Capacity Needs of Community Based Organizations in Kenya to apply for Global Fund Grants

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Dr. Maurice Odindo
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“Community-Based Organizations are civil society non-profits that operate within a single local community. They are essentially a subset of the wider group of nonprofits. Like other nonprofits they are often run on a voluntary basis and are self funding. Within community organizations there are many variations in terms of size and organizational structure. Some are formally incorporated, with a written constitution and a board of directors (also known as a committee), while others are much smaller and are more informal.

The recent evolution of community organizations, especially in developing countries, has strengthened the view that these "bottom-up" organizations are more effective addressing local needs than larger charitable organizations”

Wikipedia
### ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Artemisinin Combination Therapy</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante-natal Care</td>
</tr>
<tr>
<td>CACC</td>
<td>Constituency AIDS Control Committee</td>
</tr>
<tr>
<td>CBHW</td>
<td>Community Based Health Worker</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CORP</td>
<td>Community Owned Resource Person</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>CSS</td>
<td>Community Systems Strengthening</td>
</tr>
<tr>
<td>DCHR</td>
<td>Division of Child and Reproductive Health</td>
</tr>
<tr>
<td>DPHO</td>
<td>District Public Health Officer</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DMOH</td>
<td>District Medical Officer of Health</td>
</tr>
<tr>
<td>DOMC</td>
<td>Division of Malaria Control</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
</tr>
<tr>
<td>FMA</td>
<td>Financial Management Agents</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GLP</td>
<td>Global Level Partners</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>HMM</td>
<td>Home Management of Malaria</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technologies</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
</tr>
<tr>
<td>ITN</td>
<td>Insecticide Treated Net</td>
</tr>
<tr>
<td>KEPH</td>
<td>Kenya Essential Package for Health</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
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<tr>
<td>LLIN</td>
<td>Long Lasting Insecticide-treated Net</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MICC</td>
<td>Malaria Interagency Coordinating Committee</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHSSP</td>
<td>National Health Sector Strategic Plan</td>
</tr>
<tr>
<td>NMS</td>
<td>National Malaria Strategy</td>
</tr>
<tr>
<td>PBF</td>
<td>Performance Based Funding</td>
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<tr>
<td>PMI</td>
<td>Presidential Malaria Initiative</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient</td>
</tr>
<tr>
<td>PSCM</td>
<td>Procurement and Supply Chain Management</td>
</tr>
<tr>
<td>PSO</td>
<td>Private Sector Organization</td>
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<tr>
<td>RDT</td>
<td>Rapid Diagnostic Testing</td>
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<tr>
<td>RBM</td>
<td>Roll Back Malaria</td>
</tr>
<tr>
<td>SR</td>
<td>Sub Recipient</td>
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<tr>
<td>TOT</td>
<td>Trainer of Trainers</td>
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EXECUTIVE SUMMARY

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund to Fight AIDS, Tuberculosis and Malaria was started in 2002 and has now become a major source of financial assistance in the fight against these diseases throughout the world. However, CSO participation has been limited, and only a small proportion of these groups have been reached by the GFATM. Of the civil society groups, the Community Based Organizations have probably faced the biggest challenge in terms of applying for Global Fund grants and to implement GFATM projects to control malaria.

A Capacity Needs Assessment (CNA) among civil society organizations was initiated vigorously in representative districts of Kenya. The focus of the assessment was on all areas in Kenya that are classified as malaria endemic, highland malaria epidemic, or arid malaria epidemic. The strategy and approach of the assessment was based on several methods, including face to face interviews, telephone interviews, postage of questionnaires, emails, or a combination of postage and telephone interviews to support organizations that need guidance in responding to the questionnaire. The majority of the CBOs interviewed indicated advocacy and community mobilization as their main areas of malaria control activity. About 90% of the 201 organizations said that their organization works in the area of advocacy and community mobilization, while 58% said they work in the area of training and capacity building for malaria control. About 52% of the CBOs said they work in the area of ITN/LLIN distribution, 51% in the area of malaria treatment and case management. Another 41% worked in vector control area.

The membership and ownership of the organizations interviewed were mainly local; about 95% of the organizations interviewed were local community owned organizations. Only 2.5% were either nationally or internationally owned. Almost half, (48.8%) of the organizations that participated in the study had a target population of less than 10,000 people, 44% had a target population of between 10,001 and 100,000. Another 5.7% had a target of between 100,001 and 1 million but only 1% said they had a target population of more than 10 million people.

Most CBOs expressed inability to cover their intended project areas. Out of the 210 organizations only 1.4% were able to cover over 75% or more of their planned target population with their malaria activities. 32.4% of the organizations was able to cover only 25% of the planned target population. More than 51.9% of the organizations were able to cover between 25 and 50% of the planned target population while 14.3% covered 51 – 75% of the population.

At organizational level, 94.2% of all the organizations interviewed said that the major challenge in the implementation was a lack of training and project funds. 71.5% of all the organizations interviewed said that a major challenge in the implementation was a lack of equipment. 63.3% said the main challenge was the low level of staff training. For 61.4% the biggest challenge was the lack of transport, and 44% said it was poor infrastructure.

To be able to effectively run their projects, the CSOs pointed out the importance of strengthened capacities of the CSOs to apply for funds, effectively run programs and report on the outcomes of their malaria control projects and the financial status. International organizations agreed on technical assistance by participation in training programs for strengthening CSOs at country level.
This review has brought out the precarious situation in which the Kenyan CBOs find themselves today. Several factors stand out clearly:

- CBOs are low in capacity in most areas - including financial resources, trained personnel, materials and equipment.
- CBOs lack knowledge in specific areas of project management, including application processes, monitoring and evaluation, financial management skills, and reporting.
- CBOs are keen to learn new techniques and methods on malaria control, and how to manage the disease
- CBOs are enthusiastic and ready and willing to participate in community development, and lifting the standard of living of their members and their communities.
- CBOs do not get sufficient contact and information from relevant authorities that would enable them to apply for and acquire the funds for running their projects.
- Some CBOs have taken the initiative to apply for GFATM funds, but the lack of support from the local authorities discouraged them to a point of never seeking to apply again.

The capacity of personnel in the CBOs to fully implement malaria programs has affected their ability to apply for Global Fund grants and to implement malaria projects. It is clear from the assessment that a majority of CBOs have limited qualified personnel to effectively run field programs, especially in resource mobilization, monitoring and evaluation and assessment of project progress. CBOs also lack effective presentation in the CCM. There are only few resources for CBO projects and the information flow to the CBOs is slow and often inefficient. There is the need for capacity strengthening among these grassroots organizations.
CHAPTER 1
INTRODUCTION

1.1 THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was started in 2002 and has now become a major source of financial assistance in the fight against these diseases throughout the world. It has also established itself as a model for development financing for these major tropical diseases, combining country-level ownership of programs with institutional efficiency and effectiveness.

The GFATM is a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organizations to supplement existing efforts dealing with the three diseases.

At the end of 2008, Global Fund-supported programs were estimated to have averted more than 3.5 million deaths by providing AIDS treatment for 2.3 million people, anti-tuberculosis treatment for 5.4 million people and by distributing 88 million insecticide-treated bed nets for the prevention of malaria worldwide. The Global Fund has so far approved funding in 140 countries worth US$ 15 billion (www.theglobalfund.org), with benefits demonstrated in various countries (Armstrong et al., 2001)

1.2 BACKGROUND OF THE GLOBAL FUND AMONG CIVIL SOCIETY ORGANIZATIONS IN KENYA

Kenya has benefited greatly from the financial support from the Global Fund, with many national facilities depending directly on the GFATM for the running of their health programs at the community level.

Although both government and private organizations have benefitted from the GFATM support, there has been a disparity in the level and extent of support received by the diseases. At institutional level, the Civil Society Organizations have faced major challenges in the implementation of their programs. This is manifested by the large number of projects that are behind schedule. Due to these challenges, Kenya has missed out on some of the previous Rounds that the GFATM has granted to other countries. The hardest hit has been the Malaria Program. Since the creation of the GFATM in 2002, malaria projects have received GFATM grants in only two rounds - Round 2 (US$ 27,700,377.00) and Round 4 (US$ 162,173,085.00). Of these two approved Rounds, (total US$ 189,873,462.00), less than half of the approved amount (US$ 80,744,064.00) has been disbursed. Even then, the two phases of each Round have steeped in problems, and the second phase of Round 4 was just about to start at the time of preparing this report in July 2009.

Of the civil society groups, the Community Based Organizations have probably faced the biggest challenges in terms of applying for GFATM grants and implementing malaria control projects. In a recent review of Global Fund activities in Kenya, the Community Based Organizations indicated that they do not benefit from disbursement of Global Funds in Kenya. This study was designed to determine the capacity needs of CBOs in malaria programs in Kenya.
1.3 STOP MALARIA NOW!

Stop Malaria Now! is a consortium of nine health and development NGOs from Germany, Italy, Kenya, Poland, Spain and Switzerland. In Kenya, the organization partners with the Kenya NGOs Alliance Against Malaria (KeNAAM) in the battle against malaria. The consortium’s aim is to raise public awareness of malaria as one of the major poverty-related diseases and cause of death in Sub-Saharan Africa. It also aims to mobilize respective support for increased political, financial and strategic commitments of European governments in order to achieve the malaria-related Millennium Development Goals.

The consortium’s work is based on a strong partnership between European and African organizations cooperating in the field of awareness raising, advocacy and networking for malaria. The partnership provides for an effective exchange of knowledge, experiences as well as best practices in the field of malaria control.

1.4 EPIDEMIOLOGY OF MALARIA IN KENYA

The Capacity Needs Assessment (CNA) among civil society organizations was initiated vigorously in representative districts of Kenya. The focus of the assessment was on all areas in Kenya that are classified as malaria endemic, highland malaria epidemic, or arid malaria epidemic. These malaria prone areas cover most of the lowland areas to the east, the areas close to Lake Victoria, and the arid and semi-arid regions of the north, north west, and north east of Kenya.

1.4.1 MALARIA IN KENYA

Inevitably, the chances that a person acquires malaria depends on the chances that he/she will come into contact with one of the principal mosquito vectors - Anopheles gambiae s.1 or Anopheles funestus - and that the biting mosquito has the malaria parasite Plasmodium falciparum. Under most malaria “stable endemic” situations, the frequent exposure to the malaria parasite from birth leads to “immunity” against the clinical and fatal consequences of an infection amongst those who survive. Therefore, the clinical burden of malaria is concentrated amongst children, whose immunity is at the lowest level, and who are therefore at the highest risk of catching the disease, leading to death. In areas where the frequency of infection is very low or non-existent the population acquires clinical immunity very slowly and it is often the case that both children and adults are equally at risk of the clinical consequences of an infection.

