevant data required to effectively monitor the progress of their projects. Monitoring visits not only validated results but also ensured that grantees clearly understood the importance of maintaining quality data.

4.4—FINANCIAL AUDITS

CAP Kenya conducted at least one internal control audit of all grantees and, as necessary, also conducted ad hoc audits of grantees to verify financial reports and recommend corrective action. Audit recommendations were carefully followed up on to ensure that they were implemented. In addition to identifying potential areas of financial risk, these audits were an opportunity to expose grantees to audit requirements and procedures.

In addition to formal audits, grantee financial reports were carefully reviewed by CAP Kenya grantees every month to ensure that grantees were maintaining appropriate standards and procedures for procurement and accounting. CAP Kenya provided feedback to grantees each month, and subsequent funds disbursements by CAP Kenya were contingent on corrective action being taken when requested.

5. INSTITUTIONAL STRENGTHENING OUTPUTS

This section highlights the outputs CAP Kenya realized through its direct IS support to grantees during the life of the project. The expected IS result of the program was “increased capacity of NGOs, FBOs and CBOs to deliver quality HIV/AIDS care and support services.”

5.1—ORGANIZATIONAL DEVELOPMENT ACHIEVEMENTS

On many levels, CAP Kenya’s OD activities provided and engendered direction, clarity, structure, a sense of empowerment and a new level of professionalism for and among the grantees. This success can be largely attributed to the integrated, comprehensive and consistent approach used and the commitment by the grantees to the IS process. The approach helped grantees look at their organizations holistically and examine their governance, leadership, management, program, technical capacity, external relations and service delivery capabilities.

Table 5: Summary of CAP Kenya Institutional Strengthening Activities and Achievements

<table>
<thead>
<tr>
<th>Step</th>
<th>Activities</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>Institutional capacity assessments</td>
<td>66 conducted, including 28 re-assessments</td>
</tr>
<tr>
<td></td>
<td>HIV capacity assessment</td>
<td></td>
</tr>
<tr>
<td>Analysis and Strategy</td>
<td>CAP Kenya portfolio meetings</td>
<td></td>
</tr>
<tr>
<td>development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy implementation</td>
<td>Partners’ forums attended by all partners</td>
<td>10 partners’ forums hosted by CAP Kenya</td>
</tr>
<tr>
<td>Step</td>
<td>Activities</td>
<td>Achievements</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Strategy implementation (cont.)</td>
<td>Training workshops for specific organizations on specific topics</td>
<td>24 training workshops conducted by CAP Kenya</td>
</tr>
<tr>
<td></td>
<td>Grantee networking and exchange visits</td>
<td>115 visits conducted by grantees</td>
</tr>
<tr>
<td></td>
<td>HIV E-Updates disseminated to grantees</td>
<td>26 E-Updates disseminated</td>
</tr>
<tr>
<td></td>
<td>IS Quick Tips disseminated to grantees</td>
<td>22 IS Quick Tips disseminated</td>
</tr>
<tr>
<td></td>
<td>Performance monitoring and technical assistance visits by CAP Kenya</td>
<td>352 programmatic field visits conducted</td>
</tr>
<tr>
<td></td>
<td>Spot checks conducted by CAP Kenya</td>
<td>38 spot checks (focused on financial management) carried out in the field by CAP Kenya</td>
</tr>
<tr>
<td></td>
<td>Internal audits conducted</td>
<td>25 internal control audits were carried out and the findings followed up</td>
</tr>
<tr>
<td></td>
<td>Most significant change technique used to gauge changes in grantee institutional capacity</td>
<td>14 MSC participatory assessments facilitated by CAP Kenya</td>
</tr>
</tbody>
</table>

Under strategy implementation, CAP Kenya facilitated 24 grantee training workshops over the life of the project in key areas such as financial management, M&E, resource mobilization, leadership and succession planning, project design and management, report writing, NGO operations, policies and procedures and electronic accounting. A total of 434 individuals participated in these workshops. In addition, 21 chief executives benefited from an ongoing governance and leadership development program for founders. Figure 2 provides a breakdown of the type of trainings and the number of people who attended each.

**Figure 2: Number of Participants and Type of Trainings**

<table>
<thead>
<tr>
<th>No. of Participants</th>
<th>Report writing</th>
<th>Governance and leadership development</th>
<th>Quickbooks application</th>
<th>Project design and management</th>
<th>Leadership and succession planning</th>
<th>Resource mobilization</th>
<th>NGO operations, policies and procedures</th>
<th>Monitoring and evaluation</th>
<th>Financial management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>89</td>
<td>21</td>
<td>27</td>
<td>107</td>
<td>35</td>
<td>32</td>
<td>38</td>
<td>61</td>
<td>96</td>
</tr>
</tbody>
</table>

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Other achievements of the program included institutional assessments for all the grantees using various participatory tools. CAP Kenya staff and consultants conducted 436 separate activities tailored to individual organizations and their needs, including individualized coaching and mentoring for specialized interventions. In addition, grantees undertook 115 peer learning activities.

As of September 2010, project records show that of all the grantees, 62% had strategic plans, 89% had financial management manuals, 89% had human resources policies and 96% had received M&E training. Additionally, 84% of grantee staff at had received training in team-building skills, and 44% of their Boards of Directors had received training in Board roles and responsibilities.

Table 6 contains an illustrative list of the types of OD assistance provided to the grantees.

**Table 6: Areas and Descriptions of Interventions**

<table>
<thead>
<tr>
<th>Area of Intervention</th>
<th>Description of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic Plan Development/Review</td>
<td>Review of strategic planning processes or reviews and development of medium- to long-term strategic plans</td>
</tr>
<tr>
<td>2. Financial Policy</td>
<td>Development and documentation of financial procedures; implementation of financial policy manuals</td>
</tr>
<tr>
<td>3. Human Resources (HR) Policy</td>
<td>Development and documentation of HR procedures; implementation of HR policy manuals</td>
</tr>
<tr>
<td>4. Monitoring and Evaluation Training</td>
<td>Training on M&amp;E and/or targeted technical assistance for development of M&amp;E systems and frameworks</td>
</tr>
<tr>
<td>5. Resource Mobilization/ Fundraising</td>
<td>Training on resource mobilization and fundraising leading to development and implementation of resource mobilization strategies</td>
</tr>
<tr>
<td>6. Advocacy</td>
<td>Training on advocacy, and/or development and implementation of advocacy strategies</td>
</tr>
<tr>
<td>7. Staff Team Building</td>
<td>Team-building exercises and development of action plans for improving teamwork</td>
</tr>
<tr>
<td>8. Board Skills Development</td>
<td>Workshop or a meeting on Board development leading to development of board manuals and recruitment of appropriate Board members</td>
</tr>
<tr>
<td>9. Staff Skills Development</td>
<td>Tailored skills-building workshops that are specific and relevant to grantees’ respective technical areas</td>
</tr>
<tr>
<td>10. Accounting Software</td>
<td>Installation and use of accounting software</td>
</tr>
<tr>
<td>11. Administrative Policy</td>
<td>Development and documentation of administrative policies and SOPS; implementation of policy manuals</td>
</tr>
<tr>
<td>12. Program Evaluation</td>
<td>Received technical assistance to facilitate a program review and/or evaluation of the program</td>
</tr>
<tr>
<td>13. Media Strategy</td>
<td>Received technical assistance to develop media strategy</td>
</tr>
<tr>
<td>14. Organizational Structure</td>
<td>Received technical support to review and establish effective organizational structures, job descriptions, employment contracts, etc.</td>
</tr>
<tr>
<td>15. Web site Development</td>
<td>Received technical assistance to develop and/or upgrade organization’s Web site</td>
</tr>
<tr>
<td>16. Equipment Purchase</td>
<td>Received financial support to procure equipment that will support organizational effectiveness and efficiency (for example, computers)</td>
</tr>
<tr>
<td>17. Leadership Development/ Founder’s Forum</td>
<td>Received support to improve management effectiveness and leadership (for example, change management process, leadership</td>
</tr>
<tr>
<td>Area of Intervention</td>
<td>Description of Intervention</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>18. Financial/HR Systems Development</td>
<td>Received technical assistance to develop and strengthen financial management and/or HR management systems</td>
</tr>
</tbody>
</table>

### 5.2—Programmatic and Technical Achievements

In line with evolving PEPFAR guidance to provide wrap-around HIV services at the community level, grantee programs expanded in size and scope each year. Thus, from providing predominantly OVC and prevention services in 2006, by 2010 CAP Kenya grantees were providing a range of OVC, prevention, counseling and testing and community- and home-based care services, as well as systems strengthening. Figure 3 shows the expansion in the range of services over the program period.

**Figure 3: CAP Kenya Grantees Program Implementation Areas**

The number of individuals reached for each program implementation area was captured against standard PEPFAR indicators. CAP Kenya Project’s Performance Monitoring and Evaluation Plan (PMEP) for 2010 included 23 standard PEPFAR indicators. Through the grantees:

- 157,342 individuals were reached through community messages promoting HIV prevention with AB messages;
- 302,868 individuals were reached through community outreach promoting HIV prevention through behavior change other than AB;
- 2,950 drug users/injection drug users were reached with prevention messages;
- 36,749 individuals were provided HIV-related palliative care (including treatment for tuberculosis);
• **30,553** OVC were reached with essential services;
• **29,743** providers/caregivers were trained in caring for OVC;
• **101,615** individuals received counseling and testing for HIV and received their test results; and
• **742** individuals were trained in HIV-related institutional capacity building.

Annex 5 provides a summary of the numbers reached per year for each of the PEPFAR indicators.

CAP Kenya’s HIV technical assistance emphasized improvement in program quality. Each year, CAP staff reviewed grantee programs and provided technical assistance and one-on-one support to each organization to strengthen the design of the grantee’s program. This support included:

• workshops on the linkages between indicators and how to redesign programs to ensure that data captured all activities being undertaken. This training helped to ensure that grantees had a better grasp of the indicator definitions as defined by PEPFAR information systems team. This training led to increased reporting in the second year and onward;
• training to grantees implementing OVC programs to build their capacity in improving the quality of services delivered. The training emphasized the need to focus on household vulnerability to HIV and AIDS and how to combat this vulnerability beyond mere service delivery to children affected by HIV and AIDS; and
• targeted training on nutritional assessments and tracking, especially for OVC and young children, aimed at helping grantees explore alternative sources of nutritious food for households.

CAP Kenya trained grantees implementing HIV-prevention activities that targeted substance-using populations on minimum services to mitigate both their HIV risk and ensure access to addiction-treatment services. CAP Kenya provided further technical assistance throughout the implementation period to ensure adherence to the minimum standards of services and, in some cases, assisted with the redesign of existing programs to increase efficiency and build practical referral systems.

Umbrella grantees—Handicap International, Church World Services and HelpAge International—received specific technical assistance to ensure that the training from CAP Kenya flowed down to subrecipients.

In addition to the above, CAP Kenya prioritized efforts to ensure activities were appropriate, evidence-based and supported skills development of staff through ongoing technical learning. Varied methodologies of capacity building were used, including the following:

• HIV E-Updates, an electronic newsletter distributed monthly;
• electronic resource centers at each organization for independent study and reference;
• trainings and workshops which promoted applied learning and skills development and were accompanied with follow-on at the individual-organization level;
• one-on-one TA support through field visits, in which CAP staff worked closely with project teams to review processes, tools and approaches;
• proposal development support that fostered innovative program designs and outcome-oriented models of care;
• internal CAP pilot activities to test models of care and prevention, such as using the rites of passage related to male circumcision to introduce prevention change messages and share learning among partners; and
• program audits and strategy reviews with action plans and ongoing TA to support application of new learning.

Technical assistance activities included training in advocacy, support to establish M&E frameworks and assistance to undertake program evaluations. Some specific examples of HIV and AIDS technical assistance that CAP Kenya provided are:

• support to the WEMA Centre in adopting an integrated model of HIV and AIDS prevention. The model enabled the organization to provide individual- and group-level prevention support to beneficiaries based on their specific risks and vulnerabilities. CAP also provided the organization with tools and curricula to facilitate the development of a topic-based annual calendar of activities for HIV-prevention education.
• support to Rafiki wa Maendeleo (RWM) in developing a referral system that facilitated access to HIV service providers outside the scope of RWM’s activities and in integrating age-appropriate and comprehensive HIV-prevention activities for OVC and caregivers.
• assistance to Youth Action for Rural Development (YARD), WEMA, Community Research in Environment and Development Initiatives (CREADIS) and other in formulating comprehensive HIV and AIDS workplace policies.
• intensive training for all OVC programs on building the capacity to understand and respond to the specific HIV-related needs of children affected or infected by the virus. The training looked at specific issues of HIV infection, transmission and management with children, treatment adherence, disclosure and other aspects of psychosocial support.
• assistance and direction to the grantees listed below to design interventions that built their technical capacity in risk reduction and HIV and AIDS prevention among substance using populations. Highlights include:
  o Impact RDO, whose addiction-treatment team received assistance to improve their clinical skills and establish a palliative care reporting protocol;
  o Reachout Center Trust, which received assistance to improve clinical records management for outpatient addictions treatment and to establish a case review protocol for all cases;
  o SAPTA, which received assistance to design interventions that build the technical capacity of 10 HIV service providers to handle issues of substance use/abuse among their clients; and
  o Omari Project, which received help to develop a specialized addiction-relapse prevention program.

In 2009, 18 grantees implementing OVC programs were assessed using the self-administered HIV and AIDS Technical Assessment tool described in section 4.1. Fifteen of the 18 grantees had also been assessed for the first time in 2008 and were reassessed in 2009.

The HIV and AIDS Technical Assessment results from 2009 showed specific improvements as related to the technical areas of program implementation and institutional capacity. Significant
improvements in technical interventions were seen in the following areas: targeting relevant beneficiaries, identifying those who are HIV-positive for appropriate service provision and integrating prevention services and referrals. Significant improvements in institutional capacity were seen in the following areas: the organizations’ ability to build and sustain staff capacity through quality improvement systems, mechanisms for ongoing learning, support activities through standard operating procedures (SOPs) or other operational protocols to support quality assurance.

One major highlight is the significant improvement in the percentage of staff that had direct HIV/AIDS-related training to support their activities. At the time of the assessment in 2008, 32% of the organizations responded as having none of their staff trained and 42% responded as having 25% or less of their staff technically qualified to run their HIV-response programs. After the assessment, CAP Kenya provided need-based trainings and sensitized the organizations on the importance of prioritizing and investing in staff development. The reassessment in 2009 indicated that 44% of organizations reported having 75% or more of their staff who are appropriately trained.

CAP Kenya paid special attention 15 grantees that were assessed in 2008 and 2009, because the exact scores for those grantees could be compared over time. The changes in their overall assessment scores show significant improvement. Nine organizations show dramatic improvements, five organizations remained the same and one showed decreased technical capacity. The results of the overall scores of the HIV and AIDS Technical Assessments in 2008 and 2009 for the 15 grantees are show in Figure 4.

Figure 4: Overall Scores of 15 Grantees’ HIV and AIDS Technical Assessments, 2008 - 2009
Additionally, CAP Kenya reviewed these 15 grantees’ improvements in key achievements. Table 7 shows the breakdown of key achievements of the 15 grantees that were assessed in 2008 and 2009.

Table 7: Key Achievements of 15 grantees’ HIV and AIDS Technical Assessments, 2008 to 2009

<table>
<thead>
<tr>
<th>Program Structure and Systems Key Achievements</th>
<th># of Grantees 2008</th>
<th>% (out of 15)</th>
<th># of Grantees 2009</th>
<th>% (out of 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of OVC matches PEPFAR</td>
<td>11</td>
<td>73%</td>
<td>14</td>
<td>93%</td>
</tr>
<tr>
<td>Program delivers gender-specific services</td>
<td>10</td>
<td>67%</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Program has ongoing, planned and age-specific HIV/AIDS prevention</td>
<td>7</td>
<td>47%</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Program identifies all HIV-positive children and caregivers</td>
<td>5</td>
<td>33%</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Program facilitates care and treatment services</td>
<td>10</td>
<td>67%</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Program facilitates access to facility-based prevention services</td>
<td>6</td>
<td>40%</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Program is linked to Government of Kenya, Ministry of Health networks and committees</td>
<td>14</td>
<td>93%</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>Organization has quality assurance/quality improvement systems</td>
<td>8</td>
<td>53%</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Organization has HIV/AIDS workplace policy</td>
<td>1</td>
<td>7%</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Staff have ongoing access to HIV information and learning</td>
<td>6</td>
<td>40%</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>Organization has on-site resource library</td>
<td>8</td>
<td>53%</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Updated program SOPs or operation protocols</td>
<td>6</td>
<td>40%</td>
<td>9</td>
<td>60%</td>
</tr>
</tbody>
</table>

CAP Kenya also disseminated an electronic newsletter, HIV E-Updates, providing grantees with technical information on HIV and AIDS. The newsletter contained resources to facilitate the technical development of organizations and continuous learning necessary to support the dynamic nature of HIV response efforts. It summarized broad technical concepts on HIV and AIDS programming and included toolkits, guidelines and strategy documents. The updates also kept the grantees informed on changes and trends in the HIV and AIDS sector. The topical areas covered by this electronic newsletter included behavior change, HIV and AIDS response with children and youth, male circumcision as part of HIV prevention, and a human rights approach to HIV and AIDS programs among others. In October 2009, CAP Kenya surveyed readers to gauge satisfaction with and usability of the newsletter content and the usefulness of the topics covered. Of the readers who responded, 92% found the content to be “just right” or easy to understand; 96% found it to be useful or very useful; and 100% found it to be relevant to their programs’ needs. For the full set of all the HIV E-Updates, see Annex 6.
5.3—Mwangalizi Project and Real-Time Evaluation

Initiated at the request of the PEPFAR office, the Mwangalizi Project was an innovative pilot undertaken in response to HIV service providers’ concerns. Due to barriers to consistent follow-up and monitoring of children at HIV care and treatment facilities, providers were struggling to maintain optimum pediatric HIV management. The objective of the pilot was to strengthen the link between clinical and household settings to improve adherence to treatment and clinical retention and to ultimately improve the quality and continuum of care for HIV-positive children. Five PEPFAR-supported care and treatment sites were engaged to roll-out customized approaches to meet the project’s objective in the context of their communities. These were the Eastern Deanery AIDS Relief Program, Coptic Hospital Hope Center, the AMPATH Program, Kericho District Hospital and BOMU Health Centre.

From June 2008 to December 2009, CAP Kenya provided intensive monitoring and technical support to the Mwangalizi implementing partners, followed by an additional 10 months of data analysis, interpretation and consolidation of findings. In line with the project’s conceptual framework and using a real-time evaluation (RTE) methodology, CAP Kenya applied and documented real-time learning, measure impact and extracted best practices to determine the feasibility of scaling up the intervention.

Through the Mwangalizi Project, barriers to pediatric HIV management were reduced, demonstrated by high rates of retention within health systems and improved health outcomes. Improvements in the validation and flow of client information, health education to caregivers and contextual understanding of the children are direct results of this intervention. In addition, caregivers and children were provided with intensified psychosocial support, accessible consultation between appointment dates and alternatives for scheduled visits. The Mwangalizi community health workers created an easily accessible, relatable and consistent interface between the caregiver and the clinic. Intensified psychosocial services in both facility and household settings directly resulting from this pilot mitigated stigma-related barriers, supported improvements in physical health and reduced emotional strains that impact households coping with HIV.

Barriers to antiretroviral therapy (ART) adherence and attendance practices that were targeted through the Mwangalizi were reduced; however, they do not yield consistently sustained results. It is, therefore, noted that long-standing behavioral components of pediatric health management require ongoing support with emphasis on specific time points where drop-out or unsatisfactory adherence is predicted to occur.

A very important added benefit of this pilot was that the Mwangalizi Project and the RTE forced facilities to focus their efforts on the improvement of pediatric programs based on outcomes and impact, as opposed to outputs. This, in itself, is an achievement that was not a priority outside of this pilot. The RTE demanded that facilities ask questions beyond the SOPs of their clinical programs that may not have been explored before in any formal way. This led to more relevant and diversified pediatric care, along with instituting or improving the systems and structures to support service delivery, with quality of care and maximizing benefit becoming the focus of operations. The pilot mandated that facilities develop indicators to monitor the attendance, adherence and psychological aspects of pediatric care, which were non-existent for most
implementing facilities prior to the Mwangalizi Project. As a result, advancements were made in understanding the dynamics of care and support needed for pediatric populations in Kenya that had not previously been explored.

Based on the outcomes of the analysis, scale up of this intervention is recommended as a way to reduce barriers to improved care within both facility and household contexts. It is feasible across varied contexts and institution types. Findings from the Mwangalizi RTE have the potential to dramatically improve the next phase of PEPFAR activities by focusing on improving the link between facility and community based services, specifically through improved communication, information sharing and case management. CAP Kenya actively shared the findings of the RTE with U.S. Government agency leads and implementing partners. Dissemination of the overall findings was done in country at the ART Implementers meeting in September 2010, and attempts were made to contact the division of community health under the Ministry of Public Health and Sanitation. Internationally, Mwangalizi has been shared at the 2009 The International Conference on AIDS and STIs in Africa in Dakar and the 2010 International AIDS Conference in Austria. The full report of the Mwangalizi RTE is attached as Annex 7.

5.4—EXPANDING PARTICIPATION FOR PERSONS WITH DISABILITIES PROJECT

Since October 2008, CAP Kenya has supported the Expanding Participation of People with Disabilities (PWD) in Kenya Project, implemented by Handicap International (HI). The project was funded by USAID’s Bureau for Democracy, Conflict and Humanitarian Assistance and was included in the CAP Kenya scope of work through modification four. This project, which came to an end in September 2010, was designed to infuse the concept of inclusion as a cross-cutting issue among disabled persons organization (DPO) and non-DPO partners towards mainstreaming of disability into development. The project also sought to document and disseminate good practices to facilitate similar interventions. The key approach used in this project is the rights-based principle as informed by the United Nations Convention on the Rights of Persons with Disabilities.

5.4.1—ACHIEVEMENTS BY OBJECTIVE

Objective 1: Enhance the capacity of 15 non-DPOs to promote the inclusion of PWD in HIV/AIDS awareness raising and education programs

In order to achieve this objective, HI partnered with 15 non-DPOs with the aim of building their capacity to mainstream disability into their programs. This entailed training their staff to understand the meaning of disability and how it can be mainstreamed through the “four pillars,” comprising physical accessibility, access to goods and services, employment and policies and procedures. HI conducted two kick-off seminars and one-day sensitization workshops for each of the organizations, facilitated the development of action plans and provided technical support to implement these plans. Through use of a physical accessibility checklist that was developed by the program, HI conducted physical accessibility audits of four organizations at their physical premises. This led to recommendations for enhancing accessibility that the organizations would implement over the short and long term.

1 The main partners were the United Disabled Persons of Kenya and selected DPOs and non-DPOs. HI was the lead implementing partner while UDPK was the central coordinating point of DPOs.
Family Health Options Kenya (FHOK) is an example of a non-DPO that HI worked closely with and had an organizational commitment to mainstreaming disability. Through the project, linkages were created between DPOs and non-DPOs, such as the one between FHOK and Women Challenged to Challenge (WCC) in the area of women with disability and reproductive health. Beacon of Hope also created linkages with WCC on referral of women with disability and income-generating activities. Kenya Union for the Blind (KUB) created linkages with FHOK in making their resource center accessible to PWD. KUB has an adaptive technology department that can convert information into Braille, large font and audio.

**Objective 2: Increase the capacity of DPOs to manage and implement programs effectively and advocate for PWD rights**

The project engaged 10 DPOs by building their capacity to advocate for inclusion of PWD in development programs. This involved two kick-off seminars and two training workshops on advocacy and the development of action plans. HI provided micro-grants to enable the DPOs to implement the action plans and work with development organizations to advocate for disability mainstreaming within their localities.

Of the 10 DPOs, four had notable achievements.

1. **WCC** worked with Nyeri District Hospital to sensitize 35 reproductive health service providers on the reproductive needs of women with disabilities as well as training women with disabilities on the services available in the health facility. Six service providers were also trained in basic sign language, so that they are now able to communicate with persons with hearing disabilities.

2. **Deaf Empowerment Kenya** worked with 15 CBOs, local authorities and committees in the Embakasi and Njiru districts to sensitize them on disability inclusion.

3. **Action Network for the Disabled** worked closely with five organizations conducting physical accessibility audits.

4. **The Blind and Low Vision Network (BLINK)** worked with development organizations in Machakos to sensitize them on disability inclusion and mainstreaming. They also built the capacity of 10 BLINK staff and field mobilizers on disability inclusion and mainstreaming.

**Objective 3: Document and disseminate lessons learned on effective mainstreaming of disability in development programs**

Through partner forums and the development of a blog, the project brought together both non-DPOs and DPOs to share knowledge and learning as well as to form linkages. During the project period, a partners’ forum brought together DPOs and non-DPOs to discuss their experiences on disability inclusion and mainstreaming. In addition, the participating organizations strategized on ways to work together beyond the project period. FHOK connected with KUB to figure out how to increase access to the latter’s resource center containing materials for PWD. To improve utilization of the Internet blog developed by the project, HI linked it to Facebook and Twitter, social networking sites that partners are more familiar with and use frequently.

Two key documents developed under this objective were 1) the “Inclusion Newsletter” highlighting what the activities implemented by partners and 2) the “Inclusion Guidelines” providing practical ways to mainstream disability in development programs in Kenya.
Table 8 highlights project results based on the three indicators of the project: number of people served, number of people training (disaggregated by gender) and number of organizations strengthened.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people served</td>
<td>718</td>
<td>701</td>
<td>1419</td>
</tr>
<tr>
<td>Number of people trained</td>
<td>305</td>
<td>386</td>
<td>691</td>
</tr>
<tr>
<td>Number of organizations strengthened</td>
<td>113</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.4.2—CHALLENGES AND REMEDIAL RESPONSES

The success of the project was entirely dependent on the commitment and goodwill of the agencies involved and was, therefore, a collaborative effort. Through the implementation of activities, the project team found that a shift in approach was required. Disability inclusion is not a concept that many people understood well and, therefore, aspects of implementation were slowed as organizations grasped, internalized and adopted key concepts. With non-DPOs in particular, HI had to provide one-on-one tailored technical support during the life of the project rather than the planned group trainings.

Specific challenges encountered and addressed include the following:

**Challenge:** Introducing disability to non-DPOs, which already had planned activities and budgets, posed a challenge, as budgets did not include this extra element. Non-DPOs had their own scheduled activities with deadlines prior to joining the project and introducing and incorporating disability mainstreaming as a new concept took longer than anticipated.

**Solution:** HI had to work with non-DPOs’ schedules. Action plans were also developed with each organization to continue the integration of disability concepts beyond the project period.

**Challenge:** There were high expectations from the non-DPOs in terms of financial support to incorporate disability mainstreaming/inclusion.

**Solution:** HI was very clear in its communication to non-DPOs that disability is not a separate project but an added value to their existing activities and provision of services. HI also alerted non-DPOs to requests for proposals by the National Council for PWD for financial support.

5.4.3—LESSONS LEARNED

Key lessons learned include:

- For continuity of disability inclusion and mainstreaming in non-DPOs, the organization—not individuals—must engage in the various processes needed to own and institutionalize these concepts.
- To effectively address disability inclusion and mainstreaming issues, disability and the
various stereotypes around it need to be demystified in order to enhance understanding and adoption among non-DPOs.

• DPOs are currently doing work involving inclusion and mainstreaming without an in-depth understanding of these concepts. Capacity building is required for them to enhance understanding and adoption of a structured approach to achieve this.

• A multi-faceted approach to inclusion is critical for it to succeed; the principle “leave no gap” in terms of stakeholder involvement is paramount.

• In providing technical support to non-DPOs working in different spectrums of development and different levels of understanding on disability, the varied areas and capacities of their staff need to be considered and addressed.

• Disability mainstreaming is not an expensive undertaking if it is considered at the design and development phases of projects, services and products.

5.4.4—KEY RECOMMENDATIONS FOR FURTHER DISABILITY MAINSTREAMING

The engagement of non-DPOs and DPOs in this project was the beginning of a process of disability inclusion and mainstreaming that require more support to make a longer-lasting impact. Some of the organizations viewed the development of action plans as short-term, preferring to incorporate interventions into their long-term strategies of up to five years. The project created awareness and tools that organizations can continue to use for monitoring and technical support beyond the project period.

One of the key aspects that this project did not focus on was how to develop a single, national approach to ensure active participation by PWD. Raising the voice and participation of Kenyans with disabilities in development and reform processes can fill the gaps in the inclusion of PWD in national processes.

The final report submitted by Handicap International for this project is attached as Annex 8.

6. CHANGES IN GRANTEES’ INSTITUTIONAL CAPACITY

Between October 2009 and January 2010, an assessment of the CAP Kenya program was conducted by independent consultants of Iceberg Africa Consultants and had two overarching objectives: to evaluate what has been achieved and synthesize what lessons have been learned since CAP Kenya began and to provide guidance for the future direction of the program. The assessment included visits to and interviews with staff members from 11 of the 48 CAP Kenya-funded grantees.

A major focus of the review was the change in grantees’ institutional capacity. The assessment found that as a result of the institutional strengthening activities described, grantees providing HIV and AIDS services made substantial progress toward improving their technical and institutional capacity. This section describes this progress at two levels: overall changes in grantee organizations and changes in specific institutional elements.
6.1—OVERALL CHANGES IN GRANTEE ORGANIZATIONS

When CAP Kenya started working with the grantees, their capacity to deliver high-quality and sustainable HIV and AIDS services was limited. Some grantees were unstructured, inexperienced and lacked capacities in financial and HR management as well as administrative and program systems and policies. Key decisions were largely made by the founders and two or three Board members, and staff roles and responsibilities were unclear. Although some grantees had multiple donors, 70% or more relied on a single donor. Local resource mobilization was ad hoc, and service delivery was supply-driven, often responding to donor specifications. For the most part, communities were treated as passive recipients of interventions with little or no purposeful involvement. Collaboration with the government was not systematic, occurring only for specific tasks and projects. Examples of organizations that displayed some of these characteristics include Neighbors in Action (NIA), YARD, Beacon of Hope (BOH), Community Asset Building and Development Action (CABDA), RWM, Reachout, Kenya Network and Women with AIDS (KENWA), Women and Youth Against AIDS and Poverty (WAYAAP), CREADIS and Twana Twitu.

By the end of the program, the capacity of grantees had changed considerably. Organizations had grown in terms of program scope, budget size and staff numbers. As described in section 5.1, most had management structures and systems in place, and oversight roles have shifted from a few to include entire Boards, which have been, in many instances, reconstituted. Programs were increasingly based on long-term strategies. Some diversified donor funding; others introduced cost-recovery mechanisms for the services provided.

CAP Kenya measured these changes using the IDF tool. From January 2006 to June 2009, 22 grantees underwent IDF reassessments. The reassessment scores reflected grantees’ perceived growth in institutional capacity over time, and the results indicate that 68% of the organizations had improved their institutional capacities. For details, see Annex 9.

There were several factors that contributed to the perceived changes in institutional capacity and positive changes in overall IDF scores. These include:

1) prioritization of staff development in the improvement plans and subsequent training;
2) support and participation of the Board, senior management and staff in the IS process, which created a sense of ownership and commitment to improvement efforts; and
3) increased understanding of how the organization operates as a result of participation in the assessment and the regular coaching and mentoring support from the CAP Kenya team.

Although generally the IDF scores increased significantly, there were cases were the scores decreased. CAP explored the factors that contributed to decreased scores. Some grantees said they feared a low score would result in the loss of the grant during the initial assessment, and this induced them to report unrealistically high scores at the time. During the reassessments, and once they had a better understanding of the purpose of the assessment, grantees reported more realistic scores. Furthermore, the CAP Kenya staff had established a level of trust with the grantees by then, which enabled grantees to be more truthful. Other reasons cited include lack of consistency in the assessment participants due to staff turnover and lack of support and commitment by management to implement the improvement plans.
6.2—Changes in Specific Institutional Strengthening Elements

Grantee capacities in specific institutional elements significantly improved over the course of CAP Kenya’s period of performance. By the end of the program, grantees demonstrated:

- improved oversight and clarity of vision;
- increased capacity and professionalism in human resources;
- increased breadth and depth of technical resources;
- increased management resources;
- enhanced recognition and collaboration with external stakeholders; and
- strengthened financial management, accountability and resource mobilization capabilities.

6.2.1—Improved Oversight and Clarity of Vision

The initial institutional assessments by CAP Kenya indicated that for many grantees, accountability in the form of Board oversight was limited and in some cases totally absent. This was evident in the inactive Boards that held very few meetings and Board minutes that had little evidence of oversight decisions and strategic direction. Clarity on the roles of the Board versus management of the day-to-day operations was also lacking. Over the life of their grants, organizations’ Board oversight changed as a result of institutional strengthening interventions by CAP Kenya.

By the end of the project, most grantees had more active and effective Boards; members of the Board had a better understanding of their roles and responsibilities and functioning committees were established. This resulted in reduced conflicts between the Board and the organization’s management. For example, CREADIS established human resource and technical Board subcommittees to deal with specific areas of work, which resulted in faster decisionmaking.

Several of the grantees (for example, RWM, KENWA and SAPTA) reconstituted their Boards to enhance the competencies and balance of skills with their Boards, including financial management, legal, human resources, resource mobilization and community representation. SAPTA recruited Board members through an open advertisement. This attracted members with diverse competencies and high community standing. YARD recruited credible Board members and obtained NGO registration (it was previously registered as a CBO). These changes resulted in increased accountability and credibility and contributed to increased funding partnerships.

The Boards were also more active in providing strategic direction, formulating policies and supervising management. Some of the organizations reported that their Boards were asking more questions and challenging the management to be more professional. For example, the CABDA Board of Directors rejected an audit report due to poor quality and appraised the executive director for the first time.

By September 2010, 65% of the grantees had strategic plans in place which defined their vision and long-term goals. The strategic plans helped grantees clarify, give direction and guide operations in grantee organizations. For example, as a result of formulating its strategic plan, BOH changed its program strategy to introduce cost recovery through a 30:70 rule that requires clients to pay 30% for services. This has been applied in the entire organization and has led to improved financial sustainability as well as increased parent involvement in school activities.
Another example is CREADIS, which revised its mission to be consistent with the activities of the organization. At St. Camillus, staff and community developed a clearer understanding of the mission, vision and objectives after organizing a forum to disseminate the strategic plan. Previously, these were only understood by senior management. This resulted in improved service delivery since the staff can link their everyday activities to the overall mission of the organization.

6.2.2—**INCREASED PROFESSIONALISM AND CAPACITY IN HUMAN RESOURCES**

At the beginning of the IS process with the grantees, the HR capacity and management was characterized by lack of personnel policies, employment contracts, job descriptions, staff appraisals, workplans and, in some cases, teamwork as well as unremitted statutory deductions.

The IS interventions led to improvements in how human resources are managed. By the end of the project, 89% of grantees had established HR policies and systems. This contributed to better HR management practices, such as recruitment of the right staff for the job, formalization of statutory deductions and remittances, salary payments through the bank and formalization of employment contracts. In addition, staff appraisals became common practice in several organizations. St. Camillus, for example, established a staff appraisal system and reported increased staff motivation. Similarly, Ripples International instituted a human resources department program and saw improved staff motivation.

Staff capacity increased in most grantee organizations both in terms of numbers and skills. In most organizations, the number of staff has significantly grown in response to increased and scaled-up services. At WEMA, the number of staff more than tripled from 10 to 35, while at Ripples International the number grew from 21 to 53 in two years. Beyond increases in number, grantee staff now demonstrate enhanced skills and knowledge in areas such as fundraising, leadership, management, project planning and management, M&E, report writing, and technical HIV/AIDS.

Many grantees reported improved teamwork, more interdepartmental collaboration and improved work coordination. They developed job descriptions and outlined clear roles and responsibilities, resulting in less role overlap and conflict. Staff members also learned how to delegate more and have become increasingly involved in decisionmaking as management has become more participatory, resulting in improved efficiency in operations. Multiple organizations, such as Ripples and CREADIS, BOH, KENWA, RWM and CABDA, have instituted these types of changes.

6.2.3—**INCREASED BREADTH AND DEPTH OF TECHNICAL RESOURCES**

The CAP Kenya IDF and HIV and AIDS Technical Assessment identified various weaknesses in grantees’ technical capacity to deliver quality HIV and AIDS services. Weaknesses included the inability to integrate ongoing and age-appropriate HIV prevention into programs and significant gaps in staff technical skills, contributing to weak design and implementation of programs. Some grantees lacked clear tools and structures to collect, aggregate, report and apply information to programs. Most of the information they did collect was not properly filed and readily available.
Overall, CAP Kenya helped grantees shift their thinking about service delivery. At the beginning of the project, the grantees’ programs mainly focused on direct service delivery to beneficiaries as an end result, as opposed to using it as a short-term approach to build toward long-term interventions. CAP Kenya emphasized that service delivery should aim to build individual, family and community capacity to adopt sustainable measures in addressing the HIV and AIDS pandemic. By realigning their approaches toward leveraging available resources and building community capacity for a rights-based approach, grantees have been able to carry out more sustainable interventions for their beneficiaries.

CAP Kenya’s monitoring visits, MSC reports and interviews with 11 grantees during an internal review strongly indicate that marked changes were realized in grantees’ technical capacity to deliver HIV and AIDS services. The grantees are now better able to identify the complex needs of children in a more systematic and comprehensive way, or have a sharpened focus on identifying and addressing specific issues that relate to substance use/abuse, HIV and AIDS and behaviour change. Some grantees, such as the WEMA Centre and Makindu Children’s Centre (MCC), have integrated HIV prevention in OVC programs, whereas this was not the case before.

Most grantees developed significant programming and technical capacities to run expanded programs with greater geographical coverage, breadth and depth. They made significant progress toward meeting the PEPFAR-recommended provision of the 6+1 service package in OVC programs, which includes nutritional support, education, psychosocial support, health care, child protection, shelter and economic empowerment. The majority of grantees are now offering a minimum of three services to OVC, which is the recommended minimum standard requirement in the PEPFAR guidelines.

Additionally, some grantees expanded outreach services to communities as a result of increased technical capacity. Examples include the Raphaelites, whose drop-in center offers risk reduction outreach services to substance abuse clients; Reachout, which established an additional drop-in center as well as an addiction recovery/rehabilitation halfway house in Mombasa; and WEMA, which now has a department of HIV and AIDS established to spearhead prevention activities for the children in the Centre but also for the community.

The grantees reported greater capacity to manage program data, including improved collection, storage, analysis and reporting systems. With computerized databases fed by tested data-gathering and collation tools, grantees’ staff have up-to-date information on HIV and AIDS issues and are able to make more informed decisions for continuous program improvement. Overall, this improved knowledge, access to information and availability of data have enabled grantees to design and deliver more appropriate programs and services. These capacities have translated into improved delivery of HIV and AIDS quality services to beneficiaries.

6.2.4—IMPROVED MANAGEMENT RESOURCES

All grantees improved their M&E systems, as evidenced by the use of M&E tools, such as activity implementation plans, children databases and household assessments. Some organizations, such as BOH, WEMA, RWM, Nazareth Hospital and CREADIS among others,

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2 Those that expanded geographically include Ripples, WEMA, BOH and Nazareth Hospital.
Additionally, many organizations clarified their organizational structures. This has led to clear reporting relationships and defined roles and responsibilities of management and staff. For example, at BOH, KENWA and RWM, restructuring led to the creation of heads of department positions, which have been given mandates and space to make decisions.

Further changes among all grantees include: improved planning practices as evidenced by the widespread use of workplans, regular planning and review meetings and reporting against plans; enhanced administrative capacity due to new furniture and office equipment from CAP Kenya; and enhanced communication through the installation of Internet facilities. At CREADIS, for example, the installation of the Internet and an intercom has led to improved communication; and at Reachout, staff are able to share information more efficiently due to the computer network that was installed with CAP Kenya support.

6.2.5—ENHANCED RECOGNITION AND COLLABORATION WITH EXTERNAL STAKEHOLDERS

Grantees have increased formal and informal networking and collaboration with both external stakeholders and among themselves. Through CAP Kenya’s period of performance, organizations like CABDA, RWM, BOH and HI subgrantees established linkages with grassroots HIV and AIDS NGOs, FBOs and CBOs. The grantees were also involved in constituency and district-level HIV- and AIDS-related forums and continue to work closely with the National AIDS STI Control Program (NASCOP). Other organizations, such as Nazareth Hospital, now have formalized partnership with fellow grantees, creating referral systems for HIV-positive substance using/abusing clients with the Raphaelites and others. Furthermore, grantees gained new knowledge and information to improve the quality of programs through exchange visits among grantee staff and beneficiaries.

CAP Kenya grantees have established and maintained linkages with relevant government structures within their localities. Some notable areas of collaboration are referrals in the areas of provision of antiretrovirals (ARVs), HIV and AIDS counseling and testing, and the treatment of substance abuse medical cases and opportunistic infections in government health facilities. Most organizations worked with the Ministry of Medical Services—Health Service Delivery Points (dispensaries, health centers and district hospitals) to provide medical care for their beneficiaries. Several grantees—CREADIS, RWM, BOH and YARD—participated in district-level initiatives and forums organized by the Ministry, including the Kick Polio Out of Kenya Campaign and World AIDS Day.

Some grantees were also involved with advocacy and the mainstreaming of specific HIV and AIDS issues into national policy. An example is Handicap International and its subgrantees, which influenced inclusion of the unique needs of the disabled in Kenya’s HIV and AIDS
national policy through NASCOP and advocated for access to HIV and AIDS services for persons with disabilities.

Other grantees worked with the Department of Children Services under the Ministry of Gender and Children Affairs in the commemoration of international children days, such as World Orphans Day and the Day of the African Child. Organizations also participated in other decentralized structures, such as the Area Advisory Councils to lobby and advocate for increased allocation of resources from the Ministry of Education’s bursary funds and the Constituency Development Funds (CDF) among others to benefit children.

Many grantees (for example, WEMA Centre, RWM, BOH, CABDA, and KENWA) established linkages with the local administration, notably the chiefs and subchiefs, in the implementation of their programs activities. These structures form key entry points for all programs at the community level and are supportive in almost all areas, including the provision of birth or death certificates for the identification, selection and verification of program beneficiaries at the community level.

As many grantees strengthened their ties and collaboration with government agencies and local stakeholders and worked on the national level, they experienced increased recognition for the quality of their services, their role in fighting HIV and AIDS and their work addressing substance abuse. Significant examples are BOH, which is now recognized as the only provider of comprehensive laboratory services for HIV in the Kajiado district, and SAPTA, which stated, “We are recognised as one of the leading addiction training institutions in Africa offering diploma in addiction counselling.” Public awareness of CREADIS also improved through use of their website, brochures, newsletter and radio programs.

A major benefit of this enhanced collaboration and resulting recognition is the grantees’ increased ability to attract resources from donors and institutions. Most grantees were successful in getting food and nutrition support either through government ministries and initiatives at the district level or by mobilizing resources from the private sector. Organizations such as HEART, WEMA, Hope Worldwide and BOH successfully solicited food packages and donations from the private sector. HEART alone mobilized more than KSh. 3 million (approximately $35,000) worth of food, which it distributed among seven locations in its area of operation. NIA, RAPADO, ACE Africa, BOH, Ripples International and RWM used their strengthened relations with the Ministries of Agriculture, Livestock Development and Fisheries to secure resources for food baskets for beneficiaries. Other organizations that have contributed to grantees’ efforts include the UN’s Food and Agriculture Organization, World Food Program and Stephen Lewis Foundation.

In addition to receiving funding and donations from the Kenyan government, international agencies, and private sector, several CAP Kenya grantees are also recipients of U.S. Government funds through the AIDS, Population and Health Integrated Assistance (APHIA II) program. Ripples international, WAYAAP, and Hope Worldwide have already secured funds from APHIA II.
6.2.6—Strengthened Financial Management, Accountability and Resource Mobilization Capabilities

The IS assessments and pre-award surveys conducted at the beginning of the grantees’ partnership with CAP Kenya revealed that most organizations had weak financial systems and controls. Common financial management practices in many organizations included:

- single sourcing in procurement;
- inadequate separation of duties for the functions of ordering, receiving and authorizing purchases;
- petty cash vouchers prepared and approved by the same person;
- no documented authority for bank signatories;
- lack of prepared bank reconciliation statements;
- inadequate supporting documentation for some transactions;
- lack of annual external audits at some organizations (and, in cases where an audit was conducted, the quality was poor and audit reports did not include management letters as part of the audit process); and
- inadequate written procedures on procurement, petty cash and asset management in existing financial manuals and lack of Board approval of draft manuals.

The Iceberg assessment found that this scenario changed significantly. Grantees now have financial policy and system manuals in place that guide decisionmaking. Grantees changed from manual to computerized financial systems with well-trained staff. Procurement practices also improved, and all organizations now undertake competitive bidding before awarding any significant contract. The quality of financial reporting greatly improved as well. CAP Kenya staff confirmed a big difference in reporting standards over time as evidenced by a decrease in number of queries by CAP Kenya grants accountants on grantee financial reports. Audit practices have become common practice in grantee organizations, leading to improved accountability and transparency.

Grantees themselves reported improved ability to plan and manage budgets in line with organizational needs. They are now able to manage bigger budgets; some reporting the capacity to manage an increase of two to four times the budget in four years (for example, WEMA, BOH, KENWA, RAFIKI, MCC and Ripples).

Many grantees further reported that their funding increased as a result of improved institutional capacity. They attributed this increase to resource mobilization skills, active fundraising committees and better systems of accounting and reporting. Grantees such as BOH, CABDA, Reachout and Ripples attracted new donors, while WEMA, Raphaelites and BOH undertook successful local fundraising initiatives. Annex 10 shows the increased total grantee budgets and numbers of donors over time.

“...In our organization, project staff are now more involved in planning and budgeting; we have developed a financial manual; a tender committee is in place to vet procurement; and proper authorization is required for every payment. Furthermore, there is separation of accounts for different projects and annual financial audits are done and queries addressed. All was as a result of support from AED CAP Kenya.”

– CREADIS Staff Member
7. CHANGES IN DELIVERY OF QUALITY OF SERVICES

7.1—QUALITY STANDARDS

The key performance indicator for improved quality of service in the CAP Kenya program is **enhanced quality of HIV/AIDS and STI services provided to communities.** In addition, CAP Kenya used several other measurements to evaluate grantees performance: the HIV and AIDS Technical Assessment and PEPFAR Guidance.

The quality standards delineated in the CAP Kenya HIV and AIDS Technical Assessment parameters for OVC programs include:

- delivery of services based on child-specific needs;
- provision of three or more core services;
- program support to community participation to build long-term, sustainable HIV and AIDS response efforts;
- facilitation of HIV and related service referrals and linkages; and
- information collection and utilization.

The PEPFAR guidance on the required services of a comprehensive program to reduce the risk of HIV transmission among drug users includes:

- information and education;
- community outreach; and
- risk reduction counseling with links to appropriate care and treatment services.\(^3\)

Under these standards of performance, CAP Kenya’s assistance in strengthening the technical and institutional capacity enabled grantees to deliver better quality HIV and AIDS services to beneficiaries. Grantees now offer services based on child-specific needs, provide the minimum core services to OVC, offer comprehensive services to substance users and deliver these services in a systematic way with increased community involvement.

7.1.1—GRANTEES PROVIDE SERVICES BASED ON CHILD-SPECIFIC NEEDS

Grantees are delivering services based on the assessment of individual child needs. The assessment is guided by the child status index (CSI), which provides comprehensive data on the status and needs of a child. The services are age-specific and reflect children’s developmental stages (infancy, early childhood, middle childhood and adolescence). The services are also gender-specific and address varying needs between males and females and include ongoing age-specific HIV and AIDS prevention activities. Organizations providing child-specific services include WEMA, YARD, KENWA and BOH.

7.1.2—GRANTEES PROVIDE MINIMUM CORE SERVICES TO OVC

Prior to the provision of institutional strengthening support from CAP Kenya, grantees only offered some of the minimum core OVC services and provided them in an unsystematic way. As of September 2008, 74% of the 26 grantees providing OVC services met or exceeded the minimum quality standards of providing three OVC core services. Thirteen percent reached the full range of HIV-prevention activities by direct service provision or appropriate linkages.

“We were shallow on HIV and AIDS. AED has helped us to package services to OVC and to be more specific, because some children need one service others two or three and some need six. We now also monitor the progress on these services. Overall, we are more systematic, professional and effective. We are able to help children to move on with life, without necessarily coming to WEMA residential facilities.”

– WEMA Staff Member

7.1.3—SAP GRANTEES PROVIDE COMPREHENSIVE SERVICES

The grantees implementing SAPs are now offering comprehensive services to clients, including outreach, community education, HIV reduction among current users, voluntary counseling and testing, HIV case management, addiction recovery and commercial sex workers- and alcohol-specialized services. Since working with CAP Kenya, the Raphaelites, which primarily offered addiction recovery treatment services in the past, is now offering HIV and AIDS risk-reduction and outreach services. Reachout scaled up its outreach, established a halfway house and integrated HIV and AIDS prevention into the treatment of substance abuse. See Annex 11 for a description of improved quality of prevention activities with substance abusing populations as a result of CAP Kenya technical assistance.

7.1.4—GRANTEES INCREASE COMMUNITY INVOLVEMENT IN SERVICE DELIVERY

Most grantees reported increased community involvement in their programs. Examples include:

• WEMA, where the community is involved in identifying OVC, tracking the program, supporting family re-unification and securing identification cards and birth certificates;
• RWM, where feedback from the community is incorporated into program activities, such as facilitating OVC playgroups;
• Raphaelites, where recovered substance abusers work as outreach volunteers in the community and the organization has a newfound rapport and relationship with the local community as a result of engagement efforts propelled by their work with CAP Kenya;
• Nazareth Hospital, where caregivers and community health outreach volunteers are now people affected or infected with HIV and AIDS rather than hospital staff;
• St. Camillus where community participation has improved through increased involvement of community health worker, teachers, peer educators and caregivers in the program;
• YARD, where the community has donated land to the organization to set up a vocational centre; and
• BOH, where community members have started using the CSI forms to assess and refer OVC.

7.1.5—GRANTEES USE SYSTEMATIC AND CASE-SPECIFIC METHODS IN SERVICE DELIVERY

Grantees currently use more systematic approaches to providing substance-abuse risk-reduction and OVC services. Those implementing SAPs follow a clearly defined process of handling clients, which involves making contact, pre-assessment, assessment, clinical assessment,
treatment and referral for other services. This process is supported by use of tools that help to
document the client’s information and services provided. In the OVC programs, tools like the
CSI, which comprehensively records the individual needs of children and employs other
monitoring tools to track and document client information and services provided, are used.

Case management is now common practice in all the grantee organizations visited during the
Iceberg assessment, and grantee staff members consistently follow up on each client to ensure
continuity and effectiveness of services.

Some organizations, such as Raphaelites, Reachout and BOH, have introduced clinical
supervision and continuing education for their staff as a way to ensure quality service. The
Raphaelites staff that provide counseling services were accredited by the Kenya Association of
Professional Counselors, which has improved the quality of counseling services.

BOH and WEMA reported that the quality of teaching has improved in their early childhood
development centers. The teachers prepare functional timetables and schemes of work, practices
attributed to the training of teachers through CAP Kenya support.

The quality of service has further improved in most grantee organizations as a result of recruiting
skilled staff and ongoing technical training. For example, a staff of Reachout said, “We used to
refer clients to the rehabilitation center after counseling. We now reach them where they are,
because we have trained addiction counselors.”

8. OPERATIONAL CHALLENGES

The success of the CAP Kenya IS program was not without challenges. During the Iceberg
assessment, grantees and CAP staff had a chance to express their concerns with how the program
was operated to an outside evaluator. Some of the key operational challenges experienced by the
grantees and CAP staff are discussed below.

8.1—EXCESSIVE PAPERWORK

AND WORKLOAD

The grantees raised concerns about the workload involved in fulfilling reporting requirements
and excessive paperwork, which was too costly for some of the organizations. Grantees stated that
the CAP Kenya grants management tools, such as the financial templates and quarterly reporting
formats, changed frequently, and it was challenging to adhere to the new requirements.

8.2—EXCESSIVE EMPHASIS ON NUMBERS AND OUTPUTS

According to grantees interviewed, CAP Kenya placed too much emphasis on numbers and
targets (outputs). Grantees felt that this compromised their focus on impact as their efforts were
geared toward attaining numbers. Achieving the numbers was especially challenging for those implementing prevention programs with substance abusing populations, as changing addictive behaviour is a slow, complex process in which addicts tend to relapse, making it unrealistic to achieve large numbers for reporting. As one grantee said, “AED looks for big numbers. In SAPs, change of addiction requires long-term process and support.”

8.3—Short-Term Funding Cycle and Delayed Disbursement

The one-year funding cycle made it challenging for grantees to plan beyond that year, since they were unsure of funding. All the grantees interviewed for the 2009 Iceberg review reported a delay, sometime as long as five months, in approving modifications and the disbursement of funds. This affected implementation and their ability to meet program targets. The process of renewing contracts and getting feedback on financial reports was long and contributed to the delays.

8.4—High Staff Turnover in Grantee Organizations

High turnover of staff in grantee organizations diminished the gains made in institutional strengthening. Many staff that were trained under CAP Kenya ended up leaving their organizations with the skills and knowledge acquired. At one organization, 8 out of 11 staff left within 3 years. Although this is a common challenge in capacity-strengthening programs and the NGO sector in general, the magnitude of the challenge was large enough to warrant attention and propel CAP Kenya to find solutions for minimizing this loss. One successful approach CAP Kenya found to address this issue was to focus the institutional strengthening efforts on the whole organization and less on individual staff, so that some of the capacity remains when staff leave. Another possible solution was to help the grantees to identify and deal with the root causes of staff turnover.

8.5—Exit Strategy and Sustainability

In line with its exit strategy, CAP Kenya worked with grantees to tap into other funding sources and plan for sustainability. In addition to helping grantees to become more credible and marketable through improved institutional capacities, CAP Kenya trained grantee staff in proposal writing and resource mobilization, and it also connected some grantees to potential donors.

Despite these efforts and clear communication about the program’s exit strategy inherent in CAP Kenya’s IS approach, grantees expressed uncertainty about continuity of support as well as a sense of unpreparedness to graduate from the relationship.

On the one hand, the grantees have the responsibility to take initiative and apply the acquired capacity. As one grantee said, “AED will help open the doors, but it is up to us to walk through the doors.” Some grantees have used their new capabilities to diversify funding sources from other donors, communities and companies.

On the other hand, the sense of unpreparedness that grantees felt when approaching the end of the program raised the question, “Has CAP Kenya built enough capability for the sustainability of grantees?” The continuity of services beyond CAP Kenya support was not well planned for by
the grantees. For example, financial sustainability was a major question for the Raphaelites’ drop-in center and Reachout’s halfway house. An MCC staff member commented, “We already have OVC who we support in schools with help from AED. What happens to these children next year without the funding from AED?” To assist grantees in becoming truly sustainable organization, most grantees felt they needed more support from CAP Kenya to strengthen their ability to mobilize resources and attract future funding.

8.6—WIDE GEOGRAPHICAL DISTRIBUTION OF GRANTEES

CAP Kenya grantees were spread across the eight geographical regions of Kenya. The distances between them were extensive, and this affected staff time and travel costs. It was challenging for CAP Kenya to provide all the grantees with adequate tailored TA given the level of staffing.

9. LESSONS LEARNED

This section discusses the key lessons learned from the implementation of the CAP Kenya program. The lessons were drawn from the experiences of the grantees and CAP Kenya staff.

9.1—HOLISTIC AND INTEGRATED APPROACH LEADS TO SUCCESS

The CAP Kenya integrated IS approach was consistent with a systems perspective that views organizations as whole systems of interrelated components rather than of isolated parts. Changes in any one part of the organization have an impact on the whole organization. All the components have to be brought together in one change strategy to improve the effectiveness of the organization.

At the CAP Kenya team level, the integrated approach gave staff a common understanding of the stages of development and the dynamics of a given organization. With this knowledge, staff were been able to prescribe appropriate, time-bound, specific remedial actions to grantees and link these actions to strengthen all aspects of the organization.

Moreover, this approach made the CAP Kenya risk-management process more effective, as symptoms displayed by a grantee were analyzed holistically. Rather than addressing grantee challenges in a conventional, piecemeal way and applying short-term IS interventions, CAP Kenya addressed the root causes of organizational weaknesses and initiated sustainable change.

9.2—MENTORING AND COACHING APPROACH BUILDS TRUST AND COMMITMENT

One of the strongest aspects of the program for many of the grantees was the one-on-one coaching and mentoring they received throughout the entire IS process. This regular interaction allowed CAP Kenya staff and grantee staff to get to know one another and build mutual trust. With this relationship in place, CAP Kenya was able to foster commitment from grantees and navigate them through the difficult changes that needed to occur at the individual and organizational levels for real institutional and programmatic success.
9.3—Institutional Strengthening is Critical for Program Impact

Over the course of the program, CAP Kenya worked to improve grantee capacity in specific institutional elements. As a result, many grantees now have improved oversight and clarity of vision, enhanced HR systems and a greater range and depth of technical resources. In addition, grantees have strengthened capabilities in financial management, accountability and resource mobilization, and they have more dynamic and enhanced collaboration with external stakeholders. With these strengthened institutional capacities, grantees were able to focus on improving their technical work, design more effective programs, better serve beneficiaries and have a greater overall impact on the communities in which they work.

9.4—Participatory Methodology Fosters Ownership of the IS Process

CAP Kenya’s participatory methodology was integral to fostering a sense of ownership of the change process among the grantees and gave them space to drive their own agenda with the support of CAP Kenya staff. This was particularly notable in the participatory assessments, and subsequent development and implementation of IS improvement plans. The strengths of the IDF participatory assessment tool are its:

- participatory nature, which facilitated involvement of grantee staff, Board and beneficiaries and helped them to reflect and better understand their organization;
- wide scope, covering all the major organizational elements that enable an organization to have a holistic review of itself;
- quantitative nature, which enables comparison of changes in institutional capacity over time; and
- capacity to be administered by an organization on its own without outside help.

9.5—Peer Learning is a Powerful Capacity-Building Methodology

Most CAP Kenya grantees greatly valued coming together with other organizations to share ideas and experiences. Through partners’ forums, founders’ forums and exchange visits, grantees were able to effectively transform behavior, foster good practice and promote accountability. Many grantees reported implementing something new in their programs after learning about it from another grantee during one of the opportunities for peer learning. Peer forums and exchange visits allowed grantees to explore practical applications of management systems and program interventions and gave them models for introducing such systems into their own organizations or programs. Moreover, seeing and hearing what others are doing promoted a healthy sense of competition between the grantees and encouraged them to excel.

9.6—Reflection and Learning Play a Critical Role in the Effectiveness of IS

Consistent with the notion that institutional strengthening and capacity building are process oriented is the premise that reflecting on experiences enables continuous improvement of the program. All grantees are unique, and CAP Kenya’s methodology reflected the fact that what worked for one grantee did not necessarily work for another. While it maintained a consistent IS methodology for purposes of efficiency, CAP Kenya also took into account the different starting points and inherent strengths and weaknesses of each grantee. It further engendered a culture of reflection and learning within its own team through regular program and de-briefing meetings and encouraged individual grantees to do the same.
9.7—Integrating the Concept of Sustainability is Key

In implementing an institutional strengthening program, the concept of sustainability must be purposefully addressed with grantees from the inception of the program. This should be done by having a clear timeframe for the duration of each grant and working with grantees to design programs that are sustainable in terms of service provision for beneficiaries and grantee institutional development. Grantees must be encouraged to think about how services will be maintained after the end of the grant either by being integrated into government programs or building up community structures and household capacities to meet the beneficiaries needs.

In building up institutional capacities, the CAP Kenya team found a definite tension between imbuing a culture of sustainability within the grantees and meeting the overall PEPFAR programmatic targets. To meet the set targets, grantees sometimes scaled up services to levels that were not sustainable. Notwithstanding this tension, CAP Kenya was careful to ensure that grantees put in place management and programmatic structures and systems that will be sustainable in the long term.
Grants by Cycle

**Cycle I**
- Beacon of Hope (BOH)
- Handicap International
- Makindu Children's Centre (MCC)
- Mothers’ Rural Care for AIDS Orphans (MORCAO)
- Nazareth Hospital
- Neighbours in Action (NIA)
- Ripples International
- St. Camillus Dala Kiye Welfare Center
- Tropical Institute for Community Health (TICH)

**Cycle II**
- Ace Communications
- Africa Focus NGO
- Child Welfare Society of Kenya
- Church World Services
- Community Research in Environment and Development Initiatives (CREADIS)
- Franciscan Sisters of the Immaculate Conception of the Holy Mother of God (SFIC)
- Kenya Network of Women with AIDS (KENWA)
- Kolanya Girls Boarding Primary School
- Rural AIDS Prevention and Development Organisation (RAPADO)
- Twana Twitu
- Wema Centre Trust

**Cycle III**
- Support for Addictions Prevention and Treatment in Africa (SAPTA)
- The Raphaelites – RedHill Place

**Cycle IV**
- Action in the Community Environment (ACE) Africa
- Catholic Diocese of Homa Bay - ASUMBI
- Community Asset Building and Development Action (CABDA)
- Community Livelihood Development Forum (COLIDEF)
- Family Health Options Kenya (FHOK)
- Health Education Africa Resource Team (HEART)
- HelpAge International
- Homeless Children International
- Hope Valley Family Institute (HVFI)
- HOPE Worldwide Kenya (HWWK)
- Kenya Basic Support Foundation
- Kisumu Urban Apostolate Programmes (KUAP) – Pandipieri
- Migori Community-Based Orphans HIV/AIDS Centre (MICOBA)
- Rafiki wa Maendeleo
- Reachout Centre Trust
- St. Mary's Medical Centre, Kapsoya
- Tesia Isanga Organisation
- The Omari Project
- Tuungane (Impact Research and Development Organization)
- Wajir South Development Association (WASDA)
- WEM Integrated Health Services (WEMIHS)
- Women and Youth Against AIDS and Poverty (WAYAAP)
- Youth Action for Rural Development (YARD)

**Cycle V**
- Student Campaign Against Drugs (SCAD)
- Kenya HIV Business Council (KHBC)
- Health NGOs Network (HENNET)
ecycle I

For Cycle I, CAP Kenya did not issue the request for applications (RFA). PEPFAR/ USAID issued an open RFA in November 2004 and passed the names of the short-listed organizations to CAP at the beginning of the program in 2005.

CAP Kenya completed the selection process after reviewing applicant management questionnaires and conducting site visits. Initial grant agreements under this award were executed in April 2006 for the following organizations:

- Beacon of Hope (BOH)
- Handicap International
- Makindu Children's Centre (MCC)
- Mothers’ Rurla Care for AIDS Orphans (MORCAO)
- Nazareth Hospital
- Neighbours in Action (NIA)
- Ripples International
- St. Camillus Dala Kiye Welfare Center
- Tropical Institute for Community Health (TICH)

cycle II

Cycle II grantees included four grantees that had been short-listed from the initial USAID RFA: Ace Communications, Africa Focus NGO, Church World Services and Kolanya Girls Boarding Primary School.

In addition, seven organizations were identified through an RFA issued by CAP Kenya.

1. The RFA aimed to solicit partners working in the OVC PEPFAR program area.
2. The expected obligation was up to US$ 730,000 based on the modified budget in the grant modification.
3. The RFA was a “closed universe” request, meaning that applications were by invitation. CAP Kenya selected invitees that met the following strategic criteria:
   - Organizations that can significantly increase the number of OVCs being reached by this program.
   - Organizations with new projects that fill gaps in OVC intervention types in the existing portfolio of organizations. (While all organizations were encouraged to consider the entire well-being of the child, the aim was to increase the portfolio of organizations working in the OVC intention-to-treat area of protection, including advocacy and legal awareness.)

CAP Kenya invited the following groups of organizations to apply:

- 10 highly ranked (but not shortlisted) organizations from the USAID-initiated call for proposals in 2004;
- Approximately 30 organizations that were in CAP Kenya’s database or had been referred by USAID or other organizations; and
- 15-20 organizations referred by the Department Of Children’s Services in the Office of the President.
Through this process, CAP Kenya identified seven organizations highlighted in yellow in the table below.

<table>
<thead>
<tr>
<th>Ace Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Focus NGO</td>
</tr>
<tr>
<td>Church World Services</td>
</tr>
<tr>
<td>Kolanya Girls Boarding Primary School</td>
</tr>
<tr>
<td>Community Research in Environment and Development Initiatives</td>
</tr>
<tr>
<td>Franciscan Sisters of the Immaculate Conception of the Holy Mother of God</td>
</tr>
<tr>
<td>Kenya Network of Women with AIDS</td>
</tr>
<tr>
<td>Rural AIDS Prevention and Development Organisation</td>
</tr>
<tr>
<td>Child Welfare Society Kenya</td>
</tr>
<tr>
<td>Twana Twitu</td>
</tr>
<tr>
<td>Wema Centre Trust</td>
</tr>
</tbody>
</table>

Since CAP II started in early 2006, CAP Kenya staff were able to execute agreements with these organizations beginning February 2006, and this overlapped with the agreement period for Cycle I organizations under CAP I.

**Cycle III**

Cycle III grantees were organizations selected from a “closed universe” RFA issued by CAP Kenya. Through the RFA process, CAP selected and executed grants with two organizations: Support for Addictions Prevention and Treatment in Africa and The Raphaelites – RedHill Place.

**Cycle IV**

For Cycle IV, CAP Kenya issued two separate but concurrent “closed universe” RFAs directed at two different groups of organizations: 1) those implementing OVC programs; and 2) those implementing programs that target substance using/abusing populations.

Through this process, CAP selected and executed grants with 23 organizations. The list of organizations selected are provided in the table below.

<table>
<thead>
<tr>
<th>OVC</th>
<th>Substance Using/Abusing Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Africa</td>
<td>Catholic Diocese of Homa Bay - Asumbi</td>
</tr>
<tr>
<td>Community Asset Building and Development Action</td>
<td>Family Health Options Kenya</td>
</tr>
<tr>
<td>Community Livelihood Development Forum</td>
<td>Kisumu Urban Apostolate Programmes – Pandipieri</td>
</tr>
<tr>
<td>Health Education Africa Resource Team</td>
<td>The Omari Project</td>
</tr>
<tr>
<td>Helpage International</td>
<td>Reachout Center Trust</td>
</tr>
<tr>
<td>Homeless Children International</td>
<td>Tuungane (Impact Research &amp; Development Organisation)</td>
</tr>
<tr>
<td>Hope Valley Family Institute</td>
<td></td>
</tr>
</tbody>
</table>
Cycle V

CAP Kenya assessed and executed grant agreements with Student Campaign Against Drugs and Kenya HIV Business Council at the request of the client. Under this cycle, CAP Kenya also executed a grant agreement with Health NGOS Network (HENNET).

Close Out

The table below lists all CAP Kenya grantees and their close-out date.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Close-Out Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Communications</td>
<td>2009</td>
</tr>
<tr>
<td>Action in the Community Environment (ACE) Africa</td>
<td>2010</td>
</tr>
<tr>
<td>Africa Focus NGO</td>
<td>2007</td>
</tr>
<tr>
<td>Beacon of Hope (BOH)</td>
<td>2010</td>
</tr>
<tr>
<td>Catholic Diocese of Homa Bay - ASUMBI</td>
<td>2008</td>
</tr>
<tr>
<td>Child Welfare Society of Kenya</td>
<td>2010</td>
</tr>
<tr>
<td>Church World Services</td>
<td>2010</td>
</tr>
<tr>
<td>Community Asset Building and Development Action (CABDA)</td>
<td>2010</td>
</tr>
<tr>
<td>Community Livelihood Development Forum</td>
<td>2009</td>
</tr>
<tr>
<td>Community Research in Environment and Development Initiatives (CREADIS)</td>
<td>2010</td>
</tr>
<tr>
<td>Family Health Options Kenya (FHOK)</td>
<td>2008</td>
</tr>
<tr>
<td>Franciscan Sisters of the Immaculate Conception of the Holy Mother of God (SFIC)</td>
<td>2010</td>
</tr>
<tr>
<td>Handicap International</td>
<td>2010</td>
</tr>
<tr>
<td>Health Education Africa Resource Team (HEART) Apr-10Health NGOS Network (HENNET)</td>
<td>2010</td>
</tr>
<tr>
<td>HelpAge International</td>
<td>2010</td>
</tr>
<tr>
<td>Homeless Children International</td>
<td>2009</td>
</tr>
<tr>
<td>Hope Valley Family Institute (HVFI)</td>
<td>2010</td>
</tr>
<tr>
<td>Organization</td>
<td>Year</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>HOPE Worldwide Kenya (HWWK)</td>
<td>2010</td>
</tr>
<tr>
<td>Kenya Basic Support Foundation</td>
<td>2008</td>
</tr>
<tr>
<td>Kenya HIV Business Council (KHBC)</td>
<td>2010</td>
</tr>
<tr>
<td>Kenya Network of Women with AIDS (KENWA)</td>
<td>2010</td>
</tr>
<tr>
<td>Kisumu Urban Apostolate Programmes (KUAP) – Pandipieri</td>
<td>2010</td>
</tr>
<tr>
<td>Kolanya Girls Boarding Primary School</td>
<td>2007</td>
</tr>
<tr>
<td>Makindu Children's Centre (MCC)</td>
<td>2010</td>
</tr>
<tr>
<td>Migori Community-Based Orphans HIV/AIDS Centre (MICOBA)</td>
<td>2007</td>
</tr>
<tr>
<td>Mothers’ Rural Care for AIDS Orphans</td>
<td>2008</td>
</tr>
<tr>
<td>Nazareth Hospital</td>
<td>2010</td>
</tr>
<tr>
<td>Neighbours in Action (NIA)</td>
<td>2010</td>
</tr>
<tr>
<td>Rafiki wa Maendeleo</td>
<td>2010</td>
</tr>
<tr>
<td>Reachout Centre Trust</td>
<td>2010</td>
</tr>
<tr>
<td>Ripples International</td>
<td>2010</td>
</tr>
<tr>
<td>Rural AIDS Prevention and Development Organisation (RAPADO)</td>
<td>2010</td>
</tr>
<tr>
<td>St. Camillus Dala Kiye Welfare Center</td>
<td>2010</td>
</tr>
<tr>
<td>St. Mary's Medical Centre, Kapsoya</td>
<td>2009</td>
</tr>
<tr>
<td>Student Campaign Against Drugs</td>
<td>2009</td>
</tr>
<tr>
<td>Support for Addictions Prevention and Treatment in Africa (SAPTA)</td>
<td>2010</td>
</tr>
<tr>
<td>Tesia Isanga Organisation</td>
<td>2010</td>
</tr>
<tr>
<td>The Omari Project</td>
<td>2010</td>
</tr>
<tr>
<td>The Raphaelites – RedHill Place</td>
<td>2010</td>
</tr>
<tr>
<td>Tropical Institute for Community Health (TICH)</td>
<td>2009</td>
</tr>
<tr>
<td>Tuungane (Impact Research and Development Organization)</td>
<td>2009</td>
</tr>
<tr>
<td>Twana Twitu</td>
<td>2010</td>
</tr>
<tr>
<td>Wajir South Development Association (WASDA)</td>
<td>2010</td>
</tr>
<tr>
<td>WEM Integrated Health Services</td>
<td>2009</td>
</tr>
<tr>
<td>Wema Centre Trust</td>
<td>2010</td>
</tr>
<tr>
<td>Women and Youth Against AIDS and Poverty (WAYAAP)</td>
<td>2010</td>
</tr>
<tr>
<td>Youth Action for Rural Development (YARD)</td>
<td>2010</td>
</tr>
<tr>
<td>Ace Communications</td>
<td>2009</td>
</tr>
</tbody>
</table>

**Organizations with Subgrantees**

The following lists CAP Kenya umbrella grantees and their subgrantees.

**Church World Services subgrantees:**

1. LISP
2. GROOTS
3. Organization of African Instituted Churches Kenya (OAIC)

**Handicap International subgrantees:**

1. Disabled Group of Trans - zoia
2. Blind and Low Vision Network
3. Kenya Society for the mentally handicapped (KSMH)
4. United Disabled People of Kenya (UDPK)
5. Nairobi Family Support services (NFSS)
6. Dandora Deaf Self Help Group
7. Kenya Disabled Action Network (KEDAN)
8. Kenya Sign Language Research Project (KSLRP)

Helpage International subgrantees
1. Help the Aged Kenya
2. KESPA
3. JOOT Social Services
4. St. Francis Asumbi
<table>
<thead>
<tr>
<th>Grantee</th>
<th>Initial Agreement</th>
<th>Modification I</th>
<th>Modification II</th>
<th>Modification III</th>
<th>Modification IV</th>
<th>Modification V</th>
<th>Modification VI</th>
<th>Modification VII</th>
<th>Modification VIII</th>
<th>Completion Date</th>
<th>Total Ever Obligated KSh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Focus</td>
<td>Feb 1st 2006</td>
<td>3,135,800</td>
<td>Jan 30th 2007</td>
<td>1,519,807</td>
<td>June 29th 2007</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>Aug 31st 2007</td>
<td>4,655,607</td>
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<tr>
<td>ASUMBI</td>
<td>Feb 1st 2007</td>
<td>3,799,500</td>
<td>Jan 1st 2008</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>April 30th 2008</td>
<td>3,799,500</td>
</tr>
<tr>
<td>COLIDF</td>
<td>Feb 1st 2007</td>
<td>4,525,796</td>
<td>Jan 31st 2008</td>
<td>0</td>
<td>Feb 29th 2008</td>
<td>5,294,972</td>
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<td>Jan 31st 2009</td>
<td>9,820,768</td>
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<td>FHOK</td>
<td>Feb 1st 2007</td>
<td>4,393,803</td>
<td>Jan 1st 2008</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apr 30th 2008</td>
<td>4,393,803</td>
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<tr>
<td>Handicap Interna’l - I</td>
<td>Oct 1st 2008</td>
<td>12,591,509</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jan 31st 2010</td>
<td>12,591,509</td>
</tr>
</tbody>
</table>
## Grant Funding Tracker

<p>| Date of Agreement | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Amount KSh | Date | Completion Date | Total Ever Obligated KSh |
|-------------------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|------------|------|
| HelpAge Internat’l | Feb 1st 2007 | 10,355,476 | Nov 1st 2007 | 0 | Nov 30th 2007 | 17,948,868 | Sep 30th 2009 | 27,163,319 | Sep 30th 2009 | 0 | Dec 31st 2009 | 0 | Marc 31st 2010 | 0 | HELPFORCE Internat’l | 0 | HENNET | 11,875,899 |
| HENNET            | Mar 1st 2006 | 11,875,899 | Dec 31st 2009 | 0 | Dec 31st 2009 | 11,875,899 | Jul 31st 2010 | 0 | Dec 31st 2009 | 0 | Dec 31st 2009 | 0 | Dec 31st 2009 | 0 | HUMED | 0 | HOMELAND Children Internat’l | 13,634,258 |
| HOMELESS Children Internat’l | Apr 1st 2007 | 4,528,400 | Jan 31st 2008 | 0 | Jan 31st 2008 | 5,204,952 | Dec 31st 2009 | 0 | Jan 31st 2009 | 0 | Jan 31st 2009 | 0 | Jan 31st 2009 | 0 | HORIZON Internat’l | 0 | HOPE Worldwide Kenya | 21,643,403 |
| Kolanya           | Feb 1st 2006 | 4,597,750 | Jan 30th 2007 | 0 | Jan 31st 2007 | 247,947 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Makindu Children’s Centre | 27,097,031 |
| Makindu Children’s Centre | Feb 1st 2006 | 3,727,713 | Jan 30th 2007 | 0 | Jun 30th 2007 | 4,800,915 | Nov 1st 2007 | 6,904,212 | Sep 30th 2008 | 8,171,829 | Sep 30th 2009 | 0 | Dec 31st 2009 | 0 | Makindu Children’s Centre | 0 | Makindu Children’s Centre | 0 |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Date of Agreement</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Completion Date</th>
<th>Total Ever Obligated KSh</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORCAO</td>
<td>April 1st 2006</td>
<td>3,075,850</td>
<td>Dec 30th 2006</td>
<td>6,927,075</td>
<td>Dec 30th 2006</td>
<td>0</td>
<td>June 30th 2009</td>
<td>7,950,925</td>
<td>Dec 31st 2009</td>
<td>0</td>
<td></td>
<td></td>
<td>Dec 31st 2007</td>
<td>10,002,925</td>
<td></td>
</tr>
<tr>
<td>SAPTA</td>
<td>Nov 1st 2006</td>
<td>3,875,000</td>
<td>Nov 1st 2007</td>
<td>4,617,260</td>
<td>Sep 30th 2008</td>
<td>429,539</td>
<td>Dec 31st 2008</td>
<td>1,798,369</td>
<td>Sep 30th 2009</td>
<td>17,028,523</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCAD</td>
<td>April 1st 2008</td>
<td>4,374,230</td>
<td>March 30th 2009</td>
<td>0</td>
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<td></td>
<td>May 31st 2009</td>
<td>4,374,230</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Grant Funding Tracker

### Annex 1 – Capable Partners Program (CAP) Kenya

#### End-of-Project Report

<table>
<thead>
<tr>
<th>Organization</th>
<th>Date of Agreement</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Amount KSh</th>
<th>Date</th>
<th>Completion Date</th>
<th>Total Ever Obligated KSh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Obligations by CAP Kenya</strong></td>
<td></td>
<td><strong>277,370,776</strong></td>
<td></td>
<td><strong>203,149,726</strong></td>
<td></td>
<td><strong>301,700,185</strong></td>
<td></td>
<td><strong>196,440,239</strong></td>
<td></td>
<td><strong>134,268,379</strong></td>
<td></td>
<td><strong>26,501,063</strong></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 2—CAP KENYA GRANTS MANAGEMENT MANUAL

CAP Kenya
Small Grants and Institutional Strengthening Programs I & II
Grant Management Reference Guide for Grantees
July 2009
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INTRODUCTION
This Grant Management Manual is intended to be a guide for use by senior management at grantee agencies for administration and management of CAP Kenya grants. There is also a Finance Reference Manual with more detailed information on financial administration of CAP Kenya grants.

The Kenya Small Grant and Institutional Strengthening Program, implemented by Capable Partners Program (CAP) of the Academy for Education Development (AED), manages grant funding to non-governmental organizations in Kenya that implement projects related to PEPFAR's priority areas in HIV/AIDS prevention, treatment, and care.

CAP Kenya provides grant funding alongside technical and institutional capacity-building to a select group of organizations working in the various areas of HIV/AIDS in Kenya.

Capacity-building activities are tailored to the needs of each grantee organization based on institutional priorities identified during an organizational self-assessment.

Accountability is the cornerstone of all CAP Kenya programmatic activities. Grantees abide by a strict set of guidelines covering all aspects of their programs.

What the Manual Covers
Each section contains a description and guidelines as follows, accompanied by copies of the relevant forms and templates in the Appendix.

Section 1 Grant Award Documents: These are the contractual documents which explain the terms and conditions of the contract, outline activities to be undertaken, reporting requirements, and deliverables.

Section 2 Required Reporting: This section describes reporting requirements. More detailed guidance on financial reporting is available in the Finance Reference Manual.

Section 3 Financial Administration: This section discusses the various financial administration requirements from program commencement and throughout the grant period. More detailed guidance on financial administration is available in the Finance Reference Manual.

Section 4 Program Implementation and Management: This section will cover areas of program management and implementation, including
guidelines on how to create a workplan for implementation, and performance monitoring plan to guide monitoring and evaluation activities.

**Section 5 Institutional Strengthening (IS):** CAP Kenya provides technical assistance to grantees through the institutional strengthening aspect of this grant award. This section provides details of the process used by CAP Kenya.

**Section 6 Marking Guidelines:** Grantees must acknowledge the support of AED and USAID in all publications, reports, audio or video materials, presentations, or documents related to this program. This section provides guidelines on how to properly acknowledge the support of USAID and AED.
**SECTION 1: GRANT AWARD DOCUMENTS**

Grant award document are contractual documents which explain the terms and conditions of the contract between AED and grantee (not USAID and grantee) and outline activities to be undertaken, reporting requirements, and deliverables. The agreement documents which the grantee receives at the commencement of the award are:

- Award letter
- Schedule
- Program description
- Approved grant budget
- Standard provisions

All of these documents will list the grant agreement number which pertains to the grant award. It will be in the following format: 3253-0602-STND-07-0XX

**Award Letter**

The award letter is the key agreement document which is to be signed by authorized personnel from the grantee organization and AED. This signature signifies that the grantee makes a commitment to adhere to the provisions of the agreement.

The award letter makes reference to the award amount, obligated amount, period of performance, and relevant provisions.

*Award amount vs. obligated amount:* The award amount is the total estimated cost of the grant. Sometimes CAP Kenya will not be able to obligate the total grant amount immediately and will obligate only a portion of the total estimated cost at any one time with the intention of obligating additional amounts later.

*Period of performance:* The time period of funding for grant activities and in which the grant objectives will be met.

*Relevant provisions:* This refers to the provisions of the Mandatory Standard Provisions for Non-U.S., Non-governmental Recipients which are relevant to this award.
DATE

XXXXXX
Executive Director
P.O Box xxxxxxxx
KENYA

Subject: Agreement # 3253-0602-STND-06-xx
USAID Associate Award No. 623-A-00-06-00012-00
Under USAID Leader Award No. HFP-A-00-03-00020-00
AED Project Number 3253-0602

Dear Mx.XXXXX,

In accordance with the subject Cooperative Agreement between the Academy for Educational Development (hereinafter referred to as “Grantor”) and the United States Agency for International Development (USAID), the Grantor hereby grants to Name of Organisation (hereinafter referred to as “Recipient”), the sum of KSh XXXXX (not to exceed USD XXXXX in Kenya Shilling equivalent) to provide support for the program entitled “name of the project being funded”, as described in Attachment A: Schedule, and Attachment B: Program Description. The Grantor hereby obligates the amount KSh X,XXX,XXX for project expenditures. Funding is subject to the availability of funds, satisfactory progress, and continued relevance to AED and USAID programs. The Recipient shall not exceed the obligated amount of this Agreement without a prior written modification authorizing the increase. AED shall not be liable for any costs expended by the Recipient in excess of the obligated amount.

This Agreement is effective and obligation is made to Name of Organisation, on the condition that the funds will be administered in accordance with the terms and conditions as set forth within this agreement and that they will apply to commitments made by the Recipient in furtherance of program objectives during the period beginning on Beginning of project date and ending on Date of end of project.

The Recipient is bound by the following Attachments which are an integral part of, and incorporated by reference to, this Agreement:

- Attachment A: Schedule
- Attachment B: Program Description
- Attachment C: Approved Detailed Grant Budget
- Attachment D: Request for Payment Forms & Instructions
- Attachment E: Required Reporting
  1. Post Award Reporting Requirements and Schedules
  2. Program Reporting Forms
  3. Financial Reporting Forms
  4. Reporting of Foreign Taxes
  5. AED Document / Publication Information Form
  6. Inventory Management and Reporting Table
- Attachment F: Mandatory Standard Provisions for Non-U.S., Non-Governmental Recipients
- Attachment G: Copies of Recipient’s Signed Certifications

Please sign all copies of this letter to acknowledge your receipt of the Agreement. Retain one copy for your records and return one copies to the Grantor, AED CAP Kenya:
1.2 Schedule

A template of the schedule can be found at Appendix A.

The Schedule outlines the key elements of the agreement and defines key terms:

1. The purpose of the agreement states that CAP Kenya agrees to provide financial support for the grantee to exclusively conduct the activities as described in the Program Description.

2. The award period indicates the authorized period for spending
   
e.g., 1\textsuperscript{st} February 2007 – 31\textsuperscript{st} January 2008

3. Key personnel are staff critical to the project’s implementation or personnel directly responsible for the management of the contract. Prior approval is required for any changes in staff, including level of effort or staff replacement. Such changes related to personnel (rate of pay, level of effort, turnover and replacement of key personnel) must be approved by CAP KENYA and should be properly supported with:
   
   - Form 1420
   - CV/Resume
   - Job Description
   - Contract/Letter of Appointment

4. The amount of award states the obligated amount and the award amount (in Kenyan shillings, with a ceiling).

5. The payment section details how payments will be made to the grantee. CAP Kenya will only pay for things included in the budget. CAP Kenya will not reimburse costs in excess of the total obligated amount.

6. The award documents detail what CAP Kenya’s substantial involvement in the grant is. CAP Kenya will be substantially involved in the implementation of several areas of grant activities, e.g. IS activities. These items will also be locked line items in the budget, denoting a line item which cannot be expended without prior approval from CAP Kenya.

7. The budget section summarizes the approved grant budget under the award. (More detailed information on the budget is also found at Section 1.4)

8. The grantee is required to create a monitoring and evaluation plan in a Performance Monitoring Plan (PMP). Grantees are required to monitor
their own programs through use of this plan, which must be submitted to CAP Kenya 45 days from the grant start date.

9. Grantees are required to submit monthly financial and quarterly narrative reports. CAP Kenya will provide templates for all reports. (More detailed information on reporting guidelines is also found in Section 2). All reports will be written in English and submitted in both hard and soft copy forms.

10. AED and USAID have the right to conduct an audit or financial review at any time. The accounting system must produce sufficient financial records to substantiate charges to CAP Kenya; the grantee shall make all project-related financial records available for examination to CAP Kenya, USAID, or their authorized representatives. The grantee shall provide CAP Kenya with copies of any audit reports mandated by Kenyan law and/or regulatory agency. All financial records and documentation shall be preserved for the entire duration of this Agreement and for a period of 3 years after its conclusion.

11. There are several types of goods which require prior approval before procurement. Written approval from CAP Kenya must be sought and attained prior to purchase with award funds.

12. Grantees should become familiar with US Government laws and regulations that pertain specifically and directly to this Grant Agreement, including but not limited to the Special Provisions listed in the schedule:

   o Eligibility issues: Organizations must certify that they are not disqualified or excluded from receipt of funding from the US federal government and that they comply with E.O. 13224 as well as section 1352, title 31, USC.

   ▪ US law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorist activities. It is the legal responsibility of the grantee to ensure compliance with these laws, which the grantee signifies through signing the Anti-Terrorist Certification.

   ▪ US law prohibits the use of US Government funding to attempt to influence or lobby in connection with the awarding of US funds. Grantees must certify that they have not participated in lobbying activities in relation to federal funding through signing a Certification Regarding Lobbying.

   ▪ CAP Kenya must certify that grantees are not presently debarred, suspended, proposed for debarment, declared ineligible or excluded from covered transactions by a US
government agency, implementing E.O.s 12549 and 12689. CAP Kenya will check the database of excluded persons to verify grantee eligibility. The following are reasons for debarment:

- Conviction or indictment for fraud or another criminal offense
- Termination of a public transaction for cause or default in the last 3 years

  - There are special provisions related to condoms, prostitution and abortion which are relevant to the activities of CAP Kenya.
  - CAP Kenya is required to obtain information regarding payment of value-added taxes by grantees.
  - The grantee is required to establish a drug-free awareness program in the workplace. The grantee also must inform CAP Kenya if an employee is convicted of a drug violation in the workplace.
  - No purchase of real property is permitted under this agreement.
  - AED’s dispute resolution protocol is included in the schedule. Disagreements not resolved by CAP Kenya and the grantee will be heard by AED’s Vice President. If there are inconsistencies, the order of precedence is:

    - Agreement Schedule,
    - Standard Provisions,
    - Program Description

1.3 Program Description

A template of the Program Description can be found at Appendix C.

This document defines which activities will be undertaken during the grant period in order to achieve the proposed results. The activities listed in this document should correspond with those mentioned in the Quarterly Narrative Report (QNR) as well as the Activity Implementation Timeline (AIT). The program description will be a reference throughout the grant implementation period.

1.4 Detailed Grant Budget

A template of the Detailed Grant Budget can be found at Appendix D.
The budget provides a spending plan against which financial and program performance can be measured. The budget is also a reference which will be used throughout the grant implementation period.

1.5 Modification and Amendments

Modifications to your grant agreement are required whenever you want to change the following:

- The grant period end date
- The budget spending categories or the amount of the award
- The scope of the approved program activities

The procedure for obtaining a modification is illustrated below.

The modification agreement will describe the principal elements of the award negotiations, list items of substantial involvement, and state the payment schedule.
# TEMPLATE OF AWARD MODIFICATION DOCUMENT

## MODIFICATION OF AWARD

<table>
<thead>
<tr>
<th>1. MODIFICATION NUMBER</th>
<th>2. EFFECTIVE DATE OF MODIFICATION</th>
<th>3. AWARD NUMBER</th>
<th>4. EFFECTIVE DATE OF AWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5. GRANTEE:
- **GRANTEE:** AED CAPABLE PARTNERS PROGRAM KENYA
- **By:**
- **Title:**
- **Date:**

### 6. FUNDING SUMMARY:

<table>
<thead>
<tr>
<th>Amount Prior to this Modification</th>
<th>Obligated Amount</th>
<th>Total Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change made by this Modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New/Current Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7. DESCRIPTION OF MODIFICATION:

The purpose of this modification is to increase the award amount, extend the period of performance, and modify the program description. Specifically the contract is modified as follows:

1. Under Section B, Period of Agreement, in the Schedule (Attachment A) delete 31st December 2006 and replace with 31st December 2007 in lieu thereof:
2. Under Section D.1, Amount of Award, delete ‘KSh XXXX (not to exceed USD XXX in Kenya Shilling equivalent)’ and replace with **KSh XXXX** (not to exceed **USD XXX** in Kenya Shilling equivalent) in lieu thereof:
3. Under Section D. 2 delete ‘AED hereby obligates the amount of KSh XXXX for the purposes of this Agreement beginning the effective date of this Grant Agreement through 31st December 2006’ and replace with ‘AED hereby obligates the amount of **KSh XXXX** for the purposes of this Agreement beginning the effective date of this Grant Agreement through **date** in lieu thereof:
4. Delete Section E, Contribution Schedule and Targets in its entirety.
5. Under Section F, Payments, delete **KSh XXXX** and replace with **KSh XXXX**.
6. Under Section F, Payments, delete 10 days and replace it with 5 days in lieu thereof:
7. Under Section G, Budget, delete section G.2 and replace with the following in lieu thereof:
8. Under Section I.4.a, Financial Reporting, delete 10 days and replace it with 5 days in lieu thereof:
9. Under Section I.4.b, Financial Reporting, delete 15 days and replace it with 10 days in lieu thereof:
11. Under Section I.5.b, Performance Monitoring Reporting, delete 15 days and replace it with 10 days in lieu thereof:
12. Delete Attachment B, Program Description, in its entirety and replace with it with the attached entitled “Attachment B, Program Description” in lieu thereof:
13. Delete Attachment C, Budget, initiates entirety and replace it with the attached entitled “Attachment C, Budget” in lieu thereof:

### 8. EXCEPT FOR THE ABOVE MODIFICATIONS, ALL OTHER TERMS AND CONDITIONS OF THE GRANT REFERENCED IN BLOCK 3 ABOVE, AS IT MAY HAVE BEEN AMENDED, REMAIN UNCHANGED AND IN FULL FORCE AND EFFECT.

### 9. THE GRANTEE IS REQUIRED TO SIGN THIS DOCUMENT TO RE-CONFIRM IT IS IN AGREEMENT WITH THE CHANGES

#### 10. GRANTEE:
- **By:**
- **Title:**
- **Date:**

#### 11. AED CAPABLE PARTNERS PROGRAM KENYA
- **By:**
- **Title:**
- **Date:**
SECTION 2: REQUIRED REPORTING

This section describes CAP Kenya’s reporting requirements. The reports should be submitted to CAP Kenya by the due dates indicated. CAP Kenya staff is available to provide technical assistance and to explain reporting requirements.

2.1 Monthly Reporting

**Monthly Financial Reports (MFRs)**

Monthly financial reports with supporting documentation are due on the 5th of each month.

CAP Kenya will review and return comment on the reports each month. Grantees are required to respond to these comments in order for the report to be approved. Funds for the following period will only be disbursed once any outstanding issues are resolved.

CAP Kenya will be looking for completeness, accuracy, timeliness, and professional presentation when evaluating the MFRs.

The MFR consists of 8 templates (see Appendices H and I):

3. Bank Reconciliation Statement
4. Monthly Expenses Reporting Table
5. Monthly Financial Report Table
6. Monthly Cash Forecast
7. Request for Payment
8. Grant Summary and Cash Request

MFRs must be accompanied by supporting documentation to justify costs including, but not limited to:

For acknowledging receipt of CAP Kenya funds:
Every month upon receipt of the CAP Kenya wire to your respective CAP Kenya – designated bank account, kindly supply copies of the following:

a. A receipt in favor of CAP Kenya for the amount received
b. Copy of the bank statement, showing the amount credited to your account
c. A signed covering letter
For salaries paid under Budget Category 1 – SALARIES & PERSONNEL COSTS
a. Copy of the payroll for the CAP Kenya program Staff
b. Copies of signed pay slips
c. Copies of timesheet signed by staff and supervisor
d. Copies of approved Payment Vouchers
e. Copy of the Cheque paying statutory deductions
f. Receipts from NSSF, NHIF and PAYE
g. Copies of cheques drawn.

For payments made under Budget Category 2 – RENT & UTILITIES
a. Rent payment
   a. Copy of signed lease agreement for the period.
   b. Copy of invoice from landlord
   c. Copy of approved payment voucher
d. Copy of cheque drawn
e. Receipt from the landlord
b. Office Utilities
   a. Copies of electricity and water bills
   b. Copies of approved payment vouchers (cost allocations clearly indicated)
c. Copies of cheques drawn
d. Copies of receipts from suppliers

For payments made under Budget Category 3 – COMMUNICATION
a. Telephone/Internet expenses
   a. Copies of invoices from the phone/internet company
   b. Copies of approved payment vouchers (Cost allocations clearly indicated)
c. Copies of cheques drawn
d. Copies of receipts from vendors
b. For scratch card/call card expenses
   a. Copy of approved cash payment voucher.
   b. Copy of labeled receipt from vendor.
c. A signed list of staff issued with the scratch cards and purpose for use.

For payments made under Budget Category 4 – OFFICE SUPPLIES
It is recommended that you procure office supplies in bulk on a quarterly or monthly basis. The following documentation should accompany expenses incurred in this category.

a. Purchases of desks/tables/chairs/printers/cameras or bulk purchases of stationary:
   a. Copies of quotations sourced
b. Copy of quotation analysis worksheet and Justification

c. Copies of invoices from suppliers

d. Copies of approved payment vouchers

e. Copies of signed goods received/delivery notes

f. Copies of cheques drawn

g. Copies of receipts from suppliers

For payments made under Budget Category 5 – TRAVEL EXPENSES

a. Fares paid with no receipts issued

   a. An approved cash payment voucher signed by the cash recipient and indicating purpose of trip

b. Fuel expenses

   a. Copies of invoices and statements from fuel company.
   
   b. An authorized worksheet indicating vehicle movements.
   
   c. Copies of fuel receipts paid.
   
   d. Copies of approved payment vouchers.
   
   e. Copies of cheques drawn and receipts from suppliers.

c. Vehicle maintenance/repair expenses

   a. A copy of an authorized work/job order.
   
   b. An invoice from the vendor
   
   c. This invoice should be signed as proof that the required job was done.
   
   d. Copies of approved payment vouchers.
   
   e. Copies of cheques drawn.
   
   f. Copies of receipts from vendors.

For Payments made under Budget Category 6 - EQUIPMENT

Please refer to the procurement guidelines and remember to get prior approval from CAP Kenya before any equipment procurement. Ensure that an insurance policy is taken for all equipment purchased.

a. Copy of approval letter/email from AED.

b. Copies of at least 3 quotations sourced.

c. Copy of the quotation analysis worksheet.

d. Copies of invoices from vendors.

e. Copies of approved payment vouchers.

f. Copies of signed goods received notes/delivery notes.

g. Copies of cheques drawn for cheque payments.

h. Copies of receipts from suppliers.

For Payments made under Budget Category 7 – OTHER PROJECT COSTS

Please note that there is a process for costs incurred for trainings, institutional strengthening and for publications/media materials.

a. Procured items:

   a. Copies of at least 3 quotations sourced.

   b. Copy of the quotation analysis worksheet.
c. Copies of invoices from vendors.
d. Copies of approved payment vouchers.
e. Copies of cheques drawn.
f. Copies of receipts from suppliers.

b. Publications/media materials:
   a. In addition to the above, you are required to attach an AED CAP Kenya approved Attachment E. 5 publications/media form.

c. Items bought for distribution to beneficiaries – Uniforms, Food, etc.
   a. In addition to the other documentation listed above, attach distribution lists signed by beneficiaries/guardian.

d. Trainings/workshop costs
   a. All trainings to be conducted under this grant agreement require prior written approval from AED CAP Kenya. The request for this approval should be sent to AED CAP Kenya 2 weeks prior to the actual training. The following documentation should be presented together with a cover letter requesting this approval.
      i. Training/workshop curriculum showing duration of the training
      ii. 3 Profiles of possible facilitators for the training and the ToR
      iii. A justification for the approved facilitator
      iv. Objectives/program for the training.
   b. The following documentation should be submitted to support the expenses/costs for training.
      i. Copies of approval letter to conduct the training from AED CAP Kenya
      ii. Attach copies of quotations sourced.
      iii. Attach copies of signed contract agreements for facilitators of the training.
      iv. Copies of a signed participants list

e. Expenses relating to Institutional Strengthening:
   a. Organizations require prior approval from AED CAP Kenya to incur any costs under institutional strengthening. To request this approval, refer to the institutional strengthening process.
   b. The following documentation, in addition to the above documentation is required to support any expenses paid for activities relating to institutional strengthening.
      i. copy of approved IS activities to be conducted
      ii. an approval letter from AED CAP Kenya
iii. Activity should be accounted for in the same procedure as all other services or goods procurement process.

All documents should be neatly presented in a file and sequentially numbered. ALL relevant documents must be stamped ‘PAID’.

### 2.2 Quarterly Reporting

#### Quarterly Narrative Report (QNR)

The Quarterly Narrative Report is due each quarter, on **the 10th of the month following the end of the quarter**.

The QNR is a report by the project manager of how the project is progressing towards achieving results. It contains:
- an analysis of key achievements, or lack thereof
- challenges, obstacles, and reasons for variance
- recommendations and plans for future direction to address key issues
- lessons learned
- a summary of any networking, partnerships, and collaboration
- institutional strengthening activities

The QNR template is contained in Appendix M.

#### Quarterly Financial Report

The Quarterly Financial Report is due each quarter, on **the 10th of the month following the end of the quarter**.

The MFR should be submitted along with additional quarterly reports.

#### Quarterly Expenses Reporting Table/Pipeline Report

The template for this report can be found at Appendix L. The Pipeline Report, also known as the Quarterly Expenses Reporting Table, must be submitted to CAP Kenya each quarter, **by the 5th of the month following the end of the quarter**.

The pipeline report reflects the amount of funds obligated but not yet spent, the amount of money that is available for the grantee to draw down on for project activities.

#### Inventory Management and Reporting Table

The Inventory Management and Reporting Table (see Appendix F) must be submitted to CAP Kenya each quarter, **by the 5th of the month following the end of the quarter**.
This table is a listing of inventory purchased with grant funds. Inventory management or property management is a regular check to see that goods purchased with grant funds are being utilized for intended purposes and are in the control of the agency.

### 2.3 Other Reporting

#### Document/Publication Submission

This report is due **when applicable**.

Grantees shall not release any publications without written consent from AED. CAP Kenya requires grantees to submit 5 copies of publications produced with grant funds for approval. These 5 copies must be accompanied with an electronic copy of the publication as well as the Document/Publication Information Form (template following). Exceptions may be made to the 5 copy rule when it is not logical to produce 5 copies of an item (for example: when producing a banner).

All documents must be marked according to the guidelines which are described in Section 6.1).
Foreign Tax Reporting

The Foreign Tax Tracking Sheet should be submitted to CAP Kenya twice per calendar year (an interim report by April 30th and a final report by October 31st). Reports are required even when there were no relevant taxes paid or reimbursements made.

TEMPLATE OF FOREIGN TAX REPORT
# Foreign Taxes Tracking Sheet

**Organization Name:**

**Contact Name, Phone, Fax, and email:**

**Grant Agreement No.:**

**Period Covered:** From 03/01/2009 to 12/31/2009

<table>
<thead>
<tr>
<th>No.</th>
<th>Invoice Date</th>
<th>Invoice No.</th>
<th>Supplier Name</th>
<th>Registration No.</th>
<th>Invoice Description</th>
<th>Total Invoice Amount</th>
<th>VAT* Amount</th>
<th>Customs* Amount</th>
<th>Submitted under Claim</th>
<th>VAT and Customs Refunded</th>
<th>Date* Refund Received</th>
<th>VAT and Customs Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**N.B.** Only include invoices relating to commodity purchase transactions valued at USD 500 or more.

For the purpose of this report, “Commodities” include any material, article, supply, goods, or equipment.
The Foreign Tax Reports must contain:
1) The amount of taxes assessed by the GoK on commodity purchase transactions valued at US$500 or more, financed with grant funds. It should be a report of payments made on:
   i) Value-Added Taxes
   ii) Customs Duties
   iii) Any other tax from which the grantee has exemption status
2) Any reimbursements of taxes paid during the period (regardless of when the tax was assessed)

For further information see: www.state.gov/m/rm/c10443.htm.

Final Reports

**Thirty (30) days after the end of the award period** grantees must submit a Final Narrative Report (Appendix M) and a final Monthly Financial Report.

The Final Narrative Report is very similar to the QNR, but reflects upon the entire award period, rather than only the last quarter. The report also has a detailed section to report on IS activities, goals, achievement, challenges, and expenditures.

The final Monthly Financial Report should contain all outstanding bills which were accrued during the award period, *e.g.* utility bills for usage during the relevant time period.

---

**TIP:**

The following items are deliverables which must be submitted to CAP Kenya throughout the grant award period:

- Quarterly Narrative Reports, by the 10th of the month following the end of the quarter
- Quarterly Financial Reports, but the 5th of the month following the end of the quarter
- Monthly Financial Reports, by the 5th of each subsequent month
- Activity Implementation Timelines, within the first 30 days of the grant award period
- Performance Monitoring Plan, within the first 45 days of the grant award period
- Institutional Strengthening Deliverables
- Audit Reports, submitted annually
- Environmental Monitoring Reports, submitted annually
SECTION 3 FINANCIAL ADMINISTRATION

This section provides guidelines on the requirements for financial administration. More detailed financial management information is available in the Financial Reference Manual.

3.1 Bank Account Information

CAP Kenya funds must be isolated in a bank account which is separate from the rest of the grantee’s finances.

1. The account must:
   a. Be a brand new account
   b. Be specifically and solely for funds from CAP Kenya
   c. Have at least 2 signatories, who are not responsible for maintaining accounting records
   d. Be in the name of the agency (not any individual person or a separate entity) which was awarded the grant
   e. Be opened with a reputable bank domiciled within Kenya. (The grantee shall carefully select banks that are not likely to go under in the foreseeable future or that are not currently experiencing any liquidity problems that may lead to their winding up.)

2. The grantee must document the process used in selecting the preferred bank.

3. It shall be the responsibility of the grantee to contribute the minimum bank balances necessary for opening the account and to maintain the same until the time the award expires or is terminated.