Although the reason for this is not yet too clear, an "immune" adult woman who becomes pregnant loses some of her functional immunity during pregnancy and experiences increased risks of anemia due to malaria infection, should she be exposed to infection during her pregnancy. Further, infection during pregnancy leads to a reduced birth weight of her newborn child.

Various factors affect the distribution of malaria in Kenya, particularly the availability of breeding sites for the anopheline mosquitoes, distribution of rainfall and the prevailing temperature. Kenya has diverse climatic and ecological conditions, ranging from semi-arid deserts to the north to cold, temperate highlands. This diversity leads to a wide variation in malaria risk and subsequent disease epidemiology. Based on these factors – climate, availability of Anopheles breeding sites, and the risk of catching malaria - Kenya can be divided into various sectors to assist in both the planning and management of disease control. There are four principal groupings: Endemic malaria, highland (epidemic prone), arid (epidemic prone), and low risk. This capacity needs assessment
will be carried out on CSO groups implementing malaria programs, or with the need to implement malaria programs, in representative districts from endemic malaria, highland (epidemic prone) and arid (epidemic prone) areas.

1.5 PROBLEM STATEMENT

Community Based Organizations have been low key participants in the implementation of the Global Fund activities in Kenya. A review of Kenya CCM minutes and also responses from CSOs with regard to malaria grants by the Global Fund during a previous survey indicated that civil society organizations (including CBOs) have been unable to fully access GFATM funds. (See Odindo 2008) The Global Fund website shows that Kenya only managed to access Phase 1, Year 1 of the Global Fund Round II. It was evident that by the end of September 2008, when Global Fund Round II was expected to expire, Kenya was to lose its Phase 1 Year 2, and all Year 3, 4, 5, funding. This had inadvertently locked out CSOs/CBOs from accessing the essential funds to fight malaria in Kenya. Similarly, the slow access of Year 2 Phase 1 of Global Fund Round IV funds had left CSOs very concerned, and though Kenya received a reprieve and was to access Round IV malaria funds, it had missed out on subsequent Round V, VI, VII, and VIII funds. Although Round IX is in the process of evaluation, CBOs participation may be threatened. Inadequacy among CBOs has been fronted as one reason for this low progress in GFATM Malaria programming in Kenya.

1.6 SCOPE OF THE STUDY

This assessment aimed at determining the capacity of CBOs to apply for GFATM grants and to implement malaria programs in various programmatic areas, and recommend ways of removing the capacity barriers to accessing and utilizing GFATM funds at community level.

The study includes a review of reports produced on the Global Fund in Kenya, an examination of the critical elements in the success of the implementation of programs supported by the Global Fund, the identification of the capacity gaps of CBOs in applying for GFATM grants and implementing malaria programs, and suggestions and recommendations for remedial action to bring CBOs to the forefront in reducing malaria morbidity and mortality in Kenya.

1.7 SUMMARY

This Chapter examined the issues to be addressed in this study on assessing the capacity of CBOs to apply for GFATM grants and implement GFATM-supported malaria programs. Stop Malaria Now! was introduced, the problem that gave rise to the study was presented, and the scope of the study was given.
2.1 INTRODUCTION

The selection of methodologies for carrying out this study was based on the choice of qualitative and quantitative techniques that would lead to the assessment of views and opinions from a wide and varied cohort of respondents among the Community Based Organizations that have carried out or plan to apply for funds to control malaria in their area of project implementation. Although based on qualitative aspects, the study methods were also designed to expound on possible quantitative values and observations as experienced by the respondents.

2.2 OBJECTIVE

The objective of this study was to assess the capacity of Community Based Organizations to apply for and implement Global Fund - supported malaria projects in Kenya, and recommend ways of improving the application by community organizations for Global Fund grants.

2.3 METHODOLOGY

The study was conducted through questionnaire interviews with heads and coordinators of Community Based Organizations, and Key Informant Interviews (KII) with heads of institutions and members of KeNAAM. Both open ended qualitative and quantitative questions were used to assess the respondents’ views on key issues and to record key responses on implementation of GFATM-supported malaria projects and the general situation of malaria programs in Kenya.

2.4 FIELD ASSESSMENTS

The focus of this needs assessment were community organizations and their capacity to apply for and implement malaria programs supported by the GFATM. Therefore most persons interviewed during this survey were facilitators and members of this group of organizations. In earlier surveys, grassroots organizations had been identified as the sector of civil society organizations that needed capacity strengthening. (See Odindo 2008, 2008a, 2008b, as well as http://www.theglobalfund.org/programs/countrysite.aspx?countryid=KEN)

Of all the organizations interviewed, 190 of the 214 (about 89%) were Community Based Organizations. We managed to interview 10 National Organizations (4.7%), 9 Faith Based Organizations (4.2%) and 5 International Organizations (2.3 %).
2.4.1 QUESTIONNAIRE INTERVIEWS

Capacity Needs Assessment (CNA) questionnaire interviews were conducted with organizations already implementing GFATM supported projects as well as potential recipients of GFATM funds (among which were a sample of the over 65 KeNAAM members) to determine their needs on preparation for the implementation of Global Fund-supported malaria projects.

Fig. 2: A Research Officer (Rubina Adhiambo, left) conducting an interview with a CBO Coordinator (Seraphina Awuor, on the right) in Mulaha, Nyanza Province
Face to face interviews were therefore aimed at both recipients and non recipients of Global Fund grants. Further, some groups were contacted and interviewed through the telephone. Questionnaires were also sent to respondents through the email for self administration on-line and returning to the reviewer.

2.4.2 FACE-TO-FACE INTERVIEWS

Field face-to-face interviews were conducted in various districts covering malaria endemic, highland epidemic prone and arid epidemic prone districts. Research staff were recruited based on their qualification and previous experiences to conduct field surveys and needs assessment studies. They were posted to areas they are familiar with in terms of knowledge of the language and customs of the people, and the terrain in the rural areas.

In each site, the local community leaders were notified on the survey. The health leaders at the district level (District Medical Officers of Health, DMOH) were also approached and interviewed to provide information on the level of support and linkages with CBOs on application for Global Funds for Malaria.

The District Public Health Officers (DPHO) provided information on the access of CBOs to information from the District Health Management Teams (DHMTs). District Clinical Officers in charge of malaria programs were also approached and attended the community dialogue sessions. Local community leaders were engaged in identifying community groups in their regions, and assisted in mobilizing the identified groups for questionnaire interviews. Table 4 below shows the research officers and the sites where district interviews were conducted.
Table 1: Review teams and districts under review during the capacity needs assessment of Community Based Organizations to apply for Global Fund grants and implement malaria programs in Kenya

<table>
<thead>
<tr>
<th>Review Team</th>
<th>District covered for CBO interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lydia Kibe</td>
<td>Malindi, Lamu and Kilifi</td>
</tr>
<tr>
<td>Patrick Masiemo</td>
<td>Migori</td>
</tr>
<tr>
<td>Adonijah Nyamwanda</td>
<td>Rongo</td>
</tr>
<tr>
<td>Alphonse Okuku</td>
<td>Suba</td>
</tr>
<tr>
<td>Bernard Ogolla and Zachary Juma</td>
<td>North Rachuonyo and South Rachuonyo</td>
</tr>
<tr>
<td>Sixtus Omare and Hammre Kayando</td>
<td>Homa Bay and Kendu Bay</td>
</tr>
<tr>
<td>Valerie Munyeti</td>
<td>Kisii Central, Kisii North, Gucha, Nyamira</td>
</tr>
<tr>
<td>Nellie Luchemo</td>
<td>Kakamega, Butere, Mumias</td>
</tr>
<tr>
<td>Julius Okullu</td>
<td>Emuhaya, Vihiga and Kisumu</td>
</tr>
<tr>
<td>Paul Mukok</td>
<td>Bondo and Rarieda</td>
</tr>
<tr>
<td>Samuel Kahindi</td>
<td>Nyando</td>
</tr>
<tr>
<td>Serafina Awuor</td>
<td>Siaya</td>
</tr>
<tr>
<td>Bernard Ogolla</td>
<td>Nairobi CSOs</td>
</tr>
<tr>
<td>Maurice Odindo, Ruby Adhiambo, and Antonina Aluoch</td>
<td>Telephone interviews to arid malaria prone districts of Eastern, North Eastern and Rift Valley Provinces, and malaria endemic southern districts</td>
</tr>
</tbody>
</table>

2.4.3 TELEPHONE INTERVIEWS

A list of organizations was prepared for the telephone interviews covering the malaria prone districts in the three categories indicated in Chapter 1. Although selected through random sampling, emphasis was put on Community Based Organizations and grassroots organizations from regions that were not to be visited during the face-to-face interviews due to logistics reasons. These included the arid and semi arid north, northeast and northwest of Kenya. They also covered the expansive and sparsely populated Coast, Rift Valley, Eastern and North East Provinces.

2.4.4 KEY INFORMANT INTERVIEWS

Key Informant Interviews were conducted with key persons that provided information on the capacity of community organizations to apply for GFATM grants and implement malaria projects in their areas. They described current efforts to improve linkages between CBOs and government and non-governmental organizations on capacity development, and experiences among national health systems, especially the District Health Management Teams (DHMTs) and the Division of Malaria Control (DOMC) in applications by CBOs for Global Fund grants for malaria projects.
2.5 STUDY TOOLS

The study was conducted through a pre-coded semi-structured questionnaire (see Annex), but final responses were also drawn through probing questions to gain further information on the relevant topic. For the Key Informant Interviews, a voice recorder was used. Observations by the research officers also formed a significant part of acquiring knowledge for this survey.

2.6 SELECTION OF STUDY DISTRICTS

The study districts were randomly selected among the malaria districts from the three major regions in Kenya: Western, Nyanza, and Coast Provinces. The surveys were conducted mainly between May and June 2009.

In each district, the active community organizations were reached from several approaches: from the District Social Service Office, Constituency AIDS Committees, Churches presented lists of organizations affiliated to the various religious organizations. Subsequent groups were also reached through previously interviewed groups to reach as many groups as possible within an area. However, this strategy was limited to eight groups within an area. In all, 216 community organizations including faith based organization, women groups, and youth groups were interviewed from 24 districts in western, central, northern and coastal Kenya. At an average of 25 members per group, these CBOs represented some 5,400 people.
2.6.1 ENDEMIC MALARIA DISTRICTS

Transmission of malaria in the endemic districts is common every year, and immunity is acquired by the community before adulthood. The risk of disease and mortality from malaria occurs mostly amongst children and pregnant women. These areas can show marked seasonality in transmission co-incidental with the rains, which occur in two main seasons: the Long Rains coming between March and June, and the Short Rains falling between October and December. The increased availability of breeding sites during the rainy periods inevitably results in an upsurge of malaria infections in the communities.

The districts that fall into this category of malaria-prone districts are as follows.

Table 2: Distribution of endemic malaria districts in Kenya

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts (number - code on Map 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coast</td>
<td>Kilifi (1), Kwale (2), Lamu (3), Mombasa (4), Taita Taveta (5), Malindi (6)</td>
</tr>
<tr>
<td>Nyanza</td>
<td>Homa Bay (16), Kisumu (23), Migori (19), Siaya (20), Bondo (21), Kuria (18), Nyando (22), Suba (17), Rachuonyo (24)</td>
</tr>
<tr>
<td>Western</td>
<td>Bungoma (32), Busia (33), Mount Elgon (31), Teso (30)</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>Baringo (25), Kajiado (28), Koibatek (26), Keiyo (27), Marakwet (29)</td>
</tr>
<tr>
<td>Central</td>
<td>Kirinyaga (9), Muranga (8), Maragua (7)</td>
</tr>
<tr>
<td>Eastern</td>
<td>Machakos (15), Makuenei (10), South Meru (13), Tharaka (14), North Meru (11), Mbeere (12)</td>
</tr>
</tbody>
</table>

Most malaria project activities, including prevention, treatment, and control have been implemented in the endemic malaria districts. These districts therefore have many Community Based Organizations, and have been included in this CNA study.
Fig. 6: Malaria endemic districts, Kenya

The study also covered district hospitals in the malaria prone districts, which are the referral facilities for malaria cases from the districts, and which often interact with community organizations during the application for GFATM for malaria. In order to bring medical services closer to the people, the Government of Kenya recently introduced a new policy on the services at community-based facilities.

Fig. 7: The Siaya District Hospital, Nyanza Province - a referral hospital for community groups in the Siaya District and other neighbouring districts
2.6.2 HIGHLAND MALARIA EPIDEMIC PRONE AREAS

Malaria in highland districts is characterized by a continuous potential for limited transmission, leading to an overall low disease risk in an average year. However, variations in rainfall such as an out of season upsurge of moisture and ambient temperatures between different years can lead to malaria epidemics affecting many members of the community. Low incidence in most years means that “immunity” among adults - common in malaria endemic areas - is absent. Therefore, these epidemics lead to high numbers of people succumbing to the disease, stretching the services in health facilities especially in the rural areas. These epidemics are relatively frequent, occurring every 3-5 years. The districts falling into this category are shown in the map below, and in Table 2.

![Map of Kenya showing highland malaria epidemic prone areas](image)

**Source:** Division of Malaria Control

**Fig. 8: Highland malaria districts**

The highland malaria epidemic prone areas lie mostly in the west of the country, and are clearly linked to the endemic malaria districts around L. Victoria.

**Table 3: Distribution of highland malaria epidemic prone areas in Kenya**

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts (number - code on Map 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nyanza</td>
<td>Kisii Central (45), Kisii North (47), Gucha (46)</td>
</tr>
<tr>
<td>Western</td>
<td>Kakamega (57), Vihiga (58), Lugari/Malava (55), Butere/Mumias (56)</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>Bomet (54), Kericho (48), Nandi (49), Trans Nzoia (50), Uasin Gishu (51), West Pokot (52), Trans Mara (53), Buret(69)</td>
</tr>
</tbody>
</table>

These districts have been included in the current CNA on Community Based Organizations.
2.6.3 ARID EPIDEMIC PRONE AREAS

In the arid areas, there is no breeding of malaria vectors during most of the year. However, large mosquito populations can occur around either man-made water bodies such as dams or wells, or perennial rivers. Consequently, the risk of a malaria infection is low in most areas, and locally acquired clinical disease is rare and the population does not develop immunity. However, unusual rainfall and flooding in these areas during the rainy seasons can lead to severe epidemic crisis conditions which although rare can lead to devastating levels of disease and death among the entire population.

The arid districts are as follows:

*Table 4. Arid epidemic prone areas in Kenya*

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts (number - code on Map 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coast</td>
<td>Tana River (34)</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>Samburu (44), Turkana (43)</td>
</tr>
<tr>
<td>Eastern</td>
<td>Isiolo (39), Marsabit (38), Moyale (37), Kitui (36), Mwingi (35)</td>
</tr>
<tr>
<td>North Eastern</td>
<td>Garissa (42), Mandera (40), Wajir (41)</td>
</tr>
</tbody>
</table>

The following map shows the districts that fall under the arid epidemic prone areas in Kenya.
Representative districts were selected from among these districts for the CNA assessment.

### 2.7 DATA ANALYSIS

Most of the questionnaires were open ended, requiring opinions and views of the respondents on implementation and programming of GFATM-supported malaria projects. In order to set the responses for analysis, the answers were transcribed, grouped and coded depending on the topic. The data was analyzed using SPSS. Most of the responses came from direct face to face interviews and key informant interviews.

### 2.8 SUMMARY

In this chapter, the methodologies for this study were presented. The choice was made for assessment of proposals submitted for GFATM grants, collection of data through Key Informant Interviews, targeted questionnaire interviews focusing on key respondents, and perusal of the internet for reports. Data analysis was conducted through SPSS.
CHAPTER 3
PROFILE OF COMMUNITY BASED ORGANIZATIONS IN KENYA AND THEIR ROLE IN MALARIA CONTROL

3.1 INTRODUCTION

Community-Based Organizations are described as civil society non-profit groups that operate within a single local community to tackle issues that are pertinent to that community. Often however, such activities cross the border of communities, and in Kenya, it is not unusual to have CBOs that function right across two or more districts. Like other nonprofits, community organizations are often run on a voluntary basis and are self funding.

Within community organizations, there are many variations in terms of size and organizational structure, or the level of knowledge and skills in running their projects. Some CBOs are formally incorporated, with a written constitution and a board of directors (also known as a committee), while others are much smaller and are more informal. However, all CBOs in Kenya that aim to receive recognition or support from the government or other funding agencies are required to be registered with the Ministry of Social Services, a straightforward process that can be carried out at the local government offices within the district where the CBO operates. They are required to have a management committee consisting of a Chairman, a Secretary, a Treasurer, and two committee members. They should also have a bank account for depositing their project funds.

3.2 TYPES OF COMMUNITY BASED ORGANIZATIONS IN KENYA

There are many types of community organizations in Kenya. Broadly, they may be divided into welfare groups, whose interest is to improve the standard of living of their members, and Income Generation Activity (IGA) groups whose main agenda is to engage in some form of economic enterprise for the purpose of wealth creation for their members. A large number of both urban and rural groups are engaged in enterprise activity – from basket weaving, pottery, beads and ornament making and wood carving to more skilled commodity trading, micro enterprising and financial management. The other major group, which was the subject of this assessment, consists of CBOs that have been set up to implement programs in health, agriculture, environmental conservation at community level.

Each one of these types of CBOs has the single purpose to improve the status of their members and the members of their communities. For this reason, they are best suited to implement programs - health or non-health - that are targeted at the population as its ultimate consumer or participant. By their very nature and definition, CBOs conduct their programs in the vicinity of their site of registration and residence. Therefore, they know their environment intimately and thoroughly, and are aware of their aspirations, hopes and potentials. In order to perform well, all they need is capacity strengthening and support.

In this survey, the focus of the organizations interviewed was mainly health related, (96.8% of the organizations). However, 1.4% of the organizations were providing emergency services and the rest offered other services, as shown in Fig.11 below.
Community Based Organizations can be grouped according to the areas/themes of their operation as follows:

3.3 COMMUNITY SERVICE AND ACTION

The community service and action CBOs focus on improving the general physical characteristics of a community. They implement programs that improve the welfare and well-being of their members and other target groups. Although particular programs may be quite specific, these organizations tend to view their programs not merely as ends in themselves, but rather within a broader community perspective. Due to a broad nature of community development, the CBOs categorized here differ from other problem-oriented CBOs in being more multipurpose. They will tackle any issue that brings change to all sectors of the society. Descriptive examples of Community Service and Action CBOs are Civic Service Groups, Community Development Groups, Neighborhood-Improvement Groups, and Community Protection Groups.

3.4 HEALTH

Health CBOs focus on preserving and enhancing the physical and/or mental health of a community including treatment of health problems, aftercare, and rehabilitation. Descriptive examples of Health CBOs are Health Education, Hospitals/Health Treatment Facilities, Crisis and Suicide Hotlines, Nursing Homes, Public Health Support Services, Rehabilitative Medical Services, Emergency Assistance, Hospices, Residential/Custodial Care, Community Health Care, Drug and Alcohol Abuse Treatment and Prevention Groups, Groups for People Living with HIV/AIDS, Groups to Support TB Patients, or Groups to prevent malaria.
3.5 EDUCATIONAL

The primary goal of educational CBOs is the education or the increased learning and knowledge within their communities. These groups are either directly involved in or contribute to the educational process. Descriptive examples are School-Based Educational Programs, School-Related Tutoring Programs, Community-Serving School-Based Groups, General Adult Education, Workplace-Related Programs, Adult Continuing Education, Literacy Educational Services, Preschool and Nursery Programs, Schools for the Physically Challenged, Schools for the Blind, or Schools for the Mentally Challenged.

3.6 PERSONAL-GROWTH, SELF-DEVELOPMENT, SELF-IMPROVEMENT

Personal-Growth CBOs aim primarily to build character, personality, and skills in individuals primarily through self-help and experiential learning as opposed to formal education. Descriptive examples: Youth Development Programs, Adult Development Programs, Future Farmers, Adult/Child Matching Programs, Boys/Girls Clubs, Youth Peer Groups, Scouting Organizations, YMCA/YWCA and Behaviour Change Groups.

3.7 SOCIAL WELFARE

Social Welfare CBOs are oriented primarily towards providing for and improving the general welfare of some community groups facing serious social problems. Their focus and the prime legitimation of their activity is not the community as a whole, but rather services to particular categories of persons seen as having special needs, problems, or requirements. Descriptive examples are Marriage and Family Problems Groups, Friendship/Relations Groups, Crime and Delinquency, Employment Assistance (e.g. Job Development/Training), Vocational Rehabilitation, Volunteer Recruitment, Screening Referral and Advocacy Groups, Consulting and Technical Assistance Groups, Homeless Shelters/Temporary Housing, Housing Support Services, Women’s and Children’s Shelters, Children/Youth Support Services, Widow Support Groups, or Orphan Support Groups, Street Family Support Groups.

3.8 SELF-HELP DISADVANTAGED AND MINORITY

The focus of self-help disadvantaged and minority CBOs is the improvement of the situation of the poor, women, or other such traditionally disadvantaged groups. These CBOs are generally oriented towards improving the quality of common welfare and quality of life of their target populations through changing society’s perceptions and treatment of disadvantaged people. Descriptive examples of these groups are: Senior Citizens Programs, Programs for Persons with Physical and Cognitive Disabilities, or Groups to Support Minority Initiatives.