4. Bank account information must be reported to CAP Kenya in order to receive wires. CAP Kenya has a form for this (see template below) which should be submitted within a period of 10 days of the opening of the account. Any changes to this account, e.g. a change in signatories, must be reported to CAP Kenya by submission of this form within a period of 10 days from the change.
### 3.2 Payment Process

CAP Kenya provides monthly advances to grantees. Advances must be requested each month via the Request for Advance Payment form (Appendix I) which must be accompanied by a Monthly Financial Report (Appendix I). The initial request for payment forms consist of:

1. Annual Cash Forecast Form
2. Initial 2-month Advance Payment Form
3. Advance Request Form

The grantee may request up to two advances (one for each of Months 1 and 2) before providing the MFR for Month 1. MFRs will be reviewed and approved by CAP Kenya before the advance payment will be made. The Advance Request form is located with the MFR forms (Attachment E3 Financial Reporting Forms – I).
SAMPLE OF REQUEST FOR PAYMENT FORM

REQUEST FOR PAYMENT
STANDARD Grant

Date: ____________________________  Report #: ________________

To: The Academy for Educational Development
   Attn: Anthony Odundo
   ABC Place, 2nd Floor
   Waiyaki Way, Westlands
   P.O. Box 14500-00800, Nairobi
   Tel: 020 4260000  Fax: 020 4452676
   E-mail: aodundo@aed.org

From: ______________________________
   Address: ____________________________

Grant #: ____________________________
Title: ________________________________

Expenses reported for the month of: March-09

<table>
<thead>
<tr>
<th>Monthly Financial Reconciliation attached for the month of: March-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Balance of funds March-09</td>
</tr>
<tr>
<td>B. Total Amount Spent in March-09</td>
</tr>
<tr>
<td>C. Remaining Advance funds (A-B): 0.00</td>
</tr>
<tr>
<td>Current Month: April-09</td>
</tr>
<tr>
<td>D. Monthly Expenses Forecast for Apr-09</td>
</tr>
<tr>
<td>E. Remaining Advance funds (A-B): 0.00</td>
</tr>
<tr>
<td>F. Monthly Cash Forecast for May-09</td>
</tr>
<tr>
<td>G. Remaining Advance funds (A-B): 0.00</td>
</tr>
<tr>
<td>H. Advance Request for the month of: May-09</td>
</tr>
</tbody>
</table>

The undersigned hereby Certifies:

a) that all sums claimed comply with the terms of 22 CFR 226 and the mandatory standard provisions as they apply to this grant.
b) that payment of the sum claimed in this Request is proper and due, and that all funds provided by AED have been spent solely for the purposes described in the Grant Agreement and in accordance with all of the terms and conditions thereof.
c) that appropriate refund or credit to the grant will be made in the event of a disallowance in accordance with the terms of the grant, for nonperformance in whole or in part under this grant, in the event funds are not expended, and that any interest accrued on the funds made available herein will be refunded to AED.
d) that any detailed supporting financial information as the Grantor may require will be furnished by the Grantee promptly upon request.

Name: ____________________________  Sign: ______________________

Requests for Payment should be submitted by the 5th day of the month prior to the advance period (as a part of the MFR).

A sample schedule (for a grant beginning in November):

<table>
<thead>
<tr>
<th>Month #</th>
<th>Month 1 (November)</th>
<th>Month 2 (December)</th>
<th>Month 3 (January)</th>
<th>Month 4 (February)</th>
<th>Month 5 (March)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due Date:</td>
<td>10 Days after signing agreement</td>
<td>December 5</td>
<td>January 5</td>
<td>February 5</td>
<td>March 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month 3 Advance Request</td>
<td>Month 4 Advance Request</td>
<td>Month 5 Advance Request</td>
<td>Month 6 Advance Request</td>
</tr>
</tbody>
</table>

Financial reports shall be reviewed and approved by CAP Kenya before the advance payment is made in order to reconcile funds received against funds expended. The amount for each monthly advance will be determined by a 2-step process:
1) The MFR is reconciled with the advance received for the corresponding month; and
2) A positive balance is subtracted from (or a negative balance is added to) the current monthly advance.

Thus, there will be a difference of one month between the provision of the advance payment and the reconciliation of the advance using the MFR.

Note:
1) If the actual expenditures for the month reported were greater than the advance for that month, the difference will be added to the current request.
2) If the actual expenditures for the month reported were less than the advance for that month, the difference will be deducted from the current request.

The grantee will receive disbursements totaling no more than 90% of the total grant amount. Should payment of an advance request result in a total outlay equaling more than 90% of the total grant amount, CAP Kenya will pay only that portion of the request which will bring the total payments up to 90% of the grant amount.

The final 10% of the grant amount will be paid after the grantee’s final program and financial reports are approved.
3.3 Procurement Guidelines

CAP Kenya requires that all grantees adhere to procurement procedures that ensure transparency, competitiveness and quality of goods and services. The flowchart below shows the basic steps for procurement for all goods and services valued over Ksh 30,000:

**Steps:**
1) **Identify need.** Normally the program team will come up with a listing of the items that the project will need during the year.
2) **Set up a tender committee.** Grantees should have a simple tender committee comprised of representatives from the Board, finance and administration staff.

3) **Prepare a solicitation document and send out a request for quotation** to reputable vendors/suppliers (see the sample below).
   a. This could be done through advertisements, or sending emails or letters to the various vendors. It is critical that this process be documented to evidence that the procurement action was subject to open competition and that all potential/prospective vendors were given an equal and fair chance to participate in an open and free bidding process.
   b. At least **10 days** should be given to the suppliers to respond.

   **SAMPLE REQUEST FOR QUOTATION FORM**

   ![Blank Request for Quotation Form]

   **REQUEST FOR QUOTATION**

   To: Name of Company
   Address
   Town

   Attn:

   Kindly provide AED with a quotation on the following:

<table>
<thead>
<tr>
<th>Item/Description</th>
<th>Specifications</th>
<th>Qty</th>
<th>Unit Price</th>
<th>VAT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

   **Please quote with Payment Terms, Validity, Warranty & Delivery period.**

   Thanks and look forward to hearing from you.

   Signature: ...........................................
   Name: ...............................................
   Position: .........................................

4) **Obtain at least 3 quotations.** Any single sourcing procurement must be justified in writing and have prior approval from CAP Kenya.

5) **Do a quotation analysis** by preparing a price comparison matrix/table (see the following sample).
## SAMPLE PRICE COMPARISON WORKSHEET

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Name of Vendor</th>
<th>Qty</th>
<th>Price per item (KSH)</th>
<th>Total KSH</th>
<th>Meets Specs?</th>
<th>Warranty</th>
<th>Delivery/Lead time</th>
<th>Payment Terms</th>
<th>Quotation Validity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cheque on Draw</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cheque on Delivery</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Check within 30 days after delivery</td>
<td>14 Days</td>
<td></td>
</tr>
</tbody>
</table>

Reasons/Justifications

<table>
<thead>
<tr>
<th>Tender awarded to: Vendor # 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: xxxxxxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>Title: Procurement/ Administration</td>
</tr>
</tbody>
</table>

Recommendation Approvals By:

<table>
<thead>
<tr>
<th>Recommendation Approvals By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: xxxxxxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>Title: Finance &amp; Operations Manager</td>
</tr>
<tr>
<td>Name: xxxxxxxxxxxxxxxxxxxx</td>
</tr>
<tr>
<td>Title: Project Director</td>
</tr>
</tbody>
</table>

6) **Select vendor and document the reasons/justifications** for award choice.
   The selection process should be presided over by the tender committee.

7) **Prepare a procurement memo to CAP Kenya.** This memo together with price analysis and copies of at least 3 quotations must be submitted CAP Kenya for prior approval. The memo should:
   a. Briefly describe the process that you went through
   b. Who was involved in the vendor selection process
   c. Provide justifications for basis of selection such as – price reasonableness, best value (maximum value for money) and vendor responsiveness and vendor responsibility (e.g., after sales support, etc.)
   d. Provide justifications for single/sole sourcing procurement (which must also be approved by CAP Kenya)

8) **Issue a Local Purchase Order (LPO) to supplier.** This is the binding contractual document with the terms and conditions for the award. See sample:
## SAMPLE PURCHASE ORDER

### PURCHASE ORDER

#### 5. VENDOR NAME & ADDRESS

**TELEPHONE #:** 020-
**FAX #:** 020-
**BUSINESS IDENTIFICATION #:**

#### 6. PLACE OF DELIVERY/ACCEPTANCE

**MARK ATTN:**
**TELEPHONE #:**

#### 7. CHARGE CODE:

#### 8. VAT EXEMPTION:  [ ]Yes  [ X ]No

#### 9. CLIENT: N/A

#### 10. PURCHASE AGENT: N/A

**TELEPHONE #:**
**FAX #/E-mail:**

#### 11. TYPE OF ORDER

**BILATERAL AGREEMENT:** The signature of an authorized official of the Vendor's Organization is required in the space provided below. This agreement shall not be in effect until the authorized representatives of both parties have affixed their respective signatures to an Original of this document.

#### 12. TYPE OF BUSINESS

The Vendor certifies that it is:

- [ ]Non-US Owned/Operated Business
- [ X ]Non-Governmental Owned/Operated/Affiliated Organization

#### 13. SPECIFICATIONS

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
<th>Unit Price</th>
<th>Totals</th>
</tr>
</thead>
</table>

#### AGREEMENT OF THE PARTIES

The Vendor agrees to deliver/perform all supplies/services set forth above and on any continuation sheet(s) attached hereto for the fixed-price specified in accordance with the terms and conditions set forth herein.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (print)</td>
<td>Title</td>
<td>Name (print)</td>
<td>Title</td>
</tr>
</tbody>
</table>

**IMPORTANT! UNLESS OTHERWISE SPECIFIED, ALL PRICES INCLUDE SHIPPING & DELIVER**
9) **Received Goods/Services.** It is important that responsible personnel inspects and signs a delivery note or prepares an inspection report to confirm that the goods/services were delivered in the correct quantities and as per specifications.

**SAMPLE PURCHASE REQUISITION FORM**

![SAMPLE PURCHASE REQUISITION FORM](image)

10) **Process payment** upon receipt of original vendor invoice. Attach supporting documentation.

**RECORDKEEPING TIP:**

Procurement Checklist:
- Signed purchase request form
- Request for quotations/proposals (including internet/newspaper postings)
- Quotations/Proposals received
- Quotations/Bids Analysis (the quantitative analysis)
- Memo to explain selection (the qualitative analysis)
- Approval and/or waiver from CAP Kenya
- Approval from organization signatory policy (as applicable)
- Signed Purchase Order or contract
- Confirmation of receipt of item
- Copy of vendor’s invoice (stamped paid)
- Relevant correspondence, memos, faxes, etc.
3.4 Eligible Costs

An integral part of the procurement process is to ensure that goods and services are allowable under the grant.

All costs will be tested against the following criteria:

- **Reasonable**: Costs which are ordinary and necessary and would be incurred by any prudent person in the conduct of normal business
- **Allocable**: Costs incurred specifically for the award
- **Allowable**: Costs confirming to the limitations of the award

The US government has placed limitations on procurement of certain goods, using award funds.

- **Ineligible** goods and services should not be procured under any circumstances:
  - Military equipment
  - Surveillance equipment
  - Commodities and services for support of police or other law enforcement activities
  - Abortion equipment and services
  - Luxury goods and gambling equipment
  - Weather modification equipment

- **Restricted** goods require prior written approval from USAID (through CAP Kenya)
  - Agricultural commodities
  - Fertilizers – both organic and inorganic materials
  - Pesticides
  - Pharmaceuticals
  - Motor vehicles
  - Used equipment
  - US-government owned excess property

CAP Kenya will provide detailed guidance on what grantees may procure during the budget approval process and in partners fora.

The costs detailed below are generally considered **allowable costs**

**Communication costs.** Costs incurred for telephone services, local and long distance telephone calls, telegrams, postage, messenger, electronic or computer transmittal services and the like are allowable.

**Personnel costs/Compensation for personal services.** This includes, but is not limited to, salaries, wages, stipends, honoraria. However these costs must be:

- **reasonable** for the services rendered/level of effort
- comparable to that paid for similar work in the labor markets in which the organization competes for the kind of employees involved and
- Supported by employment contracts and timesheets/attendance records indicating the total number of hours worked each day.
- customary/required under Kenya labor law

Further note that CAP Kenya will disallow overtime payment to employees.

Fringe benefits. Fringe benefits in the form of employer contributions or expenses for social security, pension plan costs, gratuity costs, employee insurance, workmen's compensation insurance and the like, are allowable, provided such benefits are granted in accordance with established written organization policies.

Audit costs and related services. These are allowable if specifically approved by CAP Kenya as direct cost to the award.

Insurance. Costs of insurance or of any provisions for a reserve covering the risk of loss or damage to property are allowable on condition that the types and extent of coverage shall be in accordance with sound business practice and the rates and premiums shall be reasonable under the circumstances and only to the extent that the organization is liable for such loss or damage.

Advertising and public relations costs. The only allowable advertising costs are those which are solely for

- Recruitment of personnel
- Procurement of goods and services for the performance of the award.

Maintenance and repair costs. Costs incurred for necessary maintenance, repair, or upkeep of buildings and equipment are allowable (unless otherwise provided for) which, neither add to the permanent value of the property nor appreciably prolong its intended life; but keep it in an efficient operating condition.

Materials and supplies costs. Expenses incurred for materials, supplies, and fabricated parts necessary to carry out activities under the award are allowable.

Meetings and conferences. Costs of meetings, workshops and conferences, the primary purpose of which is the dissemination of technical information, are allowable. This includes costs of meals, transportation, rental of facilities, facilitators' fees, and other items incidental to such meetings or conferences.

Participant support costs. Participant support costs are direct costs for items such as stipends or subsistence allowances, travel allowances, and
registration fees paid to or on behalf of participants or trainees (but not employees) in connection with meetings, conferences, symposia, or training projects. These costs are allowable with the prior approval of CAP Kenya.

*Professional services costs.* Costs of professional and consultant services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the non-profit organization, are allowable, subject to being reasonable in relation to the services rendered.

*Rental costs (buildings and equipment) and utilities.* Rental costs are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and, the type, life expectancy, condition, and value of the property leased. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available. Rental costs **must** be supported with tenancy/lease agreement.

*Transportation costs.* Transportation costs relating either to goods purchased, in process, or delivered costs are allowable.

*Travel costs.* Travel costs are the expenses for transportation, lodging, subsistence, and related items incurred by employees who are in travel status on official business of the non-profit organization. Such costs may be charged on an actual cost basis, on a per diem or mileage basis in lieu of actual costs incurred. These expenses are allowable to the extent that they are reasonable and conform to any ceilings or restrictions that CAP Kenya may place on the non government organization.

*Non exempt taxes.* In general, taxes which the organization is required to pay and which are paid or accrued in accordance with GAAP, and payments made to local governments are allowable.

Costs that are not permitted or considered **non-Allowable costs** include the following:

*Alcoholic beverages.* Costs of alcoholic beverages are unallowable.

*Entertainment costs.* Costs of entertainment, including amusement, diversion, and social activities and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities) are unallowable.

*Bad debts.* Bad debts, including losses (whether actual or estimated) arising from uncollectible accounts and other claims, related collection costs, and related legal costs, are unallowable.

*Fines and penalties.* Costs of fines and penalties resulting from violations of, or failure of the organization to comply with local laws and regulations are
unallowable except when incurred as a result of compliance with specific provisions of an award or instructions in writing from the awarding agency.

Contingency provisions. Contributions to a contingency reserve or any similar provision made for events the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening, are unallowable.

Organization costs. Expenditures, such as incorporation fees, brokers' fees, fees to promoters, organizers or management consultants, attorneys, external accountants, or investment counselors, whether or not employees of the organization, in connection with establishment or reorganization of an organization, are unallowable except with prior approval of CAP Kenya.

Equipment and other capital expenditures. "Equipment" means an article of nonexpendable, tangible property having a useful life of more than one year and an acquisition cost which equals $5000.

- Capital expenditures for office equipment with unit costs in excess of $5,000 are non allowable. Note that any equipment with unit cost of $500 or more requires CAP Kenya prior approval.
- Capital expenditures for general purpose equipment, buildings, and land are unallowable.
- Capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life are unallowable.

Depreciation of assets and use allowances. These are unallowable since the accounting policy guiding this award is cash basis. Hence, all acquisition costs for eligible fixed assets (e.g. office equipment etc) are to be expensed directly against the grant award.

Donations and contributions. Contributions or donations, including cash, property, and services, made by the organization, regardless of the recipient, are unallowable.

Donated services received: Donated or volunteer services may be furnished to an organization by professional and technical personnel, consultants, and other skilled and unskilled labor. The value of these services is not reimbursable either as a direct or indirect cost. However, the value of donated services may be used to meet contribution requirements. Donated goods i.e., expendable personal property/supplies, and donated use of space may be furnished to a non-profit organization. The value of the goods and space is not reimbursable.

Fund raising and investment management costs. Costs of organized fund raising, including financial campaigns, endowment drives, solicitation of gifts...
and bequests, and similar expenses incurred solely to raise capital or obtain contributions are unallowable.

**Goods or services for personal use.** Expenses of goods or services for personal use of the organization’s employees are unallowable regardless of whether the cost is reported as taxable income to the employees.

**Interest.** Expenses incurred for interest on borrowed capital, bank overdrafts or temporary use of endowment funds is unallowable.

**Selling and marketing.** Costs of selling and marketing any products or services of the non-profit organization are unallowable.

**Over expenditures.** Any budget overruns or excess of costs over income.

**None budgeted costs.** Expenses incurred by the grantees, but which were not originally approved in the award contract.

**Non business/personal expenses.** Such expenses incurred by employees or officers of the organization for personal reasons are non allowable.

**Exempt Taxes.** Taxes from which exemptions are available to the organization directly or which are available to the organization based on an exemption afforded the US Government and in the latter case when the awarding agency (CAP Kenya) makes available the necessary exemption certificates are non allowable. Any refund of taxes, and any payment to the organization of interest thereon, which were allowed as award costs, will be credited either as a cost reduction or cash refund, as appropriate.

### 3.5 Audits

AED retains the right to conduct financial reviews or audits of all grantees. AED will conduct spot checks of grantees throughout the award period.

The audit should be a positive experience and not one to be feared. It is an opportunity to receive feedback on strengths and weaknesses in systems. Audits should be used to discuss ways of improving the organization’s accounting systems and procedures. Audits are important for any organization as they demonstrate a commitment to transparency and accountability and bring credibility to the organization.

Audits are conducted to ensure that an organization has internal controls in place in order to comply with the grant terms and conditions (laws, regulations, and provisions). Audits provide an independent opinion of the internal controls. For CAP Kenya this is a long-term approach to find gaps and to recommend corrective action.
Internal Audit: Internal auditing is primarily directed at improving internal controls by assessing:

- Effectiveness and efficiency of operations
- Reliability of financial reporting
- Compliance with laws and regulations

Internal audits are performed to evaluate whether an organization’s policies and Internal Control systems are designed and operating effectively and to provide recommendations for improvement.

External (or Statutory) Audit: Statutory audits are governed by the Company’s Act Cap 486. They are performed to express an opinion on whether an entity’s financial statements are free of material mis-statements. External audits provide an independent opinion of the internal controls.

CAP Kenya requires all grantees to undergo annual audits by approved auditors. The cost of this audit shall be incurred by the grantee and may be charged to the grant on a pro-rata basis. If any unallowable costs are uncovered through the audit, AED reserves the right to demand a full refund.

Donor-Specific (USAID)Audit: Regulations for audits are defined in OMB Circular A133. Non-U.S. based organizations expending US$300,000 or more per fiscal year must have a single audit conducted in accordance to OMB Circular A-133. A single audit is an audit that includes both the organization’s financial statements and the federal awards: it covers the entire operations of the auditee. It is conducted using the Generally Accepted Government Auditing Standards (GAGAS) and it is a financial as well as an administrative audit.

Steps to prepare for an audit

- Review financial, administrative, and project management systems
- Read and understand the laws, rules and regulations, terms and conditions of the award
- Identify and prepare the resources that will need to be made available to the auditor
  - Have policies and procedures in place
  - Grant agreement including any modifications
  - Monthly financial reports with fully supported documents
  - Bank statements
  - Designate a contact person who will provide the auditors with the required records and schedules
- Respond fully and on a timely basis during the audit and resolution

Types of audits

1. Financial Audits examine integrity of financial records and accounting practices
2. *Operational Audits* examine the effectiveness and efficiency of operational practices

3. *Integrated Audits* examine both financial and operations control

4. Compliance Audits examine adherence to laws, regulations, policies, and procedures

5. *Information Systems Audits* test system operations against a reference standard

6. *Forensic Audits* include detailed audit procedures to identify if there has been any illegal, unauthorized or unprocedural use of funds and assets and to establish the identity of those responsible
SECTION 4: PROGRAM IMPLEMENTATION AND MANAGEMENT

This section provides guidance on program management and implementation.

4.1 Activity Implementation Timeline

The Activity Implementation Timeline (AIT) is due to CAP Kenya within the **first 30 days** of the grant award period. A sample template of the AIT can be found at Appendix O.

The AIT is a reference document for the grantee to use throughout the implementation period. It can assist a grantee to determine:

- When is an activity due?
- What activity do we need to implement?
- Where is this activity to be implemented?
- Who is responsible for implementing this activity?
- How will we go about implementing this activity and how much does it cost? (activity based planning)

The grantee specifies within the AIT which activities will be carried out by quarter. The activities which should be listed are those which were named in the Program Description document and are organized by result.

The AIT should be used to track progress towards carrying out activities which is then reported to CAP Kenya via QNRs and the Final Report. The document works in conjunction with the Program Monitoring Plan.

4.2 Program Monitoring Plan

Monitoring and evaluation should be an ongoing process and an essential element of every program, providing a way to assess the progress of the program in achieving its goals and objectives and informing key stakeholders and program monitoring plan. Successful programs have a natural cycle of planning, implementation, monitoring, and evaluation which is ongoing and is a vital aspect of the organizational culture. For M & E to provide useful results, it must be incorporated into the program at the design or initiation stage. Therefore, the grantee will create a Program Monitoring Plan (PMP) **within the first 45 days of the program.** A sample template of the PMP can be found in Appendix P.

The PMP is a reference document to be used throughout the grant award period. It will guide the design of M & E activities, highlight what information or data needs to be collected, describe how it will be collected, and specify how the information will be used and disseminated.

The data and information in the PMP should be used actively to inform decision-making about programs, rather than just a tool to report to funders.
The PMP is a document that details:

- Program objectives;
- Interventions developed to achieve these objectives; and
- A description of indicators that will be implemented to determine whether or not objectives are met.

CAP Kenya will conduct monitoring visits throughout the award period. During visits CAP Kenya and the grantee will:

- Review progress that the grantee is making towards achieving program targets, as listed in the PMP and AIT.
- Discuss program performance, lessons learned, challenges, and, where possible, propose possible solutions
- AED will work towards validating reported program results and targets
- Review program and financial filings
- Provide financial technical assistance and review financial systems
- Discuss other program and financial aspects pertinent to the grantee

**TIP: A useful tool for Program Management**

The Project Diary

A project diary is a log of what happens during a project. It may be a confidential document written by a single person or used by a project team. The project diary is a valuable source of data for performance monitoring. It is a reflective diary which asks:

- Why did we do that?
- How well did it work?
- What other options did we consider?
- Why did we make the choice we made?
- How do we (or I) feel about this stage of the project?

*Project Diary Guidelines can be found at Appendix Q*
SECTION 5: GRANTS CLOSEOUT

When the end of the grant period has been reached, CAP Kenya requires that the grant must be “closed out.” This section provides guidance on the procedures to be followed in this process.

When the end of the grant period has been reached, or the grant is terminated, AED requires that the grant must be “closed out.”

The Closeout Process:
The grantee must submit several documents to CAP Kenya in order to close out a grant and to receive the final payment installment. These documents will be reviewed by CAP Kenya and AED in Washington, DC.

- Final Narrative and Financial Reports
  - When the grant agreement comes to an end, your organization must submit the final reports together with supporting documentation to be reviewed and approved by both CAP Kenya staff and AED/Washington staff. These reports include both the final financial and narrative reports.
  - More detailed information on these reports can be found in Section 2.3. The Final Narrative Report template can be found at Appendix M.

- Inventory list of all equipment, furniture, and supplies purchased in the grant (using the CAP Kenya template)
  - A listing of all the equipment, furniture and inventory supplies purchased with funds under the agreement must be submitted to CAP Kenya by the 30th day following the end of the grant award period.
  - Grantees are required to use the standard CAP Kenya inventory reporting template
  - Further note that this final inventory report should be based on a physical inventory taken on the last day of the grant agreement.
  - The template for the Inventory Report can be found at Appendix F.

- A request for disposition of any equipment purchased, valuing more than $500
  - Grantees must submit to AED a formal request for the disposition of the equipment and furniture purchased with acquisition costs of $500 or more per unit.
The template for this request can be found at Appendix G.

- Copies of all publications produced as a part of the grant
  - Hard and soft copies should be submitted to CAP Kenya
  - Final payment for the grant will be held until these publications are received.
- Close-out certification on the organization’s letterhead stating:
  - The organization has received all funding owed due under the agreement;
  - The organization is not owed any outstanding funding; and
  - There are no outstanding debts owed to the grantee from CAP Kenya.

**Final Payment**
- The Standard Grant agreements entered into between your organization and AED specifies that final grant payments will not be made until the final close-out of the grant is completed (e.g., all financial reports, programming reports, and publications produced with grant funds are received).
- The agreement clearly stipulates that 10 percent of the total amount of the grant is to be withheld until close-out completion.

Please note that no any other expenses can be incurred after the grant agreement end date. AED will pay for accrued expenses (expenses incurred prior to agreement end date, but billed subsequently).

**All closeout reports, letters, and forms are due by the 30th day following the end of the award period.**
SECTION 6: INSTITUTIONAL STRENGTHENING

For CAP Kenya, Institutional Strengthening (IS) is the process by which organizations improve their organizational and technical capacities to delivery high quality programs.

CAP Kenya undertakes a participatory analysis of grantee needs in the four key capacity areas – institutional development, technical, program, and financial management – as the basis for developing IS technical assistance packages.

Each grantee has Ksh 500,000 budgeted for IS activities. This will be used for the initial assessment and any of the activities identified for improvement. Funds for Institutional Strengthening can only be used once an improvement plan is approved by CAP Kenya.

Through the use of participatory assessment tools, CAP Kenya begins the IS process by assisting the grantee organization to take inventory of its strengths in each of the capacity areas and facilitates the identification of priority areas for improvement. This strategy encourages a holistic view of an NGO and requires considerable input on the part of both the grantee and CAP Kenya staff. The tools identified for CAP Kenya are outlined below. The tools are adapted to fit each unique institution but the core elements are retained.
### Institutional Strengthening Assessment Tools:

<table>
<thead>
<tr>
<th>Capacity Area</th>
<th>Description</th>
<th>Assessment tools</th>
</tr>
</thead>
</table>
| **Institutional Development**  | a process of organizational change supported by top management to raise and sustain organizational performance/effectiveness and lead to better organizational health | • Management Questionnaires  
• Institutional Development Framework (IDF)  
• Rapid Organizational Reviews  
• Staff reviews  
• Document reviews  
• Most Significant Change Technique |
| **Technical Capacity**         | Institutions’ abilities to access accurate and up to date information that is relevant to their technical program needs and thereafter translating the learning into their programming. | • HIV and AIDS technical Assessment  
• SAP technical Assessment |
| **Program Capacity**           | Ability of an organization to design and deliver programmes and services that are appropriate, cost effective and of high quality | • Data Quality Audits  
• Program Review |
| **Financial management Capacity** | The capacity to utilize financial resources appropriately, track financial transactions and report on financial status | • Monthly Financial Reports  
• Spot Checks  
• Audits |

Following the results of the respective assessments, CAP Kenya staff and stakeholders from grantee organizations will identify priority areas of improvement. CAP Kenya’s technical support team will then analyze the priority areas and identify any areas of overlap across the portfolios with an aim to develop appropriate technical assistance packages.
CAP Kenya works with the grantee to develop an improvement plan which guides the provision of technical assistance and training in the respective areas.

1) Financial & Risk Management

CAP Kenya builds the Financial Management capacity of its partners through a number of measures that not only ensure sound financial management of the award granted by CAP Kenya, but make the organization more attractive to other donors in the future.

Some of the specific areas of weakness in the financial systems that we address include strengthening procurement procedures, and ensuring adequate supporting documentation for financial transactions, enhancing accounting systems, developing financial policy manuals, and improving petty cash management.

Emphasis on financial management will be on the following:
- Introduction and compliance to financial policies and procedures manuals (created by grantees)
- Accurate accounting practices through the application of computerizing accounting systems
- Risk Assessments and follow-up based on Monthly Financial Reports
- Site visits to verify grantee reports and to audit internal control systems
2) Organizational Strengthening and Development:

Through the use of participatory organizational assessment tools, CAP Kenya assesses the organizational development of grantees and facilitates the organizations to come up with improvement plans to address areas of weakness which are also considered a priority.

By looking at aspects of oversight and vision, management resources, human resources, financial resources, external resources and HIV/AIDS technical capacity, the grantee and CAP Kenya work together to identify the priority areas. CAP Kenya then provides technical assistance (TA) for some of the aspects of the improvement plan.

3) Technical Capacity Building & Program Management:

CAP Kenya aims to see that grantees have the skills to be technical leaders in HIV and AIDS prevention and treatment and in the protection of OVC. Specifically, CAP Kenya will enhance grantee capacity in the technical areas that have been highlighted by the Government of Kenya and the Kenya PEPFAR country office.

IS Activities

Technical Assistance (TA): TA is provided throughout the grant period to strengthen the programmatic work of grantees in areas such as technical aspects of HIV/AIDS, M & E, advocacy, and community mobilization. This is done either one-on-one or in groups.

Training: Workshops will be conducted on topics of benefit to grantees, to all grantees during quarterly meetings or other organized forums, or to specific groups, e.g. PLWAs, PWDs, substance abusing communities etc. Possible topics may include, but are not limited to:

- Resource diversification
- Financial management
- Program design
- Monitoring and evaluation
- Organizational governance and management
- External relations
- Understanding gender issues, etc…

Peer Capacity Building: CAP Kenya acts as a catalyst for networking and experience sharing between grantees. At partner forums, grantees are brought together to learn from each other, share experiences and problem-solve together. These meetings, in addition to enabling grantees to share their experiences, also provide a platform for them to organize exchange visits to enhance their experiences and cross-organizational mentoring.
CAP guides the process by recommending which groups would be a good match based on information on grantees and their programs. Matches are made based on similarities in program design or identification of success models of aspects/components that others are considering incorporating or adapting into their own programs.

During the visits, grantees observe how colleague organizations implement programs, discuss best practices, and brainstorm areas of potential collaboration.

Exchange and networking visits are primarily conducted for the following objectives:
   1) To share experiences and meet beneficiaries
   2) To learn strategies & approaches and how they overcome challenges
   3) To explore possibilities of networking and collaboration

Technical assistance packages are implemented at 3 different levels:

<table>
<thead>
<tr>
<th>Target</th>
<th>Specifications</th>
<th>Response/Delivery mechanisms</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| **Individual** | • Officers in the org  
• Specific grantee | • Monitoring visits  
• TA visits  
• Sharing of resources  
• Exchange visits | • Coaching  
• Mentoring  
• Skills building  
• Peer support |
| **Group** | • Technical Area specific e.g. Finance, M&E  
• Program area e.g. OVC, SAP | • Founder’s Forum  
• Group Trainings  
• Exchange visits | • Skills building  
• Peer support |
| **Cohort** | • All grantees | • Partner’s forum  
• Sharing resource  
• Grant Management trainings | • Exposure  
• Learning  
• Peer support |
The table below provides a summary of all the IS activities and types of technical assistance provided by CAP Kenya:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring visits</td>
<td>Periodical field visits to measure progress</td>
</tr>
<tr>
<td>TA visits</td>
<td>Field visits to address specific technical support</td>
</tr>
<tr>
<td>Sharing of resources</td>
<td>Provision or resource/learning material</td>
</tr>
<tr>
<td>Exchange visits</td>
<td>Field visits between two or more grantees for specific learning purposes</td>
</tr>
<tr>
<td>Founder's Forum</td>
<td>Periodic discussion sessions between founders of organizations</td>
</tr>
<tr>
<td>Group Trainings</td>
<td>Delivery of learning to a number of organizations</td>
</tr>
<tr>
<td>Partner's forum</td>
<td>Quarterly meetings hosted by CAP to all grantees for learning and review</td>
</tr>
<tr>
<td>Grant Management trainings</td>
<td>Specific training offered to grantees to address grant management issues</td>
</tr>
<tr>
<td>Coaching</td>
<td>Enabling learning and development to occur through directing, instructing and training a person or group of people, with the aim to achieve some goal or develop specific skills</td>
</tr>
<tr>
<td>Mentoring</td>
<td>Making significant transitions in knowledge, work or thinking in a person by walking alongside the person you are instructing and inviting him or her to learn from your example</td>
</tr>
<tr>
<td>Skills building</td>
<td>Developing learning through formal teaching/training to impart knowledge that will equip the leaner with practical skills</td>
</tr>
<tr>
<td>Peer support</td>
<td>Creating relations that encourage learning amongst people with similar interests and needs.</td>
</tr>
<tr>
<td>Exposure</td>
<td>Enhancing practical skills and knowledge from real life examples that one observes and participates in.</td>
</tr>
<tr>
<td>Learning</td>
<td>Gaining new knowledge and skills</td>
</tr>
</tbody>
</table>
CAP Kenya’s Approach to Institutional Strengthening

The IS process used by CAP Kenya is guided by the BASIC model:

**B**aseline Assessments
- Organizations will be assessed to determine their baseline for capacity development using appropriate tools for the different technical areas including their institutional health, HIV & AIDS/Sub technical capacity, financial management abilities, program management capacity and M&E systems.

**A**nalysis of Needs
- The assessment profiles will be analyzed by a CAP technical team drawn from the different technical portfolios and a ranking of the institutions based on capacity needs developed.

**S**trategy for TA Provision
- Grantees are then grouped according to common and unique capacity needs and a strategy for technical assistance developed by the CAP team in TA packages for individual and group interventions.

**I**mplementation of TA
- Appropriate TA packages delivered with CAP support at three levels i.e. individual, group and community levels.

**C**onsistent monitoring & Evaluation
- Progress in implementation of the TA packages will be monitored progressively and evaluated quarterly for improvement.
SECTION 7: BRANDING AND MARKING GUIDELINES

This section outlines how CAP Kenya grantees are required to comply with the marking and branding requirement by visibly marking program activity sites, public communications, program materials, and commodities with the USAID identity.

The overall intention of the USAID marking requirement is to raise the awareness of the beneficiaries of U.S. assistance that the billions of dollars of foreign assistance expended every year are provided by the American people through USAID and to ensure that the American people are credited for the foreign assistance they finance.

Grant Agreements governing relations between AED and each grant recipient includes the following language:

“As a condition of receipt of this sub-award, marking with the USAID Identity of a size and prominence equivalent to or greater than the recipient’s, subrecipient’s, other donor’s or third party’s is required. In the event the recipient chooses not to require marking with its own identity or logo by the subrecipient, USAID may, at its discretion, require marking by the subrecipient with the USAID Identity.”

Below are examples of the correct and incorrect uses of the USAID logo

Logo + Brand Mark = Standard Graphic Identity (designed to work together as a unit)
Do not recreate the identity. Use a 1 or 2 color combination, either horizontal or vertical arrangement. No other color combination or arrangement is permitted.

Do not outline the brandmark

The logo must have a white background

Do not change proportions
The program deliverables outlined below must be marked with the USAID identity of a size and prominence equivalent to or greater than that of the grantee, AED, other donors, and other partners.

(A) Activity Sites and Infrastructure Projects

Activity sites and physical infrastructure projects funded under the CAP Kenya grant will be marked as follows:

<table>
<thead>
<tr>
<th>Program Deliverable(s)</th>
<th>Marking Materials Used, Placement and Timing</th>
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</thead>
</table>
| Renovation of schools, clinics, drop-in centers and other program sites | • USAID Identity displayed on a board outside the premises of each renovated site.  
• Timing: upon completion of site renovation and for the duration of the program period. |

(B) Communications Products and Program Materials

The following disclaimer will be included in any public communications produced by the program:

“This study/report/audio/visual/other information/media product (specify) is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of [insert recipient name] and do not necessarily reflect the views of USAID or the United States Government.”
Communications products funded under the award will be marked as follows:

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<thead>
<tr>
<th>Program Deliverable(s)</th>
<th>Marking Materials Used, Placement and Timing</th>
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</thead>
</table>
| Websites               | • USAID Identity located on every first-level page  
|                        | • USAID public communications disclaimer included  
|                        | • Timing: as materials are produced |
| Grantee publications* and promotional materials | • USAID Identity printed on the bottom of the cover page  
|                        | • USAID public communications disclaimer included  
|                        | • Timing: as materials are produced |
| Media Campaigns*       | • USAID Identity printed on the bottom of the cover page of any print materials  
|                        | • USAID public communications disclaimer included  
|                        | • For TV & Radio spots, incorporate USAID’s primary message – this aid is "from the American people" – into the narrative of each broadcast.  
|                        | • Timing: as materials are produced |

(C) Events

Events funded under the award will be marked as follows:

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<tr>
<th>Program Deliverable(s)</th>
<th>Marking Materials Used, Placement and Timing</th>
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</thead>
</table>
| Grantee trainings and workshops | • A banner with the USAID Identity located at the front of the training site for the duration of the meeting.  
|                        | • USAID Identity printed on certificates, manuals and folders as produced.  
|                        | • USAID Identity contained on PowerPoint and other presentation materials, as produced. |
| Event materials         | • USAID Identity printed on all promotional materials, as produced |

(D) Commodities

Commodities and materials funded under the award will be marked as follows:

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<tr>
<th>Program Deliverable(s)</th>
<th>Marking Materials Used, Placement and Timing</th>
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</table>

* See Grant Schedule, Section L: Publications and Media Releases.
IV. Marking Exceptions

(A) Non-Deliverable Items and Items for Administrative Use

As outlined in the 22 CFR 226.91 Final Rule, grantee staff and employees will not use the USAID Identity on business cards or other personally identifying materials.

(B) Presumptive Exceptions for Program Deliverables

The following program deliverables are exempted from marking:

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<thead>
<tr>
<th>Program Deliverable(s)</th>
<th>Justification of Exception</th>
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</thead>
<tbody>
<tr>
<td>School Uniforms</td>
<td>Presumptive Exception (vi) – Marking school uniforms with the USAID logo would inappropriately set these students apart from other students, and conflict with country norms.</td>
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<tr>
<td>School Supplies and Food</td>
<td>Presumptive Exception (v) – Marking school supplies and food would be impractical.</td>
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<tr>
<td>Goats and other Livestock</td>
<td>Presumptive Exception (vi) – Marking livestock with the USAID logo would conflict with country norms.</td>
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<tr>
<td>Internal program documents (such as work plans and M&amp;E plans) for which AED CAP Kenya is the sole intended audience and no public dissemination is contemplated by recipient or AED.</td>
<td>Presumptive Exception (v) – Marking internal program documents would be inappropriate in this context.</td>
</tr>
</tbody>
</table>
**ANNEX: USAID Standard Provisions**

AED’s regulations stem from the USAID Standard Provisions that regulate the cooperative agreement between AED and USAID. These are:

2. Required as Applicable Standard Provisions for Non-U.S. Non-governmental Recipients

In addition to the Standard Provisions, the following OMB Circulars will help to understand the Standard Provisions:

3. OMB Circular A-122, Cost Principles for Non-Profit Organizations (also referred to as 2 CFR, Part 230)
4. OMB Circular A-110, Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations (also referred to as 2 CFR, Part 215)
5. OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations

The OMB circulars can be found at: [http://www.whitehouse.gov/omb/circulars/index.html](http://www.whitehouse.gov/omb/circulars/index.html).

The Standard Provisions are provided here for your reference.
APPENDICES

The following are samples of templates.

Appendix A: Schedule
Appendix B: Certifications
Appendix C: Program Description (Final Technical Proposal)
Appendix D: Final Detailed Budget
Appendix F: Inventory List
Appendix G: Disposition of Equipment Letter
Appendix H: Monthly Financial Report Checklist
  • 4a. Monthly Check Journal of Income and Expenditures
  • 4b. Monthly Petty Cash Journal of Income and Expenditures
  • 4c. Bank Reconciliation Statement
  • 5. Monthly Expenses Reporting Table
  • 6. Monthly Financial Reporting Table
  • 7a. Cash Forecast for the Current Month
  • 7b. Cash Forecast for the Next Month
  • 8. Request for Payment
  • 9. Grant Summary and Cash Request
  • 10. Quarterly Expenses Report
Appendix J: Qualitative Reporting Guidelines
Appendix K: Level I Indicators Worksheet (QNR Report)
Appendix L: Pipeline Report (Expenditure Projection Report)
Appendix M: Final Narrative Report
Appendix N: Initial Request for Advance Worksheets
Appendix O: Activity Implementation Timeline
Appendix P: Program Monitoring Plan
Appendix Q: Project Diary
### ANNEX 3—CAP KENYA INSTITUTIONAL STRENGTHENING INTERVENTIONS BY GRANTEE

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ANNEX 4—CAP Kenya Assessment Tools

a. Institutional Development Framework (IDF)

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<tr>
<th>Aspect</th>
<th>Component</th>
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<tr>
<td><strong>OVERSIGHT/VISION:</strong> Evaluating the provision of leadership and direction to an organization</td>
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<tr>
<td>Board</td>
<td>Board’s Role</td>
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<td>Active Board</td>
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<td>Board Skills</td>
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<tr>
<td>Mission</td>
<td></td>
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<tr>
<td>Autonomy</td>
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<tr>
<td><strong>MANAGEMENT RESOURCES:</strong> Mechanisms intended to coordinate activities and facilitate processes in the organization for effective program delivery</td>
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<tr>
<td>Leadership Style</td>
<td>Board</td>
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<td>Staff Teamwork</td>
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<tr>
<td>Planning</td>
<td>Mission/ Overview</td>
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<tr>
<td></td>
<td>Participation</td>
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<td>Resource Implications</td>
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<td>Work Plan as Tool</td>
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<tr>
<td>Participatory Management</td>
<td>Appropriate Delegation</td>
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<td>Transparent Decision-Making</td>
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<td>Staff Participation</td>
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<td>Communication Flow</td>
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<td>Management Systems</td>
<td>Personnel Systems</td>
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<td>File Systems</td>
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<td>Administrative Procedures</td>
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<td>Service Delivery</td>
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<td>Community Participation</td>
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<tr>
<td>Monitoring and Evaluation</td>
<td>Integration of M&amp;E into Decision Making</td>
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<td></td>
<td>Community Feedback</td>
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</table>

Governance:
The provision of leadership and direction to an organization

Practices/capacity:
Mechanisms intended to coordinate activities and facilitate processes in the organization

Sectoral expertise/use and management of technical skills and knowledge i.e. program delivery

Programs & services carried out that are appropriate, cost effective and of high quality
### a. Institutional Development Framework (IDF)

**Human Resources:** Management and staff who have the skills, motivation and opportunity to contribute to the organization

- Employee Skills
- HR Development Strategy
- Staff Training
- Staff Mentoring
- Staff Motivation

**Financial Resources:** Resources to purchase goods & services needed to conduct an organization’s affairs, track financial transactions and report on financial status

- Financial Management
  - Financial Planning
  - Financial Control
  - Financial Reporting
  - Audits
  - Separation of Accounts
- Financial Vulnerability
  - Funding Diversity
  - Local Resource Mobilization

**Financial Viability**

**External Resources:** Relations and Interaction between an organization and other development partners

- Public Relations
  - Public Recognition
  - Media Strategy

**Advocacy**

**Community Orientation**

**Ability to work with central and local government**

**Ability to work with other NGOs/CBOs**

**Technical Resources:** Institutional capacity to possess pertinent skills and knowledge that will enable effective practice of HIV/AIDS programming

- Knowledge and Skills
  - Knowledge
  - Training
  - Access to technical Knowledge
- Principles
  - Gender and HIV/AIDS
  - Human Rights and HIV/AIDS

---

*Sustainability:* The long-term contribution of an organization, program or project

*Purpose:* Judge capacity; self understanding; launch capacity enhancement
### Institutional Strengthening Review Tool

#### Section 1: Grantee/SubGrantee Details

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<tr>
<th>Name</th>
<th>Nazareth</th>
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<tr>
<td>Location</td>
<td>Limuru, Nairobi</td>
</tr>
<tr>
<td>Date</td>
<td>15th September, 2009</td>
</tr>
<tr>
<td>Assessment team</td>
<td>Lucy Njigua</td>
</tr>
<tr>
<td>Interview respondents</td>
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</table>

#### Instructions:

- **Method of Assessment:** SI = Staff interview; R = Records Review; MI = Management interview;
- **Scoring Notes:** 3 = Yes-Completely; 2 = Partly; 1 = No-Not at all; N/A = Not applicable

#### Institutional Assessment

<table>
<thead>
<tr>
<th>1. Document Review</th>
<th>Method</th>
<th>Scoring</th>
<th>Observations/rationale for score</th>
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<tbody>
<tr>
<td>Strategic plan and/or document with vision, mission, goals, objectives, values of the organization</td>
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<tr>
<td>Organogram showing the organizational structure and positions that are filled</td>
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<tr>
<td>Constitution/by-laws of Board of Trustees or management committee</td>
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<tr>
<td>Fundraising strategy/action plan</td>
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<tr>
<td>Volunteer policy/procedures</td>
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<tr>
<td>HIV/AIDS workplace policies</td>
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<tr>
<td>Human resources procedures manual</td>
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<tr>
<td>Evidence of a salary system/volunteer expenses system</td>
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<td>Sample job descriptions</td>
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<td>Annual audit report, quarterly and annual financial reports</td>
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<td>Evaluation reports</td>
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<td>Evidence of impact on policy through advocacy work</td>
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<tr>
<td>Evidence of a monitoring and evaluation system/framework</td>
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<tr>
<td>Financial policies and procedures</td>
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<tr>
<td>Monitoring/progress reports</td>
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<td>Documented lessons learned for internal and/or external audiences</td>
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### b. Institutional Strengthening Review Tool

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#### 2. Organisational Review (Staff Interview)

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<tr>
<td><strong>2.1. Governance, strategy and structure</strong></td>
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<tr>
<td>An independent board/committee (or some other system) supervises management and takes responsibility for all actions of the NGO. This system is governed by a documented constitution/by-laws.</td>
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<tr>
<td>The board has at least six voluntary (unpaid) members with limited terms of office (e.g. only appointed for 2 years)</td>
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<td>The board has representatives from the community and from beneficiary groups. No more than 75% of board members</td>
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<tr>
<td>At least 70% of board members meet every 3 months.</td>
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<tr>
<td>Board members fundraise for the NGO and can provide legal, medical and management advice.</td>
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<tr>
<td>The NGO has a written and costed strategic plan that has been revised within the last 3 years.</td>
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<tr>
<td>Board members, staff and volunteers all know the strategic values, vision and mission of the organization.</td>
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<tr>
<td>All annual workplans and budgets are developed in line with the strategic plan.</td>
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<tr>
<td>The NGO has a documented organizational structure (organogram).</td>
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<tr>
<td>Management delegate tasks and share information with everyone through regular meetings and do not try to do everything by themselves.</td>
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<tr>
<td>The NGO is properly registered according to local regulations. The board and management ensure the NGO complies with all local reporting, tax and labour requirements.</td>
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**Total Score**

#### 2.2. Programme Management, Monitoring, Evaluation and reporting

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<tbody>
<tr>
<td>All projects follow all stages of the project cycle: • needs assessment • project design &amp; indicator; • project planning &amp; budgeting development; • regular monitoring • evaluation of project and outcomes; • re-planning of projects based on evaluation outcomes.</td>
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<tr>
<td>All stages of the project cycle are done in consultation with all stakeholders, including all project staff and members from the community.</td>
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<td>Projects and programmes are developed in line with the strategic mission, goals and objectives of the organization.</td>
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**b. Institutional Strengthening Review Tool**

<table>
<thead>
<tr>
<th>Indicators have been identified for each objective/goal. All objectives are SMART (Specific, Measurable, Achievable, Relevant, Time-based).</th>
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<tbody>
<tr>
<td>All projects have documented workplans. These are reviewed against activity and updated between staff and management at least every 3 months.</td>
</tr>
<tr>
<td>All projects have documented budgets. These are reviewed against expenditure and updated between staff and management at least every 3 months.</td>
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<tr>
<td>The NGO has a monitoring and evaluation system: • Project staff collect and submit accurate monitoring data on time.; • Collected data is summarized, analyzed and produced in reports at least every 3 months.; • Monitoring reports are used by project staff and managers to review and update workplans at least every 3 months.; The M&amp;E system is clearly documented and functions fully.</td>
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<tr>
<td>All necessary project reports are completed and sent to donors on time.</td>
</tr>
<tr>
<td>The NGO completes evaluation reports at the end of every project and distributes these to relevant audiences including management, the board and donors.</td>
</tr>
<tr>
<td>Project reports are compared to financial expenditure reports to ensure activity matches with expenditure.</td>
</tr>
<tr>
<td>Project teams all meet (or communicate) at least once a week to review and co-ordinate work.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Total Score</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>2.3. Human Resources and Administration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
</tr>
<tr>
<td>It is clear who is responsible for administrative work, such as paperwork, office maintenance, transport, paying suppliers, organising events and workshops.</td>
</tr>
<tr>
<td>The procedures for administrative tasks are understood by everyone and always followed.</td>
</tr>
<tr>
<td>All administrative procedures are documented in a manual.</td>
</tr>
<tr>
<td>There is a policy for recruitment, including how: positions are filled (internally and externally); people are interviewed; job offers are made; This policy is documented.</td>
</tr>
<tr>
<td>There is a policy on salaries and promotions, including how: salaries are structured; pay rises are given; promotions are made; This policy is documented.</td>
</tr>
<tr>
<td>All job descriptions are: clearly defined; documented; regularly reviewed.</td>
</tr>
</tbody>
</table>
b. Institutional Strengthening Review Tool

<table>
<thead>
<tr>
<th>There are clear procedures for how: • the work of staff is evaluated; • feedback is given; These procedures are documented.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>There are clear procedures for how: • staff are disciplined; • staff make grievances against the NGO; These procedures are documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are clear procedures for how volunteers are managed, including: • recruitment &amp; induction; • training; • payment of incentives/stipends.; These procedures are all documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies exist to: • ensure non-discrimination and support • minimise risk of spread of; infection for HIV+ staff between staff members; • ensure staff are fully aware of HIV; These policies are documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a clear policy for training and development, including: • identifying training needs of staff; • providing for study leave if possible; • providing financial support if possible; This policy is documented.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2.4. Financial Management and Sustainability</strong></th>
<th><strong>Method</strong></th>
<th><strong>Scoring</strong></th>
<th><strong>Observations/rationale for score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All financial transactions are recorded with relevant receipts and supporting documentation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff clearly understand the procedures for how: • income is received and accounted for • money is held in bank accounts; • staff purchase goods • staff claim expenses; • suppliers are paid • staff are paid salaries; All these financial policies and procedures are documented in a manual.</td>
<td></td>
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</tr>
<tr>
<td>Project staff plan and budget for their own projects themselves.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Management prepare an overall budget for the organisation as part of the annual planning process.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Systems are in place to prevent fraud, such as: • two signatures required for every check • regular audits of stock/inventory; • strict procedures for purchase of goods/services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All expenditure is accounted for under different account categories and different donors funds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management compares expenditure against budgets for projects and overheads at least every 3 months and investigate any variances with staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An external audit is conducted at least every 18 months and includes a review of management practices. Recommendations made in audits are implemented.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The NGO always has enough cash to pay for things on a day-to-day basis.</td>
<td></td>
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</tr>
</tbody>
</table>
b. Institutional Strengthening Review Tool

| The main funding source (donor) of the NGO provides no more than 65% of the NGO's total funds. The NGO has developed many different sources of income including the local community. |
| The NGO has the capacity to develop successful proposals and wins over 50% of the bids it applies for. |
| The NGO tries to ensure its programs and services will be sustained by the community when its funding runs out. |
| The NGO engages in external relations with the community, the media, networks and coalitions of organizations |
| Funders and external organizations invite the NGO to contribute to discussions and policy development. |

<table>
<thead>
<tr>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5. Partnerships, referral systems and co-ordination</td>
</tr>
</tbody>
</table>

| Method | Scoring | Observations/rationale for score |
|----------------|
| Major collaborations/exchanges with other organizations |
| Participation in networks and coalitions |
| Referrals made (if any) |
| Plans or desires to network with any organizations |

<table>
<thead>
<tr>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL SCORE</td>
</tr>
</tbody>
</table>
b. Institutional Strengthening Review Tool

### Institutional Strengthening Review Tool - Summary

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Follow up actions required</th>
<th>Responsible person</th>
<th>Expected completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Management, M &amp; E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR and Admin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Score</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rapid Organisational Assessment

![Rapid Organisational Assessment Diagram]
c. HIV/AIDS Technical Self-Assessment

[Organization Name] [Preparer Name] [Date: DD/MM/YY]

I. Program Structure and Systems (40pts): for this section, place an “x” in the column for either yes or no to reflect specified area of assessment according to your program and/or organization. Only select “YES” if your organization meets this section completely or in full. Partial or non-applicable areas are to be indicated as “NO.”

<table>
<thead>
<tr>
<th>OVC Program Parameters</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programmatic Definition of OVC Matches the PEPFAR guidance definition and is used to determine eligibility into the program: OVC: Child 0-17 years old who is either orphaned or made vulnerable because of HIV/AIDS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Orphan: has lost one or both parents to HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vulnerable: Is more vulnerable because of any or all of the following factors that result from HIV/AIDS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Is HIV Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Lives without adequate adult support (i.e.: lives in house with chronically ill parents, recent death from chronic illness, headed by a grandparent and or headed by a child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Lives outside of family care (i.e.: in residential care or on the street)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Marginalized, stigmatized or discriminated against</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program provides age specific services according to the following recommended stages of development:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Under 2 years = Infancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-4 years = Early Childhood/Toddler</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5-11 years = Middle Childhood</td>
<td></td>
<td></td>
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<tr>
<td>• 12-17 = Late childhood/ Adolescence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program delivers gender-specific services intended to promote equity and address varying needs between males and females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program has ongoing, planned and age-specific HIV/AIDS prevention activities using nationally or internationally approved curricula to guide content of activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Middle Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Late Childhood/Adolescence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program identifies all HIV-positive children and caregivers for the purpose of providing relevant services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program supports caregiver, household and/or community capacity building and participation in the care of OVC for long-term, sustainable HIV/AIDS response efforts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program activities that involve the training of children, caregivers and health workers follow national or internationally approved curricula with respect to the topics covered (attach curricula)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program prioritize family/household care as expressed by any or all of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enable OVC to remain in a loving family situation with stability, care, protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Keep siblings together in institutional care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Encourage strong links to extended family when in institutional care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have re-integration activities back into community and secure family based placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program nurtures the meaningful engagement of children to the extent of their abilities, through all project planning, implementation, monitoring and evaluating (i.e.: child/community committees, youth mapping of interventions, and developing strategy- materials</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Annex 4 – Capable Partners Program (CAP) Kenya
End-of-Project Report
c. HIV/AIDS Technical Self-Assessment

<table>
<thead>
<tr>
<th>Understandable by children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program involves the meaningful participation of PLWHA through all project planning, implementation monitoring and evaluation – including representation among the staff.</td>
</tr>
</tbody>
</table>

### HIV and Related Service Referrals and Linkages

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Program facilitates HIV-testing by linkages or referrals to VCT or health facilities in the areas it is working</td>
<td></td>
</tr>
<tr>
<td>Program facilitates care and treatment services for all HIV-positive children and caregivers through linkages and referrals</td>
<td></td>
</tr>
<tr>
<td>Program facilitates access to facility based prevention services for eligible beneficiaries it serves including: PMTCT, PEP, male circumcision, condoms and screening and treatment for STIs</td>
<td></td>
</tr>
<tr>
<td>Program is linked to country networks, structures and committees guiding national HIV/AIDS responses: NACC, NASCOP, CACC, MoH etc.</td>
<td></td>
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</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Staff provide written referral for the clients to take to referral point</td>
<td></td>
</tr>
<tr>
<td>Staff facilitate accessing referral services either by accompanying them or providing them with the means to access it when needed</td>
<td></td>
</tr>
<tr>
<td>A system is in place to follow-up on the outcomes of each referrals made both with the client and the service provider</td>
<td></td>
</tr>
<tr>
<td>The entire referral process is documented (i.e.: list of service providers, client referral, outcomes, follow-up)</td>
<td></td>
</tr>
<tr>
<td>Referral system is reviewed at least every 6 months with all the organizations involved</td>
<td></td>
</tr>
</tbody>
</table>

### Information Collection and Utilization

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Program assesses need and has defined eligibility criteria to access each the core services provided by the program: i.e. education, health care, protection, shelter and care, psychosocial support, nutrition and economic opportunity</td>
<td></td>
</tr>
<tr>
<td>Program has tools/forms, questionnaires, registers etc.) that collect the full range of information on the recipients (Caregivers and Children) in the following or similarly classified categories at the point of entry into the program</td>
<td></td>
</tr>
<tr>
<td><strong>Bio-data:</strong> name, age, date of birth, residence etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Health:</strong> physical health, nutrition and psychosocial assessments, HIV and other illnesses testing/status, immunizations, disabilities etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Economic:</strong> household assessments, income, access to food, employment status etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Social:</strong> information related to education, protection, social support systems, family history etc.</td>
<td></td>
</tr>
<tr>
<td>Program has tools that regularly collect the above information for monitoring progress and is conducted on a regularly scheduled basis</td>
<td></td>
</tr>
<tr>
<td>Program has mechanisms to track recipients who receive multiple services within the organization</td>
<td></td>
</tr>
<tr>
<td>Staff and volunteers have been trained on proper use of tools, forms and reporting requirements</td>
<td></td>
</tr>
<tr>
<td>Program clearly documented SOPs exist to guide data collection, validation, aggregation, and analysis of data on OVC program services</td>
<td></td>
</tr>
<tr>
<td>Program has defined indicators that are measurable and relevant to the activities and intended outcomes</td>
<td></td>
</tr>
</tbody>
</table>
c. HIV/AIDS Technical Self-Assessment

| Program utilizes and feeds-back data with relevant personnel and other stakeholders for planning and operations on a regularly scheduled basis |
| Mechanisms are in place to provide ongoing quality assurance checks on program activities (i.e.: reports, supervision, project visits, data review, random sampling) |
| Program collects information from the community and beneficiaries (statistics, surveys, FGDs etc.) for its program operations and planning |

**Staffing Support and HR Related Areas**

| Organization has a operational HIV/AIDS and Workplace policy |
| Staff have ongoing access to up-to-date information and learning related to HIV/AIDS related issues |
| Clear documented criteria exists for the selection and recruitment of project staff and volunteers |
| Organization has its own on-site resource library (of any size) for staff reference to HIV information |
| All program staff, volunteers and CHWs have been trained on issues related to the program by nationally or internationally approved curriculum (to be specified in the HIV/AIDS Inventory grid, section III) (attach curricula) |
| Staff and volunteers are informed of mechanisms to express needs, challenges and emergent issues which require action beyond their abilities or designation |
| Staff and volunteers have ongoing access to supervision and support systems to monitor performance, prevent or mitigate issues of stress and burnout |
| Updated documentation exists to provide staff with ongoing guidance/reference of protocols or standards of practice expected in the operations for each program activity |
| Staff and volunteers are evaluated, at least annually, regarding their performance as a means of quality assurance |
| Mechanisms exist to provide re-training to staff and volunteers who do not meet internal performance standards |

**II. Program Activities (20pts):** For this section, provide the data on services provided, select the **Program levels Reached** by checking the relevant boxes followed by the **program activities conducted.** Place an “X” in the column indicating the services your organization is providing in each program area—**select all that apply.** When you select “other” be sure to specify the type of activity conducted in the space provided in that row.

| Total Children reached as part of the OVC Program |
| Total Children receiving **3 or more core services** (specify below) |
| Total Households reached as part of OVC program |
| Total Caregivers within these households reached with **direct services relevant** to their level of service delivery (specify below) |
c. HIV/AIDS Technical Self-Assessment

**OVС: Food/Nutrition:** Services that have the desired outcome of a child receiving enough food to ensure adequate nutritional growth and development and an active and productive life. DOES NOT INCLUDE: BROAD BASED FOOD ASSISTANCE AND FOOD SECURITY PROGRAMS THAT SERVE THE GENERAL POPULATION

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver/Family</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Systems/Community</td>
<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

**Programmatic Activity**

- Cost-contributed feeding programs within schools and aftercare program
- Nutritional Assessments and Counseling
- Community Gardens
- Therapeutic supplementary feeding of malnourished children
- Nutrition related trainings
- Other (specify)

**OVС: Shelter and Care:** Services are those that have the desired outcome of a child having adequate shelter and supervision, and that the way the child lives is similar to others in the household and community. DOES NOT INCLUDE: FUNDING TO ESTABLISH NEW RESIDENTIAL HOMES

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver/Family</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Systems/Community</td>
<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

**Programmatic Activity**

- Provision of material goods to maintain or build shelter
- Strengthening family-based care models for children
- Provision of material household necessities:
- Other (specify)

**OVС: Protection:** Services that have the desired outcome that a child is safe from any abuse, neglect, stigma and discrimination or exploitation

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver/Family</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Systems/Community</td>
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</tbody>
</table>

**Programmatic Activity**

- Facilitating birth registration and identification documents
- Preventing or removing children from abusive or exploitive situations
- Supporting child headed households
- Protection related trainings
- Facilitating child access to grants, inheritance and insurance claims
- Other (specify)
c. HIV/AIDS Technical Self-Assessment

**OVC: Health Care:** Services are those that have the desired outcome of a child having access to the health services he/she needs. DOES NOT INCLUDE: PURCHASES OF VACCINES, IMMUNIZATION PROGRAMS FOR THE GENERAL POPULATION OR CONTRACEPTIVES

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th>Child</th>
<th>Caregiver/Family</th>
<th>Systems/Community</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Programmatic Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative and treatment healthcare</td>
</tr>
<tr>
<td>HIV/AIDS care and Treatment linkages or referrals</td>
</tr>
<tr>
<td>Growth monitoring linkages or referrals</td>
</tr>
<tr>
<td>Immunization linkages or referrals</td>
</tr>
<tr>
<td>Malaria prevention</td>
</tr>
<tr>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>Sanitation and Clean water</td>
</tr>
<tr>
<td>Health related trainings</td>
</tr>
<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

**OVC: Psychosocial:** Services that have the desired outcome of a child having the human attachments necessary for normal development and being able to participate in home and community activities. DOES NOT INCLUDE MENTAL DISABILITY ASSISTANCE

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th>Child</th>
<th>Caregiver/Family</th>
<th>Systems/Community</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Programmatic Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life skills (gender sensitive)</td>
</tr>
<tr>
<td>Improving links between HIV/AIDS affected children and their community</td>
</tr>
<tr>
<td>Counseling (grief, anxiety, trauma, grief and bereavement etc.)</td>
</tr>
<tr>
<td>HIV/AIDS sensitization</td>
</tr>
<tr>
<td>Child development</td>
</tr>
<tr>
<td>General counseling</td>
</tr>
<tr>
<td>Play therapy, socialization and recreational activities</td>
</tr>
<tr>
<td>PSS related trainings</td>
</tr>
<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

**OVC: Education and Vocational Training:** Services that have the desired outcome of a child receiving educational and vocational opportunities in accord with community norms and market driven employment options, considering gender equity. DOES NOT INCLUDE: STRENGTHENING THE EDUCATION SYSTEM OR GENERAL TEACHER TRAINING UNRELATED TO OVC NEEDS

<table>
<thead>
<tr>
<th>Program Levels Reached:</th>
<th>Child</th>
<th>Caregiver/Family</th>
<th>Systems/Community</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Programmatic Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removing barriers to primary and secondary attendance</td>
</tr>
<tr>
<td>Early childhood development programs</td>
</tr>
<tr>
<td>Access to vocational training and employment</td>
</tr>
<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>
c. HIV/AIDS Technical Self-Assessment

**OVCS: Economic Strengthening:** Services that have the desired outcome of improved household economic status to meet the needs of OVC. DOES NOT INCLUDE: DIRECTLY SUPPORTING HIV/AIDS-AFFECTED OVCS

**Program Levels Reached:**
- [ ] Child
- [ ] Caregiver/Family
- [ ] Systems/Community

**Programmatic Activity**

<table>
<thead>
<tr>
<th>IGA or Small business development</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings and loan/microfinance</td>
<td></td>
</tr>
<tr>
<td>Livelihood opportunities</td>
<td></td>
</tr>
<tr>
<td>Vocational and skills training for Caregivers</td>
<td></td>
</tr>
<tr>
<td>Establishing mechanisms to support community-based child care</td>
<td></td>
</tr>
<tr>
<td>Establishing public-private partnerships</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
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</tbody>
</table>

**PREVENTION:** Services that are addressing combined efforts which are defined by PEPFAR as HIV-prevention services targeting adults which include PMTCT, AB, Condoms and other prevention, VCT, and HIV and Other Health Services* which aide in the reduction of HIV-transmission. Services can be either individually administered or in the form of community outreach as a service activity provided directly or through a linkage/referral. Note that community outreach is defined as any effort to affect change that might include peer education, classroom, small group, and/or one-on-one information, education communication (IEC), or behavior change communication (BCC). For the purposes of reporting AB approaches, community outreach does not include large-scale public gatherings. **NOTE HIV AND OTHER HEALTH SERVICES IS NOT AN ACTIVITY AREA IDENTIFIED IN PEPFAR GUIDANCE BUT IT IS INTEGRAL TO ISSUES RELATED TO HIV-PREVENTION AND RISK-REDUCTION PROGRAMMING AND IS THEREFORE ADDED IN THE PURPOSE OF THIS ASSESSMENT**

**Program Levels Reached:**
- [ ] Child
- [ ] Caregiver/Family
- [ ] Systems/Community

**Programmatic Activity**

**PMTCT: Service Activity or Linkages**
- Counseling and testing for pregnant mothers
- Appropriate referrals for ART prophylaxis for MTCT
- Counseling and support for safe infant feeding

**AB: Service Activity or Linkages**
- Community Outreach that promote being faithful: importance of faithfulness in reducing HIV-transmission, elimination of casual sex or multiple partners, development of skills for sustaining marital fidelity, adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs/norms and adoption of social and community norms that denounced forced sexual activity in marriage/long term relationships.
- Community outreach that promote abstinence with age-appropriate messaging: importance of abstinence in reducing prevention of HIV transmission among unmarried individuals, decision of unmarried individuals to delay sexual activity until marriage, development of skills in unmarried individuals for practicing abstinence and adopting of social and community norms that support delaying sex until marriage and denounce forced sexual activity among unmarried individuals.
<table>
<thead>
<tr>
<th>Condoms and Other Prevention: Service Activity or Linkages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of condoms through fixed or mobile service outlets, for free or for sale</td>
<td></td>
</tr>
<tr>
<td>Providing targeted social marketing and education to individuals who engage in activities that increase risk of HIV transmission such as engaging in casual sex encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or partner of unknown status, using drugs or alcohol in the context of sexual interactions, IUD usage, workers who are employed away from home, male circumcision</td>
<td></td>
</tr>
<tr>
<td>Providing outreach services that promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful at outreach sites which may include drop-in centers, bars, clubs, parks but do not include large scale public gatherings</td>
<td></td>
</tr>
<tr>
<td>Training peer or health care educators in the delivery of prevention messages to the target audiences in other behavior change beyond abstinence and/or being faithful</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VCT: Service Activity or Linkages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides counseling and testing for those who seek to know their HIV-status, excluding PMTCT, at a fixed site or mobile site</td>
<td></td>
</tr>
<tr>
<td>Provides referrals for counseling and testing according to national guidelines for VCT services, at a fixed or mobile site</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIV and Other Health Services* : Activity or Linkages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide referrals and/or linkages for individuals of known HIV-positive status for care and ART services</td>
<td></td>
</tr>
<tr>
<td>Provide ongoing prevention counseling for individuals of known HIV-positive status with interventions and strategies to reduce risk of transmission and/or re-infection.</td>
<td></td>
</tr>
<tr>
<td>Referrals or linkages to relative service outlets for the early detection and treatment of STIs as a means of HIV/AIDS prevention, screening and management</td>
<td></td>
</tr>
<tr>
<td>Referrals or linkages to relative service outlets for the early detection and treatment of TB as a means of HIV/AIDS prevention, screening and management</td>
<td></td>
</tr>
</tbody>
</table>

| Other |  |
III. HIV/AIDS Training Inventory (40pts): For this section, please fill in the table according to the specified headings to record the types of HIV/AIDS or other program-related information/skills which exists within your program/organization. Internal trainings conducted by the organization can be counted ONLY if it had learning objectives, followed a curricula and specified the expected knowledge skills or competencies to be gained by the participant.

<table>
<thead>
<tr>
<th>Number of Staff and volunteers in your Program</th>
<th>Total Number of Staff and volunteers with Direct HIV/OVC Qualifications</th>
<th>Number of staff With Direct HIV/OVC Qualifications by Level of Training</th>
<th>Specialty Skills or Expertise Represented among these staff (list)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Certificate</td>
<td>Diploma</td>
</tr>
</tbody>
</table>

IV. HIV/AIDS Technical Support: For this section, please select **10 topics only** in the table according to the areas of learning which are of primary interest to your organization according to what is needed most. Prioritize them on a scale of 1-10, 1 being the highest in priority and ten being the least.

**HIV/AIDS: Biology and Medical Management Issues:** Encompasses all aspects of fundamental HIV biology and the host response to HIV. Areas of focus will include HIV infection and replication, transmission, genetics, evolution, structure and function, pathogenesis, adaptive and innate immune responses to HIV, susceptibility to HIV, co-infection etc.

- HIV-Viral History, Structure and Function
- HIV/AIDS: Diagnosis, Disease Progression and Management
- Mother to Child Transmission and Its Prevention
- Palliative Care (including HBC)
- Antiretroviral Therapy, Adherence and Resistance
- HIV/AIDS and Co Infections: TB and STI
- Epidemiology: Global and Regional Trends in Infection
- Risk and Vulnerabilities to Infection: Bio-Medical, Behavioral, Socio-economic and Institutional
- HIV Counseling and Testing: Opportunities, Strategies and Standards
- Comprehensive HIV Prevention

**Behavioral and Social Issues:** Deals with issues related to vulnerable populations, human behavior and responses, the social and cultural realities of HIV/AIDS and the way in which patients and their families perceive long-term chronic disease management.

- Child Development
- HIV/AIDS, Substance Abuse and Addiction
- HIV Risk Reduction Strategies and Behavior Change
- Stigma and Discrimination
- Psycho-social support and Disclosure for HIV-Positive Adults and Children
- Gender Based Violence, Conflict and Post Rape Response
- HIV/AIDS, Nutrition and food security
c. HIV/AIDS Technical Self-Assessment

- Socio-cultural Determinants of the HIV Epidemic
- Gender and HIV/AIDS: Concepts and Interventions
- Sex and Sexuality: Understanding Perceptions, Attitudes and Expression for Health Promotion

**Organizational and Programming**

**HIV/AIDS programmatic issues related to the design, implementation, strategy development and evaluation.** Specification geared towards prevention programs, community based responses to HIV/AIDS and decentralizing facility based services. It will include examination of methodological and programmatic advances particularly best practices in HIV prevention for vulnerable populations in resource-limited settings.

- Mainstreaming HIV/AIDS Across Program Areas
- Program Management and Supervision Systems for standardized and qualified programs
- Caring for Front-line Staff: Workplace policies and Staff Support structures
- Using Data and Information Management in HIV/AIDS programming
- Adult Learning and Methodologies for Communicating HIV/AIDS Information
- Working with Specific or Special Populations (Specify)
- HIV/AIDS Programming with Illiterate and Semi-Literate Populations
- Development and Delivery of Trainings
- PEPFAR Guidance Review
- Effective Linkages and Referral Systems for Comprehensive HIV and AIDS care

**Specify Other Topics or Areas of Interest not Identified Above:** Create additional rows as necessary for multiple additions

---

**Narrative Section**

1. What kind of HIV/OVC related trainings have you received in the past year?

2. What is your organization’s greatest strength in terms of technical knowledge and/or program approach?

3. Does your organization have any areas of HIV/AIDS response that you are planning to begin working with in the next year?

4. Have you faced any particular challenges that you feel are not captured in the above sections that you wish to specify or Explain in more detail?

5. Does your organization or staff have any special needs or other specifications that should be considered in the provision of TA services: i.e. literacy, language, disabilities, religious or cultural parameters etc.
## ANNEX 5—CAP Kenya Program Achievements 2005-2010

<table>
<thead>
<tr>
<th>PEPFAR Program Area</th>
<th>Program Area Indicators</th>
<th>Oct’05-Sept 06</th>
<th>Oct’06-Sept'07</th>
<th>Oct’07-Sept'08</th>
<th>Oct’08-Sept’09</th>
<th>Oct’09-Sept’10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention - Abstinence and/or being faithful</td>
<td>2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful</td>
<td>20,200</td>
<td>9,000</td>
<td>26,794</td>
<td>37,912</td>
<td>63,436</td>
<td>157,342</td>
</tr>
<tr>
<td></td>
<td>2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful</td>
<td>-</td>
<td>456</td>
<td>843</td>
<td>297</td>
<td></td>
<td>1,596</td>
</tr>
<tr>
<td>Prevention - Other Prevention beyond AB</td>
<td>5.1 Number of targeted condom service outlets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>627</td>
</tr>
<tr>
<td></td>
<td>5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful</td>
<td>69,153</td>
<td>29,671</td>
<td>58,639</td>
<td>64,751</td>
<td>80,654</td>
<td>302,868</td>
</tr>
<tr>
<td></td>
<td>5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abs. and/or being faithful</td>
<td>153</td>
<td>134</td>
<td>578</td>
<td>207</td>
<td>167</td>
<td>1,239</td>
</tr>
<tr>
<td>Prevention – injection and non-injecting drug use.</td>
<td>Number of individuals trained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>Number of DU/IDUs reached</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,950</td>
</tr>
<tr>
<td>Prevention – Voluntary Medical Male Circumcision (CIRC)</td>
<td>Number of grantees provided with Technical Assistance to integrate VMMC into their programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Palliative Care for HIV (incl. TB)</td>
<td>6.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)</td>
<td>1</td>
<td>97</td>
<td>80</td>
<td>29</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>6.2 Total number of individuals provided with HIV-related palliative care (including those HIV-infected individuals who received treatment for tuberculosis (TB))</td>
<td>890</td>
<td>944</td>
<td>13,331</td>
<td>19,350</td>
<td>2,234</td>
<td>36,749</td>
</tr>
<tr>
<td></td>
<td>6.3 Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals</td>
<td>954</td>
<td>443</td>
<td>822</td>
<td>413</td>
<td>956</td>
<td>3,588</td>
</tr>
</tbody>
</table>
### Orphans and Vulnerable Children

| 8.1A: Primary Direct support [3 or more services] | 12,858 | 14,725 | 13,933 | 18,569 | 18,569 |
| 8.1B: Supplemental Direct support [1 or 2 services] | 13,254 | 14,517 | 20,750 | 11,984 | 11,984 |
| **8.1 Total number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex** | 14,072 | 26,112 | 29,458 | 34,743 | 30,553 | 30,553 |
| **8.2 Number of providers/caregivers trained in caring for orphans and vulnerable children** | 2,294 | 696 | 10,276 | 3,699 | 12,778 | 29,743 |
| **8.3 Number of OVC receiving food and nutritional supplementation through OVC programs** | 16,349 | 11,065 | 9,345 | 9,345 |
| **8.4 Number of Children tested and receive their results** | | | | 5,012 | 5,012 |
| **8.5 Number of children on CTX Treatment** | | | | | 102 | 102 |

### Counseling and Testing

| 9.1 Number of service outlets providing counseling and testing according to national or international standards | 40 | 249 | 345 | 120 | 120 |
| 9.2 Number of individuals who received counseling and testing for HIV and received their test results, disaggregated by sex | 1,761 | 1,437 | 18,241 | 31,441 | 48,735 | 101,615 |
| 9.3 Number of individuals trained in counseling and testing according to national or international standards | 46 | 258 | 7 | 311 |

### Strategic Information (surveillance, HMIS, M&E)

| 13.1 Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS). | 88 | 69 | 27 | 27 |
| 13.2 Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS) | 108 | 168 | 68 | 344 |

### Policy Analysis and Systems Strengthening

<p>| 14.1 Number of local organizations provided with technical assistance for HIV-related policy development | 20 | 20 | 157 | 121 | 37 | 37 |
| 14.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building | 34 | 43 | 220 | 65 | 87 | 87 |
| 14.3 Number of individuals trained in HIV-related policy development | 14 | 110 | 167 | 144 | 435 |
| 14.4 Number of individuals trained in HIV-related institutional capacity building | - | 145 | 391 | 206 | 742 |
| 14.5 Number of individuals trained in HIV-related stigma and discrimination reduction | - | 225 | 143 | 70 | 438 |
| 14.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment | - | 99 | 5 | 16 | 120 |</p>
<table>
<thead>
<tr>
<th>OVC Core services</th>
<th>Food and Nutritional Support</th>
<th>Shelter and Care</th>
<th>Protection</th>
<th>Healthcare</th>
<th>Psychosocial support</th>
<th>Education and vocational training</th>
<th>Economic opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
<td>16,349</td>
<td>11,065</td>
<td>-</td>
<td>5,150</td>
<td>-</td>
<td>2,234</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9,345</td>
<td>3,800</td>
<td>8,299</td>
<td>3,800</td>
<td>14,172</td>
<td>3,044</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9,345</td>
<td>3,800</td>
<td>14,172</td>
<td>14,172</td>
<td>16,923</td>
<td>5,671</td>
</tr>
</tbody>
</table>
## ANNEX 6—CAP KENYA HIV E-UPDATES

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<td>Bridging the Gap - Engaging Men as Partners in HIV Responses</td>
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<td>HIV Counseling and Testing : Resources to Build Skills and Quality Assurance in Programming</td>
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<td>8</td>
<td>HIV/AIDS - Taking on a Human Rights Approach to Programs</td>
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</tr>
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<td>Understanding and Responding to the Factors that Shape Sexual Behaviors in Youth</td>
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<td>Prevention with Positives (PwP)</td>
</tr>
<tr>
<td>13</td>
<td>Home and Community Based Care</td>
</tr>
<tr>
<td>14</td>
<td>Understanding Gender and HIV</td>
</tr>
<tr>
<td>15</td>
<td>Taking on Evidence Based HIV Prevention for Adolescents</td>
</tr>
<tr>
<td>16</td>
<td>Demystifying Palliative Care for PLWHA</td>
</tr>
<tr>
<td>17</td>
<td>HIV/AIDS Workplace Policies</td>
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<td>Deconstructing the Kenya National AIDS Strategic Plan III</td>
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<td>Establishing a Learning Culture Within Your Organization</td>
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<td>New Learning from the International AIDS Society</td>
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<tr>
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<td>Responding to Violence Against Women in the HIV Context</td>
</tr>
<tr>
<td>24</td>
<td>Linking HIV and Reproductive Health Services for Improved Outcomes</td>
</tr>
</tbody>
</table>
1. 2008 UNAIDS Report & Resources from the 2008 IAC Mexico

Dear All,

Please find and explore the resources below to stay plugged into developments as they emerge in HIV/AIDS:

**UNAIDS just released their 2008 Report on the Global AIDS Epidemic.** Please follow the below link to access the report in full (or by relevant sections) in addition to other valuable fact-sheets, epidemiology slides updated to 2007! This is an excellent reference to understand what some of the trends are in HIV/AIDS infection and responses regionally and globally, in addition to some of the priority areas emerging. [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp)

This week marks the commencement of the XVII International AIDS Conference in Mexico - an international conference consolidating emerging research, learning and policy in HIV/AIDS efforts around the world. You can access information generated and shared from the conference online at [http://www.kaisernetwork.org](http://www.kaisernetwork.org) I have taken the liberty of highlighting some of the information that is available for download on the web which might be of particular interest to your programs - and will continue to do so throughout the course of the week. Find the areas covered below with brief summaries and the links where more information can be accessed. In some cases you can access and download the actual presentations made at the conferences!

**The State of the Epidemic:** The opening plenary of the conference presented information that cuts across many thematic areas of the conference looking at the state of the epidemic related to epidemiology, youth populations and HIV prevention research. Presentations and session notes available for download: [http://www.aids2008.org/Pag/PSession.aspx?s=31](http://www.aids2008.org/Pag/PSession.aspx?s=31)

**Meeting the Prevention Needs of PLWHA:** The abstract session on prevention for persons living with HIV addressed several important topics. The speakers provided a perspective on issues in positive prevention, reported the results of a study reported on the development of a peer-delivered intervention for risk reduction in MSM in primary care, reported baseline data from an ongoing HIV prevention trial for discordant African-American couples, and described data from a cross sectional retrospective survey of patients in care with HIV about sexual risk behavior. Click on this link to access the full report and even power point presentations for each of the three studies presented. [http://www.aids2008.org/Pag/PSession.aspx?s=244](http://www.aids2008.org/Pag/PSession.aspx?s=244)

**Positive Prevention:** This session will review the current concepts, perspectives and experiences on positive prevention. The session will give a "framework" for positive prevention with emphasis on positive living issues; human rights issues: implications on policy and laws for different vulnerable groups, implications of treatment and care on positive prevention and the prevention of new infections; sexual and reproductive health and rights implications on positive prevention. Presentations available: [http://www.aids2008.org/Pag/PSession.aspx?s=4](http://www.aids2008.org/Pag/PSession.aspx?s=4)
Prevention in Challenging Settings: Presentations made to explore how new developments in HIV-prevention are being made with innovative approaches to education among groups who are usually not reached. This session looks at sexual behavior and practices among HIV+ Adolescent in Uganda; Community based programs empowering sex workers in Muslim communities in Nigeria among other initiatives in Thailand and Mexico. 

Children and Youth Facing HIV/AIDS: Presentations and abstracts with targeted discussions on Youth and Children and their specific challenges and needs in relation to HIV/AIDS. This session captures programmatic examples of the impact that including young people living with HIV/AIDS can have on stigma reduction in the community, the importance of HIV-disclosure for children as a policy agenda item and situational analysis of OVCs in 11 Eastern and Southern African Countries. http://www.aids2008.org/Pag/PSession.aspx?s=316

Listen To Us! Effective Advocacy Strategies: Covers strategies of HIV advocacy as experienced by the Treatment Action Campaign (TAC) in South Africa through Networks of Influence; UNAIDS in their work addressing HIV with Sex workers, and community mobilization with drug users in the Ukraine among others. Presentation and notes available: http://www.aids2008.org/Pag/PSession.aspx?s=238

2. More New Learning from the IAC and New Data Released on AIDS in Kenya

Dear All,

More leaning posted on the internet from the Mexico International AIDS Conference which concluded on Friday 8th. Find the below description of some particular areas of leaning with a link to the website where presentations, abstracts, and in some cases web-casts can be viewed and downloaded. Most of these presentations have the contact information of the presenting organizations or speakers where you can email them for a continued exchange. When you want to download a presentation simply right-click on the link written "power point" on the left hand side of the page and save or open according to your preference. For each of these areas below you can find programmatic presentations, research findings, innovative approaches or discussions for your consideration and learning.

Optimizing HIV Testing Interventions: This session captures learning and examples from 5 countries using innovative approaches to scale up access to counseling and testing services. It reports both programmatic descriptions and research findings from several countries and models including integrating other health services as points of entry for Counseling and Testing in Mozambique, a report on behavior change among repeat testers in Namibia, the outcomes of a door-to-door testing initiative in urban Uganda. Click on the link to see the full abstract and power point presentation: [http://www.aids2008.org/Pag/PSession.aspx?s=248](http://www.aids2008.org/Pag/PSession.aspx?s=248)

Psychological Well being and Mental Health of Children: This session presents a method for measuring the well being of OVCs through the development of a standardized tool. It also presents the findings from one of the largest controlled studies on the psychological health of HIV affected children as well presents learning on managing psychological conditions of HIV impacted children in resource limited settings. Click on the link to see the full abstract and power point presentation for download or viewing: [http://www.aids2008.org/Pag/PSession.aspx?s=274](http://www.aids2008.org/Pag/PSession.aspx?s=274)

The New Frontiers of Harm Reduction among Drug Users: Our understanding of the global state of drug use has matured in recent years, so a more global approach to harm reduction has developed encompassing human rights, non-injecting drug use, alcohol and tobacco use, issues for producer countries, challenging oppressive legal systems, and engraving drug use within a broader poverty and marginalization agenda. This session will aim to outline some of the new frontiers for the developing international harm reduction agenda including the frequent violations of the human rights of drug users, the emergence of a new generation of drug users, the engagement of drug user activists in policy discussion and creation, and the changing scenarios in Africa, Latin America and the Caribbean. Click on the link to see the full abstract and power point presentation for download or viewing: [http://www.aids2008.org/Pag/PSession.aspx?s=8](http://www.aids2008.org/Pag/PSession.aspx?s=8)

HIV on the Job: Policies: Speakers presented a number of policy initiatives from different regions designed to address HIV issues in the workplace – including workplace HIV prevention programs, and strategies to combat discrimination against PLWHA - with examples from India,
South Africa, Jamaica, Canada and Russia. Click on the link to see the full abstract and power point presentation for download or viewing: [http://www.aids2008.org/Pag/PSession.aspx?s=268](http://www.aids2008.org/Pag/PSession.aspx?s=268)

**Beyond Barriers: Disabilities and AIDS:** This session presents issues dealing with HIV/AIDS prevention and response activities among disabled populations. It looks specifically at the following: Risk behavior among those with chronic mental illnesses in Brazil, the South African HIV/AIDS response for the disabled, and working with deaf communities in Cameroon and Brazil. This session can be viewed as a web-cast, in addition to accessing presentations and abstracts by following this link: [http://www.aids2008.org/Pag/PSession.aspx?s=277](http://www.aids2008.org/Pag/PSession.aspx?s=277)

**Communicating With Children About Their Illness:** With the number of children with HIV/AIDS around the world, particularly in areas such as sub-Saharan Africa, there is a great need for health professionals to feel comfortable communicating with them about illness and its possible outcomes. This workshop explores issues around communicating with children with HIV within the palliative care context e.g. using play, sharing challenges they have experienced, and hearing it from the children themselves through the use of video clips. Click on the link to see the full abstract and power point presentation for download or viewing: [http://www.aids2008.org/Pag/ppt/THSB0401.ppt](http://www.aids2008.org/Pag/ppt/THSB0401.ppt)

**Kenya AIDS Indicator Survey - 2007:** Attached to this email is the report newly released by the Ministry of Health presenting updated surveillance data on HIV prevalence in Kenya as well as coverage of testing, care and treatment services. This is an important read for you and your team.
3. HIV/AIDS Responses with Children and Youth

Dear All,

This week's HIV E-Update has a special focus on HIV/AIDS responses with children and youth: From direct points of service now available for young people in Kenya to toolkits and guidelines for program design!

**Interactive - Youth Friendly Services and Support:** In recent years much emphasis has been placed in service providers to design programs that target and support youth to access HIV and other sexual health services in a sensitive, friendly and non-judgmental environment. Apart from drop-in-services, in most cases for young people being able to ask questions and get support from the comfort of their own home can be a critical first step to accessing VCT, prevention and care and support services at a facility! Here are two up-coming resources for you to sensitize your staff and your communities about

**One-2-one Youth Hotline:** a toll-free service provided by Liverpool VCT and Care specifically for youth! They can call from a land-line or from a Safaricom line for **free** to talk to a counselor privately to seek support, advice and information on a full range of issues spanning sex and sexuality, reproductive health, relationships, rape, abuse, HIV etc... All calls are confidentially answered by trained counselors. one2one services also include sms question and responses and emails!

- **Schedule:** Weekdays 8:00am - 8:00pm, Weekends 10:00am - 8:00pm
- **Landline:** 0800 22 11 121
- **Safaricom:** 0800 720 121
- **SMS questions can be sent to +3164250035**
- **Email can be accessed on [www.one2onekenya.org](http://www.one2onekenya.org)**

**NASCOP E-counseling:** The MoH has launched an e-counseling service on the NASCOP website where individuals can email questions or concerns to a counselor through a web-based system between the hours of 9:00am - 4:00pm on Weekdays. All that you are required to have is an email address to which your questions can be responded to. to access this service visit: [http://www.aidskenya.org/E-VCT/Online-Counselling](http://www.aidskenya.org/E-VCT/Online-Counselling)

**Resources for working with Children and Youth in HIV/AIDS Programs:** When working with OVCs, it is critical as you mitigate the impact of HIV/AIDS that you are directly working to reduce the impact that stigmatization has on these affected and infected children. At the same time, building interventions that support the growth and development of children into healthy adolescents means keeping prevention as a central component throughout your activities. The below resources target these two very critical issues with actual steps, exercises and principles to adopt into your programs for more effective service delivery. I have provided the web-link as well as attached zip files to this email for both documents for you to download whichever mechanism is best suited for you.
**Understanding and Challenging HIV stigma: Toolkit for Action:** What is the impact of stigma on children? This toolkit aims to help explore and understand the different ways in which children are stigmatized, and to look at strategies to change attitudes and experiences. It provides guidance to help trainers plan educational sessions with community leaders, or to organize groups to raise awareness and promote practical action to challenge HIV stigma and discrimination. This toolkit includes how-to exercises for children and for adults to facilitate stigma and discrimination reduction programming. This is attached to this email or can also be downloaded from the link: 

**HIV/AIDS Prevention and Care Among Vulnerable Young People: a Framework for Action:** This guide reviews the evidence and identifies priority issues surrounding prevention and care of HIV and AIDS amongst especially vulnerable young people. It provides a framework within which programs should be designed - bearing in mind five core principles for HIV and AIDS programs for young people.

1. Young people and their needs should be placed at the center of the program
2. Programs must support the meaningful participation of young people in design and development.
3. Commit to protecting and promoting the rights of young people.
4. A clear gender focus must be present to respect the needs of both young women and men
5. Commit to tackle societal vulnerability and individual risk in prevention efforts.

The guide concludes by identifying impact, risk and vulnerability as three key areas in which work is needed, and lists approaches which can be effective in each of these areas. It is attached to this email but can also be found at this link: 
http://www.safepassages.soton.ac.uk/pdfs/evypframework.pdf
4. Behavior Change and HIV Response Programs

Dear All,

This week's HIV E-Update is taking a closer look Behavior Change. Great strides have been made in educating communities on HIV and its prevention; however, many individuals still struggle with their ability to affect change in their behaviors when it comes to their daily lives in the context of their relationships, families and even communities at large.

Behavior change is a cross-cutting issue for programs. No matter who you are working with; children or adults, marginalized groups or the generalized population - HIV/AIDS response efforts require an element of behavior change at all levels for all people. There are different models which can be used and should be selected according to your target audience. Attached are two documents to provide a summarized introduction to the various models of behavior change which are commonly used:

- "Behavior Change: A summary of 4 Major Theories." (attached pdf), produced by FHI for HIV and other health programs.
- "Modeling and Reinforcement to Combat HIV (MARCH) Model," (attached pdf) - specific for HIV related behavior change efforts.

But understanding Behavior Change is the first step.... Below are FREE online resources and interventions for HIV prevention, risk and stigma reduction as part of the Behavior Change (BC) Toolkit. This online Toolkit is a collection of resources that are designed to help people make healthier and safer relational and sexual choices. This online toolkit provides a background on BCC methodology but goes beyond that by providing a full range of tools to facilitate interactive health promotion with specific communities including: Youth, Faith based settings, Couples, the workplace and health care settings: You can navigate the site for tools of choice by clicking here: http://go2itech.org/HTML/BCC/bctoolkit.html. Explore these tools for your programs and for your organization as a whole.

Featured tools include:

- **The AED - SMARTWork Workplace Guide for Managers and Labor Leaders:**
  *HIV/AIDS Policies and Programs* provides a thorough, step-by-step approach to help workplaces respond to the risks of HIV/AIDS through policies, prevention education, care, and support programs. This website also offers a sample HIV/AIDS Workplace policy - with all its essential components - that you can edit to suit your own organization! [http://www.smartwork.org/pubs/](http://www.smartwork.org/pubs/)

- **Talk Time I** is a guide developed in Zimbabwe for facilitating group discussions about HIV/AIDS. It can be used in communities, churches, workplaces, and among friends and family. There are ten sessions in Talk Time I, and each one is designed to last approximately one hour. *Talk Time I* will assist people to reflect more deeply on the...
problem of HIV and AIDS, relationship dynamics and other related issues. Download the facilitators guide and the 10-sessions:

- **Auntie Stella** is a collection of 40 question and answer cards. The youth seek information and advice from Auntie Stella on a variety of topics. Each letter has a reply from Auntie Stella, as well as small-group discussion questions. There is also extra material for teachers and facilitators. *Auntie Stella* is designed to allow youth to work on their own in small, mixed-gender groups. It includes role-plays, drama, quizzes, research projects, and creating songs, stories, maps and diagrams. All have been designed to encourage critical thinking and reflection.
5. HIV Peer Education - Guides, Manuals and Standards

Dear all,

Mitigating HIV/AIDS is a balancing act between providing services to those affected and infected, as well as building the capacity of caregivers and the community to sustain long-term responses. As many of you already know (and are doing), one of the most common methods to facilitate this is by engaging peer educators in your program work! Peer education is a process of carrying out informal or organized educational activities with individuals or small groups of peers, over a period of time. Its success is attributed to being community based, culturally appropriate, economically effective and enabling for marginalized or high-risk groups - primarily because the educators share the same life experience as that of the people they are reaching.

The key to effective peer-education programs is making sure that the peer educators themselves are well equipped with qualified and relevant information as well, with the skill to know how best to communicate that information to their audience to be received and adapted. This week's E-Update provides you with resources for you to use for your training programs - both for your program staff/volunteers and for the beneficiaries you serve. These resources provide a mix of workshop guides, curricula and quality assurance checklists that can support the operations of your programs. They are individually zipped as attachments to this email for easier download.

Standards for Peer Education Programs: This guide provides a basic reference and guidance tool for program managers, supervisors, trainers, and peer educators themselves. The standards of practice provides a checklist with definitions of the minimum essential elements that should be considered or present in HIV peer-education programs from planning through monitoring and evaluation stages of the project cycle. The Standards can also provide you with a quick-assessment of the comprehensiveness of your peer-education activities that your organizations are implementing, and highlight the gaps that need to be filled according to these internationally developed best practices.

Peer Education: Outreach, Communication & Negotiation: This training manual describes ways in which NGOs may design and implement strategies and work-plans for peer education, as part of comprehensive sexual health interventions. This manual includes technical content for training of peer educators as well. This manual was developed by the Alliance in India.

Guide for Implementing TAP (Teens for AIDS Prevention): This particular manual is a youth and school based peer-education program guide that has similar components to the above documents regarding the steps and components needed for a peer-education program. However, it goes further and contains more than 150 pages of discussion guides, games and teaching aides that youth educators can use to facilitate HIV and STI prevention education with other youth. For those of you working with other populations apart from youth, these tools can be easily adopted to be more relevant for the communities you work with as well!
References for Attachments


6. Bridging the Gap - Engaging Men as Partners in HIV Responses

Dear All,

This edition of the HIV-E Update is dedicated to the importance of engaging men and boys for sustainable and comprehensive HIV-responses. Culture and other social norms attribute very specific roles, responsibilities and expectations to men and women. This often dictates our behaviors and attitudes which inevitably have an impact on all aspects of our lives - particularly health. In the context of health promotion and HIV/AIDS, we know that power dynamics, communication, types of partnerships among many other issues have strong ties to culturally defined gender norms - more often than not with men being having the upper hand.

Men should therefore be understood and engaged as key players in the process to curtail the spread of the virus, promote gender equity in the context of partners, fathers and peers as well as expand access and uptake of counseling, testing, care and treatment services. However, one of the key findings from the 2007 KAIS Report revels to that there is much work to be done to reach males in our various community responses to HIV/AIDS.

Fortunately, there are many resources that provide us with a starting point to conceive and roll out interventions that better include men in our services and responses. The below documents provide you with case studies and curricula to assist you through this process. And through these tools we can see very clearly that HIV/AIDS is connected to many other issues in the lives of men and the community at large - you programs can have great impact. And as demonstrated below- working with men in HIV-response efforts is an approach to has residual effects: Empowering, protecting and creating a more supportive environment for women and children!

**Men's Reproductive Health Curriculum:** This three-part curriculum is designed to provide a broad range of health care workers with the skills and sensitivity needed to work with male clients in the area of sexual and reproductive health. Although this curricula applies to issues broader than HIV/AIDS to include other sexual health issues and concerns - it aims to build skills to engage men in the discussion of sensitive issues to facilitate their willingness to access health services. Module 1 provides the introductory concepts that will allow you to better shape your organization to initiate and provide men's services. Module two focuses on strengthening service providers with the ability to interact, communicate and counsel men - as individuals or in the context of their partnerships. Module 3, has a clinical focus and addresses the actual training on the management of reproductive health disorders- for those of your program with facility or community based medical services. Due to the size of the documents these are not attached to the email. To download both the trainer and the participants manual separated by module click here: [http://www.engenderhealth.org/pubs/gender/mens-rh-curriculum.php](http://www.engenderhealth.org/pubs/gender/mens-rh-curriculum.php)

**Working with Men, Responding to AIDS:** is a consolidated document of case studies of programmatic approaches implemented by NGO's situated in nearly all corners of the world. This collection of case studies not only describe HIV/AIDS projects that are working with men, but also other kinds of projects that address other issues and problems relating to men (for example, gender identity, sexuality, violence) for the purpose of demonstrating the following:
Each case study captures the background, how the project works with men, what the results are and lessons learned. It even provides the contact information to the organization should you wish to engage in a more in depth discussion or get more information.

**Young Men Redefine Masculinity: a Training Manual**: This manual promotes the positive aspects of masculinity, encouraging men’s participation in sexual and reproductive health, promotes respect for sexual diversity and improves the understanding of the body and sexuality. HIV prevention is addressed within the larger framework of gender roles and relationships. Activities discussed in the manual are organized around four key themes: gender, sexuality and reproductive health, violence and HIV and AIDS prevention. It was developed through community participatory research in the Indian context and was based on a program implemented first in Brazil. This speaks to the adaptability of the manual to fit various cultural and geographic contexts. To read or download the manual click here: [http://www.popcouncil.org/pdfs/horizons/yaaridostieng.pdf](http://www.popcouncil.org/pdfs/horizons/yaaridostieng.pdf)

**Men As Partners: A Program for Supplementing the Training of Life Skills Educators**: is a life-skills development curricula developed by Engender Health to facilitate working with men to address gender norms that put men and their partners at risk for diseases and other negative reproductive health outcomes including issues gender-based violence. It contains a variety of interactive activities on gender and sexuality, male and female sexual health, HIV and AIDS and other sexually transmitted infections, relationships, and violence, as well as general resources for facilitators, including tips for improving facilitation skills and sample introductory and icebreaker activities.
7. HIV Counseling and Testing: Resources to Build Skills and Quality Assurance in Programming

Dear All,

Counseling can arguably be called the backbone of all HIV-response interventions. Whether your programs are working with people to reduce risk, support positive living and/or face the challenges HIV/AIDS may pose in their lives, counseling becomes a critical part of that process. Counseling in the context of HIV/AIDS is one that requires a mix of skill and intuitive sensitivity when dealing with the circumstances in any individual's experience. Counseling is an intensive process that requires program managers to be responsive and supportive to enable staff to remain healthy and equipped in the face of complex challenges they face in the field. Below are a set of resources that can assist your programs to do just that. These tools and manuals have been developed with the focus on skill building and supervision monitoring for HIV-counseling in various contexts: VCT, youth, children and grass-roots programming. They are attached in zip-format for easier download.

The **Interpersonal Communication and Counseling Manual on HIV and AIDS**, developed by FHI, is designed to help facilitators run a 10-day workshop. The workshop offers training in communication processes, HIV prevention counseling, counseling skills and strategies for people living with HIV/AIDS, as well as the provision of care and support services for the identified population, including orphans and vulnerable children. This is a fantastic all-in-one tool to train or re-train your project counselors and staff to be handle the issues they face in the field and to be better able to respond with strengthened skills.

**Building Resilience in Children Affected by HIV/AIDS** is a handbook designed especially to provide psychological support and therapeutic responses to children! This handbook, developed in Namibia, aims at helping parents, caregivers and teachers to understand children who are nursing a diseased parent or who have lost a parent. It provides practical advice for teachers and caregivers on how to support children who have experienced loss and death in order to help them cope. It offers ideas for discussions that can be held on a one-to-one basis in the child’s home or with a group of children in the classroom. Find within a collection of ideas, theories, tasks and exercises that should help us to understand the behavior and feelings of children affected by HIV/AIDS to guide the responses of your program staff and volunteers.

**Counseling Supervision and Training** (participant and trainer's manuals both attached) provides another all-in-one guide to training supervisors in HIV/AIDS counseling programs. This is an essential component for any program, creating quality assurance and staff-support systems for your counseling staff/volunteers. The curricula can be used to train your mid level or senior management staff responsible for activities that include but are not limited to VCT, HBC, peer and other counseling. The overall aim of the counseling supervision training course is to create pools of counseling supervisors who have the skills necessary to supervise, provide emotional support to and address the professional development of counselors by:

- Providing clear definition of professional practices and ethics in HIV/AIDS counseling
- Providing clear understanding of what is meant by counseling supervision within the
context of supporting HIV/AIDS counselors
- Clarifying roles and relationships among supervisors, counselors and organizations
- Identifying types of supervisory practices and settings
- Identifying supervisory methods and tools and their applications
- Developing supervisory skills through theory, practice and assessment tasks

Voluntary Counseling and Testing and Young People: A Summary Overview is a report designed especially to establish and meet the dynamic needs of young people in need of HIV counseling and testing services. Young people have a broad range of HIV/AIDS-related needs. Services must be developed to respond to these needs - either as a "one-stop-shop" or through strong linkages to other service providers. Youth are an especially vulnerable group because they navigate through a subset of issues that need special support like: Peer pressure, Self esteem, Risk taking and experimentation, substance use, teen-pregnancy and contraceptives, abuse, family and personal relationships, rape, sexual identity etc. This toolkit provides you with evidence based learning on how to approach youth-friendly VCT and tools on how to integrate this learning into practice

Interviewing and Counseling at the Grassroots: For many programs working in some of the more remote and undeserved communities, training is a luxury that can be out of reach for the many community health workers, volunteers and lay-counselors who are committed to respond to the affects of HIV/AIDS. You can still equip your teams with the proper skills that they will need for their field-work through the assistance of tools like this. This is a manual that builds the capacity of community-based workers and volunteers in the art of interviewing and counseling. This is the art and skill of getting the information you need from someone and going further with the skills to help someone to make their own good choices. This manual has a broad-based approach to counseling that can be applied to a full range of issues people face beyond or compounded by HIV/AIDS.
Dear All,

Human rights are universal, fundamental, inalienable rights, which all human being are entitled to regardless of their race, gender, age, social class, national origin, occupation, talent, religion, or any other personal factor. Human rights are based on the idea that every person is equal and entitled to be treated with dignity, respect, fairness and justice and are the universal moral rights that belong equally to all people simply because they are human beings. Human rights protect the dignity of all people. When human rights are not protected, people can’t achieve their full potential. In a public health context when people’s rights are not protected, it becomes difficult for them to make choices that will lead to a healthy lifestyle, and for the purposes of your work, more vulnerable to HIV-infection.

HIV and AIDS is often spoken of as a ‘human rights issue’ because in many cases, the people who are most vulnerable to HIV and AIDS around the world are also those whose human rights are limited. Additionally, Once people become infected with, or affected by HIV and AIDS, they face stigma, discrimination and denial of human rights. Even now in many contexts, HIV/AIDS health policies and programs still often discriminate against PLWHAs and vulnerable groups in society. As a result of the increasingly strong link, the World Health Organization (WHO) and Joint United Nations Program on HIV/AIDS (UNAIDS) began to encourage governments to adopt a human rights-based response to HIV/AIDS. A human rights based response to HIV is now regarded as the gold standard of all responses to HIV/AIDS. Human rights based responses to public health problems recognize that:

- The goals of human rights and public health are the same – to promote human well-being
- The main causes of disease are social problems like poverty and gender inequality
- There is a need to deal with these underlying problems, in order to promote human development and well being.