3.9 COMMUNITY BASED ORGANIZATIONS AND MALARIA CONTROL

Community organizations work within the context of the national malaria control strategy, and towards making Kenya malaria-free. In order to tackle the ever mounting problem of morbidity and mortality due to malaria among Kenyan communities, the Government of Kenya through the National Health Sector Strategic Plan (NHSSP), has made malaria a high priority disease for prevention and treatment. Furthermore, the government has developed the National Malaria Strategy (NMS) to be implemented over 10 years. The main objective of the strategy is to reduce the prevalence of
malaria (morbidity and mortality) in Kenya by 30% by the year 2006, and to sustain that improved level of control up to 2010. The National Malaria Strategy contributes directly to the MDG 3 and 5, which aim at reducing child mortality and maternal mortality, respectively, and indirectly to MDG 1 on poverty reduction. The National Malaria Strategy addresses the control of malaria in Kenya through four strategic approaches:

- Guarantee that all people have access to quick and effective treatment
- Provision of malaria prevention measures and treatment for pregnant women
- Ensure the use of ITBNs by at-risk communities
- Improve epidemic preparedness and response in epidemic-prone areas

The Malaria Communication Strategy (MOH, 2006) stresses the importance of communication as a tool for implementation of malaria programs. It also describes the functions of CBOs within malaria control. Therefore, the CBO groups work in a well structured policy scenario in Kenya.

### 3.10 AREAS OF ACTIVITY IN MALARIA CONTROL

The majority (about 90%) of the 201 organizations that answered this question indicated advocacy and community mobilization as their area of malaria control activity.

#### Table 5: Areas of activity in malaria control

<table>
<thead>
<tr>
<th>Category label</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy and community mobilization</td>
<td>90.5</td>
</tr>
<tr>
<td>Training and capacity building</td>
<td>58.7</td>
</tr>
<tr>
<td>ITN/LLIN distribution</td>
<td>52.2</td>
</tr>
<tr>
<td>Treatment/case management</td>
<td>51.7</td>
</tr>
<tr>
<td>Vector control</td>
<td>41.8</td>
</tr>
<tr>
<td>Indoor residual spraying</td>
<td>27.4</td>
</tr>
<tr>
<td>System strengthening</td>
<td>13.4</td>
</tr>
<tr>
<td>Procurement of commodities</td>
<td>6.5</td>
</tr>
<tr>
<td>Logistic management</td>
<td>5.5</td>
</tr>
<tr>
<td>Others</td>
<td>0.5</td>
</tr>
</tbody>
</table>

### 3.11 MALARIA PROGRAMMING BY CBOS

The answers of the various CBOs concerning their malaria programming indicated that in most cases, their malaria activities are placed outside their own organization and therefore beyond their control.

#### Table 6: Explanation on the best structure of the CBO malaria activities

<table>
<thead>
<tr>
<th>Area of programming</th>
<th>No. of cases</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization has program in Malaria</td>
<td>70</td>
<td>33.5</td>
</tr>
<tr>
<td>Organization has more than one malaria program</td>
<td>30</td>
<td>14.4</td>
</tr>
<tr>
<td>Organization has only one malaria project</td>
<td>25</td>
<td>12.0</td>
</tr>
<tr>
<td>Malaria project based in partner organization</td>
<td>79</td>
<td>37.8</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>
Of the 209 organizations who responded to the question on malaria programming, 37.8% said their malaria projects are based in a partner organization, they only implement some activities. 33.5% said that they have an own malaria program. Only 14.4% of the organizations said that they had more than one malaria program run by their organization.

### 3.12 COVERAGE OF CBO MALARIA PROGRAMS AT COUNTRY LEVEL

As depicted in Fig. 12 below, 98% of the organizations working on malaria operate their malaria projects in only one or more, but not more than 6 districts. Only a paltry 2% operates in between 7 – 20 districts.

![Fig. 12: Districts Coverage of CBO malaria programs](image)

### 3.13 LOCAL TARGET POPULATION OF CBO MALARIA PROGRAMS

Almost half (48.8%) of the organizations who participated in the study has a target population of less than 10,000 people, 44% have a target population of between 10,001 and 100,000. Another 5.7% have a target population of between 100,001 and 1 Million but only 1% said they have a target population of more than 10 Million people.
3.14 SIZE OF POPULATION ACTUALLY COVERED

Most CBOs expressed inability to cover their intended project areas. Out of the 210 organizations that responded to this question, only 1.4% of the organizations had been able to cover over 75% of their planned target population with their malaria activities.

Table 7: Percentage of population covered by the organizations’ malaria activities

<table>
<thead>
<tr>
<th>Percentage of planned population covered with malaria activities</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25%</td>
<td>66</td>
<td>32.4</td>
</tr>
<tr>
<td>25 - 50 %</td>
<td>109</td>
<td>51.9</td>
</tr>
<tr>
<td>51 - 75 %</td>
<td>30</td>
<td>14.3</td>
</tr>
<tr>
<td>Above 75 %</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td>100</td>
</tr>
</tbody>
</table>

3.15 SELF-ASSESSMENT ON LEVEL OF ACHIEVEMENT OF CBOS ON THEIR MALARIA ACTIVITIES

The organizations were asked to assess themselves on the achievements after the implementation of their malaria programs. As shown in Figure 14, 48.1% of the organizations studied had only been able to achieve between 25% and 50% of their planned activities, 32.7% of the organizations had been able to achieve less than 25% of the planned activities while 18.3% had achieved between 51% and 75% of their planned activities.
Fig. 14: Level of achievement of target activities by CBOs

Only 1% of the organizations had been able to achieve over 75% of their planned activities for their malaria programs/projects. This depicts an average achievement of the malaria control goal in the areas of operation.

### 3.16 AREAS OF CBO SUCCESS IN IMPLEMENTING MALARIA PROGRAMS

29% of the organizations said that their success has been the timely completion of their program activities.

<table>
<thead>
<tr>
<th>Category label</th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely completion of program activities</td>
<td>81</td>
<td>29.0</td>
</tr>
<tr>
<td>Satisfaction with project expressed by beneficiaries</td>
<td>72</td>
<td>25.8</td>
</tr>
<tr>
<td>Clear communication channels formed with</td>
<td>49</td>
<td>17.6</td>
</tr>
<tr>
<td>Funds used prudently and reported efficiently</td>
<td>59</td>
<td>21.1</td>
</tr>
<tr>
<td>Impact of implementation demonstrated</td>
<td>16</td>
<td>5.7</td>
</tr>
<tr>
<td>Timely reporting</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Total responses</td>
<td>279</td>
<td>100</td>
</tr>
</tbody>
</table>

Another 26% said their main success has been satisfaction with the project expressed by the beneficiaries. But only a paltry 0.7% said that their success was timely reporting, which shows that this is the major challenge faced by most of the organizations.
3.17 EXAMPLES OF DEMONSTRATED IMPACTS OF THE IMPLEMENTATION OF MALARIA PROJECTS

Table 9 shows some of the areas in which the community organizations felt the impact of their malaria programs at community level. Demonstrated impact is a significant achievement by the CBOs, as it would raise their status as viable institution among their membership and the community at large. It would also improve their chances of getting other funding for their programs.

Table 9: Demonstrated impacts of implementation, some examples named by the organizations

<table>
<thead>
<tr>
<th>Category label for impact</th>
<th>Number of CBOs with impact</th>
<th>Proportion of responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community awareness/ mobilization</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Medical care to community</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Bed net distribution/use ITN</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Community support and accepted the project</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Contribution overlooked by medical staff</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Clean environment</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total responses</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

30% of the organizations indicated that their impact was demonstrated through community awareness and mobilization, while 25% said that it was the availability and provision of medical care to the community and more people seeking the health services.

Some 20% of the respondents said that the impact was the distribution and use of ITNs in the community which resulted in reduced cases of malaria. 15% said the impact was support and acceptance of the projects by the community, that recognized the benefits of the malaria project.

3.18 CHALLENGES IN IMPLEMENTING MALARIA PROJECTS

Community organizations expressed a wide array of areas where they faced challenges during the application for project funds or during the implementation of their programs.

At organizational level, 94.2% of the organizations interviewed said that the challenges in the implementation were lack of funds. 71.5% of all the organizations responses indicated that the challenges in their implementation had been lack of equipment; 63.3% said the challenge was low level of staff training; 61.4% said that the challenge has been the lack of transport. But 44% of the responses indicated their challenge had been poor infrastructure.

The organizations said that the community has now recognized the benefits of the malaria project.
Table 10: Challenges in implementing malaria projects

<table>
<thead>
<tr>
<th>Category label</th>
<th>Number</th>
<th>Proportion of responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of funds</td>
<td>195</td>
<td>20.8</td>
</tr>
<tr>
<td>Lack of equipments</td>
<td>148</td>
<td>15.8</td>
</tr>
<tr>
<td>Low level of staff training</td>
<td>131</td>
<td>14.0</td>
</tr>
<tr>
<td>Lack of transport</td>
<td>127</td>
<td>13.5</td>
</tr>
<tr>
<td>Poor infrastructure</td>
<td>91</td>
<td>9.7</td>
</tr>
<tr>
<td>Lack of qualified staff</td>
<td>89</td>
<td>9.5</td>
</tr>
<tr>
<td>Lack of commodities</td>
<td>82</td>
<td>8.7</td>
</tr>
<tr>
<td>Delay in funds disbursement</td>
<td>27</td>
<td>2.9</td>
</tr>
<tr>
<td>Poor reporting and feedback</td>
<td>26</td>
<td>2.8</td>
</tr>
<tr>
<td>Unsatisfactory communication with key partners</td>
<td>20</td>
<td>2.1</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>Total responses</td>
<td>938</td>
<td>100</td>
</tr>
</tbody>
</table>

3.19 COMMUNITY ORGANIZATIONS’ KNOWLEDGE ABOUT THE GLOBAL FUND

3.19.1 COMMUNITY ORGANIZATIONS’ KNOWLEDGE ABOUT THE DISEASES SUPPORTED BY THE GLOBAL FUND

Most organizations (39.6%) indicated that the GFATM grants for mainly towards Malaria programs, followed by HIV/AIDS (35.2%) and TB (25.3%).

![Fig. 15: Proportion (%) of CBOs expressing knowledge of areas supported by the Global Fund](image)

3.19.2 KNOWLEDGE ON INSTITUTIONS THAT CAN APPLY FOR GFATM FUNDS

The CBOs knew fairly well about who can apply for Global Fund grants, with close to 40% of the organizations aware that they could apply for GFATM funds, if they had a chance. However, the least number of CBOs were aware that the private sector (PSOs) can apply for GFATM funds for malaria.
Fig. 16 below presents the CBOs knowledge on who can apply for GFATM grants for malaria.

![Bar chart showing proportions of knowledge on who can apply for Global Fund grants](image)

**Fig. 16: CBOs’ knowledge on who can apply for Global Fund grants**

It was also notable that the CBOs were aware that the Ministry of Health could apply for the funds.