As we continue to experience advances in our ability to understand the nature of the HIV virus and various medical responses, we know that our efforts to make impact on the very socio-cultural and political issues which create environments that foster the continued spread of the virus: i.e. poverty, gender inequality, stigma and discrimination and the criminalization of marginalized, groups. These are major obstacles to meeting the target of universal access to HIV prevention, care and treatment. Therefore, the protection of human rights remains critical to a successful response to HIV and AIDS. Protection of human rights, both of those vulnerable to HIV infection and those already infected, is not only a right, but also produces positive public health results against HIV. This approach asks us to look at the real human rights problems behind HIV infection. It makes human rights as a key element of the design, implementation, monitoring and evaluation of health related policies and programs. This requires countries to think carefully about how policies and programs are developed to make sure they protect and promote the health care rights of all people. In addition, people affected by policies and
programs would be involved in all stages of the standard project-cycle to ensure that all people have equal access to information, education, health services, privacy and social assistance as a means to reduce both vulnerability to infection as well as the impact of the epidemic.

Impact at a national level often begins by the example of civil society organizations, whose programs and activities hold communities and governments accountable as well often fill the gap of protecting human rights by providing HIV-response services and support to those infected or affected by the virus. The following documents and tools aim to help you design programs and institutional frameworks that respond to HIV and AIDS with these principals of human rights as core to their design and delivery. All are saved as zipped pdf files for easier download when using slower connections:

**The UNESCO Guidelines on Language and Content in HIV and AIDS Related Materials:** Often times, programs and practitioners unknowingly perpetuate stigma through the use of terms and language that have negative connotation, are imprecise to specific contexts and even express opinions rather than fact. These Guidelines on the preferred proper use of language for the development of HIV/AIDS related communication materials and programs. In general, they are intended to provide guidance towards using uniform, correct, gender-sensitive, non-discriminatory and culturally-appropriate language that promotes universal human rights. This is an excellent tool to sensitize your staff to create uniformed factual and unbiased communication when discussing issues and working with communities impacted by HIV and AIDS. This tool should be used to frame the language used in your policy documents, tools, training and IEC materials as well.

**HIV/AIDS and Human Rights : Young People in Action** : This toolkit facilitates the planning and implementation of human rights based responses in HIV related work. This toolkit was developed in close collaboration with various youth organizations, as key stakeholders in advocacy, social change and community activism. The kit presents actionable steps as divided into 3 categories with their respective aims:

**Public Education and Peer Education:** To reject myths and misconceptions, and fight unnecessary HIV/AIDS related discrimination. To empower young people, to promote their rights and to inform them about how HIV can and cannot be transmitted, and how they can protect themselves. To discuss more openly sexuality and sexually transmitted diseases, as well as injecting drug use. To draw the attention of people in general and those in positions of authority in particular to accept the reality of HIV in our communities, and to recognize the rights of people living with HIV/AIDS.

**Advocacy:** To challenge and change laws, attitudes and practices that are contrary to human rights and to effective action against HIV/AIDS. To campaign for better services for people living with HIV/AIDS, including access to medicine, counseling and other support(s) needed to defend the right to life and to health care. To involve more and more people living with HIV/AIDS in campaigns and education activities.

**Care and Support:** To support and encourage people living with HIV/AIDS to participate in life in the community and to comfort those who are sick and may die through counseling, home
visiting or other programs. To inform people living with HIV/AIDS about their rights and about treatments. To give services and support to people who may be at risk, including women, children and young people, men who have sex with men, injecting drug users and commercial sex workers.

**Stop AIDS Discrimination:** This document developed by the Youth Initiative on HIV/AIDS aims to help empower young people to take action in their communities against the spread of HIV and the stigma and discrimination related to it. This youth friendly and concise guide provides practical examples of community and youth led approaches to combat HIV related stigma through programs and activities that use the human rights approach as the platform for which these activities should be conducted.

**International Guidelines on HIV/AIDS and Human Rights:** This document from UNAIDS consolidates the Guidelines adopted at the Second International Consultation on HIV/AIDS and Human Rights (1996), and revised Guideline 6 on access to prevention, treatment, care and support adopted at the Third International Consultation on HIV/AIDS and Human Rights (2002). The purpose of these Guidelines is to assist States in creating a positive, rights-based response to HIV that is effective in reducing the transmission and impact of HIV and AIDS and is consistent with human rights and fundamental freedoms. This document is important for your organizations to remain conversant with the universal rights relative to HIV and AIDS related issues to inform your policy development, programming and advocacy work. The guidelines are divided into 3 parts:

- **Guidelines for State action:** comprising action-oriented measures to be employed by Governments in the areas of law, administrative policy and practice that will protect human rights and achieve HIV-related public health goals

- **Recommendations** for dissemination and implementation of the Guidelines in the context of institutional level responses and roles within civil society

- **International human rights obligations and HIV:** which describes the human rights principles underlying a positive response to HIV
9. Male Circumcision as Part of HIV-Prevention

Dear all,

Happy New Year! It is amazing how a new year can spark so much reflection as well, propel us forward with much motivation to strive towards new resolutions and goals. Just as we do this in our personal lives, we can as well take on the same with our programs! As much as we have all achieved in the context of our work, let this be a year where we are each dedicated to making a real difference in the communities we serve with a new commitment to HIV-prevention!

In the past ten years, rigorous promotion of the ABC's of safer sex has helped make tremendous strides in reducing the HIV-prevalence that once peaked at nearly 10% in 1999. Along with such behavioral activities, developments and the availability of bio-medical prevention methods through PMTCT, PEP, and scaling up access to ART further supported the reduction of new infections and reducing the infectiousness that also leads to transmission. The result of these concerted efforts, through programs such as yours, was the reduced national prevalence to a low of 5.9% in 2007.

The increase in national prevalence released last year in the KAIS Report reminds us we must not get too comfortable with past successes, and still take HIV-prevention as a prioritized and ongoing part of our work mitigating HIV and AIDS in the community. We also know from years of work and research that the most effective way to take on HIV-prevention through an integrated approach. This means combining various prevention methods and messages for a more comprehensive approach that is tailored for specific target audiences. This means acquainting your programs with the facts on HIV prevention beyond ABC and learning how to communicate, build skills, and refer for the services in prevention that are outside of your own service provision.

Perhaps one of the more recent developments in HIV-prevention is the integration of Male Circumcision (MC). What is MC? Male circumcision is the removal of the foreskin, fold of skin that covers the head of the penis. It is the oldest surgical procedure and depending on which area of the globe you look at, or which cultural group you work with, this practice can take on many forms. We can see this cultural diversity exemplified in Kenya alone! Research tells us that male circumcision can reduce a man's chance of acquiring HIV by 60%. There are multiple reasons for this reduced risk as determined by research:

- The inner surface of the foreskin has a high density of HIV-target cells (these are called the Langerhan's cells along with CD4 T-cells and macrophages which are A type of white blood that ingests foreign material). This is an area of vulnerability where as the outer surface and the glands of the penis are protected by a layer called the squamous epithelium.
- Greater difficulties with hygiene with an un-circumcised penis may also be associated with more exposure to vaginal fluids and thus more exposure to HIV.
- We also know that removing the foreskin reduces the occurrence of genital ulcers,
infection of STIs like HPV and Chlamydia - co-infections which make a person more susceptible to infection when exposed to HIV.

In response to this overwhelming evidence, MC has risen on the national agenda and collaborative efforts in 2008 with other stakeholders in Kenya to ensure MC services can be scaled and integrated into the national prevention strategy. The National Policy on Male Circumcision aims to ensure that the benefits of MC are effectively and appropriately communicated, safe, qualified and confidential services are made available for those who voluntarily seek this service and that all activities are monitored and evaluated properly to ensure that we can learn from and improve from our efforts and approaches. The policy also seeks to promote MC to males of all ages in a culturally sensitive manner to minimize stigma that might otherwise be associated with circumcision status. Although this policy has national coverage and applicability - there are some immediate priorities in areas of high disease burden and infection: Nyanza Province

Even if your programs are not doing direct work in this area, the responsibility to be informed is there. Staying informed in how MC works to reduce the risk of infection will enable you to provide accurate information to the communities you work with. Misinformation about male circumcision as well as strong opinions, both for and against the procedure, present challenges and you play a role in mitigating them. In this context it is vital that the following points are clearly emphasized:

- Male circumcision acts as a preventative method for HIV-negative men. It is recommended that male circumcision should not be promoted for men who are already infected with HIV but it should not be denied unless medically contra-indicated. For HIV positive men there is no demonstrated public health benefit for reduced HIV transmission to their partners and men with severe immunodeficiency are at an increased risk of complications following surgery. HIV positive men who become circumcised benefit directly from reduced genital ulcer disease, but not reduced HIV-transmission.

- Male circumcision reduces the risk of HIV infection for men but only provides partial protection. It is additional to and not a substitute for other proven HIV prevention methods.

- Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.

- All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.

- Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.

- Information on HIV risk reduction and other benefits for male sexual and reproductive health need to be widely available to ensure individuals make informed choices about male circumcision.
It is important to clearly distinguish between male circumcision and female genital mutilation/cutting which must be discouraged as a harmful practice with demonstrated adverse health effects and no health benefits.

While it is important for you to be aware of how MC works to support prevention, it can never be communicated or provided as a stand-alone approach. MC is most effective when combined into a broader range of prevention support activities – behavioral and bio-medical. The attached resources are to provide you with more information and specific messaging to support your work. These documents have been gathered by the National Task-force on Male Circumcision, which CAP is seated on. I encourage you to read these documents to keep you and your team informed and able to move forward in your work.

In support of the Development of a Male Circumcision Communication Strategy in Kenya: This is a formative research report using a Knowledge, Attitude and Practice approach between December 2007 and January 2008 focusing on Nyanza (specifically Migori and Siyaya), Nairobi as a city with significant populations of Luo, in addition to Teso and Turkana where other non-circumcising communities reside. This formative research provides the background on the key target populations with regard to their attitudes and perceptions about male circumcision in order to develop effective key messages and approaches for communication.

Kenya National Policy: As NASCOP continues to develop the supporting documents, and guidelines that will shape national activities around MC, it is important your program is informed on the national strategy for MC as a whole. This document delineates the approach, priorities and strategy that the government will take to roll out MC as part of national prevention activities. All national activities are organized into 3 categories: Communication, Service Delivery and M&E – each playing a distinct role in the scale up of MC nationally. It is important that all of our activities remain constant and harmonized. Familiarizing yourself with this document will enable this.

Medical Male Circumcision – Key Messages & Frequently Asked Questions About Male Circumcision: For programs working specifically in Nyanza or with communities who do not traditionally circumcise, this document deals with the frequently asked questions and provides you with the responses to guide your discussions on communicating MC.

For those of you who are interested in reading more about the research in MC – find the attached research summary of various social science findings related to MC including issues of acceptability, risk complications and sexual function.

Approaching HIV-prevention as a comprehensive and integrated part of your programs will be central to much of our work in 2009 so that whether you are working with OVC, caregivers, special needs populations, businesses etc... you are able to best support them to make informed decisions that can protect themselves and their loved ones.
10. Understanding and Responding to the Factors that Shape Sexual Behaviors in Youth

Dear All:

In spite of much efforts to educate and empower young people with the facts on HIV transmission and associated risks, nearly half of new infections worldwide occur in young people aged 15 – 24. This is a powerful statistic, especially for those of us working with children and youth. Prevention services are being made more available as well as integration of HIV prevention and life skills into formal and/or recreational learning for youth and children. However, there is an element of sustained behavior change that is still weak. Our work has certainly not been in vain! None the less, a statistic of that magnitude should provoke the questions: What are we not doing? What questions are we not asking? What is it that we do not understand?

Perhaps an even more targeted question is: What are the factors that lead young people to still engage in sexually risky activities in spite of the knowledge they have relative to HIV and other sexual health issues? A systematic review of qualitative research surrounding young people’s sexual behaviors was conducted [1] consolidating the findings from nearly 300 research publications on this topic. The findings presents seven key themes that are cross-cutting to countries and cultures that were represented spanning the globe. These themes capture socio-cultural norms, pressures and expectations assigned to youth according to gender as key determinants and motivators that shape behavior. These factors dominate the way in which sexuality is expressed and perceived – irrespective of the knowledge of HIV and other sexual health risks. The seven key themes that emerged from the expansive review of qualitative studies on sexual behaviors of youth are listed below.

1. **Young people subjectively assess the risks from sexual partners on the basis of whether they are “clean” or “unclean”:** Young people are more likely to use condoms in short-term, unstable relationships rather than long-term partnerships and based on perceptions and assumptions unlinked to actual risk or behavior patterns in their partners. While condom usage in casual contexts is important, we now know that concurrent partnerships is driving transmission through the creation of sexual networks that are perceived as “low-risk” and are therefore unprotected.

2. **Sexual partners have an important influence on behavior and social standing:** There is a great deal of social pressure and weight placed on a person’s ability to maintain a relationship, particularly females. Failed partnerships can be interpreted as a reflection of social position and/or femininity – Thus behaviors within the context of a relationship aim to maintain security and/or stability in a relationship. Sex can be perceived as something that will strengthen a relationship, please a partner or even ensure a level of commitment. Fear of sexual violence or retribution if sex is refused is also a factor in this case.

3. **Condoms can be stigmatizing and associated with lack of trust:** Carrying or buying condoms can imply sexual experience which is especially undesirable for women, and
conversely acceptable for men. Asking for a condom in the context of a sexual encounter by a woman is often tied to perceptions of her promiscuity, lack of trust in her partner which in both cases has implications on the relationship. This makes negotiating the use of condoms by females difficult and completely dependent upon her male partner.

4. **Gender stereotypes are crucial in determining social expectations and behavior:** Across cultures, countries and contexts studies affirm that gender stereotypes in relation to expected behavior of males versus females are shared. Males are expected to be heterosexually active and dominant and females chaste and timid. While sexual intercourse is a sign of entrance into adulthood for males, women are expected to maintain virginity. Perhaps the most ironic is that although women’s ability to leverage the use of condoms or other contraception is unacceptable, they are perceived as fully responsible for pregnancy prevention.

5. **Society assigns penalties and rewards to sex for young people:** A person’s ability to comply with societal expectations can raise social status and legitimize standing. For males, this is linked to having multiple partners and for females by maintaining secure, stable relationships and chastity. There are penalties associated with being “caught in the act,” making sex a clandestine activity among young people. It can also be seen as a way to escape a turbulent home or obtaining economic support from a partner.

6. **Reputations and social displays of sexual activity/inactivity are important:** Reputation, as touched upon in some of the aforementioned themes, is a crucial factor involved in expressions of sexuality. Young people have to balance the degree at which they are perceived to be sexually active in order to preserve their social status, eligibility for marriage and normative association with their gender. The result of being too promiscuous or inexperienced for females and males respectively could result in marginalization, violence, rape or even death.

7. **Social Expectations hinder communication about sex:** given the roles and expectations assigned by society in relation to sexuality – many young people avoid speaking about sex and other sexual health issues with their partners or with elders who could educate and advise them. Seen as taboo or a trigger for stereotyping, this lack of communication among partners leads to ambiguity and miscommunication that have direct implications on each person’s preparation and mutual willingness to engage in sex.

Our ability to understand the factors that influence sexual behaviors is key to being able to design interventions that support their ability to adopt and sustain safer practices. To effectively address HIV risk with consideration of these factors, programmatic responses need be mindful of the day to day experiences and expectations that young people face. Responses need to consider the context, promote change or present options for how to positively cope with the circumstances surrounding their lives. This can include, but is not limited to the following:

- Challenge existing roles and expectations related to gender and sexuality with healthy, balanced and rights-based understandings of gender. Promote tolerance. Deconstruct the perception that certain behaviors are determinants of masculinity or femininity. This
means working to create an environment where men and women can act outside of more traditional expectations and still be accepted for who they are.

- Engage young people in discussions on partner selection. Empower young people to proactively explore the values, characteristics they would like to see in their partners – beyond assumptions and perceptions that can be made based on where a person is from and what they look like. It is important to address false-stereotypes that relate to perceptions of being risky or “unclean,” Rather, understanding that HIV-risk cannot be determined by superficial assessments or classifications or people. Teach young people what questions to ask their partners and how to discuss difficult experiences and topics to ensure that they are making safe choices.

- Facilitate relationship building skills by educating youth on the nature of different types of relationships (i.e. friendship, romantic, family etc.) and the dynamics that are involved. What are signs of healthy and/or unhealthy relationships? Reinforce the value that young men and women have in their selves as individuals. Engage them in setting personal goals, ambitions and support their development to achieve them. This inevitably means challenging social norms and other cultural constructs.

- Build communication skills in the context of these relationships, highlighting the importance of discussing contraception, health status, condoms, defining relationships, sex etc. The more likely a couple discusses sex prior to their initial sexual experience, the more likely they will be prepared for it. Provide skills in how to negotiate safer practices and how to positively affirm your decisions in a way that is clear and defined. Communication skills are also essential for parents and other elders to be able to engage in meaningful discussions on sex in a manner that allows for honest and trusted conversation.

- Create safe spaces for youth to seek help, ask questions and access essential services for HIV prevention and reproductive health services which are confidential, non-judgmental and youth-friendly. Service providers should be ready to address some of the underlying issues that manifest itself in sexual risk such as issues relative to self-esteem, violence and coercion, poverty, domestic issues etc. and respond with appropriate psychosocial support services.

**Additional Resources:** To support this, the following resources are available for you to adopt or use as curricula, skills building activities and reference materials to equip your staff in working with young populations on issues to do with HIV prevention:

**Chill Club Curricula:** Developed by PSI in Kenya to support child-parent-teacher communication on adolescent sexual health issues. This curricula, targeting ages 10 – 14, is an excellent resource touching on the essential topics that young people grapple with through the sensitive time in their life: This includes issues of puberty, different types of relationships and emotions relating to peers, gender stereotypes and the facts and myths about pregnancy, HIV and STIs. The sessions also incorporate skill building discussions on self-esteem, assertiveness, decision making, goal-setting, exploitation and dealing with peer pressure. To download this file as PDF click here: [http://misaccess.psi.org/bcc_catalog/web/files/Chill%20Club%20Curriculum%20FINAL](http://misaccess.psi.org/bcc_catalog/web/files/Chill%20Club%20Curriculum%20FINAL)

**Tuko Pamoja:** The second edition of this Kenya Adolescent Reproductive Health curriculum
created by PATH, is designed with the aims of delaying sexual debut, promote reproductive health, and equip adolescents with life skills that will support making informed and healthy decisions. Designed for ages 10 to 19 this curricula includes sections that are appropriate for ages 10 to 14 which are specified in the document: Click here to download the PDF: http://www.path.org/files/CP_kenya_KARHP_curric_3-06.pdf

**More tools and curricula on teaching adults to speak with youth about sex and HIV prevention including specific tools to use for faith based perspectives, both Christian and Muslim click here: http://www.infoforhealth.org/youthwg/trainingmaterials.shtml**

**Adolescent Social Support and Help-Seeking Behavior:** This paper aims to provide greater understanding to the kinds of social support services young people seek and who they are likely to seek these services from. Using literature reviews to create a greater understanding to help-seeking behavior patterns of youth along with consultations from existing health programs from around the world, the document extracts recommendations on approaches to providing support services. It also includes tools for rapid assessments on support service programs. To access this click on the following link: http://whqlibdoc.who.int/publications/2007/9789241595711_eng.pdf

**Youth Friendly Services:** This manual is an excellent tool for program staff to be sensitized to the specialized issues related to adolescent health and development, as well assess the extent to which your program is able to serve these special needs. The curriculum helps providers understand cross-cultural principles of adolescent development and health. It allows staff to reflect upon and assess their own beliefs about adolescent sexuality while ensuring that those values and attitudes do not interfere with the program’s ability to protect and promote these health rights. It also includes site assessments and action plan templates to facilitate integrating learning into your programs. http://www.engenderhealth.org/pubs/gender/youth-friendly-services.php

25 years of efforts understanding and responding to the presence of HIV in our communities has surly taught us that HIV prevention is not simplistic. We are at a time where we know more about the virus and have more options to prevent its transmission than ever before – and we should use this range of information and services to empower and support healthy decision making by the individuals and communities we serve.

11. Treatment Adherence Support in Community Based HIV-Responses

Dear All,

This Month's edition of the CAP HIV-E Update explores the necessity of treatment adherence support as a part of community based HIV-responses. Working with communities infected and affected by HIV will undoubtedly bring you into the realm of Antiretroviral Therapy (ART), the course of medical treatment available for HIV. Supporting people living with HIV who are on treatment is a very critical component of the philosophy of positive living, as well integral to home-based palliative care activities. This is especially important given the sensitive nature of the therapy and the way that it works to suppress the HIV-virus in the body.

The guidelines for Antiretroviral Therapy, also commonly referred to as Highly-Active Antiretroviral Therapy (HAART) is a combination of 3 or more antiretroviral medications to be taken together. The goal of this course of treatment is to achieve maximal and durable suppression of the virus replication in the body. This in turn reduces the destruction of CD4 cells, reduces immune suppression and slows disease progression. Success with ART can be seen in rising CD4 cell counts, undetectable viral loads and clinical improvement in patients.

Adherence is defined as ‘the act or quality of sticking to something—to adhere to something’. In the context of treatment with medications, adherence means to take doses according to their prescribed dosages through the full length of the course. An Individual’s adherence practices are an essential component of their treatment success. Research supports that greater than 95% adherence, the equivalent of missing less than 3 doses per month, is needed in order to maximize the benefits of ART on clinical and immunological outcomes. Poor adherence practices are also associated with increased risk of developing drug-resistant viral strains, which poses a greater public health concern in the long run.

In recent years, much has been done to expand access to ART in resource limited settings to ensure that people who are living with HIV can start and sustain care and treatment. And as much as people are now able to access this life-saving treatment for free across the country, staying on this life-long therapy requires a full range of support that includes: psychological preparation, education and adherence support. Programmatic efforts that provide support to PLWHAs, whether adults or children, should integrate ART education and adherence support for those currently on treatment, or who one day might start treatment.

Supporting a person who is on ART requires you understand the different challenges and circumstances that are related to taking their medications daily. For children, the issue of adherence becomes even more sensitive as they are completely dependent upon an adult caregiver to give them their medications as directed by the doctor. There are many different factors that can affect a person’s ability to take their medications that can include, but is not limited to:

- stigma within the household
- forgetfulness
• Illness
• lack of food
• side-effects
• lack of motivation or support
• depression
• high pill-burdens
• loss or theft of medications

Adherence support takes on different forms and, similar to other types of interventions, needs to be sensitive to the individually specific needs or challenges that are experienced. Here are some basic components that become part of adherence support:

• Developing a trusting relationship
• Providing consistent education
• Identifying and addressing adherence barriers (problem solving)
• Providing psychosocial and emotional support
• Managing side-effects
• On-Going adherence assessment and support
• Monitoring adherence practices for persons with special needs, including pill counts and/or directly observed therapy (DOT)
• Nutritional advisement
• Supporting access to routine monitoring at medical facility

The 2008 KAIS Preliminary Report informs us that 63% of Kenyans are in need of ART and are not accessing it because they do not have accurate knowledge of their HIV-status. Therefore, your programs play an important role in educating the community on the presence and benefits of ART, which can provide a hopeful motivation to know one’s status early on. These types of activities, often coined treatment literacy, become critical entry-points for people to seek counseling and testing followed by medical management of their HIV-status. Providing support as a person prepares for or considers starting ART is also key to ensuring they have full information, realistic expectations and a solid grasp on the kind of commitment that it warrants for long-term health.

Additional Resources: The following technical resources and sample programs can support your staff and volunteers develop the skills and knowledge base needed to provide qualified home-based adherence support in the context of your current program activities. I encourage you to explore these resources and share it with your teams to support their ability to offer qualified and relevant support to the communities they serve.

Healthy Living is a counseling guide for health workers that covers a range of topics including opportunistic Infections, antiretroviral therapy (ART) and the management of ART side effects. These resources include a collection of low-literacy guides, flipcharts and brochures covering ART and opportunistic infections, with both English and Swahili versions of some materials available. This is highly recommended! To download click here: http://www.fhi.org/en/CountryProfiles/Kenya/res_healthy.htm
**Learning to Live Positively:** This document is a consolidated presentation of a program model called, “How to Live Positively (HTLP),” implemented in rural communities in Benin, Malawi, Nigeria and Zimbabwe. The intervention aims to help promote household health, nutrition and promote treatment preparedness for persons who are eligible to start ART. Adopting a participatory approach, the document explains the methodology of the program, training approach and methodologies used. Results are included that speak to the impact of the program in terms of community buy-in, sustainability and scale up.

**Adherence Support Worker Training Materials:** This curriculum supports a two-week intensive course that teaches community volunteers to work alongside nurses and doctors at the community level in the provision of adherence support to PLWHA. It teaches participants how to interact with patients in clinical, community, and home settings where they provide HIV education, treatment support, and ART adherence counseling. It also covers issues of referral systems and how to engage treatment defaulters. Modules include didactic sessions, role plays, and group exercises. To download these materials click here: [http://www.fhi.org/en/HIVAIDS/pub/res_ASW_CD.htm](http://www.fhi.org/en/HIVAIDS/pub/res_ASW_CD.htm)

**Adherence to Antiretroviral Therapy in Adults:** This training manual was designed for health workers such as physicians, clinical officers and adherence nurse counselors in ARV programs. This document provides a more technical approach to understanding the concepts surrounding ART management and adherence programs and covers the following modules in detail: Basic information on adherence and patient preparation for adherence. This manual distinguishes adherence counseling into initial or preparatory adherence counseling and follow-up or ongoing adherence counseling with guiding principles and practices that support client adherence from the start through the length of their treatment experience.
12. Prevention with Positives (PwP)

Dear All,

Looking back on more than two decades in the fight against HIV, prevention efforts traditionally focused on changing behavior or reducing risk that would result in HIV acquisition. Whether provided at an individual level or through large campaigns, the audiences targeted were presumed to be of HIV negative status. Wrongly assuming that PLWHA had no further needs or role to play in the area of prevention, this approach left out an entire population of people whose leadership and involvement would prove paramount.

In recent years there has been a paradigm shift in the understanding of HIV prevention to focus on the inclusion of PLWHAs as individuals in need of services and critical to infection control as every new infection involves a person who is HIV positive. The ever growing body of research tells us that continued prevention after an HIV diagnosis is important not only to partners but, also for the health of the individual living with HIV. Re-infection still poses health risks including increased viral load and the introduction of different strains of the virus including those resistant to ART.

Prevention with Positives (PwP), refers to prevention efforts that target and support HIV infected persons and their partners to reduce their risk of HIV transmission. PwP is based on the realities and perspectives of PLWHAs. It acknowledges that they have varying needs and desires which gives each the personal right to make decisions about their sex life, relationships and families. It focuses on communicating information and support. It does not blame, judge or stigmatize. PwP interventions encompass a combination of behavioral, medical and psychosocial strategies that aim to:

- Reduce infectiousness by improving and maintaining clinical health
- Reduce opportunities for transmission through safer practices
- Empower individuals and their partners to communicate and make informed decisions about their relationships and families
- Create a supportive environment for PLWA in their homes and communities with reduced risk of stigma, violence and barriers to health related services.

In 2007 PwP was identified by NASCOP as an important yet neglected priority for advancing prevention efforts nationally. The roll out of PwP represents a shift in national prevention strategies from targeting the general population and working with the one million HIV positive individuals to intensify efforts to improve health, quality of life, and prevent new infections.

What Should Community PwP Programs Look Like? NASCOP developed a national standard for PwP activities occurring both in medical facilities as well as in the community. It defines the following as the minimum service package for community level PwP to include the following in the form of educational messages, support services and referrals:
• Provision of counseling and testing: The KAIS preliminary report tells us that an alarming 82% of HIV positive adults do not know their accurate HIV status! Supporting your beneficiaries to know their status by seeking counseling and testing is the starting point for the individuals and families you are working with who are unsure of their status or have not gone for testing recently and could be at risk.

• Facilitate partner disclosure: Disclosing one’s HIV status is a critical part of living positively. Disclosure has direct implications on an individual’s ability to adopt safer sex practices, receive psychosocial support and access medical services for optimum health. Disclosure support is not just supporting a client to talk about their status. It also means taking measures to prepare the individual and in some cases their partners before it happens, as well to take measures that will reduce post-disclosure related violence, stigma and discrimination.

• Promote couple and family counseling and testing: This approach should be standard in follow-up when a beneficiary knows his or her status. 50% of all HIV positive married/co-habitating men and women have and uninfected partner. These statistics tell us that partners need to be tested as early on as possible to ensure that they have the right support to maintain an HIV negative status or to access health and prevention services if they test positive. HIV testing for children is critical to ensure they have access to care and treatment.

• Sustaining risk reduction behaviors through counseling and support: By identifying and addressing areas of risk in a person’s life, they can develop strategies to reduce them. This can include, but is not limited to using condoms, partner reduction, reduction of substance use, male circumcision and accessing other prevention services. This also means empowering individuals with communication and negotiation skills to be able to adopt safer practices.

• Educate, promote and dispense condoms. Ensure your beneficiaries know how to use condoms properly, have the correct information about their effectiveness and have knowledge of the points where they can be accessed for free and/or at a cost.

• Educate and refer for family planning (FP) services: FP is important to prevent unintended pregnancies. Still, Motherhood is an important part of life for many women irrespective of their HIV-status. Conception should be planned to preserve the health of the mother based on clinical indicators and monthly fertility cycles, as determined by her medical doctor. Planning pregnancies also prevents vertical transmission by timely access of PMTCT services.

• Facilitate the enrollment of PLWHAs into care and treatment facilities: This is crucial to ensure access to ART, contrimoxazole (CTX) and TB (IPT) prophylaxis treatments and routine clinical monitoring. All of these medical interventions reduce a person’s infectiousness as well as their susceptibility to other infections.

• Provide adherence support for persons on ART: This can include monitoring adherence practices, supporting individuals who need assistance to take their medications, education on side-effects and how to manage them at home, and proper storage and care. When adherence practices meet clinical standards, ART can suppress viral replication and reduce infectiousness of PLWHA by up to 98%!
• Screen PLWHA for TB and STIs refer with referral services for facility based service provision. Very simple questions about symptoms, when asked sensitively by CHWs, can encourage or identify the need for seeking medical services.

Manuals of the Facility based PwP Training curricula entitled “HIV Prevention for People Living with HIV/AIDS” are available through NASCOP. Community level training materials and tools are currently being development by the MoH. Still, this should not stop you from maximizing your contacts with individuals, families and the community to better support their ability to understand and access the full range of prevention services they need. The following resources provide immediate support for you to provide standard and qualified prevention services to persons living with HIV. And remember, as with all your activities involving information about a person’s HIV status – ensure the protection of a person’s rights, honor confidentiality and privacy.

**Prevention in the Care Setting:** Developed by FHI, this complete set of materials will enable you to train your staff and volunteers on the different components of PwP. It includes a facilitator manual for the trainer, PowerPoint presentation for the trainees and supplemental materials for management covering basic facts on how to talk about prevention with HIV positive clients. The course’s objectives aim to help service providers
  - **o** Explain why prevention for positives is important.
  - **o** Define strategies that allow providers to assess needs and optimize prevention for positives.
  - **o** Describe important patient education messages for prevention for positives.
To download the materials click here:  

**Positive Prevention:** Developed by the International HIV/AIDS Alliance, Positive Prevention aims to provide a starting point from which NGOs and HIV service providers can support HIV positive people to lead full and healthy lives by integrating HIV prevention for, by and with PLWHAs. This manual follows the following thematic areas with specific strategies to apply each:
  - **o** Individually focused health education and support
  - **o** Ensuring access, scaling up and improving service delivery
  - **o** Community mobilization
  - **o** Advocacy and policy change

To download this as a PDF file click here:  

**Behavior Change and HIV Prevention:** This report from the Global HIV Prevention Working Group (PWG) focuses specifically on behavioral HIV prevention. The report consolidates information on what is known of effective behavior change strategies, what we still need to learn, and forecasts priorities in the coming years. Based on a comprehensive review of hundreds of studies conducted on behavior change for HIV prevention, this paper will inform the strategies adopted for programmatic application.
To download this as a PDF file click here: http://www.globalhivprevention.org/pdfs/PWG_Executive%20Summary_FINAL.pdf

To request the facility level PwP training materials and get more information on the national program contact NASCOP at: tel: 020 2729502/ 2714972 or email: headnascop@aidskenya.org.
13. Home and Community Based Care

Dear All,

When you hear the term **Home Based Care**, what do you think of? There was a time when home based care was only option for HIV positive individuals when there was limited capacity for HIV-care in national health systems or when they could not access or afford facility based services. Also, in the absence of ART, home based care was more commonly associated with end of life care for persons living with AIDS. Are these the same things you had in mind? Today, Home based care goes far beyond those associations and in a time when ART is available and accessible – Home based care takes on additional responsibilities and services to compliment and support the national health system in the roll out of HIV management programs.

More recently reclassified as Home and community based care (HCBC) by NASCOP; this critical component of HIV care and support is the extension of care to those infected and affected by HIV from the facility to the home and community environments. It is an ongoing collaborative effort between facilities, families and the community, and it spans support services that extend well beyond medical (nursing or clinical care) in the absence or inability to access a medical facility. HCBC incorporates physiotherapy, psychosocial care, emotional and spiritual support, nutritional counseling, hygiene and sanitation support, prevention and infection control, adherence support, disclosure and promoting counseling and testing, HCBC plays a critical role in serving PLWHA and their families. In doing so and as defined by the MoH, HCBC aims to achieve the following objectives [1]:

- Promote family and community awareness on HIV/AIDS prevention and care
- Empower the patients and their family members, care providers and the community with the knowledge needed to ensure long term care and support at home
- Reduce stigma and discrimination
- Support the decentralization of congested health systems by providing ongoing health services to the chronically ill in the context of their homes, for non-emergent but necessary needs.
- Ensure that persons living in areas with limited access of other restrictions to health services can still receive basic care and support in the context of their home and community between scheduled visits.
- Strengthen referrals to facility based services

HCBC is not solely about service provision. It also aims to build the capacity and competence of caregivers and community members on how to care for persons living with HIV or AIDS. It fosters the creation of environments that are capable in providing a continuum of care and support from starting from within the home itself.

Achieving these goals is not a small task. Thus it requires an investment of time and effort to ensure that volunteers and community health workers are adequately trained and well oriented.
for the role that they play.

The following resources should be used to inform your activities at all points: from training, program design and implementation:

**An Implementation Framework for Home and Community-Based Care in Kenya:** The HCBC framework is a guide to implementers to ensure that HBC activities are in line with the Kenya MoH standards of practice and greater national strategy. The goal is to ensure the provision of quality care for the HIV infected and other chronically ill people at the home and community level. This document delineates both comprehensive and minimum service packages, implementation strategies, training standards and M&E frameworks established by NASCOP for community level activities. This is an important resource to ensure that activities conducted by your organization meet the expectations of the MoH as well, fall within the guiding principles, values and objectives of HCBC as a concept in the greater national health system. To download this in PDF form click here: [http://www.aidskenya.org/public_site/webroot/cache/article/file/HCBC_Framework.pdf](http://www.aidskenya.org/public_site/webroot/cache/article/file/HCBC_Framework.pdf)

**HCBC Referral Form:** Due to limited supplies in stock at the NASCOP office, we are providing this scanned version of the MoH referral form to be used as part of HBC programs. Provided by the HCBC Program, this tool can be replicated by your programs and used in the absence of stocks with your respective DASCO offices.

**Key Health Messages for Level 1 of the Kenya Essential Package for Health:** Communities are the heart of the MoH strategic plan! Defined as Level 1 service providers, the community is the starting point by which people have access to services for improved health, that tickles up through the 6 levels of service provision. This manual provides reference for promoting household health practices and is intended to be used by CHWs or other community resource persons whose role is to engage with households in health promotion. The manual provides a set of essential health information designed for specific age groups and demographic population sets, the aim of which is to help people attain behaviors and attitudes necessary to keep their household members healthy.

**Community Home Based Care Trainers Guide:** Developed by Pathfinder International, this resource is a manual that can be used to facilitate training of CHWs and other volunteers responsible for the delivery of HBC related services. The model used by this manual is one that aims to build the capacity of local organizations, community health workers, and facility-based health care providers through intensive interactive training curricula that covers the following topics and more:
- Prevention
- Care and training for caregivers of PLWHA
- Community sensitization and mobilization
- Two-way referral linkages
- Support for orphans and vulnerable children
- Record Keeping
o Family planning
o Communication skills
o Transferring skills

To download the PDF click here: http://www.pathfind.org/site/PageServer?pagename=Publications_Training_and_Capacity_Building_CHBC

14. Understanding Gender and HIV

Dear All:

This edition of the HIV E-Update explores the link between Gender related issues and HIV/AIDS. Gender refers to the socially constructed roles and responsibilities assigned to women and men in a given culture. Gender perspectives arise from communities’ knowledge, beliefs, and attitudes. Thus, gender is distinct from sex, which is biologically determined. Gender concerns are paramount in the context of HIV/AIDS and other areas of health communication. Where issues related to gender are directly linked to power-dynamics in relationships, sexual and reproductive health rights, economic authority, and sexual violence; They are also linked to a person’s ability to access and utilize HIV testing, risk reduction/prevention, care and support services.

In the context of your work, you are bound to encounter challenges that link gender roles with health and development – either working with men or women. Your work in communicating health messages and implementing HIV-response interventions can reinforce existing beliefs and social norms or challenge them, ultimately establish new beliefs, attitudes, and social norms. This is not an easy task. However, understanding the role that gender plays in addressing HIV impact and risk at the community level, will dramatically inform the effectiveness of your programs in creating long-lasting social change.

Building gender specific programs does not mean working with any one sex in isolation. It means working with both, with specific messages and approaches to create an environment where healthy social norms, basic human rights and access to services are shared among men and women. The following resources provide the technical backing, tools and approaches that can better support gender-sensitive approaches to your program’s in the context of the communities you work in.

**UNAIDS Gender and HIV/AIDS Factsheet:** This document explains how gender inequality is driving the HIV/AIDS pandemic and the need for a rights-based approach both to improve responses to HIV/AIDS and to protect and promote the rights of subordinated groups. It provides a conceptual framework for program implementation from a rights perspective, and carefully constructed tools and checklists to help development programs effectively respond. It is further supplemented by various thematic Fact Sheets that aim to provide core facts and issues in thematic areas and are underpinned by an analysis which clarifies how gender issues are fuelling the crisis.

**The Gender Guide for Health Communication:** The purpose of the Gender Guide is to encourage the incorporation of gender-based roles and responsibilities in the design, implementation, and evaluation of health communication programs. The guide does not directly address broad-based issues of gender equity. It does, however, provide questions to help program managers determine how gender roles, for both women and men, may impede access to health information, restrict use of health services, or limit beneficial health outcomes. By identifying this information, health communication programs can encourage individuals and communities to
pay attention to resolving gender inequities. To download the PDF click here: http://www.jhuccp.org/pubs/cp/102/102.pdf

**Keep the Best Change the Rest:** The toolkit gives guidance on how to build relations and trust with key community stakeholders in order to support this work that facilitates addressing cultural issues of gender inequality and addressing negative social norms. Developed in the Zambian Context, the toolkit contains participatory activities which enable groups of men and women of different ages to explore how gender and sexuality affect their lives and identify changes which they wish to make to improve their relationships and sexual health. The tools involve community members using techniques such as role-play and making diagrams using local resources such as the ground, sticks and everyday objects to generate discussion. Contents include sections on: Gender, sexuality and vulnerability, Sex and relationships, Sexual violence, Working together and Making an action plan. To download the PDF Click here: http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=257&language=en

**Doorway I Program on School Related Gender Based Violence:** Violence in and around schools is a worldwide problem with serious implications for the educational attainment, health and well-being of all children. This Doorways training programme was designed the Safe Schools Program to enable teachers, community members and students to prevent and respond to school-related gender-based violence (SRGBV). This manual is the first in a series of three from the Doorways program, designed to help students learn how to prevent violence and increase their self-efficacy through enhanced knowledge, attitudes and skills regarding healthy relationships, reproductive health issues, HIV prevention and children’s rights and responsibilities. To download the PDF Click here: http://www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/Doorways_I_Student_Manual.pdf

**Young Men Redefine Masculinity: A Training Manual:** This manual was shared in a previous HIV E-Update in October 2008. However has a good place here and is worth redistributing. It promotes the positive aspects of masculinity, encouraging men’s participation in sexual and reproductive health, promotes respect for sexual diversity and improves the understanding of the body and sexuality. HIV prevention is addressed within the larger framework of gender roles and relationships. Activities discussed in the manual are organized around four key themes: gender, sexuality and reproductive health, violence and HIV and AIDS prevention. It was developed through community participatory research in the Indian context and was based on a program implemented first in Brazil. This speaks to the adaptability of the manual to fit various cultural and geographic contexts. To download the manual click here: http://www.popcouncil.org/pdfs/horizons/yaaridostieng.pdf
15. Taking on Evidence Based HIV Prevention for Adolescents

Dear All,

This edition of the HIV E-Update explores HIV prevention among adolescents using evidence based approaches. Peter Piot, former UNAIDS executive director once said, “there is no silver bullet to HIV-prevention,” particularly when it comes to matching successes in behavioral strategies to those of the bio-medical advancements that now are available. There has to be a more effective way for programs to respond when standing at the crossroads where social culture, individual-behavior and health sciences intersect in the context of prevention efforts. This can only be done by reflectively assessing the impact by specific interventions and programs. In an effort to better support this, research efforts are being invested more now than ever before in qualitative assessments on the efficacy of HIV prevention programs and their critical components to assist implementers to match their field work with evidence based responses. This is particularly important in the context of programs serving adolescents, a subgroup representing the highest rate of new annual infections globally!

In a recently published study in the journal *AIDS and Behavior*, "Common Principles Embedded in Effective Adolescent HIV Prevention Programs," effective and evidence based adolescent HIV prevention programs were subjected to quantitative analysis. The aim of the study was to determine and extract the common principles or elements that are cross cutting in these pre-packaged programs that can be attributed to their success. In doing so, **10 core principles** have been identified and are now being appreciated as **essential components** to evaluate the effectiveness of prevention curricula, activities and interventions with young people across various settings.

It is important to note that these principles convey not only behavioral and cognitive change but the development of more mature ways of functioning, which is critical in the adolescent context. The researchers take into consideration that HIV-prevention for youth must address aspects of normative adolescent development issues such as impulse control, lack of future orientation, novelty and sensation seeking, peer pressure, decision making skills and the difficulties in maintaining a sense of positive self-worth. The following highlights these essential principles which the study affirms to be central to the success of acclaimed evidence based prevention programs, as well as how they can be demonstrated in the context of a program. The phrases used to capture each principle were conceptualized by the researchers based on a coding process as part of the research methodology:

- **Believe in your own worth and your right to a happy future**: In each of the programs, there was an assumption that positive feelings about yourself support the ability to resist peer-pressure and act in a self-protecting manner. Being able to identify self-worth apart from approval or love from another person supports this, as well as being able to see hope in the future. Thus programs must help young people identify personal values, act in a manner consistent with their goals, strengthen inner sources of self-esteem and the behavioral skills to say “no” to pressures surrounding high-risk activities.
• **Distinguish fact from myth:** HIV prevention cannot happen if people lack basic knowledge about the virus, its transmission and the methods of protection. Prevention programs must incorporate didactic components that not only teach accurate information about HIV and AIDS but also reveal the common myths and false assumptions that are prevalent within their community. It is equally critical to ensure that the facts that are known are consistent with updated information. Beyond this, programs must articulate that all wise decisions must be based on accurate information, thus should incorporate skills on how to independently access trusted resources for self-education.

• **Evaluate options and consequences:** This principle is a critical part of the decision making process. Each program that was studied argued that self-protective behaviors have desirable long-term outcomes and are therefore preferable to unsafe behaviors which often have short term rewards. The philosophy behind this principle is to teach participants how to distinguish the difference between "rationalization" from "sound reasoning" and the effects that follow.

• **Commit to change:** Once an individual is able to evaluate options, the individual needs to make a choice which can most effectively be adhered to through an expressed personal commitment. Since behaviors that put people at risk are often pleasurable and can occur impulsively, programs aim to reinforce the concept of personal commitment, often linked to the recognition of personal value and acknowledgment of personal vulnerabilities - dispelling the dangerous perception that "it cannot happen to me."

• **Plan ahead and be prepared:** Risky situations often arise unexpectedly. Unless programs equip young people with the skills to be prepared, they will face difficulty in maintaining personal commitments to reduce risk. The programs under review in the study integrated skills development activities to assist participants to rehearse and understand thought patterns, communication skills and resist and cope with peer pressure. Some explored how to anticipate and avoid risky situations as well as take universal precautions through messages like “always carry a condom.”

• **Practice self-control:** Given that sexual intercourse involves stages or sequences of verbal and non-verbal behaviors, and recognizing how difficult it can be to stop in the middle of such a sequence it is essential for adolescents to have a strategy that is cognizant of this. Self-control requires awareness of one’s emotional states and recognition of stimulation triggers supported by behavioral rehearsals which prepares to either avoid or break the sequence where risks are high. Programs must inform participants on the link between substance use and the weakening of self-control as well to allow them to make decisions what will allow them to maintain sound decisions.

• **Know pleasurable alternatives to high risk sexual activity:** the notion of self-control is further enhanced when there are pleasurable alternatives besides providing youth with only two extremes: abstinence or unsafe sex. Developing skills and perceptions that make safe sexual contact enjoyable are present in all the evidence based programs. Simultaneously, programs help youth identify independently that many emotional needs are often linked to sex including stress reduction, approval, closeness and love and that there are alternative ways to meet these needs that would not put them at risk of infection.

• **Negotiate verbally and nonverbally:** By encouraging verbal negotiation, youth are more able to interrupt a sequence of events that might put them at risk. To implement verbal
negotiation, youth must be acquainted with what to say and how to say it. They must have matching verbal and non-verbal behaviors in order to assert themselves with conviction. Still, they need to know that in doing so they are not refusing the value in that relationship – a common assumption that saying “no,” will drive someone away. Verbal negotiation supports personal commitment to self-protection, strengthens the principles behind improving self-worth and helps shape social networks that are supportive to their decisions to practice prevention.

- **Choose to limit your freedom:** this principle, though controversial in phrasing, is necessary for all self-enhancing behaviors that involve self-discipline in the face of pleasure. Since youth often resist rules externally imposed by authorities, it is essential for them to take the responsibility for creating their own rules and limits. When limitations are seen as self-determined and necessary for protecting health and achieving goals, youth are more likely to accept them.

- **Act to help others protect themselves:** This final common principle in the evidence based program analysis, endorses the sense of personal responsibility that participants have for others, especially their partners. Some of them take on the approach of “friends don’t let friends engage in risky behaviors” while others include the importance of informing past partners and protecting future partners with information related to personal health, risk, and HIV status.

The 10 principles identified in the study embrace motivational factors, problem solving and decision making skills development. They incorporate behavioral and developmental concepts of autonomy, maturity, critical thinking and social responsibility – rather than asserting externally driven rules, key messages and instructions. It is critical for implementing programs to review current strategies used in HIV-prevention programming with youth to assess the complete presence of these 10 principles, proven in their impact. It is important to note that re-designing or adopting these programmatic strategies does not mean that an implementing program cannot tailor their responses based on community specific needs. These concepts can be universally adopted, and the study affirms that it is encouraged to maintain flexibility in the delivery of the activities according to the audience – so long as the concepts within each of the principles is covered in the most relevant and receivable manner.

The following resources aim to support your understanding and adoption of evidence based prevention strategies targeting adolescent populations. As you explore these documents in the context of your OVC, AB and palliative care programs remember… HIV Prevention must be an integrated component of work you do to mitigate their vulnerability and risk in the long term.

- **Diffusion of Evidence Behavioral Interventions (DEBI):** This AED supported project is a website which houses the descriptions and supporting documentation to allow implementing partners to replicate the evidence based successes of behavioral prevention programs. The specific interventions which were part of the above study, along with other promising programs can be read about in more detail on this website. Although you cannot access the curricula in full, you can access their protocols and documents to support your program’s ability to successfully replicate they key activities by visiting the “Resources and Tools” link on the left hand side of each intervention’s page. To visit the
website and explore the collection of research and interventions click here: http://effectiveinterventions.org/

- **Science and Success in Developing Countries:** Holistic Programs that Work to Prevent Teen Pregnancy, HIV and STIs: This publication highlights 10 programs from seven developing countries around the world. All 10 programs produced beneficial changes in sexual risk behaviors among sexually experienced youth while six of these programs also delayed the initiation of sex. This report will assist you in deconstructing programs to isolate the components that facilitate change to be applied to your programs context. To download the PDF click here http://www.advocatesforyouth.org/storage/advfy/documents/sciencesuccess_developing_es.pdf

- **Advocates for Youth Sex Education Resource Center:** is an online clearing house of programs with complete guides to implementation, interactive exercises, participant handouts and supplemental facilitators’ guides. The online resource center contains the following downloadable resources to support your work with community members – be it children, youth or their caregivers:
  - Life Planning Education (Life skills program)
  - Toolkit for creating safe spaces for sexual minority groups
  - Implementation guide for the Teen for AIDS Prevention (TAP) peer education program
  - Parent-Child Communication curricula
  - “There is no place Like Home” Newsletters to assist parents to talk about sexual health issues within the home

- To visit the resource center click here: http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=950&Itemid=628
16. Demystifying Palliative Care for PLWHA

Dear All:

Palliative care remains a mystery to many working in HIV/AIDS response programs. Most practitioners often limit palliative care to the scope of services that fall within home based care, however the reality is that Palliative care extends well beyond spanning clinical, preventative, psychological, social and spiritual arenas of care. In fact, most if not all of you are already actively providing palliative care to your beneficiaries, however are often unaware of it because of this very misunderstanding! It is a broad area of services that provide support and care for persons living with HIV or AIDS.

Palliative care aims to optimize the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through end of life care. It is an approach which is family centered, meaning it engages the wider family and caregivers as much as it aims to provide direct services to the person(s) infected. An easy way of looking at it is to simply ask yourselves, “What are we doing to help or support HIV positive members of our programs?” Nearly all of your responses can be categorized within the scope of palliative care, as we will look at this in more depth below.

In an age where ART is accessible and affordable, some people may question the value of this work as it no longer takes on the end-of-life care focus. The answer is simple: palliative care remains an essential component of a comprehensive package of care and treatment for PLWHAs because of the variety of symptoms they can experience and support needs that arise through the length of their life, including but not limited to their physical health! This is especially true for communities where there is a high burden of HIV infection as it allows for the provision of a continuum of care and support starting from but, extending beyond the health facility to the home and community. This allows for an essential decentralization of care for often over-burdened facilities and workers. Wherever palliative care is provided, quality and sustainability should be central concerns to ensure support is relevant, appropriate, qualified and ongoing.

Given all of this, you still may be asking: How is it done? The following will provide basic guidance on the “who, what and where” of palliative care to allow your programs to better contextualize the implementation of this service area:

Who can typically provide palliative care?

Health workers: can provide basic medical and psychological support including necessary drugs to control pain and other symptoms that occur as a result of HIV related disease, infection control and prevention, treatment of OIs, adherence support etc.

Family and community caregivers: when patients choose to be at home, caregivers can be trained by health workers to effectively provide the prescribed medications and other physical and psychological support that may be needed. Friends, relatives and others in the community can be trained to ensure that the patient is comfortable and well supported. Medical attention from health facility workers (home visits) should be available as needed. Bereavement counseling is
an opportunity to support the loss of affected loved ones and to consider future plans.

**What kind of specific support activities are typically provided? (taken from the PEPFAR Guidance, 2007)**

Clinical/medical care services include: prevention and treatment of opportunistic infections (OIs) including tuberculosis (TB); alleviation of HIV-related symptoms and pain; nutritional assessment; treatment of HIV-related psychiatric illnesses such as depression and anxiety; routine follow-up to determine the optimal time to initiate ART; and support for adherence to ART.

Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling; support groups; support for disclosure of HIV status; and bereavement care.

Spiritual care services should be sensitive to the culture and rituals of the individual and community and may include (but are not limited to): life review and assessment; and counseling related to hopes and fears, meaning and purpose, guilt and forgiveness. Spiritual care may involve clergy and/or traditional/spiritual leaders.

Social care services assist individuals and family members in maintaining linkages to and use of various social services, including: community-based support groups; community mobilization and leadership development of PLWHA; efforts to reduce stigma; transportation support; legal services to assist with succession planning, inheritance rights, and legal documentation (such as a living will or power of attorney); assistance to secure government grants, housing, or health care; linkages to food support and income-generating programs; vocational training; efforts to increase community awareness of HIV care, treatment, and prevention services; and other activities to strengthen affected households and communities. Social services must be targeted at PLWHA and their families.

Prevention care services are designed to prevent transmission of HIV to others. Models to provide these interventions can include: risk assessment and behavioral counseling to achieve risk reduction; referrals to confidential counseling and testing of family members and sex partners; interventions for sero-discordant couples; community and clinic-based support groups; and case-management and provider-delivered prevention messages focused on disclosure, partner testing, correct and consistent condom use for PLWHA, and mutual fidelity.

**What standards should guide the provision of palliative care services?**

Using national or international guidelines, where available that prescribe basic or minimum standards of care, schedules for monitoring, protocols for assessments and referrals etc. In our context, a good resource for guidelines and standards for HIV care and support activities is NASCOP ([www.aidskenya.org](http://www.aidskenya.org)). Similarly for training, using national or internationally recognized curricula on sub-areas of palliative care for any persons who will be engaged in the provision of services including health workers, family members and caregivers, community health workers, other volunteers or project staff. Training must be supported by regular assessments as a quality assurance measure, and also to provide support and prevent burn out of field staff.
The following resources are also available to provide guidance on the different areas of palliative care programming. I highly encourage you to download and share these with your program staff and teams to support your organization's efforts:

**Essential Prevention and Care Interventions for Adults and Adolescents Living With HIV in Resource Limited Settings:** This document by WHO, is the result of an effort to review evidence and develop recommendations for interventions to reduce illness associated with HIV infection and prevent transmission. It follows on an expert panel convened in June 2006. This review meeting used a standardized rating system and a structured guidance development process. Recommendations were formulated covering thirteen areas of intervention seen as low cost and of particular importance for people living with HIV. These areas are:

- Psychosocial counseling and support
- Disclosure, partner notification and testing and counseling;
- Co-trimoxazole prophylaxis
- Tuberculosis (TB)
- Preventing fungal infections
- Sexually transmitted and other reproductive tract infections
- Preventing malaria
- Selected vaccine preventable diseases
- Nutrition
- Family planning
- Preventing mother-to-child transmission of HIV
- Needle-syringe programmes and opioid substitution therapy
- Water, sanitation and hygiene.

To download the pdf click here: [http://www.who.int/entity/hiv/pub/plhiv/plhiv_treatment_care.pdf](http://www.who.int/entity/hiv/pub/plhiv/plhiv_treatment_care.pdf)

**ARV Treatment Fact Sheet: Symptom Control and Palliative Care:** This fact sheet from the International HIV/AIDS Alliance provides information on how to control the painful symptoms of antiretroviral treatment (ART) for people living with HIV. The fact sheet is designed for people working in community-based health settings, and also for people caring for relatives affected by HIV at home. It outlines the common side effects experienced by people receiving ART, and provides a guide to help carers communicate with the person for whom they are caring to identify the source and type of their pain. The fact sheet emphasizes the importance of taking a holistic approach which provides treatment for the physical cause of the pain, but also responds to emotional and social issues that may be causing the patient stress and contributing to their pain. To download this MS word document click here: [http://www.aidsalliance.org/graphics/secretariat/publications/FS18.doc](http://www.aidsalliance.org/graphics/secretariat/publications/FS18.doc)

**Legal Aspects of Palliative Care:** This guide is aimed at palliative care practitioners as well as patients, families and hospice staff. Published by the Hospice Palliative Care Association of South Africa, this document offers guidance on policy and ways to improve the identification and referral of legal problems, with the ultimate aim of integrating this knowledge into the practice of high-quality palliative care and legal services. In the first three chapters, the authors...
discuss theory – palliative care, human rights and ethics, and the following chapters are practically oriented to assist with legal issues encountered in palliative care. It was developed in response to their conclusion that life-limiting illnesses bring practical problems, some with legal overtones. This guide provides up-to-date approaches, and set them in a helpful framework for dealing effectively with the legal issues that arise in palliative care. To download the pdf document click here: http://www.hospicepalliativecaresa.co.za/pdf/legal/Legal%20Aspects%20of%20Palliative%20Care%20-%20Entire%20book.pdf

I would also like to reference you to previous **CAP HIV E-Updates** that covered topics which constitute specific palliative care activities; Each one with tools and resources to support each respective area:

- HIV Counseling and Testing: Skill building and QA Resources, October 2008
- Treatment Adherence Support in Community Based HIV-Responses, March 2009
- Home and Community Based Care (HCBC), June 2009
- Prevention with Positives (PWP), April 2009
17. HIV/AIDS Workplace Policies

Dear All,

Policies are almost universally seen as the first step to take action in any sector or thematic area of response in a way that is harmonized and systematic. We can see this at national level as well as within the context of the organizations we work in. Institutional policies set the foundation and platform upon which active responses are made and people/systems can be held accountable. A HIV/AIDS workplace policy works in the same way. This policy provides the framework for how an organization will actively manage the impact of HIV and AIDS on its staff and the context it is working within. More specifically the policy serves multiple purposes within this broader objective which includes:

- Expressing an explicit commitment to corporate action
- Encourages consistency with national laws and policy
- Lays down a standard of behavior for all employees irrespective of their status
- Provides guidance to supervisors and managers
- Helps employees living with HIV or AIDS to understand what support and care they will receive from the organization or through established linkages
- Supports the spread of the virus through prevention programs

An HIV/AIDS workplace policy provides the basis upon which your organization can establish a more comprehensive HIV Workplace Program combining prevention, care, and the protection of your employee’s rights. There is no single policy that is relevant for all situations. Each organization needs to develop one according to its context, institutional stances and capabilities. Still, there are basic components to a work-place policy that are recommended [i] (about:blank#_edn1 ) to be included as a minimum standard.

i. **General Statement**: This introductory statement for the policy relates to the local context and existing practices of the organization to frame the reason why the HIV/AIDS policy is in place, how the policy relates to other policies within the organization and compliance with national laws.

ii. **Policy Framework and General Principles**: These include general statements that includes areas of non-discrimination, recruitment, commitment to maintaining a safe and healthy work environment for all employees etc.

iii. **Specific provisions**: At a minimum to include protection of the rights of PLWHA, prevention through information, education and training, care and support for workers and their families, competency through organizational learning

iv. **Implementation and Monitoring**: A clause to reflect the commitment of the management and employees to pledge their full support and adherence to the policy. It should also include budgetary allocations, communication strategies, schedule for revision of the policy and mechanisms of evaluation of its impact and relevance.

II. Many of your programs are now in the process of developing work place policies. To support this please see the resources provided below. These free and easy to use
references will support a broader understanding on how workplace policies are developed and implemented:

**A Step by Step Approach to Take Action on HIV/AIDS in the Workplace:** This website houses the steps and stages that an organization should take in its policy development. Starting with an understanding on the basics of HIV/AIDS, and ranging topics like gender, it also specifies the importance of each subsequent step and how it plays a role in policy and practice. The components provided can also be modified as part of your policy documents itself. To visit the site click here: [http://www.ilo.org/public/english/protection/trav/aids/_steps/index.htm](http://www.ilo.org/public/english/protection/trav/aids/_steps/index.htm)

**AED Smartwork – Workplace Policy Program:** Another step-by-step approach provided for managers and other organizational leaders to ensure that workplaces are responding to the risks of HIV/AIDS through policies and programs. Developed by AED, this online toolkit provides best practices, sample policy templates and other references from organizations around the world who have experienced positive gains through their efforts in this area. To visit the site and download all its resources click here: [http://www.smartwork.org/pubs/](http://www.smartwork.org/pubs/)

**ILO Codes of Practice on HIV/AIDS and the world of Work:** This reference tool-kit developed by the International Labor Organization provides recommended codes of conduct, and principles that guide workplace policies and programs with respect to HIV/AIDS. In addition to this, a training manual is provided to orient organizational stakeholders on how the code of conduct should be used for policy development. Each module as part of the manual is designed to involve people in active learning through discussion of key issues, case studies, learning activities and sample policies and agreements. To visit the website click here: [http://www.ilo.org/public/english/protection/trav/aids/publ/code.htm](http://www.ilo.org/public/english/protection/trav/aids/publ/code.htm)

[i] (about:blank#_ednref1) ILO Programme on HIV/AIDS and the World of Work, [www.ilo.org/aids](http://www.ilo.org/aids)
Dear All:

Over the past decade, the HIV/AIDS epidemic has emerged as one of the biggest causes of disease, death, and vulnerability for children. Worldwide, 2.3 million children are living with HIV. 90 percent of these children were infected during childbirth, despite the fact that a simple and highly effective treatment for prevention of mother-to-child transmission (PMTCT) of HIV is available. Without treatment, 50 percent of newborns infected with HIV will die before their second birthdays. (UNAIDS, Towards Universal Access 2009).

This edition of the HIV E-Update will explore Pediatric HIV testing: Why is it important and How can it be done. Supporting universal pediatric testing and counseling is an priority component of the National Strategy as well as partners including PEPFAR, which will then translate into getting children into care and on treatment as early as possible. As your programs continue to respond to the many layers involved in HIV and AIDS as it affects OVC, adults, special and/or most at risk populations; you will encounter families and children. Their entry point into appropriate support and care will always depend on an accurate HIV test.

Why is Testing Important?

As long as barriers for pregnant mothers to access health services exist, interventions to reach infants and children with HIV testing is critical. The KAIS Report also informs us that as many as 82% of Kenyans do not know their accurate HIV status, which means unknowingly partners and unborn children (where there is pregnancy) are at risk. HIV prevalence among pregnant women attending Antenatal clinics are estimated to be 7.8%. This translates to 78,000 women HIV positive annually and infection among infants is estimated 50,000 - 60,000 annually as a result of mother-to-child transmission. (NASCOP)

In the case of your programs working with children who are orphaned and made vulnerable from HIV and AIDS means that you may be working with large information gaps. Do you know for certain if the parents died from AIDS? Do you know if the child has been tested? Is stigma also creating a barrier to disclosed information and accessing health services? Do you know if the mother had access to antenatal care and PMTCT services? Was the child delivered in a health facility? The questions can go on and on! In the end, it is your role to ensure that the children enrolled in your programs have access to the full range of health services to support their optimum health, growth and development among which confirming HIV status is one. And to do this, you must understand more about HIV in children and how testing is done.

How Does HIV Manifest in Children?

There are specific “red flags” you can identify in children to determine whether or not they may be in need of HIV testing.

*HIV-Infected children get sick frequently and severely:* HIV-infected children can get the same infections as uninfected children however, since a child with HIV has a weakened immune system, these infections can be more frequent, more severe, and harder to cure.
HIV-infected children can also demonstrate swollen glands, breathing problems, fever, poor weight gain, and slow development. If the immune system is weakened beyond a certain point, children may also get infected with germs that would not cause disease in children with normal immune systems, or they may get sicker and have more extensive illness. They may develop opportunistic infections. In addition, tuberculosis, diarrhea, and respiratory illnesses are more frequent in children living with HIV.

**Sexually Activity:** Children who are living in un-ideal situations are more vulnerable to a range of factors that can result in exposure and participation to sexual activity. Sexual coercion, assault or early consensual sexual debut are all indicators that a child should be engaged in health services for HIV and STI screening and treatment where necessary.

**Determination of Parent’s HIV status:** In the course of your work with the household, if you are able to determine that the mother is HIV positive or if deceased was more than likely to have died from AIDS it will be important to have children access testing services, as a good practice not knowing if the children have been tested before.

**How are Infants and Children Tested for HIV?**
There are different ways to diagnose HIV, depending on the age of the person.

**Antibody testing (18 Months +):** When HIV gets into the body, the immune system makes a substance called an HIV antibody. HIV infection can be detected by an HIV antibody test, which is used for children 18 months of age and older. This laboratory test is called an ELIZA test used to detect the presence of antibodies in the blood. A rapid HIV test, used in VCT settings, is also an antibody test. Babies born to women infected with HIV will test positive for the HIV antibody at birth. This is because the mother’s antibody to HIV is passed to the baby in the womb. These babies are considered to be HIV-exposed. A newborn with HIV antibodies is not necessarily infected with HIV. This is why there is an age restriction associated with Antibody tests.

**DNA (PCR) Testing (> 18 months):** The best way to diagnose HIV infection in an infant younger than 18 months is to look for the virus itself in the infant’s blood. The most common test is called an HIV DNA PCR, which looks for the DNA (genetic material) of the virus. PCR can identify the virus in more than 90% of infants infected before birth and during delivery by the time they are one month of age, and in almost all infants infected before or during delivery by the time they are three to six months of age. This can only be accessed in a hospital or health center with laboratory services for PCR and NOT in a VCT.

**What are the Issues Surrounding Pediatric Testing?**
In a community setting the primary issue that creates a barrier for testing is consent. Consent is a very important part of almost all health services and involves the person receiving the service to affirm that they agree to receive it, with a sound mind. The minimum age for testing in a VCT is 18 years. Considerations are made within the VCT for persons under the age of 18 who are married, pregnant, parents, engaged in behaviors that can put them at risk of infection (i.e. sex work) are considered mature minors and can receive a VCT service without adult consent (National VCT Guidelines, NASCOP).
For all other cases of children, or minors, in a VCT or facility based testing facility, written consent or documentation of verbal consent from parent or guardian is required, consistent with general requirements for consent for diagnosis and care of minors (HIV Testing in Clinical Settings, NASCOP 2006). Children should be given an age-appropriate explanation of procedures, including HIV testing, and in older children (age 8 to 15) their assent for testing is desirable.

**What Happens After the Test?**

The HIV-test is just the beginning. And irrespective of the results there are lots of follow-up work that your program must be prepared to provide the family. This will include age specific and ongoing HIV prevention support for negative clients and positive-prevention support for those that test positive (prevention is for everyone!), referrals to enroll into HIV care and treatment programs, PMTCT services for future needs and if HIV positive, preparations for disclosure for the child followed with long-standing psycho-social support. Children have a right to know their HIV status. And where as there is not a formal guideline on when disclosure should happen, that when done with appropriate psychological support, age-relevant information and positive reinforcement, the earlier the better the health outcomes and self-acceptance. The same support should be provided to caregivers and parents who are newly diagnosed. The key is age-relevant information.

All of the information above can be read in the following Kenya-specific reference materials provided as PDF attachments or on the web. Please read these and make them available for your staff so you can be best prepared to facilitate this service and the follow-on support that it requires:

**HIV Testing in Clinical Settings:** This guidance document developed by NASCOP explains in detail the various types of testing that can be done within a health setting, by who, and for who it is most appropriate for. Special considerations are explained for minors and is a good reference tool for you and your teams to understand the different circumstances that can inform how an HIV test is administered. Click here to download: [http://www.aidskenya.org/public_site/webroot/cache/article/file/HIV_Testing_in_Clinical_Settings.pdf](http://www.aidskenya.org/public_site/webroot/cache/article/file/HIV_Testing_in_Clinical_Settings.pdf)

**National Guidelines for Voluntary Counseling and Testing:** Also from NASCOP, this document will provide you with all the information behind the standards and processes of an HIV test conducted at a VCT. This will help your program be able to explain in depth to apprehensive clients what they can expect, the level of confidentiality that is warranted for their protection, and even the code of ethics that counselors are bound to. You can read more of the above age-specific guidelines for children and minors as well. Click here to read: [http://www.aidskenya.org/public_site/webroot/cache/article/file/vct_guidelines.htm](http://www.aidskenya.org/public_site/webroot/cache/article/file/vct_guidelines.htm)

**National Guidelines for HIV Testing and Counseling:** Released in 2008, this is the most up-to-date document surrounding HIV testing in Kenya and consolidates the different strategies and mechanisms by which testing is issued, provided. These guidelines were developed in the context of existing Kenyan laws, policies and support the provision of HTC to children, youth, and adults, according to their circumstances. This document remains consistent with previous documents, but in addition have outlined some of the emerging evidence based approaches and
lessons learnt in the implementation of HTC in the last eight years.

**Pediatric Disclosure:** As mentioned above, there are no fixed guidelines for pediatric disclosure. It is a process that requires a counselor’s experiential expertise and intuition to initiate and see through. Still, there are some recommended practices which have been documented by the University of Nairobi through the ACTS program. This is important tool for your staff to become very comfortable with. Use it as a training tool with role-plays and case reviews.
Dear All:

Global strategies to halt the spread and reserve the impact of HIV and AIDS on communities has taken a turn that focus on targeted and evidence-based responses that saturate efforts where needed most. As these strategies find their way into application, attention is shifting more than ever before to populations who are most at risk or most vulnerable to infection, compared to the risks facing the broader general population. Epidemiological evidence tells us that within national prevalence rates there are sub-populations or groups with higher rates of infection due to a range of behavioral, biological or structural risk factors that make them more vulnerable and often at perpetuated risk.

Men who have sex with men (MSM), intravenous drug users (IDU), commercial sex workers (CSW), persons with disabilities (PWD), incarcerated Persons, and vulnerable children comprise the prioritized groups on national and international agendas for intensified HIV-prevention care and support responses. Each group has specialized needs and considerations which require interventions that aim to support these populations to go beyond service provision but also demand addressing issues of criminalization, marginalization, inequitable access to health and other support services. More specific components of HIV prevention programs among these key populations should include:

- Raising awareness and understanding of HIV and STIs by producing Information, Education and Communication materials
- Promoting safe behaviors
- Reducing stigma, discrimination and violence
- Stimulating demand for condoms, lubricants and sterile injecting equipment and ensure that they are accessible
- Ensuring access to, STI care, voluntary testing and treatment for AIDS.
- Support for policy and advocacy on issues related to vulnerability including on human and social inclusion issues.
- Reaching and involving MARP through outreach, peer education, drop-in centers, welfare support and cultural activities.
- Creating physical and/or “virtual” spaces where vulnerable people can gather to gain confidence, develop solidarity and access information services and support in privacy
- Training and sensitization of health workers to enable them to deliver appropriate services to vulnerable communities and individuals.

Among the broader classification of most at risk populations (MARPS) are some highly controversial and disputed issues relating to MSM, CSW and IDU. There are many different views that challenge discussions on morality, culture, the law and how governments should act in response. It is critical to state that as health and development practitioners, when it comes to responding to needs related to health and human rights, personal opinions and moral judgments
need to be put aside, and we must focus on what really works and the ethics that guide our action – reaching out to people in need of health services and protection, all the while involving them in the fight against HIV.

This edition of the HIV E-update provides you with the resources that will enable your programs to be more sensitive to the needs and issues surrounding these most at risk groups. If you are considering working with special populations for the first time, or if you have been working with them already, the following collection of technical briefs, narrative testimonials and program tools will help to strengthen your competency and facilitate evidence-based implementation. Organized into categories, the first will provide general multi-population technical support followed by group-specific tools and guides for MSM, IDU, PWDs, CSWs and OVC.

**Broad Multi-population Technical Tools:**

**HIV Prevention among Vulnerable Populations:** This document captures the institutional learning from Pathfinder International working with most at risk groups. Lessons learned highlight that effective HIV prevention strategies for these groups should integrate three key elements at a minimum:

- identify, develop, and pursue effective interventions that promote individual behavior and social change
- guarantee equal access to comprehensive quality health services
- promote respect of fundamental human rights.

This technical guidance offers insight and suggestions for designing such programs intending to effective interventions aimed at the reduction of HIV and AIDS among the most vulnerable and susceptible groups. To download click here: [http://www.aidsportal.org/repos/HIV%20Prevention%25%0b20Among%20Vulnerable%20Populations%20The%20Pathfinder%20International%20Approach.pdf](http://www.aidsportal.org/repos/HIV%20Prevention%25%0b20Among%20Vulnerable%20Populations%20The%20Pathfinder%20International%20Approach.pdf)

**Guide to Participatory Production of Resources for HIV Prevention Among Vulnerable Populations:** This document is an introductory guide to producing Information, Education and Communication (IEC) materials for use in HIV prevention and care programs with ‘key populations’ (e.g. MSM, IDU, PLHIV, CSW). This unique methodology ensures the development of materials tools with program developers and members of most at risk groups to ensure the products are sound, non-stigmatizing, address relevant needs and are appropriate. The tools range dramas, handouts, short films etc. To Download click here: [http://www.aidsalliance.org/includes/Publication/iec_guide.pdf](http://www.aidsalliance.org/includes/Publication/iec_guide.pdf)

**Unheard Voices, Hidden Lives (Parts 1-3):** The marginalization of sex workers and men who have sex with men is the direct result of stigma and social discrimination which do not allow for their voices or stories to be heard, and thus their lives understood. As a result, the International HIV/AIDS Alliance created this series of testimonials. In their own words and images the individuals in this book invite us into their lives to share their experiences, hopes and fears. This gives voice and visibility to communities are all too often unheard and hidden, and can be used by your program as an instructional tool to build sensitivity, knowledge and
break patterns of stigma that exist. To download each of the parts click on the links below:

- [http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part1.pdf](http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part1.pdf)
- [http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part2.pdf](http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part2.pdf)
- [http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part3.pdf](http://www.aidsalliance.org/includes/Publication/Unheard Voices_hidden_lives_part3.pdf)

Men who Have Sex with Men

**Responding to the HIV-Related Needs of MSM in Africa:** This guide has been produced for programs that want to improve their ability to respond to HIV related needs of MSM in African communities. The guide, developed by the International HIV/AIDS Alliance, provides a set of activities and tools for you to facilitate a meeting with key stakeholders who are responsible for improving local and national responses to HIV among MSM. It includes instructions on how to run sessions, together with a variety of resource material and PowerPoint presentations. It aims to increase understanding about MSM and the issues surrounding their vulnerability to HIV infection. It goes a step further and takes participants through processes that: Explore their own attitudes and feelings about working with MSM Identify what is being done already, or has been done elsewhere, that could be usefully adapted to their local setting Identify and plan a course of action in response to local situations.

This toolkit is a critical first-step to build a consensus, address prejudices and increase understanding about this community of men who have been omitted from HIV response programs at a much larger level. To download click here: [http://www.aidsalliance.org/publicationsdetails.aspx?id=416](http://www.aidsalliance.org/publicationsdetails.aspx?id=416)

**Meeting the Sexual Health Needs of Men who have Sex with Men in Senegal:** This report describes research carried out in Dakar by the Population Council, to elicit information about the needs, behaviors, knowledge, and attitudes of MSM. Overall, the findings found an extremely high level of stigma, violence and discrimination in society and from the authorities. There is a lack of sexual health services and information available to meet the particular needs of MSM. This research provides translatable recommendations within the African context that must inform programmatic design, advocacy activities and individual level service provision. To download the report click here: [http://www.popcouncil.org/pdfs/horizons/msmsenegal.pdf](http://www.popcouncil.org/pdfs/horizons/msmsenegal.pdf)

Intravenous and other Drug Users

**Developing HIV/AIDS Work with Drug Users:** There is an urgent need to mobilize community action on the links between drugs and HIV/AIDS, and specifically, to support work with drug users. But before this work can begin, an effective assessment must be carried out. This publication describes the steps to designing and carrying out a participatory assessment of the drug-related HIV/AIDS epidemic and other drug-related harms, drawing on regional workshops and experiences of the Alliance and its partners in Asia and the Ukraine. It uses a participatory assessment and response approach including setting up an advisory group, making contact and building trust, and analyzing information. To download click here:
Standard Package of Activities for Drug Users: The primary goal of this guidance document is to assist partners in appropriately and effectively developing, adapting, costing and implementing their activities. The document outlines comprehensive packages of priorities for drug users at risk of infection or already infected by HIV. Developed in the Ukraine, the learning is adaptable to different cultural contexts and delineates approaches by four areas: Prevention, Impact mitigation and Health, Capacity Building and Supporting Environment. This tool can help your program re-conceptualize approaches and activities against broader objectives to support drug using populations: To download click here: http://www.aidsalliance.org/includes/Publication/Package_of_Activities_Drug_Users.pdf

Persons with Disabilities (PWD)

Studies on Reproductive Health and HIV/AIDS Among Persons with Disabilities: The following two studies provide a deeper understanding to the issues surrounding PWD concerning reproductive health and HIV/AIDS. The studies, conducted in Malawi and Uganda, were designed to explore and understand the sexual and reproductive health needs and experiences of people with disabilities, their perceptions about HIV/AIDS and how best information on HIV/AIDS can be communicated to people with various forms of disabilities.

- To Download the study in Malawi click here: http://v1.dpi.org/files/uploads/reports/%0bFinalReportforFedomaStudyOctober2004.doc
- To Download the study in Uganda, click here: http://v1.dpi.org/files/uploads/%0bppublications/study%20in%20kampala.pdf

Disability, Inclusion and Development Website: This website, designed by the International Information Support Centre aims to strengthen the management, use and impact of information on health and disability. It contains 300 of the most practical and useful disability resources are listed in the Source International Information Centre directory and CD-ROM, “Disability, development and inclusion: key information resources”. It covers a wide range of themes including human rights, gender, poverty and main streaming, as well as planning and management of disability programs and service delivery relating to children, community-based rehabilitation, mental health and HIV and AIDS. To access and browse the resources click here: www.asksource.info/res_library/disability.htm

Commercial Sex Workers

Toolkit for Targetted HIV/AIDS Prevention and Care in Sex Work Settings: This WHO Developed toolkit aims to provide guidance on the development and implementation of effective HIV interventions in diverse sex-work settings. It indicates the key steps and issues involved in the development and implementation of interventions working with CSW. It also provides links to a wider range of manuals, reports and research studies that can provide a more in-depth understanding of this sensitive area of response. The toolkit provides supporting documentation to inform you, as the reader, whether or not the referenced source would be relevant to your context. The toolkit is divided into four sections which provide an introduction to sex work contexts and the basic steps for program design within it.
**Sex Work, Violence and HIV:** Lessons learned from successful programs tell us that programs must go beyond peer education about HIV/AIDS to have a more sustained impact on HIV prevention efforts. This is because where CSW do not have the power or authority to apply their knowledge, their risk will still persist. The issue remains then, addressing issues of violence and empowerment. This guide discusses the challenges involved in ensuring that violence is addressed in HIV programs, gives a detailed understanding of violence in relation to sex work and challenges some common assumptions. The guide also provides examples from real programs that illustrate ways in which HIV and AIDS projects can help reduce the incidence of violence against sex workers and provide support to those who experience violence. To download click here: [http://www.aidsalliance.org/includes/Publication/%0bSex_%20work_violence_and_HIV.pdf](http://www.aidsalliance.org/includes/Publication/%0bSex_%20work_violence_and_HIV.pdf)

**Violence Against Sex Workers and HIV Prevention:** This technical brief developed by the World Health Organization (WHO), provides a concise summary to the many HIV related risks facing CSWs, and how reducing the incidence of violence can have dramatic impact on broader risk reduction. By addressing the underlying social and economic problems that make sex workers so vulnerable to HIV – for instance, by giving them greater legal protection against violence, and by working to reduce the discrimination they face – HIV infection rates amongst sex workers could be cut dramatically through the reduction of rape, forced sexual exchange without a condom, vaginal trauma which increases susceptibility to infection etc. This document highlights the successes that can be experienced in reducing HIV risk by developing programs that empower CSW with self-defense skills and utilize other strategies for violence mitigation. To download click here: [http://www.who.int/gender/documents/%0bsexworkers.pdf](http://www.who.int/gender/documents/%0bsexworkers.pdf)

**Orphans and Vulnerable Children**

**OVCSupport.net:** Is a global hub on children and HIV. This one website is an all-inclusive resource housing news, policy, technical guides, research and programmatic examples relevant to the specific issues and needs surrounding OVCs. If you are looking for technical support to any of the 6-core service areas, technical tool-kits or reports to inform evidence-based decisions or learn about some of the latest developments in the region related to OVC this website houses it all. You can even participate in discussion groups that share challenges and experiences of other practitioners around the globe. This website is an invaluable tool to support widening your program’s scope of operation and technical knowledge for OVC response activities. To Access and search this website click here: [http://www.ovcsupport.net/s/](http://www.ovcsupport.net/s/)
20. CAP HIV E-Update: Deconstructing the Kenya National AIDS Strategic Plan III

Dear All:

Have you read the Kenya National AIDS Strategic Plan (KNASP) III? I know it might appear as a slightly daunting document but its contents are critical for any organization working in the field of HIV and AIDS, and intending to continue responding to its affects. This plan’s strategic emphasis is on effectively responding to the evidence base and providing coordinated, comprehensive, high-quality combination prevention, treatment and care services, mobilized and strengthened communities for ‘AIDS competence’, and, effective sectoral main streaming of HIV. In order to provide Universal Access to essential services, strategic decisions are required to prioritize interventions that will translate into results.

The KNASP III reflects priorities extracted from the Kenya AIDA Indicator Survey (KAIS), the Modes of Transmission (MoT) Study among other national data, and also captures the epidemic-based responses delineated at the international level within a much larger global HIV/AIDS response. Understanding the outcomes, strategies, priorities and opportunities highlighted in the KNASP will ensure that your efforts are contributing to the much larger picture of what is needed!

This Strategic Plan aims to achieve the following six outcomes:

**Outcome 1:** Reduced risky behavior among the general, infected, most-at-risk and vulnerable populations.

**Outcome 2:** Proportion of eligible PLHIV on care and treatment increased and sustained.

**Outcome 3:** Health systems deliver comprehensive HIV services.

**Outcome 4:** HIV mainstreamed in sector-specific policies and sector strategies.

**Outcome 5:** Communities and PLHIV networks respond to HIV within their local context.

**Outcome 6:** Stakeholders to this Strategic Plan aligned and held accountable for results.

KNASP III will achieve these outcomes by implementing the following four Strategies:

- Provision of cost-effective prevention, treatment, care and support services, informed by an engendered rights-based approach to realize Universal Access.
- Mainstreaming HIV in key sectors through long term programming addressing both the root causes and effects of the epidemic.
- Targeted, community-based programs supporting achievement of Universal Access and social transformation for an AIDS competent society.
- Ensuring that all stakeholders are coordinated and operate within a nationally owned strategy and aligned results framework, grounded in mutual accountability, gender, equality and human rights.

KNASP III is based on four linked pillars that operate as an integrated program. First, the *Health Sector HIV Service Delivery Pillar* will ensure that ministries responsible for health play
a key role in delivering Universal Access to prevention, care and support services. It will also ensure that all HIV programs implemented by all health sector partners are coordinated under one framework. Secondly, the Sectoral Mainstreaming of HIV Pillar will address both the root causes and effects of the epidemic within our public and private sector establishments in Kenya. Thirdly, the Community-based HIV Programs Pillar will enhance community engagement and capacity towards Universal Access and strengthen social transformation into an HIV competent society. Lastly, the Governance and Strategic Information Pillar will focus on leadership and coordination so that all stakeholders operate within a fully harmonized and aligned results framework that is linked to full accountability for results at all levels.

Cutting across all of the four strategies will be a central focus on Most at Risk Populations (MARP) and vulnerable groups in order to directly address existing epidemiological evidence and the sources of new HIV infections.

Below are the strategic objectives that your programs are most likely to contribute to. The KNASP III highlights prioritized interventions for each of the objectives which should inform your own programmatic emphasis. For the purpose of your programming, below each of the strategic objectives are some resources that can support the application of evidence based programs and services

Objective 1: Reduced risk behavior among the general, infected, most at risk and vulnerable populations
- Communication for social behavior change and character formation, community outreach to reinforce accurate knowledge and demand for services in the general population
- promoting increased and consistent condom use and skills to enable this
- Skills building activities and education that support the delayed sexual debut
- behavior change communication campaigns and social change initiatives to reinforce partner reduction, supported by condom use, HIV Testing and Counseling, community mobilization in the general population
- Couple-based HIV testing, supported by increased male involvement/ couple counseling in PMTCT and by intensive counseling and support groups, to identify discordant couples and motivate them to use condoms
- Scaling up of tested interventions for MARPs
- Identify and remedy barriers to access, uptake and effectiveness of PMTCT services
- Strengthen male involvement and couple counseling, quality assurance and early infant diagnosis
- Mobilize uncircumcised communities and expand access to safe, affordable and voluntary male circumcision
- PEP kits procurement and distribution, and establishment of post-rape care services
- Development, dissemination, and building the capacity of partners to implement the GBV standard operating procedures

Outcome 2: Proportion of eligible PLHIV on care and treatment increased and sustained
- Strengthen community knowledge on antiretroviral treatment literacy
- Expand tested programs to enroll PLHIV on ART
• Strengthen HCBC services, and provision of support to HCBC groups
• Provision of testing and counseling services for TB
• ART for patients who are co-infected with TB and HIV and counseling for prevention of TB transmission, strengthen referral linkages with TB services, strengthen capacity of health care workers on ART tools to capture PLHIV screened for TB and TB patients on ART
• Provision of nutritional supplementary and therapeutic support for persons on care and treatment

Outcome 5: Communities respond to HIV within their local context
• Mapping of service providers by program and locality
• Assessment of needs, research best practices, develop capacity guidelines, deliver capacity development programs
• Formative research to identify groups, needs and vulnerabilities, design programs, design targeted prevention programs by population groups, monitor and evaluate
• Risk awareness creation and reduction, advocacy, capacity building, research and policy dialogue, mobilization, outreach activities along hot-spots and community drop-in centers
• Research and development of formal linkage mechanisms

In addition to the KNASP III, emailed earlier but re-attached to this email for convenience, the following strategy documents will also inform your organization to be attuned to the shifts happening as we transition from PEPFAR I to PEPFAR II. It is important to note that there is a strong harmony between strategies set by the Government of Kenya in the KNASP, PEPFAR and a range of other government or multi-lateral funding mechanisms.

• Kenya National AIDS Strategic Plan III
• PEPFAR II Strategy and Annex Documents: Click Here to download: http://www.pepfar.gov/strategy/
• MoH Community Health Strategies
21. Establishing a Learning Culture Within Your Organization

Dear All:

This edition of the HIV E-Update is dedicated to promoting ongoing learning within your organizations. As you all know, this is not a new concept, rather one that has been of primary importance, thus a reoccurring theme in our discussion, forums and field visits over the past two years. Developing mechanisms for ongoing learning and skills development is a critical component of sustainability planning. It all begins with setting a culture that enables and promotes learning.

A learning culture is defined as accepting a set of attitudes, values and practices which support and encourage a continuous process of learning within your organization and among its members. A learning culture is invaluable for organizations to remain competent and cutting edge in a competitive market. It allows programs to continuously challenge its methods and approaches, ensuring continuous improvement and capacity development.

Instilling a learning culture is a long-term commitment and requires deliberate effort to instill and cultivate in environments that are often time-, resource- or personnel-constrained. Although a challenge, the good news is that learning cultures can be achieved in programs and organizations of all sizes! Ongoing learning is even more critical in the context of HIV/AIDS response work:

- It’s a dynamic field where new information, learning and interventions are generated continually;
- HIV is a chronic condition that warrants long-term support by your staff. They need to be “refreshed” on skills, knowledge etc.;
- It often requires discussing sensitive topics that warrant lots of practice and reinforcement of messages, techniques and approaches;
- CBOs often work with volunteers and staff with less technical training and exposure, thus integrating ongoing learning into their working environment helping to build skills and competencies; and
- Communicating issues related to HIV and AIDS requires accuracy to prevent misconceptions, stigma and inaccurate beliefs.

Online references to support ongoing learning in the area of HIV/AIDS and community health are many. They simply require Internet access and in some cases, an e-mail address. The resources below are categorized by type or themes to help you build an e-library to promote learning in your organization. Visit these websites to expand your library’s references and ensure that you and your teams have access to the most up-to-date information.

To help you translate these resources from the point of an enabling culture into actionable learning activities, see the attachment to this e-mail. It provides cost-friendly ways to incorporate opportunities for ongoing learning into your program’s routine. If you haven’t already begun doing so, start today.
HIV/AIDS General Information

- The Center for Disease Control and Prevention: http://www.cdc.gov/hiv/

Policy, Guidance and Best Practice Documents


Training Curricula and Other Supporting Materials

- International Training & Education Center on Health (I-TECH) www.go2itech.org

Online Training Modules

- Just Ask! Communicating Confidently about STD’s HIV and Sexual Activity: CDC, http://www.justaskstd.com/
22. New Learning from the International AIDS Society

Dear All:

The International AIDS Conference (AIDS 2010), organized by the International AIDS Society (IAS), is the single largest gathering of interdisciplinary experts, advocates and implementers working in the field of HIV/AIDS. Occurring bi-annually, this conference highlights the latest in scientific research, policy developments, advocacy needs and programmatic implementation. This year’s theme was “Rights Here, Rights Now.” Picking up on the 2010 deadline for universal access set by world leaders, AIDS 2010 aimed to critical connection between human rights and HIV; a dialogue which began years ago, but is now at the forefront of global priorities to serve the needs of most at risk and underserved populations. The right to universal access is a discussion expanded access HIV prevention, treatment, care and support – as a continuum of needs which must be available to all. With a global economic crisis threatening to undermine public investments the conference provided a forum to present the urgency of the need at this time and demonstrated the importance of continued HIV investments to broader health and development goals – and to discuss exactly how these issues intersect.

This edition of the HIV E-update captures some new learning shared within a set of predominant themes which emerged out of the conference. These issues will be critical for your programs to become familiar with for any future placement in national HIV-response activities as it aligns with the GoK KNASP, USAID/PEPFAR and other international priorities/strategies. These themes include

- Gender inequality
- Most at risk populations including MSM, DU/IDU, CSW and bridging populations
- Intensified HIV prevention (combined and new approaches)
- Children and adolescents
- Social Protection for individuals and families
- Social and cultural research
- Health systems strengthening and human resources

Highlighted in this mailing are presentations that address broad concepts or programmatic learning regarding the these areas as it pertains to HIV risk and service access as well as basic human rights. Each session presented below by title is followed with a brief description along with links to the conference website where you can download each speaker’s PowerPoint presentation and in some cases view and listen to the presentations, questions and answer sessions. This will provide a unique opportunity to engage dialogue of the conference from the view-point of practitioners from all over the globe, and synthesize it as your program can best learn from it in your community’s context. This is only a small fraction of topics, presentations, videos and other resources which are available on the conference website for free. I urge you all to explore it according to the specific areas of interest, which well exceed the predominant themes above. You can do so by visiting http://pag.aids2010.org/.
• **Gender Inequality and Sexuality: New Solutions for Old Problems?** This session focused on approaches addressing gender-based violence and women's sexual rights. The speakers outlined the successful approach of a comprehensive model of care, from development of life skills, to mental health management of women and their family members, parenting and health education. Results point to successful social reintegration in both cases. Presentations include perspectives from Jamaica, Thailand, South Africa the Democratic Republic of the Congo and Kazakhstan. To view the individual presentations or download the presentations click here: [http://pag.aids2010.org/session.aspx?s=422](http://pag.aids2010.org/session.aspx?s=422).

• **Men Who Have Sex With Men: Homophobia and HIV in Africa** HIV epidemics among MSM are unfolding across Africa. MSM are 19 times more likely to be infected with HIV in low and middle-income countries around the world and only one in five have access to the HIV prevention, care and treatment services they need. This session outlined the political, cultural and social barriers quality service provision for MSM in Africa, from a variety of African leadership perspectives: human rights, religious politics, legal and political framework, and service delivery in Malawian, Cameroonian and Zambian contexts. To view the individual presentations or download the presentations click here: [http://pag.aids2010.org/session.aspx?s=160](http://pag.aids2010.org/session.aspx?s=160).

• **Why and How to Prevent HIV and HCV in Drug Users** The session provided findings from studies in different settings, using different approaches, for understanding practical ways in which to reduce transmission of blood-borne viruses among people who inject drugs. Presentations include needle and syringe programs in Afghanistan, substance abuse treatment in the United States, safer inhalation programs from Canada and a discussion on cost-effectiveness of harm reduction programs, and the impact of criminalization on health programs in the Ukraine. To view the individual presentations or download the presentations click here: [http://pag.aids2010.org/session.aspx?s=450](http://pag.aids2010.org/session.aspx?s=450).

• **Combination Prevention Evaluation - What's New?** Combination prevention programs include a rights-based, evidence-informed and community-owned mix of biomedical, behavioral, social and structural interventions. Combination prevention programs are complex, involving multiple strategies that are planned and designed to overcome individual, group, and societal barriers, and to promote mutually reinforcing, even synergistic effects, especially over the long term. This double session will catalyze discussion of the challenges of building evidence for combination prevention, and will point to innovative methodologies that handle complex interventions connecting individual experiences with the structural level interventions. To view the individual presentations or download the presentations click here: [http://pag.aids2010.org/session.aspx?s=577](http://pag.aids2010.org/session.aspx?s=577).

• **Integration of OST, TB, ARVs, Treatment and Scale-Up for IDUs** The quality of the available public services which provide medical and social support are far from meeting
the needs of injecting drug users (IDUs) and people living with HIV (PLHIV). This session discusses a comprehensive approach or the principle of a “social supermarket,” combining the highest number of the most important services into the same place. This is an integrated approach based on real cooperation among all components - opioid substitution therapy (OST), highly active antiretroviral therapy (HAART), directly observed therapy (DOTs), harm reduction, and rehabilitation. Such an approach will allow for an effective approach to IDUs, Prisoners and other most at risk populations (MARPs) and will result in influencing the pace of the epidemic. Presentations made from Eastern Europe and Asia represent issues of access, scale up, adherence and operational experiences. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=698.

- **Addressing Risk for HIV among Female Sex Workers** This session presented the findings from various programs implementing HIV prevention programs with sex workers in the Asian and African Context. The collective discussion from the session presents models and best practices for comprehensive service provision, factors to associate with improved risk reduction practices, overlapping issues of drug use and commercial sex work, and specific cultural practices which require contextual consideration when working with high-risk populations. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=439.

- **Managing Multiple Identities: "Bridging" Populations** In the context of HIV/AIDS, bridging populations are defined as those that may be seen as having the potential to transmit HIV or STIs from a high-risk population to a less risky one. This session explores the experience working with and understanding the social and behavioral dynamics of individuals falling within a bridging population in the Caribbean and Asia. The aim of this discussion is the better understand how to mitigate issues of risk as they pertain to the individual who engage in high-risk sexual practices and their partners, who do not know. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=427.

- **Sexuality Education and its Role in HIV Programs** HIV prevention activities with youth and children often involve broader initiatives to integrate sex and health education into formal and informal school settings. This session presents various experiences that can inform practitioners to apply stronger approaches through minimum packages for school-based activities with children and adolescents. It also looks at how programs can involve families in taking a lead on discussing sex and sexuality with their children. Additional presenters look at patterns of sexual behavior and partner selection among university campuses, as well as the link between sexuality and citizenship among youth. Represented in this session are perspectives from the United States, Uganda, South Africa, Columbia and Mexico. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=170.

- **Prevention of Sexual Transmission of HIV** This session looks at a range of behavioral,
biomedical and cultural aspects that relate to sexual transmission of HIV. From issues of intimate partner violence (IPV), couples-based behavioral intervention models and male circumcision, the session looks at a range of experiences in the African context and beyond to broaden an understanding of opportunities to intensify HIV prevention efforts as experienced by these practitioners. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=433.

• **Successful AIDS Sensitive Social Protection: What is it? Why Is It Important? What's New and What Works?** The session evaluated the importance of social protection and its relevance to HIV and AIDS, and the Millennium Development Goals (MDGs). Social research has demonstrated how social protection programs have contributed to stronger local and national responses to HIV. Through a series of country case studies, the impact of social protection is examined. The session will close with a number of recommendations, among which greater donor engagement to fund social protection programs in a more sustainable way is a priority. It is also important to ensure the inclusion of initiatives which can further strengthen health systems, community systems and social protection programs while integrating marginalized populations. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=677.

• **Social Sciences and Interventions: Putting Theories into Practice** The session provided a series of examples and an opportunity to debate some key issues on the utility and methodologies of social science as applied to HIV prevention treatment and care. The approaches explored in this session looked at those targeting children affected by HIV/AIDS, reducing sexual risk among sex workers and discordant couples, improving the results of broad social marketing campaigns – countries represented in the session include Brazil, Kenya, the United States and India. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=622.

• **Strategies to Support Health Workers to Deliver Care** This session explores issues related to human resources for health systems, aiming to bring to the forefront discussions on mitigating burn-out, motivating performance, and developing cost-effective models in resource constrained settings. The presenters explore concepts and models for successful task-shifting, improving service delivery with non-formal service providers, time-management approaches and implementing savings and credit schemes for staff. Experiences are shared from Uganda, Bangladesh and the United States with recommendations on cross-cultural applications. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=167.

• **Youth: Providing Leadership on AIDS and Demanding Accountability** Too many young people are living with or otherwise affected by HIV. While countries have committed themselves to ensuring that young people receive adequate information and services to protect themselves from HIV infection and have access to HIV treatment, care and support when living with HIV, progress on implementation of the commitments is
very slow. This interactive session with four youth leaders and four highest-level representatives of UN agencies and national or international AIDS programs discussed and debate HIV-related policies and programs targeting young people and identify the gaps and challenges to achieving universal access for young people. Young people will ask these adult leaders to make further commitments for young people, and to ensure meaningful youth participation in all aspects of the response to HIV. To view the individual presentations or download the presentations click here: http://pag.aids2010.org/session.aspx?s=690.
23. Responding to Violence Against Women in the HIV Context

Dear all,

Consider the following statistics:

- Every year, about 5,000 women are murdered by family members in the name of honor each year worldwide.
- Worldwide, up to one in five women experiencing sexual abuse as children. Children subjected to sexual abuse are much more likely to encounter other forms of abuse later in life.
- At least one in every three women, or up to 1 billion women, have been beaten, forced into sex, or otherwise abused in their lifetimes. Usually, the abuser is a member of her own family or someone known to her (L Heise, M Ellsberg, M Gottemoeller 1999).
- Up to 70% of female murder victims are killed by their male partners (WHO 2002).
- In Kenya more than one woman a week was reportedly killed by her male partner (Joni Seager 2003).
- In Egypt 35% of women reported being beaten by their husband at some point in their marriage (UNICEF 2000).
- A WHO study found that at least 30% of women in some locations reported that their first sexual experience was coerced or forced.
- In Rwanda another WHO study found that incidence of HIV went up from 1% before the conflict to 11% in 1997 (WHO 2004).

Gender-based violence, or specifically violence against women (VAW), is a major global issue that has implications beyond human rights, into public health and social development. The UN defines VAW as, “any act of gender based violence that results in, or is likely to result, in physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life.”

It takes on many forms and can include sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); trafficking for forced labor or sex; and such traditional practices as forced or child marriages, dowry-related violence; and honor killings, when women are murdered in the name of family honor. Systematic sexual abuse in conflict situations or coercive violence by actors of the state is also included as a form of VAW.

These statistics are just the tip of the ice-berg as this type of violence is frequently invisible, happening closed doors. Moreover, legal systems and cultural norms often do not treat it as a crime, but rather as a "private" family matter or a normal part of life. As a result, many women do not seek help or even report acts of violence when they occur. The implications VAW has on health are often minimized against matters of human rights, however, directly intersect with matter of sexual and reproductive health in lethal ways. Transmission of STIs including HIV,
unintended pregnancy and subsequent unsafe abortions, untimely health service access or inability to access at all, complications to pregnancy or irreversible damage to the reproductive track are just some of the many physical implications that result from VAW. These in turn, have profound and life-long psychological and social consequences which create cycles of vulnerability, risk and abuse.

It is not just a matter of domestic or intimate partner violence alone. VAW are often systemic mechanisms to perpetrate social control, deliberately exploit or stigmatize the already vulnerable sub groups of women and girls: Forced sterilization, denial of pre-natal care, other discrimination or denial of right to women living with HIV; Violence or coercion against female sex workers or women who use drugs, “corrective” rape or violence against women with lesbian or bi-sexual orientations use of rape or sexual slavery during times of conflict.

In the context of HIV-programs, we must be aware of the intersections VAW has with the full range of activities your organizations are involved in for HIV prevention, care, treatment and support. For example:

- Prevention of HIV for non-consensual sex, in the form of PEP, and other post-rape care must be accessible and in a time sensitive manner.
- Approach barriers to testing (partner initiated or VCT), ART treatment access and other adherence support from the perspective of non-disclosure related to the fear of violence to ensure access while protecting the livelihood and welfare of women.
- Advocacy campaigns to contextualize implications of mandatory testing, non-consensual disclosure and criminalization of HIV-transmission in settings where VAW is normalized and rampant.
- Deliberate social mobilization to support community intolerance for VAW along with the mechanisms to report acts of violence, support survivors and hold perpetrators accountable to their actions.
- Foster behavior formation with children and youth that promote gender equity, non-violent communication, conflict resolution skills, as well as healthy self-image, empowerment of personal rights and mechanisms to seek legal protection.
- Advocacy for victims and wider knowledge of available resources for abused women (including legal assistance, housing and child care) as social support services.
- Psychological support services for victims of violence or children who have witnessed but not been subjected to violence.

The following resources have been selected to better establish an understanding of this issue, as well as support your programs to take pro-active steps to prevent or mitigate VAW in the context of your HIV prevention and care activities.

- **Guidelines for Medico-legal Care for Victims of Sexual Violence:** Developed by WHO, the aim of these guidelines are to improve professional health services for all victims of sexual violence by providing: Health care workers with the knowledge and skills that are necessary for the management of victims of sexual violence; standards for the provision of both health care and forensic services to victims of sexual violence; and
guidance on the establishment of health and forensic services for victims of sexual violence. Programs can adopt these guidelines as a day-to-day service document and/or as a tool to guide the development of health services for victims of sexual violence. It can also be used to prepare in-service training courses on sexual violence for multi-disciplinary teams.


- **Addressing Violence Against Women in HIV Testing and Counseling Settings:** This document consolidates findings from an international meeting convened by the specific departments within the WHO to discuss how HIV counseling and testing programs can take into account and address necessary intimate partner violence and other concerns related to women. This report not only consolidates the scope of issues, but presents recommendations for practitioners, policy makers and implementers to take forward in application.


- **Reducing HIV stigma and Gender Based Violence: Toolkit for Health Care Providers:** This toolkit, published by the International Center for Research on Women (ICRW), is a collection of participatory educational exercises for educating health care providers on the issues of stigma and gender-based violence. Developed in the Indian context, it is designed to facilitate open discussion on HIV stigma and gender violence, and on what health workers can do to promote a change in attitude and practice.


- **Painful Tradeoffs: Intimate-partner Violence and Sexual and Reproductive Health Rights in Kenya:** The authors of this position paper show how economic factors lead many women to subordinate their sexual and reproductive rights to their material needs and those of their children. Understanding the root causes provides a better understanding of how to respond. This document offers various recommendations to the government of Kenya including that relevant ministries should take action to strengthen standards and improve coordination between services for women affected by violence. Additional recommendations at community level for social change are also discussed. This is especially useful for the development of advocacy plans and social change approaches.


- **Violence Against Women and Girls: a Compendium of Monitoring and Evaluation Indicators:** This document aimed at program managers and organizations working to combat VAW, provides a framework within which to monitor and evaluate related activities. The author discusses the ethical considerations of monitoring and evaluation (M&E) of VAW, what makes a good indicator and where to go for more information on M&E. This document includes a wide range of indicators based on characteristics that define types of VAG and cut across programmatic sectors of health, education, justice/security and social welfare to ensure that M&E of VAW is integrated into your

- **Mental Health Aspects of Women’s Reproductive Health: a Global Review of the Literature:** This literature review examines the link between mental health and women’s reproductive health. It explores the key issues affecting women throughout the life cycle and provides an evidence base that highlights the effects of these development processes on women, with specific emphasis to women’s health in the context of HIV and AIDS. To download click here: [http://whqlibdoc.who.int/publications/2009/9789241563567_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563567_eng.pdf).
24. Linking HIV and Reproductive Health Services for Improved Outcomes

Dear All:

Within the framework of WHO's definition of health, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Linking HIV/AIDS and reproductive health programs is particularly strategic and has the potential to significantly curtail the spread of the HIV virus, as the inherent association between HIV/AIDS and reproductive health is undeniable: Over 75% of HIV infections are acquired through sexual transmission or through transmission during pregnancy, labor and delivery, or during breast feeding. The presence of other sexually transmitted infections increases the risk of HIV transmission. Aside from these obvious direct associations, many of the same root causes affecting sexual and reproductive health issues also affect HIV/AIDS namely, gender inequality, poverty, stigma, discrimination and marginalization of vulnerable groups.