### 3.20 SUMMARY

This Chapter reviewed the status of Kenyan CBOs, and placed them among health and community welfare organizations. Their contribution to and impact on community benefits in malaria control was also explained.
CHAPTER 4
RESOURCE BASE OF Community Based Organizations

4.1 INTRODUCTION

The current application process for Global Fund grants in Kenya requires that the applicant organization indicates its resources, and how much of them will presumably be used in the implementation of the project. The application also requires the applicant to show the experience and capability of the organization to handle financial resources. This chapter presents the result of the survey on the resources of community organizations that have applied for Global Fund grants for malaria projects or that want to apply for these funds.

A significant feature in the survey was the poor resource base of the community organizations. This was the fact for the personnel implementing the program activities, as well as for the program equipment and the finances to be used in the operations of the programs.

4.2 HUMAN RESOURCES

The majority of the surveyed organizations relied on temporary staff to implement their programs. Figure 17 below shows the distribution of the temporary staffing and volunteers in the community organizations surveyed.

Fig. 17: Number of temporary staff and volunteers engaged in malaria programs

34.7% of organizations interviewed had between 7 and 20 of their staff and volunteers engaged in their malaria program; in 31.6% of the organizations, between 21 and 50 of the employees worked within the malaria program and in 23.8% between 1 and 6 staff members worked on malaria. Only 7 organization, i.e. 3.6%, had none of their staff and volunteers engaged in their malaria program; and 12 organizations (6.2%) had over 51 of their staff and volunteers engaged in their malaria program.
4.3 NUMBER OF LOCAL LONG TERM EMPLOYEES IMPLEMENTING MALARIA PROJECTS

The number of employees implementing activities among the surveyed organizations varied from 1 to 12 among the smaller CBOs to more than 51 from among the larger international NGOs. The survey showed that 59.3% of organizations interviewed had between 1 and 12 of their Long-Term employees implementing their malaria projects. 25.7% had between 13 and 24 of their employees while 10.7% had between 25 and 20 of their employees implementing their malaria projects. Only 4 Organization, 1.4% had 51 and over of their employees implementing their malaria projects.

\[ \text{Fig. 18: Number of local long term employees implementing malaria projects} \]

The majority of the CBOs relied on local volunteers for implementing their programs. The highest education of their volunteers was basic education (High School) and they also lacked further training in other areas.

4.4 NUMBER OF INTERNATIONAL LONG TERM EMPLOYEES IMPLEMENTING MALARIA PROJECTS

International employees represented only a small part in CBO programming. The survey showed that 89.9% of the organizations interviewed had no long term international employee implementing their malaria projects. 7.7% had between 1 and 12 of their employees implementing their malaria projects while in 1.2% there were between 13 and 24 employees working on malaria projects classifiable as international long term.

Only one organization (0.6%) had between 21 and 51 and one (0.6%) had over 51 employees implementing their malaria projects.
Although most of the personnel lacked expertise in project implementation, some of the CBOs had qualified staff, particularly organizations that were familiar with project implementation.

### 4.5 FINANCIAL RESOURCES

Community organizations are in dire need of financial support to be able to carry out their programs. At the moment, CBOs rely almost entirely on voluntary contributions from members and well-wishers. The few lucky ones receive some financial support from benefactors, but even here there is very little leverage for independent and planned expenditure from the organizations themselves. The results show that the CBOs lack funding for all the planned programs.

A small proportion of the CBOs received external funding for their programs (Table 11). As shown in the table below, the major source of funding for malaria projects for most of the organizations interviewed was through their own members and volunteers.

#### Table 11: Sources of funding for malaria

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Global Fund to fight AIDS, TB and Malaria</td>
<td>5.5</td>
</tr>
<tr>
<td>Presidential Malaria Initiative</td>
<td>0.9</td>
</tr>
<tr>
<td>Roll Back Malaria</td>
<td>0.9</td>
</tr>
<tr>
<td>Bill and Melinda Gates Foundation</td>
<td>3.2</td>
</tr>
<tr>
<td>Through partnership with NGOS/FBOs/CBOs</td>
<td>29.9</td>
</tr>
<tr>
<td>Through CBO/FBO/NGO members and volunteers</td>
<td>47.0</td>
</tr>
<tr>
<td>None</td>
<td>12.3</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
Over 47% of the respondents said that their major source of funding were their own members and volunteers, 29.2% get their funding through partnership with other NGOs, FBOs and CBOs. Only a 5.5% of the respondents said they had received funds from the GFATM.

4.6 ANNUAL FINANCIAL BUDGET FOR CBO MALARIA PROJECTS

The CBOs function and carry out their projects through small shoe string budgets. Over 87.6% of the organizations had a budget of less than KES 1 Million (c. Euros 10,000), 9% of the organizations were spending between KES 1 – 5 million (c. Euros 10,000 – 50,000), and only 1.7% had a budget of 5 – 10 million (c. Euros 50,000 – 100,000) and over KES 10 million (>Euros 100,000), respectively (See Fig. 20).

Fig. 20: Current annual financial budget for your malaria Project

Most of the organizations relied mostly on malaria budgets for funds. 37.5% of the organizations interviewed said that their current annual financing budget for malaria constitutes 25 to 50% of their annual budget. 25% of the organizations said the budget constitutes less that 25% of their annual budget while 14.8% said it constitutes 100% of their annual budget.

Fig. 21: Annual budget proportions spent on malaria programming

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4.7 MANAGEMENT OF FINANCIAL RESOURCES

Most organizations have people other than an accountant managing their project funds. Some 38.3% of the organizations interviewed had no accountant managing their funds, and other staff managed the finances - 28.2% had a non financial employee managing their funds. However, 22.3% had a part time accountant managing their funds. A large proportion of the CBOs (39%) had no financial management system.

Fig. 22: Persons responsible for managing project funds

Only 11.2% had a full time accountant managing their projects funds.

4.8 FINANCIAL REPORTING

Most organizations have people other than an accountant preparing their financial returns and reports (Fig. 23). Almost a similar figure as above, 38.8% of the organizations we interviewed had no accountant preparing their financial returns and reports. Another 23.5% had a non financial employee preparing their financial returns and reports.

Fig. 23: Responsible persons for financial reporting by CBOs
However, 26.2% had a part time accountant preparing their financial returns and reports. Again here only 11.5% had a full time accountant preparing financial returns and reports.

4.9 MATERIAL RESOURCES

Community organizations were found to lack the basic equipment that would be required for project implementation. Some basic equipment including computers, printers, photocopiers, or scanning machines that would be used for production and reproduction of materials for advocacy, community mobilization or training were not available in some of the organizations. Other equipment found to be lacking were vehicles for transport, or basic equipment for transportation such as motorcycles or bicycles.

Computers appear to be the most valuable item for a relatively large number of the CBOs. Therefore, surprisingly, 50% of the CBOs had at least 2 computers, and most of these computers were relatively new, less than 5 years old; 38.9% of the organizations interviewed had at least 1 computer each, 60% of which were 1 year old. The better endowed international NGOs had more than 20 computers.

4.10 SUMMARY

In this chapter, the focus was placed on the assessment of the resource base of community organizations. The human, material and financial base of the organizations was evaluated, and the results presented for each category. An essential resource base was mostly lacking, and most CBOs struggle to build the basic resources required to apply for funding and implement their programs. Key elements in qualification were lacking including qualification and skills in resource or project management.
CHAPTER 5
CAPACITY OF COMMUNITY BASED ORGANIZATIONS TO CARRY OUT MALARIA PROGRAMS

5.1 INTRODUCTION

Civil Society Organizations have been most affected by the slow pace of disbursement of Global Fund grants in Kenya, and opportunities have been missed that could have provided the much needed resources for malaria control.

Years passed without Kenya participating in GFATM grant awards have meant missed chances for advocacy and community mobilization, capacity strengthening for the personnel and their organizations and a missed chance to contribute to the control of a disease that probably causes morbidity and mortality at a level higher than any other in the tropics. It is therefore important to assess the capacity of Community Based Organizations to carry out malaria programs. Those organizations that have received GFATM grants have to be identified and their ability to implement malaria programs and their experiences have to be examined. And finally the organizations that have not received such funds have to be analyzed regarding their capacity and their expectations from the GFATM and observations on malaria programs.

5.2 PROBLEM AREAS FOR GLOBAL FUND APPLICATIONS BY COMMUNITY ORGANIZATIONS

Community Based Organizations indicated specific areas where they felt they had gaps. These covered both programmatic and financial management areas. The CBOs indicated various areas where they lacked skills as shown in Table 12 below.

<table>
<thead>
<tr>
<th>Category label</th>
<th>Proportion (%) of responses</th>
<th>Proportion (%) of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in proposal writing</td>
<td>16.8</td>
<td>90.0</td>
</tr>
<tr>
<td>Training in application processes</td>
<td>15.8</td>
<td>84.8</td>
</tr>
<tr>
<td>Training in financial management</td>
<td>13.9</td>
<td>74.3</td>
</tr>
<tr>
<td>Training in writing project reports</td>
<td>13.6</td>
<td>72.9</td>
</tr>
<tr>
<td>Training in malaria control</td>
<td>13.4</td>
<td>71.9</td>
</tr>
<tr>
<td>Training in monitoring and evaluation</td>
<td>13.2</td>
<td>70.5</td>
</tr>
<tr>
<td>Provided with personnel</td>
<td>6.7</td>
<td>35.7</td>
</tr>
<tr>
<td>Provided with equipment</td>
<td>6.6</td>
<td>35.2</td>
</tr>
</tbody>
</table>

Training was the major area of concern for the CBOs, and more than 86% of the organizations noted one area of training or the other as an area of need.
5.2.1 PROPOSAL DEVELOPMENT

Proposal development is a problem area for most CBOs. Since this is the very first step in applying for funding, it basically means that CBOs have a difficult start every time they apply for funds if they do meet the requirements for the Global Fund.

Fig. 24: CBO capacity in proposal development

A previous assessment of CBO proposals has shown that CBOs often miss such things as project title when preparing proposals. Without a title, a reviewer faces a difficult time structuring the purpose and site for implementation of the project, thus making it difficult to identify the basis and areas (physical and thematic) for the project implementation. Other structural problems found in CSO proposals the lack of any form of introduction and background on malaria. Those that have an introduction are not strong enough to bring out the current factors relevant to the targeted and planned field programs. The previous assessment showed that about 46% of the proposals lacked an introductory paragraph to give a brief account on the current status on the planned activities (Odindo, 2008).

A major problem area for CBO proposals is the determination of objectives to guide the project implementation. The better proposals from the larger CSOs are usually well written and have clear objectives supported by clear service delivery areas to strengthen and support implementation. However, the CBOs, societies and smaller NGOs do not have clear objectives supported by targets on implementation and outputs. The objectives in the majority of the proposals are usually poorly described and not useful to monitor program activities or evaluate the direction of project progress towards attaining project objectives.