As we move into the new phase of program priorities set, broader health services of which reproductive health emerges, becomes the entry point for clients to engage in HIV related services, even as initial as testing. By intersecting reproductive health discussions, services and advocacy in an HIV-context will intensify outcomes of your programs benefiting individuals, families and communities at large irrespective of age, sex or HIV-status to be better informed to make healthier decisions and choices.

The following resources are provided to support your programs and staff to better understand and integrate concepts within reproductive health into your programs. It includes resources for capacity development, training and continued learning as new developments are published in this crucial area of work.

- **Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services:** This document is based on a combination of expert opinions, recommendations from literature, and lessons learned from field experience with integrated approaches to HIV/FP. It offers a range of activities for program planners to consider implementing in order to enhance new or existing linkages. This document is intended to help program planners identify action steps. It also provides links to existing resources, such as facility-assessment tools, training curricula, and job aids that will support the implementation of action steps. To download click here: [http://www.who.int/entity/reproductivehealth/publications/](http://www.who.int/entity/reproductivehealth/publications/)
Youth Friendly Services for Married Youth: A Curriculum for Trainers: This manual aims to enhance health care providers’ understanding of the reproductive health needs of young married men and women and enable providers to offer appropriate information, support, and services. It also encourages health care providers to reach out to community members and adults and help them create a supportive environment to encourage acceptability and uptake of services. To download click here: [http://www.acquireproject.org/archive/files/8.0_program_for_young_married_clients/8.2_resources/8.2.5_tools/Young_Married_Trainers_final.pdf](http://www.acquireproject.org/archive/files/8.0_program_for_young_married_clients/8.2_resources/8.2.5_tools/Young_Married_Trainers_final.pdf).

Comprehensive Counseling for Reproductive Health: An Integrated Curriculum: This curriculum is designed to put the concept of integrated reproductive health services into practice by helping all levels of service providers develop the communication and counseling skills needed to assess and address their clients’ comprehensive sexual and reproductive health needs. Includes activities designed to increase providers’ comfort in discussing health care issues and behaviors relating to the sensitive topics of sexuality and reproduction, to sensitize providers to issues of gender and rights related to reproductive health, and to help trainees develop client profiles to tailor training to local situations. To download click here: [http://engenderhealth.org/pubs/counseling-informed-choice/comprehensive-counseling-for-rh.php](http://engenderhealth.org/pubs/counseling-informed-choice/comprehensive-counseling-for-rh.php).

The WHO reproductive health Library: This is an electronic library of review journals published by the Department of Reproductive Health and Research at WHO Headquarters in Geneva, Switzerland. The RHL takes the best available evidence on sexual and reproductive health and presents it as practical actions for practitioners (and policy-makers) to improve health outcomes, especially in developing countries. To access the website click here: [http://apps.who.int/rhl/resources/about/en/index.html](http://apps.who.int/rhl/resources/about/en/index.html).

Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: A Manual for Trainers and Program Managers: This manual, developed in collaboration with the International Community of Women Living with HIV (ICW), provides information and a structure for a four-day training and a two-day planning workshop that will enable program managers and health workers to provide comprehensive, nonjudgmental, and high-quality SRH care and support to HIV-positive women and adolescent girls. The manual also urges male involvement, promotes a holistic approach to integrated SRH counseling, and emphasizes program planning that links SRH and HIV services. To download click here: [http://engenderhealth.org/pubs/hiv-aids-sti/srh-hiv-positive-women-girls.php](http://engenderhealth.org/pubs/hiv-aids-sti/srh-hiv-positive-women-girls.php).

**Newsletters and News feeds**

- Male Circumcision Clearinghouse: comprehensive source of information and resources about male circumcision for HIV prevention subscribe to newsletter on website, [http://www.malecircumcision.org/](http://www.malecircumcision.org/)
• HIV This Weeks: UNAIDS developed email newsletter on scientific updates and journal discussions, http://hivthisweek.unaids.org/


• IRIN Humanitarian News and Analysis: sign up on the website for newsletter specified by country, region or topic of interests, http://ww.irinnews.org/Region.aspx?Region=EAF

• Global Health Magazine: online blog of public health experts providing updates and insights to broad health issues, most focusing on HIV and its prevention, http://www.globalhealthmagazine.com/subscribe/
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## Acronyms and Abbreviations

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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
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<tr>
<td>AMPATH</td>
<td>Academic Model Providing Access to Health Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ATLAS</td>
<td>Analysis Software for Qualitative Data</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>CAP</td>
<td>Capable Partners Program</td>
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<tr>
<td>CHHC</td>
<td>Coptic Hospital Hope Center</td>
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<tr>
<td>CM</td>
<td>Centimeter</td>
</tr>
<tr>
<td>EDARP</td>
<td>Eastern Deanery AIDS Relief Programs</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IQR</td>
<td>Inter-Quartile Range</td>
</tr>
<tr>
<td>KDH</td>
<td>Kericho District Hospital</td>
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<tr>
<td>KG</td>
<td>Kilogram</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>U.S President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>RTE</td>
<td>Real-Time Evaluation</td>
</tr>
<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>STATA</td>
<td>Statistical Analysis Software</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Background

In recent years, significant scale-up and capacity development within the health sector has enabled health facilities to become better providers in comprehensive HIV medical management for children. The presence of pediatric ART formulations, early-infant diagnosis technologies among other diversified services are taking the capabilities of pediatric management to more advanced levels which are clinically proven to improve the length and quality of life for children. Still, the uptake of services and retention of children in clinical settings remains a significant challenge in the Kenyan context.

Even with improved accessibility of such services, children are fully dependent upon adult caregivers to reap its benefits. Providers across Kenya assert that a child’s ability to receive proper and long-term medical management requires the presence of a consistent and committed caregiver. Compounded by psycho-social and economic barriers at the household level, and limitations from centralized models of facility-based service delivery, children remain at risk for intermitted or discontinued care, if such services are initiated at all.

This model proposed by the Mwangalizi Project was piloted in response to concerns expressed by providers that optimum pediatric HIV management is difficult to maintain due to barriers hindering consistent follow-up and monitoring of children at HIV care and treatment facilities in Kenya. Often the result of children’s dependency upon their caregivers to initiate facility-based care and follow-through on treatment plans at home, the negative effects are burdened by the children both clinically and psychologically, resulting in poor adherence, drop-out and poor quality of life.

Modifying traditional components of a community health model, the objective of the pilot was to strengthen the link between clinical and household settings for better quality and continuum for care of HIV-positive children as expressed through improved adherence and clinic retention. Five PEPFAR supported care and treatment were engaged to roll-out customized approaches to meet this objective according to the context of the communities they reach. These are: the Eastern Deanery AIDS Relief Program (EADRP), Coptic Hospital Hope Center, the AMPATH Program, Kericho District Hospital (KDH) and BOMU Medical Centre.

Conceptual Framework

The conceptual framework below depicts the two focal points of care in pediatric HIV management. These are the HIV treatment facility (i.e. ART dispensing clinic, hospital, medical center etc.) and the household. Surrounding each of these focal points of care are various barriers and/or limitations that affect a child’s ability to receive appropriate care and support. The barriers specified in the framework are not exhaustive rather represent the more predominant barriers noted by facilities operating in the Kenyan context. The Mwangalizi linkage in the center captures the services provided both to households and the facility through or by a specialized CHW called a Mwangalizi in the form of monitoring, information exchanges and other specific service provision which will be specified in later sections of this paper.
In an effort to mitigate the barriers, facility-identified Mwangalizi, Swahili for caregiver, are assigned to children enrolled in ART programs in an effort to create a continuum of care between the facility and the household. The link forged by the presence of the Mwangalizi allows for continued monitoring, support, counseling and education and information documentation at the home benefiting children and caregivers. They also facilitate access to the facility by accompanying the children to clinic visits in the absence of the caregiver, making referrals or initiating care for emerging medical concerns and provide the facility with information relevant to their medical management and adherence monitoring that occurs in the home.

Integral to the conception of the pilot is the provision for the five participating sites to develop activities using an open methodology. This affords the design of tailored approaches based on site-specific knowledge and experiences working in their respective communities. This open methodology in program design facilitates a critical “learning by doing” approach, which is complimentary to the adoption of a real-time evaluative methodology. However, the following guiding principles were applied as a minimum standard for program design to hold partners closely to the objectives desired from the conceptual framework:

- The intervention must create a link between the facility and the household with the intended purpose of supporting clinic retention and treatment adherence
- The intervention cannot be an expansion of a traditional OVC program model
- The intervention serves HIV-positive children up to age 14 who are currently, or will one day be, on ART
- The Mwangalizi are encouraged to be members of the clinics’ ART program or are other HIV-positive individuals who are positively living.

**Real Time Evaluation Methodology and Parameters**

By design, a Real Time Evaluation (RTE) is a chosen methodology that provides credible real-time feedback on operational performance and identification of emerging systems issues. The emphasis of the RTE method is on learning through a program’s implementation from the point of inception, rather than reflecting near or at its end. It is a model that focuses more on processes
rather than impact, typically due to the shorter timeframe within which a RTE is conducted.\footnote{“Real-Time Evaluation: Where does its Value lie?” Herson and Mitchell UNHCR Evaluation and Policy Unit (EAPU), www.odihpn.org} Therefore the underlying principle of this methodology is that the RTE can and should affect programming as it happens.

For the purpose of the Mwangalizi Project, the RTE served a dual purpose of extracting outcomes and learning, as well, provided a critical review of activities with the intended purpose of immediately translating feedback into the implementation process to produce optimum programming results. It used both qualitative and quantitative data to test the viability of the conceptual framework to reduce pediatric HIV-clinical management barriers by comparing various strategies and processes implemented by the different sites according to phased, thematic focus during the 18-month pilot. The following are targeted areas of interest that were central to the RTE:

- **Impact Assessment**: With direct benefits targeting the child, the evaluation extracted the impact this type of intervention had in supporting their treatment adherence and clinic retention. It also considered the extent that impact is felt beyond the children themselves by examining the effect on caregivers and other household members. Specifications related to the data analysis for this component of the RTE are discussed in the next section.

- **Program Design and Strategy**: Looking at various structural elements of program design and implementation through ongoing documentation, the evaluation will consider the varied approaches and methodologies that are utilized across the five sites, focusing on how optimized results can be achieved in varied contexts. Through thematic exploration of the implementation period, the RTE extrapolated lessons learned and best practices that can be adopted across varied settings in the Kenyan context and beyond providing evidence based recommendations to support on methodologies for programmatic composition and scale up throughout PEPFAR country operations.

### I. **REAL TIME EVALUATION FINDINGS**

#### Impact Assessment

The evaluation integrated mechanisms for collecting information from the clinic and Mwangalizi field visits in a standardized format and schedule over an 18 month period; both quantitative and qualitative in nature. The combined data set utilized in the analysis represents HIV-positive children age 14 years and younger who participated in the Mwangalizi Project at each facility between June 2008 and November 2009.

#### Quantitative Data:

Data cleaning and preparation were conducted to ensure that data sets were complete and ready for analysis. These processes involved identification and verification of outliers and other erroneous variables. Data sets from the five facilities were then merged into one combined data
set. Indicators includes: age (years), sex, ART adherence, CD4%, height in centimeters (cm), weight in kilograms (kg) and diagnosis of opportunistic infection.

Where necessary, coding of categorical variables was done for standardization purposes in accordance with national and international standards as follows:

- World Health Organization (WHO) staging according to CD4%
- WHO Nutritional status classification

The total population of children represented at baseline and cumulative enrollment at the close of the RTE is 1,057 and 3,174, respectively. For the purpose of the RTE and in line with its framework, the analysis was applied to the cohort of participants in the pilot as an overall population. Where indicated, data were segregated according to the children’s ART status and age. Facility-level comparisons and analysis are included. Furthermore, as the Mwangalizi RTE is a programmatic evaluation of a pilot intervention applied to pre-existing clinical programs with enrollment and drop-outs taking place during the life of the study period, no formal sample-size calculations were performed.

**Qualitative Data:**
Focus group discussions (FGDs) and key informant interviews (KIIs) were digitally voice recorded and transcribed, mainly vernacular-English to English and Kiswahili to English. Transcriptions were supported with supplemental notes taken at the time of interviews by the interviewer. Each session had a translator present where translations were necessary.

Using data from FGDs and KIIs, particularly those involving caregivers and clinic staff relating their perceptions of and experiences with the care of children in the Mwangalizi Project, qualitative analysis using content and matrix approaches was conducted to provide more insight into the findings of the pilot.

**Statistical Methods**
Descriptive analysis was applied to baseline and follow-up data sets. The data were summarized using both means (standard deviation–SD) and medians (inter-quartile ranges–IQR) when continuous, and proportions when binary or categorical. Survival analysis, including graphical presentations of the Kaplan-Meier Survival Curves, has been applied when analyzing data for ART adherence and clinic attendance to determine “time to event” and probabilities. Regression models of repeated measures for the parameters of height, weight and CD4% taken throughout the follow-up period have been used to estimate the changes in parameters over time. The test for statistical significance has been determined at a 5% level with a 95% confidence interval presented for each parameter estimate.

**Analysis of Health Outcomes**

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2 WHO nutritional classification is based on weight for height up to age five and BMI for age z-scores age six years and above.
3 ART status refers to whether or not the child is taking ART. Subsequent tables will reflect this as “ART” and “Non-ART.”
4 This was done to account for clinical distinctions that apply to age sets for children below 6 years and 6 years and above.
Analysis was performed with the data sets at month 6, 12 and 18, as indicated in Table 1.

Table 1. RTE Parameter Mean Values at 6-, 12- and 18-Month Time Points (All Facilities)

<table>
<thead>
<tr>
<th></th>
<th>Month 6</th>
<th>Month 12</th>
<th>Month 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean (SD)</td>
<td>N</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age&lt;6 yrs</td>
<td>531</td>
<td>14.0 (7.8)</td>
<td>163</td>
</tr>
<tr>
<td>age&gt;=6 yrs</td>
<td>521</td>
<td>25.5 (8.2)</td>
<td>394</td>
</tr>
<tr>
<td>Height (cm)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age&lt;6 yrs</td>
<td>486</td>
<td>91.3 (17.4)</td>
<td>158</td>
</tr>
<tr>
<td>age&gt;=6 yrs</td>
<td>493</td>
<td>124 (18.4)</td>
<td>387</td>
</tr>
<tr>
<td>CD4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age&lt;6 yrs</td>
<td>132</td>
<td>23.9 (11.7)</td>
<td>17</td>
</tr>
<tr>
<td>age&gt;=6 yrs</td>
<td>139</td>
<td>20.2 (11.3)</td>
<td>46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional Status</th>
<th>Month 6</th>
<th>Month 12</th>
<th>Month 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean (SD)</td>
<td>N</td>
</tr>
<tr>
<td>Overweight, n (%)</td>
<td>157</td>
<td>(17.5)</td>
<td>37 (11.3)</td>
</tr>
<tr>
<td>Normal, n (%)</td>
<td>665</td>
<td>(74.2)</td>
<td>261 (79.6)</td>
</tr>
<tr>
<td>Underweight, n (%)</td>
<td>41 (4.6)</td>
<td>21 (6.4)</td>
<td>64 (6.2)</td>
</tr>
<tr>
<td>S. Underweight, n (%)</td>
<td>33 (3.7)</td>
<td>9 (2.7)</td>
<td>28 (2.7)</td>
</tr>
</tbody>
</table>

Improvements are seen across all areas at the three time points with the most improvements in clinical parameters occurring for height, weight and nutritional status at month 6, and month 12 for CD4%. The overall mean CD4% at month 18 for children below six years is 25.3%, while for those above six years it is 23.3%.

There are shifts in WHO staging over the length of the intervention (Figure 1). At baseline 36.5% of the patients were considered severe based on the WHO classification (Figure 1), whereas by month 18, this had reduced to 24.6%, a significant improvement in CD4% change between the two time points (p<0.001). Similar shifts are seen in the classification of nutritional status with reductions in children falling below a normal classification to 8.9% at 18 months compared to 11.5% at baseline (Table 1), as well an increase of 4% of children considered to be within the normal parameters compared to baseline.

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5 Based on test of proportions (baseline and month 18).
Repeat measures modeling of the parameters (Table 2) adjusting for ART status, facility and age indicates increases in weight, height and CD4% as a result of the intervention that are statistically significant.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>N</th>
<th>Coefficient† (95% CI)</th>
<th>Coefficient‡ (95% CI)</th>
<th>p-value†</th>
<th>p-value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (kg)</td>
<td>3111</td>
<td>21.83 (21.27 to 22.38)</td>
<td>14.53 (13.93 to 15.13)</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>2302</td>
<td>111.50 (110.42 to 112.57)</td>
<td>93.0 (91.63 to 94.36)</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CD4%</td>
<td>712</td>
<td>25.29 (22.72 to 27.86)</td>
<td>25.95 (23.90 to 27.99)</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Regression coefficient estimating change during follow-up † unadjusted p-value and ‡ adjusted p-value for facility, ART status and age (below or above 5 years) from Wald test.

Caregivers expressed a notable change in their children’s health as a result of the health education and support provided through Mwangalizi Project, which affirms the quantitative clinical data. During the FGDs, many caregivers stated that prior to Mwangalizi, they were unable to identify when an illness or medical concern warranted clinical attention, which resulted in delaying or discounting the need to seek medical attention. However, the health education and health assessments conducted by Waangalizi during home visits or phone calls affirmed the necessity for care and enabled caregivers to be more proactive in seeking medical services for children:

*Whenever the Mwangalizi is close by and I just send word that the child is unwell, they must make it a point to come and check on the child to see how they’re getting on and to give me advice on what I should do.*
– Caregiver, AMPATH

She comes nearly every month. Last week she came and found that the child was unwell and also my mum was very sick, so they brought the child to the hospital, and he was treated and then brought him back home. But when she comes, she also does therapy for him in the house.

– Caregiver, Coptic Hope Center

**Analysis of ART Adherence**

The population of children enrolled in the intervention showed high rates of ART adherence on a monthly basis (Figure 2), with an average of 85.75% reporting satisfactory adherence and a range of 76% to 98% over the 18 months with a slight decrease over time. This is consistent with literature that documents pediatric ART adherence estimates ranging from 49% to 100%, with the majority of studies reporting pediatric ART adherence greater than 75%.6

![Figure 2. Percent of Children on ART Reporting Satisfactory (<95%) ART Adherence by Month](chart.png)

Further analysis was conducted to determine how many children were able to maintain satisfactory adherence throughout it is important to note that the measure for adherence is subject to client memory and forthrightness and that adherence reflects behavioral aspects of an individual’s health management that are not static.

In Figure 6, Kaplan-Meier survival analysis was conducted to explore probabilities surrounding ART adherence, with time to event or failure considered as the time to unsatisfactory adherence. The probability of adherence reduces over the follow-up time from 96% at month 6 to below 50% at month 18. Unsatisfactory adherence occurs at month 16 of follow-up.7 This information suggests that intensified efforts need to be in place from month 12 and onward to ensure adherence is maintained.

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7 Ninety-five percent C.I: 14 months and above.
Figure 3. Kaplan-Meier Survival Curve Predicting the Probability of ART Adherence

One hundred percent of clinic staff who participated in KII's asserts that there is a comparative improvement in the children’s reported adherence practices since the Mwangalizi intervention. Caregivers documented that with the support of the Mwangalizi, 87% of respondents experienced an improvement in their ability to administer their child’s medication as prescribed. Ninety-seven percent of respondents reported an improvement in their child’s willingness to take their medications.

My child nowadays is very happy about taking the medication because he knows what is happening...to an extent that he even knows the time he’s supposed to take the medicine – even if I’m not around, the baby knows, ‘by 6:15 I am supposed to take this’ – he goes, he takes the medicine where they’re kept and takes them on his own. So, I’m very happy about it, the child knows what is happening and they’re taking the medicine even [before I tell him]...

–Caregiver, Bomu Medical Center

A wide representation of caregivers felt there was a correlation between a child’s understanding of his or her HIV status and an increased appreciation of and commitment to treatment, the result of intensified child-centered service provision through Mwangalizi Project. Caregivers also affirmed an increase in the quality of communication with children and an improved ability to understand and respond to the needs of HIV-positive children as a result of psychosocial support systems put in place as part of the intervention. All of these are further supported by research as correlates of adherence. 8,9,10,11 The Mwangalizi intervention also assists caregivers in planning for anticipated missed appointments that will affect adherence.

Sometimes when [Waangalizi] visit and find I am not at home, they leave a report for me on how the child is doing and what transpired during the visit. If they find me at home, they advise me on how to administer the medication—how to count the medicine, so I know when it is almost running out; like for instance if I have medicine for three days remaining, I can arrange with them to go and get from the clinic... If, for instance, the medication is running out, they’re the ones who go to the clinic and collect the medicine and if they haven’t brought, I can call and have them bring the medicine from the clinic.

– Caregiver, AMPATH

Although we see an expressed improvement in caregivers’ and children’s abilities to understand and adhere to medication regimens, the data tells us that long-term and consistent adherence is affected by other factors and is not guaranteed by the presence of a Mwangalizi. This indicates that improvements towards achieving satisfactory adherence at any one time, or span of time, does not ensure that it will be sustained and thus, requires ongoing support to directly address the issues surrounding non-adherence as it is likely to occur.

**Analysis of Clinic Attendance and Retention**

There is very little existing data to illustrate patterns of attendance within the participating facilities prior to the Mwangalizi Project, as attendance patterns were not consistently tracked through the facilities’ routine monitoring and evaluation. In order to assess the impact of the intervention on clinic attendance, the RTE categorized and examined attendance practices against the following definitions:

- **Perfect attendance**: when a child attends all of his or her clinic visits, once per month without interruption.\(^\text{12}\)
- **Drop-out**: when a child stops attending clinic and does not return again at any time point within the 18-month period of the RTE.
- **Missed appointment**: missing any number of visits during the length of the intervention, but returning to the clinic prior to the end of the intervention.

Of the total population in the pilot, 97.6% achieved perfect attendance, and overall the facilities maintained a very low drop-out rate of 4.8% for Mwangalizi-enrolled children. As depicted by the survival curve in Figure 7, although the probability of dropping out of the clinic remained consistently low through month 18, it is most probable to occur within the first eight months, after which point it stabilized between months 12 to 18.

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\(^{12}\) This schedule was documented during phase I of the RTE by each of the facilities in the description of their standardized clinical management activities for children. Once per month being the standard minimum number of visits a child is expected to have at the clinic.
This indicates that the most intensive work to keep children in the clinic system and minimize the risk of drop-out must occur within the first eight months. Based on literature on retention rates in regimented clinical studies conducted with similar or shorter time frames, drop-out rates normally exceed those in this evaluation.\textsuperscript{13,14} This and the graph above suggest that the intervention of a Mwangalizi increases the likelihood of a child remaining within the clinic setting.

For children in the pilot who missed appointments, absences were documented for as little as two and as great as nine months, with a median of six months. Such absences were disconcerting considering that the standard of practice for the facilities is a minimum clinic follow-up at one-month intervals, particularly for those on ART, and an absence longer than three months is classified as being lost to follow-up.

Ninety percent of caregivers interviewed reported an improved ability to ensure that the child’s appointments were kept as scheduled by the clinic. This was attributed to the Mwangalizi reminding caregivers of appointments, empowering children to know when their visits were scheduled or planning for alternative accompaniment in the event of schedule conflicts. Similarly, 94% of caregivers reported an improved willingness for their children to go to the clinics. They attributed this to various factors, including an improved understanding of its importance in relation to the child’s disclosed HIV status, increased comfort and reduced fear with the clinic and staff, as well as a desire to see their Mwangalizi.

\textit{Sometimes when I am sick, I just call her and tell her, “Today I am not feeling that good, today the date is for the child to come to visit the doctor...but I am not...”}

\textsuperscript{13} Griensven JV et al, \textit{Success with Antiretroviral Treatment for Children in Kigali, Rwanda: Experience with Health Center/Nurse-Based Care} BMC Pediatrics 2008, 8:39.
\textsuperscript{14} Screening, recruiting and predicting retention of participants in the NIMH Multisite HIV Prevention Trial. AIDS 1997, Vol. 11(Suppl 2) S13-S19.
well to go” so she takes the child to the hospital. Then me, I am remaining at home, she brings for me feedback; so I am very happy about that.

– Caregiver, Bomu Medical Center

When I have to go out there to the lake to fish, I leave the child in their care. They take the child to the hospital for his appointments.

– Caregiver, AMPATH

Oh, it has improved! For me, [my child] even asks, “You know, daddy, these dates we’re going to the clinic...”

– Caregiver, Coptic Hope Center

Before, they would refuse to come to clinic, but currently when it is their clinic appointment date, they get ready early and even start asking, “Where’s the Mwangalizi we go to the clinic?”

– Caregiver, KDH

Similar to the findings on adherence, the presence of the Mwangalizi and the varied services provided to ensure attendance is maintained were not a guarantee that attendance was maintained.

**Conclusions from the Impact Assessment**

Barriers that hinder pediatric HIV management were reduced by the Mwangalizi Project, demonstrated by high rates of retention within health systems and improved health outcomes. Improvements in the validation and flow of client information, health education to caregivers and contextual understanding of the children are direct results of this intervention. These were further supported by providing caregivers and children with intensified psychosocial support, accessible consultation between appointment dates and alternatives to access health facilities for scheduled visits. The Mwangalizi created an easily accessible, relatable and consistent interface between the caregiver and the clinic. Intensified psychosocial services directly resulting from this pilot in both facility and household settings mitigated stigma-related barriers, supported improvements in physical health and reduced emotional strains that impact households coping with HIV.

Barriers to ART adherence and attendance practices that were targeted through the Mwangalizi were reduced; however, they do not yield consistently sustained results. It is, therefore, noted that long-standing behavioral components of pediatric health management require ongoing support with emphasis on specific time points where drop-out or unsatisfactory adherence is predicted to occur.

The emphasis on improving adherence and attendance practices must occur through strengthening health systems to provide accessible data from client monitoring so that relevant responses can be made and to pre-empt failures through alternative strategies delivered by Waangalizi. Similarly, emphasis on maintaining the momentum of the Mwangalizi and high-quality performance by program staff is critical, particularly at the critical time points
highlighted in the analysis, to ensure that the most necessary support for adherence and attendance are provided.

Persistent barriers which were not mitigated through Mwangalizi Project and were cited as being continual challenges to clinical management\textsuperscript{15} include barriers related to household poverty that result in food insecurity, school drop-outs and poor understanding of peripheral health care access not provided within free treatment programs. These challenges remain irrespective of referrals by Waangalizi to social service programs in the community. Similarly, barriers related to infrastructure, such as poor roads or environmental changes that create physical obstacles to accessing care, are not mitigated by the intervention and pose equally difficult access problems for Waangalizi to reach client households. Intentional linkages between facility-based ART programs and community-based OVC programs need to be created, particularly within the context of PEPFAR implementation strategies. This should be considered as early on in the partner selection process by various PEPFAR funding agencies to ensure that coverage of services are deliberately paired by geographic location and target setting. This will help connect HIV-positive children and their caregivers, who are eligible for services in accordance with the OVC program guidance, but are not targeted, to community programs that operate independently for recruitment of eligible beneficiaries.

Further analysis of participant bio-data and social factors would provide deeper understanding of characteristics that are associated with outcomes, such as economic variables, geographic location and composition of household. It would also inform facilities on populations of children who require the most investment.

\section*{II. RTE LEARNING AND BEST PRACTICES FOR IMPROVED OUTCOMES}

Mwangalizi Project utilized concepts commonly practiced with community health and outreach models, however was able to intensify outcomes through the evaluation’s deliberate efforts to maximize the effectiveness to the intervention. Through the RTE programmatic and operational recommendations have been extracted to guide implementation by other partners interested in replicating this model to improve pediatric programs. Given that the pilot was tested with varied facility types and locations, findings are consolidated into guidance principles on various components surrounding the management and operations of the program. The following are recommendations based on learning experienced during the RTE corresponding with components of program design and overall strategy

\textit{Minimum package of services}

Based on the findings of all phases of the RTE, an open methodology is important for contextual customization of this project and facility ownership of activities. However, facilities should provide a minimum package of services as shared by the five facilities. This includes health education and counseling, clinic accompaniment, adherence monitoring, attendance monitoring, psychological counseling, disclosure preparation and health monitoring. A facility’s ability to go beyond these services is optional and dependent upon its financial and programmatic capacity.

\textsuperscript{15} Mwangalizi Project Real Time Evaluation, Phase II Report.
Documentation and communication of findings during household visits and targeted service provision by the Mwangalizi are arguably among the most critical components of this intervention, as they are the mechanisms for the facility-level providers to modify treatment plans.

There were immediate improvements in health outcomes for children enrolled in the Mwangalizi Project. The greatest change is seen at 6 months (height and weight) and 12 months (CD4%). Analysis of drop-out rates and ART adherence show that there are points in time when support services to mitigate or prevent failure are most needed. In specific cases where problems of adherence and attendance intersect, more aggressive facility initiatives need to be tested. If children who do not attend their appointments are absent from the clinic for an average of 6 months, and the standard of practice is to issue one month of medication and schedule a follow-up within three months, optimized management does not occur. In these cases, alternative strategies need to be explored, including home-delivery of ART by the Waangalizi or enforcement of Mwangalizi-accompaniment initiated by the facility rather than by the caregiver.

**Human Resources**

Approaches taken by the facilities regarding human resources varied according to organizational culture, standards of practice and budgetary allocations. The guiding principles of the pilot program encouraged the recruitment of PLWHA, more specifically clients within the facility’s patient population.

**Table 3: Recruitment Models Applied By Mwangalizi Implementing Facilities**

<table>
<thead>
<tr>
<th>Recruitment Strategy</th>
<th>EDARP</th>
<th>Coptic</th>
<th>Bomu</th>
<th>KDH</th>
<th>AMPATH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruitment Strategy</strong></td>
<td>•Selected from existing CHW pool •Community nominated volunteers</td>
<td>*Traditional application process •General circulation &amp; clinic posting</td>
<td>*Patient selection by staff</td>
<td>*Initial: Patient Selection by staff *Repeat: posting of position in clinics &amp; application process</td>
<td>*Traditional application process *General circulation &amp; clinic postings</td>
</tr>
<tr>
<td><strong>Criteria</strong></td>
<td>*Minimum of 5 children in their care *6 month qualification process and 6 month</td>
<td>*Minimum level of training, education *Interview</td>
<td>*Clinical qualifiers and disclosure requirements *Interview to determine client interest</td>
<td>*Initial: Interview to determine interest &amp; expectations. *Repeat: application</td>
<td>*Minimum level of education and grades *Preferred experience and training</td>
</tr>
<tr>
<td></td>
<td>attachment</td>
<td>&amp; expectations</td>
<td>process with qualifying criteria and interviews</td>
<td>*HIV+ encouraged to apply</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>No. of Mwangalizi</strong></td>
<td>274</td>
<td>11</td>
<td>38</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td><strong>Turn Over</strong></td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>
| **Reasons**                   | *Death     | *Performance based dismissals | *Death                                          | *Poor reputation with community
*Performance based dismissals
*Over-committed
*Change in areas of operation |

Given the difference in recruitment strategies, Waangalizi education levels ranged three years of primary level education through varied levels of post-secondary education. They have between zero and ten years of relevant work experience in community health or development. The primary interest and motivation to engage in this work as expressed by the Mwangalizi is one of charitable service. For Mwangalizi who are also clients from these facilities, they feel it is important to give back to the institutions that helped them, as well to support their peers whose needs they can understand first hand.
### Table 4: Staffing Models Applied By Mwangalizi Implementing Facilities

<table>
<thead>
<tr>
<th></th>
<th>EDARP</th>
<th>Coptic</th>
<th>Bomu</th>
<th>KDH</th>
<th>AMPATH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment status</strong></td>
<td>Volunteer (part time)</td>
<td>Staff (full time)</td>
<td>Staff (full time)</td>
<td>Volunteer (part time)</td>
<td>Volunteer (part time)</td>
</tr>
<tr>
<td><strong>Level of Effort for Mwangalizi Duties</strong></td>
<td>70%(^{16})</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Work Load (child case management)</strong></td>
<td>5-15</td>
<td>38-42</td>
<td>6 - 10</td>
<td>2-10</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Work Schedule (field work)</strong></td>
<td>2 days per week (15 hours)</td>
<td>4 days</td>
<td>3 days</td>
<td>2 days</td>
<td>4 days (30 hours)</td>
</tr>
<tr>
<td><strong>Compensation/Incentives</strong></td>
<td>1,800 KSH T-shirt Cap Raincoat Umbrella</td>
<td>15,000 KSH Staff benefits</td>
<td>10,000 KSH</td>
<td>3,000 KSH</td>
<td>5,000 KSH</td>
</tr>
<tr>
<td><strong>Additional Materials Provided</strong></td>
<td>Stationery Field Manual Phone credit</td>
<td>Stationery First Aid Kit Bags Phone credit Transport costs Umbrellas</td>
<td>Stationery Phone credit Umbrellas</td>
<td>Stationery Reimburse transport for clinic visits Bags</td>
<td>Stationery Bicycles(^{17})</td>
</tr>
</tbody>
</table>

Across all facilities, the Mwangalizi were classified differently within the organizations as either part time volunteers or full time staff. Their compensation packages, level of effort, schedules and workload are different at each facility based on what they felt would best suit the different institutional cultures, capacities for management and compensation scales.

\(^{16}\) The remaining 30% of time engaged with EDARP is fulfilling general CHW duties as part of EDARP’s community outreach activities.

\(^{17}\) Bicycles were donated from another project in AMPATH and not purchased as part of Mwangalizi Project funds.
Irrespective of the model’s chosen the key element to productivity and performance of a Mwangalizi was the Facility’s success in best matching the people with the processes at each site according to what is manageable, sustainable and suited to the institution’s design. Similarly to selection of recruitment strategies, the implementing partners attribute their successes with staffing to their ability establish clearly defined roles, shared expectations on performance and buy-in to institutional culture. Furthermore, community involvement in the selection of Mwangalizi proves critical to the acceptability and longevity of a Mwangalizi’s term of service. Community involvement is best facilitated through personal references made by local leadership on character, reputation and ethics. Additionally, monitoring community feedback on Mwangalizi activities verifies individual productivity and quality of service provision.

It is important to note that the a Mwangalizi’s time was best utilized when field work schedules were determined by client availability, thus requiring their work hours to be flexible after school or business hours and on weekends, rather than traditional business hour schedule of the facilities themselves. Similarly, hours worked do not have to be consecutive as long as they meet the expected quota of visits or hours worked.

Facilities that engage the Mwangalizi as volunteers experienced difficulty in holding them accountable to increased demands on work performance compared to employees. To manage this relationship, providing the Mwangalizi with written position descriptions and performance agreements are necessary to maintaining standards of performance irrespective of employment status, and directly linking compensation to performance measures. The key to encouraging high performance outputs of volunteers was to ensure that their time commitment was relative to what they were receiving as financial compensation. This allows the Waangalizi the time to source alternative forms of income for self-sustenance while meeting expectations to the project. Compensation must be provided above and beyond inputs required to facilitate field work through transport, supplies and communications, otherwise the rate of turn-over in Mwangalizi will be accelerated.

Supervision and compensation of Waangalizi should be centralized to one body, the facility. Alternative models of community health work suggest a shared obligation between the health facility and the community structures as a way to encourage community ownership and sustainability in funding. The degree of attention required on managerial accountability does not lend well to distribution of authority, thus community ownership can still be built in though the recruitment process and performance evaluations. Sustainability is also best explored through other mechanisms than through management.

Use of standard CHW trainings is sufficient to provide a good basis on broad health and HIV related issues however needs supplementation with exhaustive provision on the following topics: pediatric ART regimens and adherence, disclosure, psychosocial support, child development, counseling methodologies and communications. These proved to be the most required information beyond a basic level of comprehension to support the work that Waangalizi conduct. Methodologies of training must be flexible to suit the audience based on variables like age and level of education and is best approached by having shorter blocks of time for training over a longer period of time, mixing didactic and applied skills training to keep participants engaged. To support the initial training provided for the project, all facilities incorporate mechanisms to support ongoing learning to address technical gaps identified in the course of field work. Each
facility is equipped with an on-site resource center that is available to the Mwangalizi as a reference. According to findings from the FGDs, Mwangalizi feel they are able to answer questions and provide information comfortably based on the initial trainings they received. However, they did express a need to deepen their knowledge and skills in the aforementioned training areas, to be able to explain concepts and processes as opposed to reiterating facts.

Reinforcing technical trainings with skills development activities are necessary. This coincides with catering for the less stringent requirements for education levels in the recruitment process. To facilitate facilities must incorporate supervised assessments, simulated role-plays, practical demonstrations, group brainstorms and case reviews during weekly meetings as part of their ongoing development, in addition to technical trainings. These methodologies are successful for adult-learners and encourage experientially based learning in real time.

**Program Management and administrative systems**

A program of this nature requires good management, coordination and supervisory strategies. In the context of Mwangalizi Project, the majority of the implementing partners are engaging in activities that decentralize services outside of its facility for the first time. In addition to this, working with a cadre of staff with limited training and having limited resources for compensation in a field of work where accuracy in service provision is important can be a challenge. For the children to gain maximum benefit from the continuum of care provided by the project, it is important that a well supported system is in place to integrate the project and information gathered by the staff at clinic level.

To enable this integration each facility has organizational charts that place the Mwangalizi Project within the context of the larger organization: officially placing its operations and staff within the context of the facility. This dually informs the flow of communication between departments and relationship between project personnel and activities. It is recommended that a coordinator be designated who is responsible in full for the management and coordination of Mwangalizi project with the greater facility activities and personnel, and that the management be fully to the facility. The combination of management and administrative structures establish the relevance of the community-based activities to facility services and improve efficacy in client care. Interdepartmental meetings and case reviews, providing duplicates of the Mwangalizi questionnaires into client records and creating opportunities for personnel to interact within clinic operations are all examples of mechanisms that can better support this.

**Quality Control**

There is a range of approaches the facilities implemented to support quality control of project activities. This is of primary importance given the pre-requisite for recruitment are flexible, while the nature of work requires accuracy and precision in care and support provided to clients outside of a clinical setting. All of the respondents in the focus groups expressed a need for reference guides to direct expected service provision in the field. Thus it is recommended that standard operating procedures are developed to delineate and guide the provision, documentation

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and monitoring of services. Field supervision has proven a valuable tool for implementing partners. Supervision refers to more senior program staff providing field-based support to the Mwangalizi in the form of assessing their skills, providing feedback on areas of improvement and validating the standard of their performance. Methods of quality assurance utilized across the sites include phone calls and in-clinic interviews with caregivers and children, random sampling of client files and reports, and supervision visits in the field.

Analysis confirmed that this intervention requires long-term application to affect change in the barriers related to adherence and attendance. Therefore, mechanisms to ensure quality control in service delivery, documentation and data collection are critical components to ensuring success. These mechanisms could include deliberate initiatives to maintain staff motivation, mitigate issues of stress and burnout and reinforce technical components. The Mwangalizi Project will not yield the same successful impacts as a loosely organized community health program, but requires deliberate application of case-management strategies, communication with health providers and coordination of activities in and out of the facility.

**Specifications in Project Activities**

Targeted reviews of core program activities during the RTE captured the emergence of regional characteristics for Mwangalizi Project that should be considered when replicating in areas with similar profiles. This learning speaks to the issues of acceptability, favored approaches and relevance of service packages adopted by the five implementing partners. These specifications must be considered when scaling-up or replicating the intervention to other areas.

- **Mwangalizi Selection:** In rural settings, caregivers prefer that Mwangalizi to reside within the community or neighborhood, stigma is not a concern in this factor; rather it is based on familiarity, accessibility and trust. Contrarily, in urban contexts caregivers prefer to have Mwangalizi who are unknown in their residential community to ensure privacy and minimize the possibility of stigma.

- **Variables related to client enrollment:** Facilities also reported that where caregiver education and income levels was higher, the acceptability of Mwangalizi services for that household was reduced and more intensive education on the program was often required before the household would consent to enroll in the program.

- **Accompaniment Services:** is less acceptable in demographically diverse settings, with more economically stable households, or where costs associated with accessing the facility are negligible. Other factors that are associated with acceptability of accompaniment include trust, interest of caregiver to be present at all appointments and perceived stigma. In rural communities where costs and distances to the clinic are larger, caregivers prefer to utilize accompaniment services. These areas also represent communities that are more closely knit and have a strong cultural identity.

- **Disclosure:** Practices and protocols need to be tailored according to cultural norms relating to the acceptability of certain family members to discuss issues related to sexuality and issues of relationships. Formal delineations of adult mentors or advisors are often designated which are not the mother or father, rather an elder from within the extended family. This strong cultural presence is more common in rural areas. Flexibility is also required around both caregiver and child readiness, and thus must occur in a
phased approach related to milestones in psychological progress rather than time-bound markers.

**Child Centered Clinical and Psychosocial Models of Care**

With intentional efforts to support pediatric disclosure, clinics should distinguish between early, middle and late childhood/adolescence and develop age-specific services that consider developmental stages of children as part of their clinical and psychosocial support services.\(^{20}\) This child-centered approach acknowledges that children are capable and interested in being directly engaged in their health management. This requires a deliberate shift in the culture of clinical management in Kenyan health facilities, by directly including children in discussions related to the management of their current and future healthcare. Not only is their participation critical for behavior formation related to living with a chronic health condition, but it also improves coping mechanisms related to the complex issues surrounding HIV/AIDS.

To facilitate the creation of child-centered programs, facilities should use materials and teaching aids that build knowledge and skills surrounding living with HIV, ART, treatment adherence and communicating health issues with providers. This can include, but is not limited to\(^{21}\): calendars, watches or alarms, treatment diaries and information, education and communication (IEC) materials that explain concepts surrounding HIV/AIDS in a manner to which children can relate. Providing play therapy and other recreational activities within clinical setting further strengthens the relationship between the child and the clinic environment and reduces fears associated with health facilities. Creation of social support groups that address age-associated priorities and allow children to build relationships with peers living with HIV is critical to self-acceptance and healthy development. Issues that the groups should discuss include disclosure, self-expression, sex and relationship building, positive prevention and reproductive health.

Available research, although limited, on the impact of peer support group therapy and other psychosocial interventions on HIV positive children reinforces the findings reported by Mwangalizi implementing partners. These children tend to become preoccupied about health and disclosure related issues particularly the impact it will have on their futures.\(^{22}\) It was further determined that children and youth living with HIV are motivated to share their experiences and difficulties with their HIV-infected peers. Beyond the necessity of psychosocial interventions to mitigate emotional and social health, there is additional evidence to support that family and psychosocial factors affect pediatric ART adherence, thus translating to overall clinical wellbeing. Significance was found between poor parent-child communication and borderline significance was found between disclosure and child stress\(^{23}\), issues expressed by children enrolled in Mwangalizi project.

\(^{21}\) Winghem JV, Telfer, Reid T, Ouko J, Mutunga A, Jama, Z, Vakil S. *Implementation of a comprehensive program including psychosocial and treatment literacy activities to improve adherence to HIV care and treatment for a pediatric population in Kenya.* BMC Pediatrics 2008 8:52
Through the evaluation framework, facilities documented important information on the emerging needs of the children, expressed by them through the length of the pilot. The below graph represents the frequency of child-initiated concerns reported to Mwangalizi during the RTE. This shows the range of concerns that most feature with the cohort of children of mixed disclosure status at each facility over the 18 month period. These findings should inform the composition of psychosocial and other support interventions.

**Figure 5:** Frequency of Issues and Concerns Discussed with Mwangalizi as Initiated by Children from June 2008 – November 2009

Interestingly, observations from this data highlight the prioritized concern related to how children relate to others. Children often compare themselves to their peers for differences in reaching developmental milestones or reason why they are HIV positive and others are not. They sought guidance on how to better communicate and express themselves with others, specifically their caregivers. Their health status raises concerns about self-image and how they will be able to have normal social and sexual relationships in the future as well. Addressing the psychosocial needs of children is critical for them achieve better health outcomes.

**III. CONCLUSIONS AND WAY FORWARD**

A very important added benefit of this pilot was that the Mwangalizi Project and the RTE forced facilities to focus their efforts on the improvement of pediatric programs based on outcomes and impact, as opposed to outputs. This, in itself, is an achievement that was not a priority outside of this pilot. The RTE demanded that facilities ask questions beyond the standard operating procedures of their clinical programs and, in many cases, ones that were not explored before in any formal way. This led to more relevant and diversified pediatric care, along with instituting or

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24 Source: Monthly program report. Facilities report the 3 most frequently discussed issues or concerns initiated by children. These reports are aggregated by topic to generate frequency.
improving the systems and structures to support service delivery. Quality of care and maximizing benefit became the focus of operations. The pilot mandated that facilities develop indicators to monitor the attendance, adherence and psychological aspects of pediatric care, which were non-existent for most implementing facilities prior to the Mwangalizi Project. As a result, advancements were made in understanding the dynamics of care and support needed for pediatric populations in Kenya that had not previously been explored.

Based on the outcomes of the analysis, scale up of this intervention is recommended as a way to reduce barriers to improved care within both facility and household contexts. It is feasible across varied contexts and institution types. Longitudinal monitoring is required to determine how sustainable, if at all, the Mwangalizi approach is in supporting challenging behavioral areas, such as adherence and clinic attendance in Kenya. At the very least, it could provide evidence-based expectations on patterns of behavior that can inform more targeted interventions. Improved longitudinal investigation can provide valuable information on various aspects of pediatric HIV management and care.
Handicap International

Final Narrative Report

Expanding Participation of Persons with Disabilities in Kenya project

MARCH 2009 - SEPTEMBER 2010
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List of abbreviations and acronyms

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<tr>
<td>ANDY</td>
<td>Action Network for the Disabled</td>
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<td>Blind and Low Vision Network</td>
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<td>BOH</td>
<td>Beacon of Hope</td>
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<td>CACC</td>
<td>Constituency AIDS Control Committee</td>
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<td>DEK</td>
<td>Deaf Empowerment Kenya</td>
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<td>MOYA</td>
<td>Ministry of Youth Affairs</td>
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<td>NCPWD</td>
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<td>NFSS</td>
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<td>UCCATM</td>
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<td>UNCRPD</td>
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Please describe the project’s progress over the Grant Period, making sure to address each of the areas and questions listed below.

**Section I  Project Strategies and approaches**

**Problem Statement:** This brief statement, explains “why” the project was undertaken. The statement should identify the problem, need, or opportunity that the project sought to solve or address in addition to the targeted population and geographical area.

The overall rate of disability in Kenya is 4.6%; this translates to 1.6 million the number of persons with disability (KNSPWD ¹ 2008). A majority of this population is illiterate and jobless, dependent at a higher risk of contracting HIV. Persons with disability (PWD) are barely considered in development and emergency relief programs, whether they are local or national program implemented by the government of Kenya, whether they are funded and/or implemented by local, national or international non state actors. This includes crucial development programs that empower PWD, such as Health Promotion, Education and Livelihood.

Expanding participation of persons with disabilities in Kenya project was designed to promote inclusion of PWD in development programs and towards realization of their rights through enhancing capacity of Non-DPO ² as well as DPO in advocacy to mainstream disability in development activities. The projects also sought to document and disseminate good practices to facilitate similar interventions. The project was designed to reach organizations with different capacities and understand how to better support them at different levels to mainstream and include disability

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¹ Kenya National Survey for Persons with Disability, 2009
² Disabled Persons Organization
Project Conceptual Framework, Strategies and Approaches:
Clearly stipulate:

- The framework, strategies and approaches your organization utilized to achieve the objectives of the project.

Rights Based approach
Disability is an unavoidable and universal part of human diversity and DPOs and Non DPOs are bound by both local and international legal instruments and frameworks on disability. HI and UDPK\(^3\) as the implementing organizations used this as one of the major bases to encourage implementing partners to abide by any legislation that has recognized rights of persons with disabilities.

The key approach used in this project is the rights-based principle as informed by the UN Convention on the Rights of Persons with Disabilities. HI is and has been actively participating in the “Making it Work” project, implemented by the International Disability and Development Consortium (IDDC- http://www.iddc.org.uk).

Throughout the project it was emphasized to partners that a shift in perspective has taken place on how to consider a person with disability: from object of charity and burden to subject of law. This shift implies that four core values of human rights are especially relevant in the context of disability:

- **Dignity**: respect of physical and moral integrity of the person...
- **Autonomy**: capacity for self-directed action, decision and behaviour…
- **Equality**: prohibition of discrimination…
- **Solidarity**: collaboration, support…belonging to (family, society)

Existing legal instruments
The rights-based approach as discussed above is a principle beyond doubt, that persons with disabilities have equal rights like any other world citizen. During project implementation much reference has been made to three key legal instruments: the Kenya Persons with Disabilities Act of 2003, and the draft Kenya Constitution (made legal in August, 2010) which are local documents and the UN Convention on the Rights of Persons with Disabilities where these rights are principally and proactively entrenched. These instruments were used as reference in awareness and trainings with partners in the project.

Twin-track approach:

The project targeted both Disabled Persons Organizations - DPOs and Non DPOs as a key strategy to achieve the ultimate goal of inclusion. This strategy adopted the twin-track approach: **Mainstreaming**—focusing on the society to remove the barriers that exclude persons with disability; and **Disability-specific**—focusing on the group of persons who are excluded, to build their capacity and support them to lobby for their inclusion. Mainstreaming is about focusing on inequalities between persons with disability and the non-disabled in all strategic areas of work. On the other hand, being disability-specific is about supporting specific disability initiatives to enhance the empowerment of persons with disability. Both initiatives are aimed at one objective: enhancement of equality of rights and opportunities for persons with disability. This strategy is very key in disability

\(^{3}\) United Disabled Persons of Kenya
mainstreaming to counter the misconception that inclusion is about the non-disabled changing to accommodate persons with disability. Persons with disability have an equal role of ensuring the process takes place by building self confidence towards realization of self rights for self advocacy. This is a central role of Disabled Persons Organizations and function for the second objective (Increase the capacity of DPO to manage and implement programs effectively and advocate for PWD rights) within the Expanding Participation of PWD project.

The Social Model of Disability
The Social Model of Disability also as recognized by the human rights principle of disability was the cornerstone of the project implementation. The model is based on the way society is organized and its organization which determine whether it discriminates and excludes persons with disability from participation. It recognizes that society itself needs to adapt to the needs of persons with disabilities and as such there is a great deal that society can do to reduce and remove disabling barriers. This task is the responsibility of society, rather than the person with disability. By organizing things differently a society can enable persons with disabilities – though their impairment may not change. This explains the reason why Non DPOs were a target of the project.

Other disability mainstreaming approaches
The transformation of the rights-based approach to a principle does not disqualify other earlier or existing approaches to disability mainstreaming. In fact the rights-based principle has incorporated a number of aspects of the social model that shifts the needs of persons with impairments to the society rather than the individual with impairment. Charity, medical and social models can positively be applied and were used in the implementation of this project. Both DPOs and Non DPOs came up with action plans and strategies for disability mainstreaming and inclusion. These action plans were reviewed between HI, UDPK and implementing partners to make sure emphasis is not on equating the process of mainstreaming to ‘a monetary burden’ but a process with concerns that need equal redress. It was also emphasized that mainstreaming is not about the non-disabled ‘coming over’ to the disabled but a process where both parties come together to complement each other to achieve the ultimate goal of inclusion in programming and practice.

Partnership
The main partners in this project were the United Disabled Persons of Kenya and selected DPOs and Non DPOs. HI was the lead implementing partner while UDPK was the central coordinating point of DPOs since it is already a network of DPOs in Kenya. Persons with disability had been ineffective speakers in advocacy therefore the time was ripe for their audience to be better mobilized and more interactive towards a united front. Non- DPOs and DPOs were brought together to build an integrated approach in management of programmes and policies thus aiming at reducing stigma and isolation among persons with disability.

DPOs were specifically granted to undertake specific disability mainstreaming and inclusion initiatives. The aspect of granting was a key strategy to earn commitment from DPOs to enhance their capacity for their effective and full participation of persons with disability. Sub-granting has its own challenges since before implementing any activity with funds an organization has to have the capacity to manage the funds and perform proper reporting. This strategy worked since most of the DPOs sub granted have been HI sub-
grantees prior to the project and have undergone institutional strengthening in the same area. Sub-granting was based on the following priority areas:

a) **Priority Area 1** - Documentation on good practices in disability inclusion and mainstreaming in development policy, programming and the workplace.

b) **Priority area 2** - Advocacy
Using the guidelines on advocacy from the NCPWD, DPOs underwent capacity building to develop disability inclusion and mainstreaming initiatives on: enhancing internal capacity and institutional strengthening as far as capacity to mainstream disability is concerned, to provide knowledge and skills to persons with disability to effectively engage and advocate on disability inclusion, plan, implement and monitor disability mainstreaming in community initiatives.

c) **Priority area 3 - Capacity Building in the following areas**:
- design, implement and monitor targeted innovative advocacy initiatives based on disability inclusion, and engagement of both disabled and non-disabled persons organizations, communities and governments in advocacy for inclusive development approaches

■ **Community level structures, linkages, referral mechanisms and collaboration put in place to support achievement of the objectives as well as for service delivery**

The Expanding Participation of PWD project took advantage of the already existing linkages between HI and DPOs during the 5-year HIV/AIDS & Disability project on mainstreaming of disability in HIV/AIDS initiatives and sub-granting and institutional strengthening of DPOs to implement such initiatives. Most DPOs, namely, Deaf Empowerment Kenya (DEK), Action Network for the Disabled (ANDY), Nairobi Family Support Services (NFSS), United Disabled Persons of Kenya (UDPK) and Blind and Low Vision Network of Kenya (BLINK) who were involved in the project have been in contact with HI since 2006. UDPK, which is the DPO national umbrella body, specifically prepared and laid the ground for the project within project areas/partners at the community level for a smooth kick-off. Also involved were the CAP-Kenya sub-grantees, namely, Beacon of Hope (BOH), Kenya Network of Women Living with HIV/AIDS (KENWA) and Health Rights Advocacy Forum (HERAF) with who AED/USAID together facilitated an introduction of Non DPOs to the project.

■ **Provide an analysis of activities that were implemented during the period of performance and how these contributed to the strategies adopted by the program.**

**Kick-off meetings with partners**
There were two kick-off workshops that brought together DPOs and Non DPOs. The one-day meetings were held in the 1st quarter (March – June, 2009) with 24 partners participating. The objective of the meetings was to share with partners basic concepts on disability and inclusion of disability in project programming and development. This was next followed by specific visits to partners by HI and UDPK to further elaborate on the concepts and carry out baseline surveys to find out the extent of understanding of these concepts and exclusion of persons with disability in program and project interventions. Bringing together DPOs and Non DPOs was an achievement of the twin-track approach.

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4 National Council for Persons with Disability
Training on disability inclusion and mainstreaming
These Kick-offs and surveys were then followed by trainings on disability inclusion and mainstreaming tailored to meet specific needs of each select organization.

The awareness trainings were aimed at building the capacities of development partners to include/ mainstream disability in their project interventions. These trainings had the following specific and cross-cutting objectives:

a) To develop a common understanding of concepts on disability models
b) To conduct a participatory internal assessment (accessibility and programs) with the view of identifying gaps that expanding participation project could address
c) To explore areas of collaboration as far as inclusion and mainstreaming of disability is concerned
d) To share tools (accessibility checklist/ disability proofing, inclusion policy etc)

The trainings were based on various approaches to disability including the human rights principle and delivered from September 2009 until June 2010 to Green Care Habitat (GRECAH), World Vision (WV), Beacon of Hope (BOH), Health Rights Advocacy Forum (HERAF), Kenya Network of Women Living with AIDS (KENWA), Slums Information Development and Resource Centre (SIDAREC), United Civil Society Coalition Against AIDS, TB and Malaria (UCCATM), Family Health Options of Kenya (FHOK), Users and Survivors of Psychiatry (USP).

Technical support to Non- DPOs
Based on identified needs and concerns during survey and trainings which served as a point of information, organizations (Non – DPOs) were given technical support based on the following areas also as informed by the UNCRPD and other legal instruments on disability (as discussed above):

a) Awareness and sensitization on disability
b) Accessibility of physical facilities and premises
c) Employment and retention of persons with disabilities, and their retention and provision of reasonable accommodation in the course of employment
d) Organization policies and practices sensitive to persons with disability needs
e) Organization programs, projects and activities targeting persons with disabilities and their concerns in the project life-cycle

Technical support to DPOs
DPOs were also given technical support based on the five key areas above (under Technical support to non-DPOs) to ensure stronger quality and capacity to advocate for inclusion both within DPOs and Non DPOs.

Development of tools
The hallmark of the Expanding Participation of PWD project alongside trainings and technical support was the production of tools, checklists and ideals of accessibility in the five areas as mentioned under Technical Support above. To guide partners on issues relating to disability inclusion and mainstreaming in development programming beyond the life of the project, the *The Information Guideline on Disability Inclusion for Development Programs in Kenya* was developed.

DPO disability inclusion and mainstreaming advocacy training
At the end of the January – March 2010 quarter DPOs were taken through a 2-day training on disability inclusion and mainstreaming advocacy with the objectives of 1) enabling 9 DPOs and 2 networks (DPOs) to establish and strengthen coordination links on advocacy
for disability inclusion in development among DPOs and, 2) to enable them (DPOs) to develop action plans for advocacy on inclusion in development for the DPOs. The DPOs were empowered and the result of this was notably the IEC materials developed with various positive messages on disability mainstreaming. Albinism Society of Kenya documented stories of successful persons with albinism in Kenya while Nairobi Family Support Services and Riruta HGM Primary School constructed ramps in the school to enable physical accessibility by learners with physical disabilities.

**Micro-grants**

After the DPO advocacy training of March 2010, they were specifically granted to undertake specific disability mainstreaming and inclusion initiatives in the quarters of April – June and July – September, 2010. The aspect of granting was a key strategy to earn commitment for effective and full participation of persons with disability from DPOs.

**Documentation of best practices**

This activity was the primary focus of the project during April – June and July - September, 2010 quarters. Establishment of the Disability Mainstreaming blog ([http://disabilityinclusionandmainstreaming.wordpress.com](http://disabilityinclusionandmainstreaming.wordpress.com)), publication of the Kenya Disability Newsletter *(special issue on disability mainstreaming within the project)* and development of The Information Guideline on Disability Inclusion for Development Programs in Kenya were key strategies of sharing and documentation of best practices.

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**Section II  Project Outputs and Outcomes**

In this section, the focus is on impact – the meaningful change that the program had on your target population.

1. How did the strategies and approaches adopted above achieve the objectives of the program?

**Objective 1: Enhance the capacity of 15 non-DPO to promote the inclusion of PWD in HIV/AIDS awareness raising and education programs.**

In order to achieve this objective, Handicap International partnered with fifteen development/Non-Disabled Persons Organizations with the aim of building their capacity to mainstream disability into their programs. This included engaging the organizations by training them to understand what disability means and how they can as an organization mainstream disability in the four pillars that is physical accessibility, access to goods and services, employment and their policies and procedures. The organizations were taken through two kick off seminars, one day sensitization workshops and development of action plans were given technical support by Handicap International on how they can implement their action plans. Through use of physical accessibility checklist that was developed, Handicap International conducted physical accessibility audits for four organizations on their physical premises. This then lead to recommendations that the organizations are to implement in both short term and long term period.

The developed action plans by the organizations gave an opportunity to HI to work closely with the organizations. We were able to conduct physical accessibility audit of four organizations using the physical accessibility.
Objective 2: Increase the capacity of DPO to manage and implement programs effectively and advocate for PWD rights

Ten Disabled Persons organizations were engaged in the project through building their capacity on their rights and how to advocate for inclusion of persons with Disability in development programs. This involved one kick-off seminar and two training workshops on advocacy which was then followed by development of action plans. To be able to implement the action plans the DPOs were given sub grants to work with development organizations to advocate for disability mainstreaming within their localities. Women Challenged to Challenge worked with Nyeri District Hospital to sensitize 35 service providers on Reproductive Health on the needs of women with Disability as well as training women with disability on the available services in the health facility on reproductive Health and family planning. Six service providers were also trained in basic sign language to be able to communicate with persons with hearing. Deaf Empowerment Kenya sensitized 15 CBOs, local authorities and committees in Embakasi and Njiru Districts to sensitize them on disability inclusion. ANDY worked closely with five organizations on accessibility of their services for PWDs and they also conducted physical accessibility audit with recommendations as well as responding to the needs of persons with disability. BLINK worked with development organizations in Machakos to sensitize them on disability inclusion and mainstreaming. They also built the capacity ten BLINK staff and field mobilizers on disability inclusion and mainstreaming.

Objective 3: Document and disseminate lessons learned on effective mainstreaming of disability in development programs

Through partner forums and development of a blog both non-DPOs and DPOs were brought together to share experiences as well as to form linkages and learn from each other. During the project period a two days partner forum was conducted that brought together both DPOs and Non-DPOs to share experiences on disability inclusion and mainstreaming and how they can form linkages to work together even beyond the project period. Family Health Options Kenya networked with Kenya Union for the Blind on how they can make their resource center have their material accessible to persons with disability. Talks have been ongoing with the two organizations. The use of the blog has not been quite active and in order to make it more active it was linked to Face book and Twitter which are social sites that partners are more familiar with and log in quite often.

2. Describe and/or provide an analysis of the key outputs and outcomes achieved by the program.

Outputs achievement analysis:

Result 1: By the end of the program 15 non- DPO (development/implementing) agencies (including USAID funded programs) have strengthened capacity to implement inclusive and disability-friendly programs and activities that include PWD in their target groups.

Ten development agencies were actively engaged and strengthened on disability inclusion and mainstreaming. This involved their involvement in two kick off seminars and sensitization trainings on disability inclusion and mainstreaming for project staff and management. Further to this six agencies went ahead to develop action plans on how they were going to mainstream disability in their organizations in short term (one to three years) as well as long term ( Five years and beyond) period of time. Family Health Options Kenya went ahead to develop a proposal to NCPWD on the different aspects on their action plan for funding under the National development fund.
Result 2: By the end of the program, 11 DPO have implemented advocacy action plans and conducted innovative actions that promote Inclusion

10 DPOs were supported through micro-grants to implement innovative actions that promote inclusion. Through the action plans developed during inclusion and advocacy trainings that were done thematic areas form each of the organizations were picked to be supported to actualize by use of the micro-grants. The DPOs dealt with areas of access to family planning and reproductive health for women with Disability, disability inclusion and mainstreaming though media, access to employment by youth with disability in corporate organizations, creating awareness to local administration on disability inclusion and mainstreaming and physical accessibility in schools.

Result3: By the end of the program the result of 6 pilot initiatives and 15 actions are documented and shared with the targeted stakeholders

During the project period five hundred copies of one edition of inclusion newsletter was developed that focused on the different initiatives that partners were carrying out on disability inclusion and mainstreaming.

Outcome analysis

Objective 1: Enhance the capacity of 15 non-DPO to promote the inclusion of PWD in HIV/AIDS awareness raising and education programs.

Handicap International was actively engaged with eleven Non -DPO organizations in sensitization and training as well as development of action plans on disability inclusion and mainstreaming and out of which technical support was given to four organizations to carry out accessibility audit using physical accessibility checklist tool that was developed. Family Health Options Kenya was one of the organizations that Handicap International worked very closely to give technical support as there was organizational commitment to mainstream disability.

Linkages were also created between DPOs and Non- DPOs for example Family Health Options Kenya with Women Challenged to Challenge to the area of women with disability and reproductive health. Beacon of Hope also created linkages with WCC on referral of women with Disability and Income Generating activities. Kenya Union for the Blind created linkages with Family Health Options Kenya in making their resource center accessible to PWDs. KUB has an adaptive technology department that can convert information into Braille, large font and audio.

Objective 2: Increase the capacity of DPO to manage and implement programs effectively and advocate for PWD rights

Two trainings on advocacy and inclusion were conducted for DPOs to be able to advocate for the rights of PWD. Based on advocacy trainings eleven action plans were developed and ten DPOs received micro-grants to implement the action plans.

Objective 3: Document and disseminate lessons learned on effective mainstreaming of disability in development programs

Throughout the project period documentation of lessons learnt was done and two documents were developed as a result of this: Inclusion newsletter highlighting what was implemented by partners and Inclusion guideline that give practical ways of how to mainstream disability in development programmes in Kenya.
The engagement of Non-DPOs and DPOs in this project was seen as a beginning of a process of disability inclusion and mainstreaming and was just a step that still requires more support to be able to actualize and have an impact. Such a project requires a longer period of time for the impact to be achieved. Some of the organizations looked at development of action plans in form of a long term strategy of five years for example UCCATM. The project has just created awareness and tools that organizations can still continue to use thus monitoring and technical support is still required even beyond the project period.

One of the key aspects that this project did not focus on was how can we have one voice at the national level and ensure active participation by persons with disability. Raising the voice and participation of Kenyans with disability in development and reform process is a project that closely picks up on the gaps of how persons with disability can voice their concerns and be involved in the reform process in Kenya. The gap left out of these two projects is specifically on access by persons with disability to basic services that is education and health among others and how can we influence policy making process to be inclusive and institutionalized in Kenya.

3. Analyze amendments made during the program implementation. How did these support the program to achieve the laid out objective of the program

There was a change of strategy from collective training and technical support among Non DPOs to individual institutional support. The Non-DPOs were dealing with diverse areas which included media, Health rights, HIV and AIDS, reproductive Health and Family planning, refugees and advocacy.

The same has been approved for DPOs since their institutional needs and capacity are diverse. UDPK worked closely with two organizations that is Matungu Disabled group and Kajiado Disabled Peoples Program to implement build their capacity while at the same time working with stakeholders in their area to advocate for inclusion of persons with Disability. HI also worked closely with BLINK staff to train and sensitize development partners in

4. Lessons learnt from the implementation period that led to the achievement of the results and the objectives

- Disability is a new concept not well understood by many, therefore it is a slow process that would require a long time to be internalized and adopted by many organizations.
- For continuity of disability inclusion and mainstreaming in non-DPO organizations, the concept needs to be owned by the organization and not the individuals engaged in the various processes.
- To effectively address disability inclusion and mainstreaming issues, it is important to demystify disability and the various stereotypes around it to enhance understanding and uptake among Non DPO organizations.
- A lot is being done by DPO themselves in terms of inclusion and mainstreaming however without any in depth understanding of the concept, therefore capacity building to enhance understanding and adopt a structured approach and process facilitated the process of achieving disability inclusion and mainstreaming in development initiatives with support from DPO.
- A Multi-faceted approach to inclusion is very critical for it to succeed, the
principle ‘leave no gap’ as far as far as stakeholder involvement is concerned is paramount.

- Expanding Participation of PWD project sought to entrench the concept of disability mainstreaming as a cross-cutting issue among non DPOs. This was still a new concept that the project addressed through sensitization forums with the various agencies.
- The project also involved organizations working in different spectrums of development and different levels of understanding on disability but their interest on disability inclusion and mainstreaming remained significant. This proved very challenging in terms of change in methodology to employ as there were varied areas and capacities of staff.

Disability mainstreaming and inclusion is a development agenda of both DPOs and Non DPOs. Disability mainstreaming is not an event but a long term process that should begin with change of attitudes if inclusion has to be achieved. Disability mainstreaming cannot only be enforced through local and international legal instruments. There are other social and business advantages that should be pegged on disability inclusion. Disability mainstreaming has a set of defined principles that are cross-cutting irrespective of nature of organization. Disability mainstreaming is not an expensive affair if it is considered at the design and development phase of project/ service/ product.

5. Challenges faced in implementation and what new strategies were put in place to overcome these

- The success of the project was entirely dependant on the commitment and goodwill of the other agencies involved, therefore calling for adoption of an approach that is not patronizing to the organization. A one on one approach and flexibility in meeting with the organizations was used. Therefore the physical visits to the organizations and meeting with high level staff within the organizations helped clear some concerns and provide a go ahead to fully engage with HI.
- Development organizations have their own scheduled activities with deadlines and therefore introducing disability mainstreaming as a new concept to them has been a challenge thus a longer time taken. HI has had to fit in their schedule and re-plan the activities. Action plans were also developed with each organization beyond the project period to be able to make follow up and also fit into their planning of the following year as most of the organizations had already done 2010 budget planning.
- High expectation from the non DPO organizations in terms of financial support to take up disability mainstreaming/ inclusion. HI has been very clear in the engagement with the non DPOs that this is not a separate project to them but an added value to their existing activity implementation and provision of services. Call for proposals by National Council for PWD was also shared with most organizations to be able to apply for financial support.

Section III Networking, Collaboration and Partnership

1. How have you worked with counterparts and other stakeholders during the project period? (Including both governmental and non-governmental entities)

HI partnered with NCPWD in sharing of tools and carrying out the physical assessment of Kenyatta International Conference Center KICC. This partnership has helped to harmonize and develop tools for physical access. HI also
partnered with National Council for Persons with Disability to train DPOs in advocacy and included use of advocacy guideline developed by NCPWD as well as facilitation during the trainings.

UDPK, the umbrella organization of PWD has been engaged as a main implementing partner in this project. HI together with UDPK collected and analyzed a number of tools notably the UN Convention on the Rights of Persons with Disabilities, the Kenya Disability Act of 2003 and the VSO *Handbook on Mainstreaming*. UDPK worked closely with 15 DPOs in building their capacity on advocacy and inclusion of persons with Disability.

This project used a networking and collaborative approach towards advocacy and involvement of all stakeholders from the development as well as government bodies in the Expanding Participation of Persons with Disabilities in Kenya. The kick-off workshop brought 24 Non-DPO organizations across various development areas for the meeting on Expanding Participation of Persons with Disabilities. Some of the organizations included United Nations Higher Commission of Refugees (UNCHCR), GTZ, Slums Information Development and Resource Center (SIDAREC) and Women for Justice among others.
Section IV  Institutional Strengthening

In this section, describe the organization’s institutional strengthening journey clearly describing institutional strengthening priorities identified in the various assessments.

i. **Using the table below indicate what Institutional strengthening activities have been undertaken during the project implementation period.**

<table>
<thead>
<tr>
<th>Institutional Improvement Plan priorities</th>
<th>Activities undertaken</th>
<th>Results achieved in the specific organization development area</th>
</tr>
</thead>
</table>
| Assessment and Baseline on disability inclusion and mainstreaming | • Accessibility assessment for 15 Non-DPOs
• One-day training and awareness on disability inclusion and mainstreaming | • Identification of inclusion gaps and for the purposes of identifying contact persons and profiling Non-DPOs across various development sectors
• Clear understanding of the mandate of each organization |
| Accessibility monitoring of 15 non-DPO’s | • Accessibility monitoring of 11 non-DPO’s | • Development of 4 action plans by UCCATM, FHOK, KENWA, BOH
• Training/sensitization on disability inclusion and mainstreaming |
| Technical support to Non-DPOs | • Technical support to non-DPOs through implementation of action plans
• Development of an internet blog | • Accessibility audits conducted in four organizations BOH, UCCATM, FHOK (2 stations – Headquarters and youth center) |
| Training | • Training on Inclusion for Non-DPO; residential for 30 persons | • Inclusion training and sensitization of 30 staff from 11 non-DPO
• Action planning |
| Advocacy needs assessment | • Advocacy needs assessment of 11 DPO’s and DPO networks
• Advocacy training for DPO’s - Residential
• Half-day visits to various DPOs | • Advocacy needs Assessment for 11 DPOs
• Advocacy training for 31 DPO staff
• Action planning |
| Support DPOs implement innovative inclusion and advocacy with micro-grants | • Sub-grant DPOs to implement innovative action plans on advocacy & inclusion | • 10 DPOs sub granted to implement action plans on disability inclusion and mainstreaming in different development areas |
Technical support to DPOs

- One day training in Kajiado and Butere districts to build the capacity of DPO in effective engagement of non-DPO and service sectors
- Two open forums with private sectors and mainstream service providers in Butere and Kajiado
- Develop a memorandum to media highlighting the need for media to provide accessible formats for the deaf
- Half-day meeting with stakeholders from deaf organizations to refine and validate the memorandum

- Provided an opportunity for DPOs to present disability issues to public and private sectors
- Persons with disabilities are increasingly involved in development activities and actively seeking representation in policy and decision making at their levels
- Enhanced advocacy skills by DPOs

Documentation and sharing of best practices

- Partners quarterly meetings
- Inclusion newsletter

- Linkages created between DPOs and Non-DPOs
- Experiences on disability inclusion and mainstreaming shared as well as articles collected for inclusion newsletter

**ii. What support have you received from CAP Kenya to implement your plan?**

[Indicate other support received from CAP Kenya over and above implementation of the institutional improvement plan]

AED has given support in terms of development of project documents, financial and technical support throughout the project period. HI used documents adapted form AED for pre-award visits conducted with partners to assess their organizational capacity.

**iii. Key Achievements for the project period** (you can provide key changes that have occurred in the organization as a result of various institutional strengthening activities, peer learning and participation in any AED CAP Kenya organized workshops and Forums)

- Full gazettment and operationalization of the Persons with Disability Act (2003) on 1st January 2010, attributable to lobbying activities by UDPK and other organizations of and for PWD
- Improved engagement with media, a key component of advocacy (which is UDPK’s key mandate)
Based on the skills gained during the implementation period of the Expanding Participation of PWD project, UDPK and member DPOs have scaled up their advocacy activities at different levels including national and grassroots levels. They include advocacy with policy makers for implementation of the Persons with Disabilities Act (2003) through meetings, media, etc.

- Improved resource mobilization skills through capacity building of DPOs with technical support from HI
- Review of the Persons with Disabilities Act 2003 in relation to the UN Convention on the Rights of Persons with Disabilities with a view to make recommendations that will help synchronize the act with the provisions of the UNCRPD
- Networking and linkage with organizations interested in disability inclusion; UDPK and HI shared the physical accessibility checklist with various organizations such as KICC, Architectural Society of Kenya, Wida Highway Hotel, Lenana Conference Center, Kenya Comfort Hotel and ACK St. James Church, Kiambu
- Lobby for physical access for persons with disabilities in the urban housing project in Kibera slums
- Nanyuki Municipality Disabled Group has experienced more and more positive consultation between PWD and non-disabled. PWD are now represented in various mainstream committees and boards (e.g. DDC, Health Board, CACC and the local polytechnic). For the first time, a DPO in the district was funded by National AIDS Control Council in the Total War Against AIDS round 2 and our organization’s proposal in round 3 has already been approved at the Constituency AIDS Control Council level

iv. **Challenges Faced in implementation of Institutional Improvement plan**

- Obtaining commitment from organizations to undertake disability inclusion/mainstreaming was forecasted to require a 3-year time frame therefore the reduced time frame posed a significant challenge. Therefore the physical visits to the organizations and meeting with high level staff within the organizations helped clear some concerns and provided a go ahead to fully engage with HI.
- Development organizations have their own mandate and predetermined set of activities with deadlines and therefore encouraging them towards disability mainstreaming in existing activities and strategies has been a challenge thus a longer time was taken. HI has had to fit in their schedule and re-plan the activities.
- High expectations from the non DPO organizations in terms of financial support to take up disability mainstreaming/ inclusion. HI has been very clear in the engagement with the non DPOs that this is not an additional project but an added value to their existing program activities and provision of services.
- A lot needs to be done in terms of capacity building and technical support to both Non DPOs as well as DPO especially on disability-related information that would guide inclusion policy formulation and implementation at programming as well as work place level.
Section V Publications and Media

As appropriate, provide information on any materials produced during the implementation period. This could include pamphlets, other printed material, audio or visual materials produced during the implementation period using AED CAP Kenya grant.

Part of DPOs action plans and sub-grants went for the development of the following publications/media:

T-shirts
a) Blind and Low Vision Network of Kenya (BLINK); message; “BLINK – Blind but Able”; quantity; 40.
b) Deaf Empowerment Kenya (DEK); message; “Accessibility and inclusiveness is a right to people with disability”; quantity; 20.

Pamphlets
c) Blind and Low Vision Network of Kenya (BLINK); message; “Service charter of BLINK”; quantity; 400.
d) Nairobi Family Support Service (NFSS) produced pamphlets; message; “I am proud of my friends with disability” and “I care for friends with disability” quantity; 500 (250 per message).

Newsletter
e) United Disabled Persons of Kenya (UDPK); the title of the newsletter is “Wezesha” a Kiswahili word meaning enable. It highlights various activities by UDPK under the project and in the wider context for the inclusion of persons with disabilities quantity; 150 copies.

Poster
f) Action Network for the Disabled (ANDY); message; “An inclusive society is a healthy society, do not exclude people with disabilities!!” quantity; 600.

Other publications
g) Disability Newsletter; message; (special issue on disability mainstreaming within the project); quantity 500.
h) The Information Guideline on Disability Inclusion for Development Programs in Kenya handbook and CD; quantity; 300 and 500 respectively.

Section VI Annexes

1. Please place any extensive descriptive material, e.g., schedules, activity descriptions in the annex and simply refer to them in the text of the project period.

2. Using the qualitative reporting guidelines describe are other aspects of the project that you would like to share e.g. case studies, success stories, and attach them as part of this report.
Section VII  Results and Evidence Reporting Worksheet

Level I indicators
In this section, we are interested in TOTAL numbers, irrespective of the type and number of services received according to the following indicators:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
</tr>
<tr>
<td>Number of people served</td>
<td>718</td>
</tr>
<tr>
<td>Number of people trained</td>
<td>305</td>
</tr>
<tr>
<td>Number of organizations strengthened</td>
<td>113</td>
</tr>
</tbody>
</table>

Level II indicators
In this table, provide the information requested in the Table below. Please refer to your Performance Monitoring Matrix for Planned targets. Insert in this table the indicators (evidence) for each of the results. Indicate the planned and actual targets for the reporting Period by filling in the spaces below [planned targets should be the same as those in your performance monitoring plan]

<table>
<thead>
<tr>
<th>Results and Evidence</th>
<th>Start Date - March 2009</th>
<th>End Date - September 2010</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Planned Targets</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Result 1: By the end of the program 15 non- DPO (development/implementing) agencies(including USAID funded programs) have strengthened capacity to implement inclusive and disability-friendly programs and activities that include PWD in their target groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ev. 1.1 Number of PWD receiving support services recorded</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Ev 1.2 Number of implementing agency staff sensitized on disability Rights</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Ev. 1.3: Number of internal policies/action plans developed on inclusion</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Ev 1.4 Number of tools/resources adopted especially for OVC and HIV prevention programmes</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td><strong>Ev 1.5:</strong> Number of non-DPO staff trained</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td><strong>EV.1.6:</strong> Number of USAID funded programmes with enhanced participation of PWD</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Result 2.1:** By the end of the program, 11 DPO have implemented advocacy action plans and conducted innovative actions that promote Inclusion

| **Ev.2.1.1:** Number of DPO members trained in advocacy | 116 | 147 |
| **Ev. 2.1.2:** Number of advocacy action plans developed by DPO | 11 |
| **Ev. 2.1.3:** Number PWD participating in DPO action plan implementation | 216 | 185 |

**Result 2.2:** By the end of the program 3 DPO networks will have improved financial management, strategic planning and M&E capability

| **Ev. 2.2.2:** Number of DPO with finance and operations procedures | 11 |
| **Ev. 2.2.3:** Number of DPOs with specific project M&E plans | 11 |
| **Ev. 2.2.4:** Number of DPO with an M&E review mechanism | 11 |

**Result 3:** By the end of the program the result of 6 pilot initiatives and 15 actions are documented and shared with the targeted stakeholders

| **Ev 3.1:** Number of innovative initiatives that promote inclusion | 11 |
| **Ev 3.2:** Number of stakeholders receiving lessons learnt | 500 |
## ANNEX 9—CHANGES IN GRANTEE ORGANIZATIONAL CAPACITY OVER TIME

<table>
<thead>
<tr>
<th>Grantee</th>
<th>IDF 1 scores</th>
<th>IDF 2 Score</th>
<th>Avg. Growth</th>
<th>% growth</th>
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## ANNEX 10—FUNDING DIVERSIFICATION BY GRANTEE

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<td>8</td>
<td>41.7</td>
<td></td>
</tr>
<tr>
<td>KUAP</td>
<td>5</td>
<td>33.7</td>
<td>6</td>
<td>22</td>
<td>5</td>
<td>49.2</td>
<td>4</td>
<td>35.5</td>
<td>4</td>
<td>16.8</td>
</tr>
<tr>
<td>MCC</td>
<td>6</td>
<td>7.4</td>
<td>6</td>
<td>9.6</td>
<td>5</td>
<td>10.9</td>
<td>4</td>
<td>11.8</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>NIA</td>
<td>1</td>
<td>5.9</td>
<td>2</td>
<td>8.8</td>
<td>5</td>
<td>14.7</td>
<td>4</td>
<td>15.1</td>
<td>4</td>
<td>48.9</td>
</tr>
<tr>
<td>Redhill</td>
<td>4</td>
<td>1.1</td>
<td>2</td>
<td>0.5</td>
<td>5</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ace Africa</td>
<td>7</td>
<td>26</td>
<td>11</td>
<td>42.2</td>
<td>12</td>
<td>52.5</td>
<td>12</td>
<td>53.5</td>
<td>13</td>
<td>55.9</td>
</tr>
<tr>
<td>Omari</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WASDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raphaelites</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*Source: CAPABLE Partners Program*
ANNEX 11—TECHNICAL ASSISTANCE FOR PREVENTION ACTIVITIES WITH POPULATIONS ABUSING SUBSTANCES

Substance Abuse Programs
Technical Capacity Development

**Background**
Technical assistance begins in the very early stages in writing the RFA guidelines. This essentially provides a frame work that provides some guidance on how to structure initial program and to write concept papers.

Once grantees have been selected, program design work begins with each of the NGO/CBOs in developing effective programs. Considerable time is taken to draw out grantee’s existing experience and knowledge to develop programs that are applicable to the population they serve in their geographical area. Program design involves a combination of researched interventions, best practices approaches that have been used by other providers and incorporating the knowledge of grantees working the target populations in their geographical area.

Once an initial program has been developed and gets implemented, a close monitoring of the program outcomes occurs through both monitoring and evaluation systems and qualitative information is collected from the early implementation phases. CAP works with grantees to monitor carefully effectiveness of program implementation and review alternative design options or modifications in the early part of program intervention. Some programs need considerably more start up time to determine if an intervention approach effective.

In addition to program design, effective delivery of services is critical in order to determine if an intervention is effective or not. CAP TA team provides both onsite and offsite training for staff to ensure that services are delivered at a high quality level. One of the greatest challenges is ensuring that high quality technical services are being provided. CAP also supports staff among the grantee organizations to obtain further specialized. In the case of the high risk substance abusers, CAP has provided advanced training in the field of addictions and treatment recovery services, which is a specialized skill.

CAP TA team minimally physically visits each site quarterly providing on site monitoring, training, and program development. Outside of the quarterly visits, teleconference meetings are often held with different components of the program as well as the management team. In addition, ongoing support is provided through routine telephone calls in reviewing program progress, implementation challenges, reviewing options and empowering staff to explore alternatives that can be more effective in order to improve programs and their effectiveness.

Monthly data and quarterly narrative reports are submitted to CAP. This information is reviewed and feedback is provided along with holding a dialogue regarding program challenges and successes. Case studies are also reviewed that allows for a more qualitative review of program implantation and effectiveness.
The key to the CAP TA model is the consistent follow up with grantees and the development of a supportive relationship in order to assist grantees providing high quality services. Personal on site visits allow both CAP TA staff and grantees to mutually understand program challenges and how to jointly explore and implement alternatives.

Building technical capacity requires a good organizational structure. CAP TA staff must work closely with finance, M&E, IS staff. These programs must provide a seamless level of support in developing the organization’s capacity to effectively deliver services. Good technical services are foster in a supportive organizational environment that has the necessary structures in place to follow up and ensure that high quality technical services are being provided. Some organizations are better equipped to absorb TA while other organizations struggle with maintaining more basic services and it becomes more difficult for them to take on the challenges of delivering highly technical services. One of the lessons learned through the process of providing TA is the need for accountability and transparency. This is accomplished by ensuring that both the grantee and CAP staff work closely with the organization to ensure that systems are working effectively.

**SAP Grantees**

Many organizations received technical capacity building in the area of HIV and substance abuse throughout the duration of the CAP Kenya implementation period. Substance abuse technical assistance was provided with various OVC organizations but ten organizations received intensive technical support. Nine of these organization focused interventions primarily in the area of HIV and substance abuse. The first nine organizations in the list below exclusively provided HIV and substance abuse interventions; the tenth organization (KHBC) incorporated HIV and substance abuse into its program.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Locations Served</th>
<th>Dates of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Omari Project</td>
<td>Malindi, Kilifi, Lamu</td>
<td>Feb 2007 – Sep 2010</td>
</tr>
<tr>
<td>2. Reachout Centre Trust</td>
<td>Mombasa, Ukunda, Mtwapa</td>
<td>Feb 2007 – Sep 2010</td>
</tr>
<tr>
<td>8. Support for Addictions Prevention and Treatment in Africa (SAPTA) Trust and SAPTA Center</td>
<td>Nairobi based, covered Coast, Nairobi and Nyanza/Rift regions</td>
<td>Nov 2006 – Sept 2010</td>
</tr>
<tr>
<td>9. The Students’ Campaign Against Drugs</td>
<td>Nairobi</td>
<td>Apr 2008 – May 2009</td>
</tr>
</tbody>
</table>
Over the years of implementation the technical capacity was developed in the following key areas:

- Outreach, HIV risk reduction
- HIV testing
- HIV case management, palliative care
- Addiction treatment services
- Transitional services for recovering alcohol/drug users
- Education on HIV and substance abuse

The first seven of the ten organizations list above provided Outreach, HIV risk reduction, HIV testing, HIV case management, palliative care, addiction treatment services and education on HIV and substance abuse. Only one organization (Reachout Centre Trust) provided transitional services for recovering alcohol/drug users.

One organization (SAPTA) provided training to a cadre of health and other professionals in screening and interventions with alcohol/drug abusers and a second organization (SCAD) was a school based peer educator program that utilized peer group discussions as the primary intervention mechanism and included some one-on-one contacts. The other organization (KHBC) provided HIV education, employee policy development in the areas of HIV; concentration in this area was dealing appropriately with employee HIV and substance abuse issues.

The table below provides a breakdown of services provided by each of the organizations and changes in their capacity to provide technical services over the course of the project implementation.

<table>
<thead>
<tr>
<th>Service</th>
<th>Omari Begin</th>
<th>Omari End</th>
<th>Reachout Begin</th>
<th>Reachout End</th>
<th>Raphaelites Begin</th>
<th>Raphaelites End</th>
<th>KUAP Begin</th>
<th>KUAP End</th>
<th>Asumbi Begin</th>
<th>Asumbi End</th>
<th>FHOK Begin</th>
<th>FHOK End</th>
<th>Tuungane Begin</th>
<th>Tuungane End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach (HIV Risk Reduction) Program Components</td>
<td>No</td>
<td>Yes ++</td>
<td>Yes</td>
<td>Yes ++</td>
<td>No</td>
<td>Yes ++</td>
<td>No</td>
<td>Yes ++</td>
<td>Yes</td>
<td>Yes ++</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes ++</td>
</tr>
<tr>
<td>Community Education</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV Reduction among current users</td>
<td>No</td>
<td>Yes</td>
<td>Part</td>
<td>Yes</td>
<td>No</td>
<td>Yes ++</td>
<td>No</td>
<td>Yes</td>
<td>Yes ++</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>VCT testing</td>
<td>No</td>
<td>Yes</td>
<td>Part</td>
<td>Full</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes ++</td>
<td>Yes ++</td>
<td>Yes ++</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes ++</td>
<td>Yes ++</td>
</tr>
<tr>
<td>HIV case management</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Addiction recovery treatment</td>
<td>Residential only</td>
<td>Full cadre of services</td>
<td>Residential only</td>
<td>Full cadre of services</td>
<td>No (not for this population)</td>
<td>Full cadre of services</td>
<td>No</td>
<td>Full cadre of services</td>
<td>Primarily residential</td>
<td>Full cadre of services</td>
<td>No</td>
<td>Partly</td>
<td>Full cadre of services</td>
<td></td>
</tr>
</tbody>
</table>

(Table similar to one above but a different format)
Changes in Program Implementation Among HIV & Substance Abuse Grantees

<table>
<thead>
<tr>
<th>SAP Services</th>
<th>Omari</th>
<th>Reachout</th>
<th>Raphaelites</th>
<th>KUAP</th>
<th>Asumbi</th>
<th>FHOK</th>
<th>Tuungane</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Begin</td>
<td>End</td>
<td>Begin</td>
<td>End</td>
<td>Begin</td>
<td>End</td>
<td>Begin</td>
</tr>
<tr>
<td>Outreach (HIV Risk Reduction) Program Components</td>
<td>No</td>
<td>Yes++</td>
<td>Yes++</td>
<td>No</td>
<td>Yes++</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Education</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV Reduction among current users</td>
<td>No</td>
<td>Yes+</td>
<td>Yes++</td>
<td>No</td>
<td>Yes+</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>VCT testing</td>
<td>No</td>
<td>Yes</td>
<td>Yes++</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV case management</td>
<td>No</td>
<td>Yes+</td>
<td>Yes++</td>
<td>No</td>
<td>Yes+</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Addiction recovery treatment</td>
<td>Yes</td>
<td>Yes++</td>
<td>Yes++</td>
<td>Yes</td>
<td>Yes+</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Case Review</td>
<td>No</td>
<td>Yes-</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Commercial sex workers and alcohol specialized services</td>
<td>No</td>
<td>Yes+</td>
<td>No</td>
<td>Yes++</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Services within HIV/AIDS treatment centers (specialized services)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Legend:
No: Services not provided
Yes+: Services being provided on limited basis, very early in development
Yes: Services adequately being provided
Yes+: Services are provided above minimum standard
Yes++: Services are excellent

In addition to the services provided, technical services were developed with the Raphaelites in two additional areas:
- Day treatment intensive outpatient recovery program for sex workers
- Integrated services within HIV and AIDS treatment center to provide conjoint services for individuals with substance abuse issues, onsite assessment, intervention/treatment, group recovery services and recovery tracking of these joint clients.

Each organization identified above utilized a behavior change intervention, targeting individuals primarily through outreach. Internationally accepted outreach models were used and modified for the geographical regional they served. Outcome indicators were collected in terms of behavior change over the course of intervention.

Throughout the course of the project, the seven HIV/substance abuse community service organizations provided the core outreach risk reduction and associated programs. The table below shows the number of outreach contacts made over the course of the project and number of total individuals reached as well as VCT tests performed.
**Name of organization** | **Total Number of One-on-one Risk Reduction education/counseling contacts** | **Total Number of Individuals receiving Risk Reduction education/counseling** | **Total Number of VCT tests performed**
--- | --- | --- | ---
The Omari Project | 11,666 | 6,465 | 4,279
Reachout Centre Trust | 21,776 | 16,149 | 9,756
The Raphaelites – RedHill Place | 14,156 | 10,997 | 954
Kisumu Urban Apostolate Programmes (KUAP) Pandipieri | 22,619 | 11,685 | 4,710
Catholic Diocese of Homa Bay: Asumbi Project | 2,104 | 1,944 | 541
Family Health Options Kenya (FHOK) | 9,489 | 7,709 | 939
Impact RDO - Tuungane Project | 10,016 | 9,227 | 568

**Progression of Technical Capacity Development**

Each organization significantly improved technical capacity to deliver services over the course of the grant period. Organizations that had a history of providing addictions treatment services developed new technical capacity with skills in HIV risk reduction services. Organizations that had a history of doing HIV prevention work, developed the technical capacity to work with the substance abusing population, developing added skills in counseling and addiction recovery services.

Most organizations had limited technical capacity in HIV and addictions treatment. Most interventions were based on didactic educational strategies, with limited to no consideration to incorporate planned behavior change interventions. Education was general in nature, utilizing generic messages and the same approach used, not tailored to the specific population or individual. Assessment of knowledge base was not part of the process to develop client specific interventions and there had been no follow-up with clients on any behavior change intervention plans.

Developing technical capacity among all organizations involved extensive training and follow up with each of the organizations. Much of the training was in the form of ongoing program implementation oversight and meeting with the implementation teams on a regular basis to provide them with added skills and technical knowledge. Initially, there were no systems in place to provide services and programs were extremely informal. Throughout the course of the project, one-on-one meetings were held with managers and program leaders to develop their capacity to implement more structured programs. Meetings with the outreach teams occurred regularly as well.
All outreach teams were trained to incorporate four basic components into the risk reduction outreach work with every client they met:

1. Obtain basic client demographic information to be able to identify client for follow up purposes
2. Obtain client baseline sexual risk behavior information and substance use details (which included a screening for substance abusing clients).
3. Provide education and counseling and develop a specific behavior change intervention plan, based on that client’s sexual and substance abuse risk history.
4. Obtain information of past referral services and make referrals to appropriate services based on current needs. This also included providing case management to ensure clients are accessing services or accompanying clients to service sites.

Systems were established to collect this information in the field and all details were maintained in a database for each client. Subsequent contacts involved a planned intervention with a combination of education and counseling as part of a comprehensive behavior change intervention plan.

As part of comprehensive services, technical support was provided to design and implement specialized HIV testing for the substance abusing population. These programs were among the first in the country to provide mobile VCT testing, where over 90% of testing was provided at drug and alcohol using sites and nearby locations easily accessible from using sites. Staff among all programs were trained to provide specialized HIV testing services for substance abusers, understanding baseline substance use and when the best time to test someone who is a chronic user.

Prior to the implementation of specialized HIV testing at the grantee, drug and alcohol users were referred to existing VCT sites. Frequently, they would not attend, and tracking their participation was extremely difficult. The VCT counselors at these sites often did not have the knowledge or expertise in testing substance abusers, and many individuals requesting services would be denied HIV testing because of their substance use.

A specialized HIV positive case management program for substance abusers was established to facilitate their participation in HIV care and treatment services. Many of them used substances to deal with their HIV status, instead of participating in HIV care and treatment services. The HIV case management program involved training the VCT counselors who worked with clients that were referred by outreach workers. VCT counselor would engage with the HIV positive client to gain consent into the case management program. Case management services were then provided by their outreach worker. Outreach workers would follow up all the HIV positive clients in the field to get them engaged in HIV care and treatment services.

Technical capacity development for the three remaining organizations varied from the seven outreach risk reduction based programs.

Technical capacity development with SAPTA focused on training and program development work to help SAPTA staff in turn develop the technical capacity of health providers to deal with the substance abusing population. Incorporating HIV as part of understanding addictions issues
was a major part of the training design. The work of SAPTA later broadened to help develop the capacity of HIV treatment sites and OVC organizations to more effectively deal with patients and care providers dealing with substance abuse issues. Technical support also focused on developing SAPTA’s capacity to not only transfer knowledge to these organizations but support each organization in the technical implementation of these newly developed programs.

Technical capacity development with SCAD focused on helping this youth based organization to improve on their skills to effectively deal with substance abuse issues and HIV risks among peers. This was designed to go beyond simple education about substance abuse and HIV but design effective peer intervention programs with one-on-one and small group activities to deal with substance abuse and HIV transmission issues.

KHBC received technical support in improving training programs at the employee level. This was intended to help employers better recognize substance abuse issues among employees and to ensure not only that HIV policies were in the workplace. In addition, the program was designed to help employers better understand substance abuse issues and provide supports for employees dealing with substance abuse. KHBC modified training materials to assist employers in developing more effective work place policies to deal with substance abuse and HIV. KHBC was also equipped to help employers explore EAP (Employee Assistance Program) within their company/organization.

**Program Success Story, KUAP**

Organizations developed technical capacity at different rates. Some began with a basic technical foundation while others had practically no experience in the field of HIV and substance abuse. KUAP was an example of an organization that grew immensely after extensive TA work. CAP was actually considering closing out the program because of its poor performance. Many of KUAP’s problems were associated with their organizational structure and their capacity to absorb/incorporate technical support and guidance. KUAP’s structure could not support intensive work requiring more professional skills and interventions to effectively achieve behavior change among the hard to reach population of substance abusers.

Team members from the different portfolios worked to KUAP to help restructure the way in which this particular project was managed. Recommendations were made from a technical program implementation perspective to completely redesign their HIV substance abuse program. The previous program they attempted to modify was unable to yield results or collect necessary data to report on program outcomes.

Over a two year period, intensive work was provided to help KAUP advance their technical skills. They implemented a part-time time outreach worker model, an approached they wanted to maintain to gain a broader coverage. This was unconventional from the more highly trained individuals working for time in the field as outreach workers. Through staff changes and program redesign, KUAP was able to put in place a very effective program with part-time staff. They were able to maintain a team of almost 20 part-time workers, who acquired excellent skills in this field and were able to provide more coverage into the community and eventually reach more people than any other program.
KUAP was a program that was HIV based and knew little about substance abuse. Over the course of the program implementation with extensive technical support, KUAP was also able to offer comprehensive outpatient addictions services at three sites, perform comprehensive clinical assessments and treatment planning, while maintaining a very strong demand for outpatient addictions services, which is difficult to achieve. CAP worked with interested members in the community to develop peer supported addiction recovery groups and a training workshop was provided by KUAP to help strengthen community based self-help recovery programs.

The chart below provides information on the number of initial contacts and total follow up contacts with clients receiving outreach services. The program redesign and changes took place the 3rd quarter of 2008. There is a notable change in productivity and services from that point forward. The VCT testing also improved over time but more significantly, the target population of substance abusers was getting reached consistently. The earlier VCT testing component for substance abusers was not successfully reaching the target population as more non-substance abusers were getting tested as compared to the substance abusing population. KUAP was the first program to engage in home based VCT testing among substance abusers with extremely effective results.

**Success Story Addictions Treatment Programs**

Attached is information that is in the final process for publication in “The African Journal of Drug & Alcohol Studies”. All these program interventions were performed as part of the CAP funding which included the program development over time, looking at the utilization of the outpatient addictions treatment services as well as client recovery after treatment services.
Data in the table below provides details about the outpatient addictions treatment programs at four of the implementing sites. These four sites were selected because of the duration of program implementation that allowed us to better understand updated of outpatient addictions treatment services with possible outcomes.

A total of 1,847 clients (1,421 males and 426 females) took part in outpatient addictions treatment services at the four sites during the three-year period. The table below provides a breakdown for each of the outpatient treatment sites.

### Participation in Outpatient Addictions Treatment by Site

<table>
<thead>
<tr>
<th></th>
<th>OMARI</th>
<th>Reachout</th>
<th>Raphaelites</th>
<th>KUAP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of new intake assessments</td>
<td>No. of clients participating in Tx</td>
<td>No. of client sessions provided</td>
<td>No. of new intake assessments</td>
</tr>
<tr>
<td>2007 Q1&amp;2</td>
<td>46</td>
<td>20</td>
<td>25</td>
<td>88</td>
</tr>
<tr>
<td>2007 Q3&amp;4</td>
<td>17</td>
<td>21</td>
<td>43</td>
<td>130</td>
</tr>
<tr>
<td>2008 Q1&amp;2</td>
<td>48</td>
<td>42</td>
<td>74</td>
<td>93</td>
</tr>
<tr>
<td>2008 Q3&amp;4</td>
<td>35</td>
<td>66</td>
<td>111</td>
<td>64</td>
</tr>
<tr>
<td>2009 Q1&amp;2</td>
<td>80</td>
<td>157</td>
<td>691</td>
<td>126</td>
</tr>
<tr>
<td>2009 Q3&amp;4</td>
<td>83</td>
<td>187</td>
<td>543</td>
<td>71</td>
</tr>
<tr>
<td>2010 Q1&amp;2</td>
<td>45</td>
<td>188</td>
<td>644</td>
<td>47</td>
</tr>
</tbody>
</table>

Data in the table above indicate an increase in client participation in addictions treatment programs over time, especially when looking at the number of clients participating in treatment and the number of client sessions provided for OMARI and Reachout. Client sessions represent the total number of sessions provided to clients. The number of intake/assessments did not increase significantly as compared to the number of clients participating in treatment and the number of client sessions provided. Clients who were already enrolled in treatment attended more sessions over time, indicating a higher level of engagement and retention in services.

The chart below is a graphic representation of the data presented in the table above. It presents combined data for OMARI, Reachout and Raphaelites of the number of new intake/assessments, number of clients participating in treatment and the number of client sessions provided. Data reported for the KUAP program are not presented in the graph, since their program was initially based on workshop interventions coupled with support groups, it was only later that they began providing addiction treatment services.
OMARI, Reachout and Raphaelites Client Participation in Addictions Treatment

The chart shows that client intake/assessment remained fairly consistent over time with some slight increases. The significant changes are in the number of clients participating in treatment and the number of client sessions provided. The mean number of sessions also increased over time. The Raphaelites program experienced disruptions in their addictions treatment program due to staffing issues. When the Raphaelites data is removed, the mean number of sessions per client increases more significantly, with 8.1 sessions per client in Q1&2 2010.

The table below provides outcome data based on client self-report during the survey contacts with the outreach workers. Data collected and reported were based on an abstinence model; therefore, clients who reduced alcohol consumption were still identified as having relapsed if they consumed at all. Similarly, if a client used another substance, other than his/her drug of choice, he/she would also be identified as having relapsed.
## Recovery/relapse Among Clients Attending Outpatient Addictions Treatment

<table>
<thead>
<tr>
<th>Organization</th>
<th>Alcohol and Cannabis</th>
<th></th>
<th></th>
<th></th>
<th>% abstinence</th>
<th>Abstinent clients receiving residential Tx</th>
<th>% abstinent clients who received residential Tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMARI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>9</td>
<td>6</td>
<td>1 to 11</td>
<td>40%</td>
<td>56%</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td>1 to 16</td>
<td>50%</td>
<td>50%</td>
<td>0</td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
<td>19</td>
<td>19</td>
<td>0 to 36</td>
<td>50%</td>
<td>40%</td>
<td>13</td>
</tr>
<tr>
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<td>5</td>
<td>3</td>
<td>2</td>
<td>2 to 24</td>
<td>40%</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>35</td>
<td>32</td>
<td></td>
<td>48%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>28</td>
<td>23</td>
<td>0 to 18</td>
<td>45%</td>
<td>50%</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>0 to 27</td>
<td>50%</td>
<td>42%</td>
<td>8</td>
</tr>
<tr>
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<td>67</td>
<td>39</td>
<td>28</td>
<td>0 to 24</td>
<td>50%</td>
<td>57%</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>3 to 16</td>
<td>50%</td>
<td>44%</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>75</td>
<td>60</td>
<td></td>
<td>44%</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>35</td>
<td>20</td>
<td>15</td>
<td>0 to 26</td>
<td>43%</td>
<td>42%</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>25</td>
<td>17</td>
<td>0 to 15</td>
<td>40%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>45</td>
<td>32</td>
<td></td>
<td>42%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>47</td>
<td>21</td>
<td>3 to 18</td>
<td>31%</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>15</td>
<td>10</td>
<td>3 to 18</td>
<td>40%</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>62</td>
<td>31</td>
<td></td>
<td>33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Organizations</td>
<td>372</td>
<td>217</td>
<td>155</td>
<td></td>
<td>42%</td>
<td>26</td>
<td>12%</td>
</tr>
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</table>

The data in the table above show that 42% of all the clients surveyed (155 out of 372) in all four programs, reported they had stopped using substances (abstinence).

Therefore a 42% overall abstinence rate among all four sites. A 45% abstinence rate was reported for the two more established sites of OMARI and Reachout, with broader and deeper clinical services. Studies have published abstinence rates following addictions treatment services, but typically not beyond 40% abstinence rates. Although one cannot attribute absence solely to the addiction treatment intervention, it is still notable that following treatment, 42% of clients would have maintained sobriety.