None of the proposals reviewed had SMART objectives to assist evaluate the implementation of the project. Objectives are considered to be SMART if they are Specific, Measurable, Achievable, Realistic and Time-bound. Some of the proposals had long and un-implementable objectives (one had 13 objectives) - an obvious indicator for a program that is not clearly planned and written. The description of the activities was a further problem. Where large CSOs had clear planned activities, as well as strategies for the planned activities in their malaria proposals, the CBO and society proposals did not include any activities or implementation plans. Program activities give direction to the tasks to be undertaken. About 25% of the CSOs did not clearly state their intended activities in their proposals. It is difficult to achieve any outputs and objectives without planned activities. A well-written proposal should also have a monitoring and evaluation plan, which those from the smaller organizations did not have.
Proposals also need to show an expected plan for the project implementation. In spite of the requirement for the GFATM applicants to submit proposals with targets and a table of indicators to support the component strategy section and to refer explicitly to the programmatic needs and gap analysis, most proposals lacked any expected outcomes. Proposals also need a vision on the expected outputs - the immediate results from the activities and outcomes of the project – the longer-term effects of project activities, or what the project would lead to after its implementation. In a proposal, the section on the Expected Impact provides an opportunity for the applicant to indicate the global common benefit to the community as a result of the implementation of the project. It provides an opportunity for judgment whether the project programming is visionary. This section had the worst performance index, only 11.6% of the proposals had an “Expected Impact” section.

The section of Project Sustainability in a proposal shows that the benefits will have a long term impact even when the project is already finished. Applicants need to build this section into their proposals – even if it is only to show that they are aware that the resources from this grant will dry up and the project needs to continue in the period to come.

The GFATM proposes a Performance Based Funding. The critical point here is that the funding request should be tied to an activity. This should be reflected in the budget to show - even in a broad outline - how the funds will be driving the project towards attaining project objectives. As in other areas, the budgets in the proposals of the large organizations were well structured, but the CBOs had poorly structured budgets, making them difficult to support. In one case, the objectives targeted for support were repeated for all the 5 years, as was the level of funds requested.

However, in many of the proposals, there was no linkage between the project budget level and the requested amounts. As a consequence, many requested funds were excessive and unrelated to the expected outputs. Even then, 69.2% of the proposals lacked any budget.

The study showed that out of the 26 proposals examined, only six had a score of 50% and above in terms of presence of all sections of a proposal (Title, Executive Summary, Introduction, Justification/Rationale, SMART Objectives, Expected outputs/Outcomes, Activities, Indicators, Strategies, Work Plan, Monitoring and Evaluation, Expected Impact, Sustainability, Budget).

5.2.2 BUDGET DEVELOPMENT

Only a small proportion of CBOs reviewed in this study indicated high proficiency in budget development in applying for Global Fund grants (Table 13).

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>11.2</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>33.7</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>35.7</td>
</tr>
<tr>
<td>None</td>
<td>19.4</td>
</tr>
</tbody>
</table>

The requirements for budget development are best developed in MS Excel, especially where there is a gradient of annual increase as in salaries (appreciation) or decrease as in value of equipment (depreciation).
Further, GFATM budgeting requires a detailed budget for the first year of planned project implementation, a less detailed budget for Years 2 and 3, and only major areas of expenditure for Year 4 and 5. Although this sounds simple in theory, in practice, many organizations find preparing this budget a major hardship. It was therefore not surprising to find that many of the interviewed organizations expressed the need for training in budget development. These are areas that, without proper and detailed training at least for a cohort of implementers within an organization, there would be major constraints.

5.2.3 WORK PLAN DEVELOPMENT

Work plan development was a moderately covered area, and most organizations indicated their ability to develop a work plan (Table 14).

Table 14: Organizations’ knowledge and ability to apply for GFATM funds in the area of work plan development

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>20.8</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>40.6</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>37.2</td>
</tr>
<tr>
<td>None</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Although the work plan is mandatory for GFATM proposals, it is generally one of the worst areas of performance in the proposals. Yet it is the work plan that gives a time frame and indication on when the outputs can be expected – a milestone and target on the project performance. It would be difficult to determine at what stage activities are being implemented, and which outputs are progressively being attained.

5.2.4 COMMUNITY ENTRY PROCESS PRIOR TO THE PROJECT IMPLEMENTATION

Community organizations do not have problems with community entry process. This is to be expected, since most of them are formed by resident groups trying to uplift the standard of living of their own people (Table 15).

Table 15: Organizations’ knowledge and ability to apply for GFATM funds in the area of Community entry process prior to project implementation

<table>
<thead>
<tr>
<th>Organizations’ knowledge and ability to apply for GFATM funds</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>80</td>
<td>38.1</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>83</td>
<td>39.5</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>40</td>
<td>19.0</td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td>100</td>
</tr>
</tbody>
</table>

In this study, only 3.3% of the respondents indicated lack of ability to carry out community entry process.
5.2.5 COMMUNITY MOBILIZATION

Similar to the community entry process, community mobilization was an area that most organizations felt comfortable in, and 90% of the community groups were confident that they had sufficient skills to carry out community mobilization (Figure 25).

![Fig. 25: Proportion of CBOs with the capability to carry out community mobilization](image)

5.2.6 INVOLVEMENT OF COMMUNITIES IN PROJECT PLANNING

The majority of interviewed organizations indicated that they do not involve their communities in project planning. This is partially due to the fact that many CBOs are given duties by larger organizations or government agencies such as the National AIDS Control Council to carry out specific duties.

More than 80% of the organizations indicated that they involve their communities in planning their community programs (Figure 26).

![Fig. 26: Involvement of communities in project planning by CBOs](image)
International Organizations also assign specific community duties such as community mobilization to women groups, youth groups and other restricted duties and responsibilities, where there is very little chance for interacting with their communities in planning any project responsibilities.

5.2.7 INVOLVEMENT OF COMMUNITIES IN PROJECT IMPLEMENTATION

The CBOs indicated that they involve communities in the implementation of their programs, following the joint planning sessions (Figure 27).

![Bar chart showing involvement of communities in project implementation by CBOs]

**Fig. 27: Involvement of communities in project implementation by CBOs**

Since the CBOs are embedded within their communities, they have the ideal starting position to conduct programs within the target areas and to conduct such activities as advocacy programs, mobilization of community groups for project implementation, distribution of nets, training of community groups to conduct mosquito vector control activities, and carry out sustainability programs that would support the future of malaria control activities in the communities.
5.2.8 INVOLVEMENT OF COMMUNITIES IN PROJECT APPRAISALS

Project appraisal is an area that most CBOs do not get involved in and where they therefore have limited skills. Involvement of communities in the appraisal of projects under implementation by community groups presupposes that the groups themselves can conduct appraisals.

Fig. 28: Involvement of communities in project appraisal by CBOs

This was found not to be the case, and therefore little contact takes place between CBOs and the communities that they have been serving. As indicated in Fig. 28, more than 45% of the respondents were not involving communities in project appraisal or review.

5.2.9 PRIORITIZING MALARIA INTERVENTION ACTIVITIES

Community organizations often lack skills concerning priority setting. Most of them indicated that they do not have the capacity to set intervention priorities, mostly due to the fact that intervention areas are usually set elsewhere, mainly by the organizations that they cooperate with.

Fig. 29: Capacity of CBO to prioritize intervention activities
5.2.10 FOLLOWING LAID-DOWN WORK PLAN

The community groups indicated that they have skills in following their laid-down work plans.

Fig. 30: Organizations knowledge and ability to apply for GFATM funds in the area of following laid-down work plans

The work plan, although required and mandatory for GFATM proposals, was one of the worst areas of performance for CBOs, and was generally missing in the CSO proposals. Yet it is the work plan that gives a timeframe and indication on when the outputs can be expected – a milestone and target on the project performance. Without a work plan, it is difficult to determine when activities are being implemented, and which outputs are progressively being achieved.

5.2.11 IMPLEMENTATION OF PROJECT ACTIVITIES

Most organizations indicated their ability to implement their project activities – with more than 70% of the organizations indicating that they have the ability to implement all their program activities at moderate or high level (Figure 31). This was to be expected, since most CBOs usually are involved in community mobilization and advocacy programs, and net distribution. Of course, single aspects of implementation such as data and record keeping, monitoring and evaluation represent challenges, as indicated below.

Fig. 31: Organizations’ knowledge and ability to implement their activities
Although the larger organizations have clear and well-articulated strategies and implementation plans, the CBOs and smaller CSOs do not indicate how they will implement their activities and lacked any plan of action. Without a strategy it would be difficult for implementers and GFATM to determine the course of action of the proposed project.

5.2.12 SELECTING INDICATORS FOR MONITORING AND EVALUATION

Indicator selection and utilization is a problematic area for most organizations—even major groups, as shown in the results below (Table 16).

Table 16: Organizations’ knowledge and ability to apply for GFATM funds in the area of selecting indicators for monitoring and evaluation

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>16.7</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>26.5</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>41.7</td>
</tr>
<tr>
<td>None</td>
<td>15.2</td>
</tr>
</tbody>
</table>

Indicators are either qualitative - to measure the dynamic sustainability, which involves people’s adaptability to a changing environment, their behaviors and attitudes post implementation of the malaria project, or quantitative - to measure the efficiency of carrying out the project. Indicators are important tools particularly for assessing project progress and determining any achievements. For this reason, indicators are required to be

- Factual
- Measurable
- Valid (based on project factors not external factors),
- Based on obtainable data,
- Have a standard (a minimum level/range of performance considered on expert opinion, past performance or established norms),
- Ethical (in terms of the right of every individual to confidentiality, freedom of choice, informed consent),
- Independent (measuring only one factor)
- Understandable (simple and unambiguous, easy to interpret in terms of project status.)
- Reliable (same value would result if measurements were repeated), understandable and accessible in terms of data required to generate results and access)

These are skills that community organizations basically lack. In a previous review of CSO proposals it was actually found that indicators are usually overlooked by CSOs while they are preparing proposals for Global Funds. The CSO proposals therefore lacked qualitative or quantitative indicators to guide the implementation and evaluation of the projects. In the data shown above, about 57% had either low or no capacity to use indicators. It is therefore difficult for the Global Fund to assess and evaluate projects and to determine if outcomes of the project are being achieved and if they are, at what level.
5.2.13 MONITORING PROJECT ACTIVITIES

Monitoring basically means keeping up-to-date records on project progress. It also means comparing the programs conducted so far and the results obtained with the planned activities and expected results and indicators. In monitoring project activities, it is presupposed that good records have been kept at various stages of implementation, and that a good analysis has been made and proper reports have been regularly prepared. In this survey, close to 45% of the organizations expressed low or no ability to monitor their programs, as shown in Table 17 below.

Table 17: Organizations’ knowledge and ability to apply for GFATM grants in the area of monitoring project activities

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>25.6</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>29.6</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>41.1</td>
</tr>
<tr>
<td>None</td>
<td>3.4</td>
</tr>
</tbody>
</table>

5.2.14 THE CAPACITY OF COMMUNITY ORGANIZATION TO IMPLEMENT PROGRAMMATIC AND FINANCIAL ACTIVITIES

The CBOs ability to carry out programmatic and financial obligations as required for Global Fund grants is low, as expressed by the number of organizations that indicated their ability in program implementation. The CBOs were asked to indicate the capacity of their organization to carry out the certain activities with regard to the GFATM by rating them whether their capacity was high, moderate or low, the COSs gave varied responses depending on how they rated the strength of their organizations in various areas. In most of the areas, they rated the capacities of their organizations as high.

5.2.15 EVALUATION OF PROJECT ACTIVITIES

The evaluation of projects was indicated to be a problem area for CBOs. Close to 50% of the organizations had either low or no capacity to evaluate their progress (Figure 32).

![Percent of CBOs](image)

Fig. 32: Organizations’ knowledge and ability to evaluate their project progress
Without either monitoring indicators to show evidence of whether project activities run as scheduled (process and output indicators), nor evaluation indicators to show whether project objectives have been achieved (results and impact indicators), it is hard to implement an M&E strategy.

5.2.16 PROGRAMMATIC REPORTING

Reporting skills are key for project success and have been a major stumbling block in the poor performance of Global Fund supported projects in Kenya. In the past, long delays in submitting the final reports have in turn delayed the disbursement of Global Fund grants for various Rounds of the GFATM, especially for HIV/AIDS and malaria projects. In the current survey, community organizations expressed lack of expertise in programmatic reporting (Table 18).

Table 18: Organizations’ knowledge and ability in programmatic reporting

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>19.6</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>34.7</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>34.7</td>
</tr>
<tr>
<td>None</td>
<td>11.1</td>
</tr>
</tbody>
</table>

5.2.17 FINANCIAL MANAGEMENT AND REPORTING

Financial management and reporting are two crucial areas of project management. Many community based programs in Kenya fail due to a lack of transparency and accountability in the use of project funds, or a lack of proper records on how the funds were used.

In most cases, the funds were used well, but due to poor record keeping, it is often difficult to trace back the expenditures. This lack of skills in financial management and reporting was reflected in the results from the survey, as shown in Table 19 below. More than 53% of the respondents had either low or no ability in financial reporting to apply for GFATM grants.

Table 19: Organizations’ knowledge and ability to apply for GFATM funds in the area of financial reporting

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>20.7</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>26.1</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>45.3</td>
</tr>
<tr>
<td>None</td>
<td>7.9</td>
</tr>
</tbody>
</table>

5.2.18 VERIFICATION OF DATA QUALITY

The success of a program is as good as the data (and therefore information) that is finally accrued for the implementation of the project. Data verification is a quality assessment process that puts added value towards the results from the field implementation of a program.
Fig. 33: Organizations’ knowledge and ability to apply for GFATM funds in the area of verification of data quality

More than 57% of the organizations had either low or no capacity to verify data quality.

5.2.19 COMPLIANCE WITH SPECIFIC DONOR REQUIREMENTS AND REPORTING FORMATS FOR GFATM

Compliance with specific donor requirements, especially the reporting formats for the Global Fund, has always been a thorny issue for civil society organizations, and more so for the community organizations.

Fig. 34: Organizations’ knowledge and ability to apply for GFATM in the area of compliance with specific donor requirements, reporting formats for GFATM

About 60% of the organizations had low or no ability to comply with GFATM requirements when they apply for Global Funds (Figure 34).

5.2.20 USE OF INFORMATION COMMUNICATION TECHNOLOGIES (ICTS) IN MALARIA PROGRAMMING

Information technologies and their use in the health sector is a generally new area of programming, but one that is likely to grow immensely over the next few years, especially with the arrival of fiber optics in Kenya.
Fig. 35: Organizations’ knowledge and ability to apply for GFATM funds in the area of use of information communication technologies (ICTs) in malaria programming

Information and Communication Technologies are greatly appropriate for community mobilization and advocacy against malaria at community level.

A study on the use of ICTs for the mitigation of HIV/AIDS that covered Kenya, Uganda, Tanzania, Botswana and South Africa (Nyamai, Odindo, Adhiambo and Okello, 2007) showed that various ICTs were quite suitable for community organizations to implement their programs. Conventional ICTs (radio, telephone, TV) were the most widely used, followed by traditional methods (song, dance, theatre, drama, puppetry), and the least used were the modern ICTs (internet, CD ROM, SMS, mobile phone) for all the various types of HIV/AIDS interventions. They were used mainly for prevention, followed by care and mitigation, then treatment and diagnosis. Of the conventional ICTs, print media (84%) was most widely used by respondent organizations for prevention, followed by care and mitigation (48%). Drama was highly used (75%) to communicate prevention messages.

Most of the modern ICTs were used for prevention and care/mitigation and less frequently for diagnosis and treatment. The main types of modern ICTs that were widely used by respondent organizations are computers (databases) (22%), the Internet (21%), short message service (SMS - 16%), and compact discs (CD ROMs - 16%). Others are mobile telephones,(14%), and World Space technology (5%).

There were many excellent examples of how modern ICTs have been applied to strengthen HIV/AIDS programs that have been documented as case studies. These ranged from a telephone counseling service with Internet support to a combination of modern and traditional communication methods for prevention, to use of computer databases to increase ARV rollout, and SMS services to support home based acre and extend the reach of the few counselors available.

The traditional ICTs were rated as most effective (80% to 100%), followed by the conventional ones, (68% to 82%) and finally the modern ones (40% to 70%), for all the services that they were used for (prevention, treatment, care and support).

Malaria, like HIV/AIDS, has a strong community mobilization and advocacy component, whether for health seeking behaviour, use of protection methods such as LLITNs, or correct and client-targeted use of ACTs.
In this survey, only a small proportion of the CBOs interviewed were actually aware that ICTs could be used for malaria programming, and an even smaller proportion (about 11%) were using ICTs in their programs.

5.2.21 HOME MANAGEMENT OF MALARIA (HMM)

Home Management of Malaria (HMM) is a new area of programming for malaria in Kenya. Community organizations together with other civil society organizations are expected to support and contribute to Kenya’s commitment to scale up access to treatment services in order to reach universal coverage. This implies that Kenya is committed to ensuring that all persons suffering from malaria have prompt access to affordable and appropriate treatment within 24 hours of onset of symptoms. To achieve this target, the National Malaria Control Strategy recognizes the importance of scaling up Home-based Management of Malaria (HMM).

Table 20: Organizations’ knowledge and ability to apply for GFATM funds in the area of Home Management of Malaria

<table>
<thead>
<tr>
<th>Level of organizational knowledge</th>
<th>Percent of CBOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (More than 75% achievement)</td>
<td>24.9</td>
</tr>
<tr>
<td>Moderate (45% - 75%) achievement</td>
<td>41.6</td>
</tr>
<tr>
<td>Low (1% - 44%) achievement</td>
<td>15.8</td>
</tr>
<tr>
<td>None</td>
<td>17.7</td>
</tr>
</tbody>
</table>

Home Management of Malaria with ACTs has been piloted in various parts of the country with promising results. With sufficient targeted training, CBOs are in a relevant position to participate fully in rolling out and expanding the HMM strategy among both rural and urban communities in Kenya.

Under GFTM Round 9, HMM was introduced for participating organizations to participate in the government intent to build on experiences from the government’s pilots and scale up HMM in selected districts in Kenya, including Malindi District, Kwale District and a few other districts in Western Province. HMM is therefore to become an important aspect of the management of malaria in Kenya in the future, and one that offers opportunities for community organizations.

5.2.22 RESOURCE MOBILIZATION FOR PROJECT SUSTAINABILITY

Community groups are well placed to mobilize resources for the sustainability of their programs. With proper planning and early involvement, such malaria prevention measures conducted at community level would include income generation activities, membership of microfinance institutions, and formation of merry-go-rounds among community groups.

Probably the best form of building resources for project sustainability lies in communities acquiring skills from trainings conducted during project implementation. Since it is close to impossible to train whole communities, the best approach is to select a cohort of community own resource persons (CORPs) for training, who act as Trainers of Trainers, and would continuously provide the required training for the rest of the community.
### Fig. 36: Organizations’ knowledge and ability to apply for GFATM funds in the area of resource mobilization for project sustainability

Since these resource persons are embedded within their communities, they would always be available to provide the required advisory services and skills in project implementation to their communities even after the project is expired.

From the results it is apparent that some organizations are not aware of opportunities they have in areas of project sustainability (Figure 36).

An important area of project sustainability is the continuous contact with public institutions that would ensure government support. Contact with public health departments in government hospitals is therefore important for ensuring sustainability and continuity.

### Fig. 37: A public health office in Malindi for decision-making on control and management of malaria and community health issues. Public Health offices may support CBOs after the expiry of Global Fund grants

### 5.3 SUMMARY

The views and observations of the CBOs on the GFATM programming in Kenya have been presented in this Chapter. The CBOs recognize the limitations of their knowledge and skills and express the need for further capacity building to enable them to undertake programs in malaria control and ensure their sustainability.
CHAPTER 6
KNOWLEDGE ON THE GLOBAL FUND AND THE COUNTRY COORDINATION MECHANISM

6.1 INTRODUCTION

Country Coordinating Mechanisms (CCMs) are fundamental to the Global Fund’s commitment to local ownership and participatory decision-making at the country level. The CCM is a partnership within each country that develops and submits grant proposals to the Global Fund based on priority needs at the national level (Kenya CCM, 2006). After grant approval, the CCM oversees progress during the implementation, based on a pre-agreed time and work plan.

The Country Coordinating Mechanism includes representatives from the public and private sectors as well as the civil society organizations, government Ministries, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases. The Country Coordinating Mechanism also has the responsibility of nominating one or a few public or private organizations to serve as Principal Recipient for each grant. In Kenya, the CCM is hosted at the Ministry of Health, and the Permanent Secretary of the Ministry of Health serves as the Chairperson for the CCM meetings.

6.2 KNOWLEDGE ABOUT THE GLOBAL FUND

Knowledge about the Global Fund was generally high among the community organizations. The GFATM has been in Kenya for about eight years, and CSOs have tried to obtain funds throughout this period. This is reflected in Figure 38 below. More than half of the respondents knew about the Global Fund.

Fig. 38: Knowledge about the Global Fund by CBOs

6.3 CBO RESPONSES ON THE CCM

There was very limited knowledge on the Country Coordinating Mechanism of the Global Fund or its functions. Out of the 207 CBOs interviewed, only 78 (37.7%) knew about the CCM (Figure 39).
Fig. 39: CBOs’ knowledge on the Kenya Global Fund Country Coordination Mechanism

Of those who knew about the CCM, the knowledge about its various roles was evenly distributed, except in the area of providing a catalyzing effect in entrenching and harmonizing Global Fund programs. This is shown in Fig. 40 below.

Fig. 40: CBOs knowledge on recipients of the Global Fund for Malaria

Less than 10% of the respondents knew that one of the key roles of the CCM is to provide catalysis in entrenching and harmonizing GFATM programs.

6.4. SUMMARY

This chapter presented the results on community organizations’ knowledge on the Global Fund and the Kenya Country Coordinating Mechanism. It was shown that the CCM is hardly known at the CBO level, much less its specific functions.
CHAPTER 7
EXPERIENCES WITH THE GLOBAL FUND FOR MALARIA

7.1 INTRODUCTION

The few community organizations that have had access to grants of the Global Fund do not have favourable comments on either application process or disbursement of the funds. The process of application starts with getting information on the opportunity to hand in a proposal. The necessary forms and guidelines can usually be accessed through the internet.

The process of applying and mobilizing resources for the implementation of malaria programs involves the availability of resources as well as the allocation of these resources in order to gain the highest level of returns. It involves putting in place the mechanisms through which such scarce resources offered by the Global Fund can be aligned and realigned to achieve the expected impact. Key in mobilization and utilization of resources is the capacity building for implementing organizations to efficiently run their programs, and present achievements credibly and effectively.

In this chapter, the experiences of CBOs that have conducted GFATM supported programs are presented.

7.2 EXPERIENCES WITH THE APPLICATION PROCESS

Only a small proportion of Community Based Organizations interviewed had applied for Global Fund grants for Malaria, and CBOs find the application process lengthy, complex, and distressful – 94.9% of those interviewed had not applied compared to 5.1% who had applied (Figure 41).

![Proportion of CBOs that have applied](image)

Fig. 41: Proportion of CBOs that applied for GFATM funds for Malaria

Of those that applied, only a small fraction actually received the funds.
7.3 INFORMATION ON OPPORTUNITIES TO APPLY FOR GLOBAL FUND GRANTS

The channels used by the CCM to announce the opportunity to apply for Global Fund grants leaves out many CBOs. The announcements are made in the daily newspapers, which cost about 0.35 Euros – a considerable amount of money for the rural based community groups where the average daily income still falls below 1 US$ per day. Without knowing when the announcement is placed the papers, or in which of the main daily papers, the CBOs would have to purchase a paper each day – which would be very expensive for them. The consequence is that the CBOs do not get to know about the Global Fund application announcements, and when they do, the submission date is often long passed and it is too late. The announcements are also often posted online. As CBOs are often not connected to the internet, this communication channel is also not suitable for them and they again do not get the information needed. The net result is that extremely low numbers of CBOs actually apply for Global Fund grants, and even lower numbers ever feature in those that get to implement projects.

7.4 KNOWLEDGE ABOUT THE APPLICATION PROCESS

The application process for Global Fund grants has been fairly complex, and even though it has been simplified in the last two GFATM Rounds, the CBOs indicated that it is complicated enough to keep them away from applying (Figure 43).
7.5 PROPOSAL DEVELOPMENT

The preparation of credible proposals that are good enough to get funds for projects has been always a challenge to civil society organizations. The task is particularly hard for community based groups. During the survey, nearly all the CBOs interviewed indicated the need for training in proposal writing. The CBO leaders have recognized their inadequacy and lack of experience in preparation of proposals for GFATM funding.

7.6 PRIORITIZING MALARIA INTERVENTION ACTIVITIES

Prioritizing of project interventions on malaria is an area that requires a good knowledge on project management capacity which was found to be lacking in the community organizations. It hinges on the national priorities, and the capability of the organization to implement programs. The organizations then need to have the personnel to conduct the prioritization of programming.

7.7 BUDGET DEVELOPMENT

Development of credible budgets that are not out of pace with the planned activities has always been an area of challenge for some civil society organization. In previous Rounds, CBOs have been known to submit proposals with budgets way out of synchrony with the planned activities.

7.8 WORK PLAN DEVELOPMENT

Community organizations indicated that they had performance skills in the area of work plan development. However they also indicated that they would need retraining in work plan development to enhance their skills.

---

**Fig. 43: Knowledge about GFATM application procedures**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>89</td>
</tr>
</tbody>
</table>

Do you know the procedures required for applying for GF funds
7.9 PROCUREMENT OF PROJECT MATERIALS

Once developed, the proposal needs to be assessed before it is forwarded to the CCM. The majority of the CBOs indicated that they lacked the skills to evaluate the proposals. This is to be expected as they also indicated that they lacked skills to develop the proposals.

7.10 IMPLEMENTATION OF PROJECT ACTIVITIES

The implementation of planned project activities was one of the areas in which CBOs expressed most confidence in their capabilities. They indicated that they were able to provide the required services in every area of malaria control that they had decided on.

7.11 SELECTING INDICATORS FOR M&E

Selection of indicators is a difficult area for community organizations implementing malaria programs. Although the CBOs indicated that they knew how to select indicators, experience indicated that CBOs usually do not achieve the set indicators. This is the consequence of setting indicators that are not attainable, and of a lack of financial, organizational and human abilities and resources.

7.12 MONITORING PROJECT ACTIVITIES

The majority of CBOs that have implemented or are implementing GFATM programs indicated that they have the capacity to monitor project activities, as they can keep records of their activities.

7.13 EVALUATION OF PROJECT ACTIVITIES

Evaluation of programs was an area in which CBOs indicated low capacity during the implementation of programs. This has led to CBOs lacking the capacity to correct the direction of their programs as they implement their programs.

7.14 REPORTING

The CBOs indicated that they can report their program activities. However, experience has shown that CBOs often have problems scheduling GFATM supported programs. In previous rounds, CBOs implementing programs have failed to give their reports in time, especially financial reports. Due to this, programs in all areas supported by the Global Fund (HIV/AIDS, TB and Malaria) lagged behind in financial disbursement in previous rounds.

7.15 VERIFICATION OF DATA QUALITY

Community organizations indicated lack of ability to verify data quality. They indicated the need to have a program oversight to verify the quality of their data and their programming in general.
7.16 COMPLIANCE WITH GFATM REQUIREMENTS, E.G. PBF

Compliance with GFATM requirements is a sticky area for CSOs in general and CBOs in particular. Such areas as Performance Based Funding which form a cornerstone for implementing GFATM program is alien to most CBOs even those implementing GFATM projects (www.theglobalfund.org).

When the organizations were asked if they would like to receive GFATM funds to implement malaria programs, nearly all the CBOs expressed the wish to receive these funds.

![Graph showing the proportion of organizations that would like to receive Global Fund grants for their malaria programs. 99% said yes, 1% said no.]

**Fig. 44: Proportion of organizations that would like to receive Global Fund grants for their malaria programs**

7.17 SUMMARY

This Chapter provided an overview on the capacity of community organizations to put together proposals for seeking project funds from the Global Fund. It also examined some of the areas in which community groups will need capacity building to improve their knowledge and skills in project implementation.
CHAPTER 8
ORGANIZATIONAL KNOWLEDGE AND SKILLS ON IMPLEMENTING GLOBAL FUND PROJECTS

8.1 INTRODUCTION

Institutional capacity development is a key area in project implementation. An organization needs to have key structures and personnel in place for it to fully carry out its responsibilities during the project implementation. The implementation of Global Fund supported projects needs a functional program environment for success.

8.2 PROSPECTS FOR CBO INVOLVEMENT IN MALARIA CONTROL IN KENYA

All development practitioners and experts agree on that there can be no meaningful development until the day that development programs include all targeted communities directly, and that these communities will own and directly participate in these programs.

Throughout this survey, not a single community organization felt as “owner” of the malaria control programs in their areas. The programs rather belonged to the implementing international organization (where these were present), or the more common scenario, organizations that should have been players on the ground had no knowledge of Global Fund grants for Malaria. The issue here then is how will the organization that should be implementing a malaria program support it and sustain its activities if that organization neither acknowledges its presence nor participates in its programs?

The question is what will be done to involve the CSOs in general and in particular the CBOs implementing malaria programs in Kenya? How will the “universal coverage” approach that is now adopted by the malaria authorities in Kenya become truly universal for the CBOs of Kenya? What does it take to really engage the civil society in implementing malaria programs in Kenya?

The answer to these seemingly easy questions must surely lie in the goal of the malaria program in Kenya. KeNAAM has set its major agenda on a “Malaria-free Kenya”. This in itself is not achievable unless a program including all is put in place – a program that has its direct links with grassroots organizations for implementation. The present GFATM program is not inclusive. Too many organizations that should be involved are left out, even though sufficient funds are allocated. Too few organizations are participating in the program. Too small an area is covered by the program activities. Too little impact is felt on the ground. Too few CBOs that should drive the processes at grassroots level are supportive of the process.

It is interesting that several CBOS expressed the confidence to have the capability to implement GFATM programs – although this is still only 56% of the respondents.
8.3 MONITORING AND EVALUATION

The CBOs indicated that that their programs suffered from a lack of expertise in monitoring and evaluation of their projects.

8.4 REPORTING

Reporting by CBOs has been a contentious issue in the implementation of Global Fund projects in Kenya. CBOs have been blamed for late reporting of their activities, and have tended to lag behind the agreed plan of implementation. They also tended not to follow the laid down program of action (work plan) during project implementation. Indeed in the past, this has been the single most important factor that has derailed GFATM grants for CBOs. Funds provided to CBOs through the PR had not been accounted for adequately and fully in the time allocated to allow continuous disbursement, causing a backlog on funding disbursement. As a result, many programs have faced a delay in funding and subsequently had to delay their programming, so that it was not corresponding to the plan of action laid down in the proposal any more.

It is apparent that the capacity of personnel in the CBOs to fully implement malaria programs has affected the Global Fund. The assessment shows that a majority of CBOs, FBOs and small NGOs do not have the experience, facilities and especially personnel with the necessary qualifications and knowledge to effectively run field programs, especially in monitoring, evaluation and assessment of project progress. According to the assessment, CBO personnel and their heads as well as implementing field staff also sometimes lack the qualification, experience and skills in malaria management and control.

Related to this is the lack of knowledge about the areas that are targeted for malaria control – the malaria focal districts. Few of the organizations presenting proposals for support for malaria projects know the distribution of such districts in Kenya. Intensified assessments of all organizations forwarding proposals to the GFATM before actually awarding the grants would ensure that only credible organizations with the programmatic and financial capacity get the funds to implement their projects.
Figure 46 below outlines some of the areas that CBOs indicated as gaps for their programming.

![Proportion (%) of CBOs](image)

**Proportion (%) of CBOs**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Proportion (%) of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total responses</td>
<td>100</td>
</tr>
<tr>
<td>Involving members in proposal writing</td>
<td>4.6</td>
</tr>
<tr>
<td>Lack of bank account</td>
<td>2.8</td>
</tr>
<tr>
<td>Knowledge of projects eligible for fund</td>
<td>12</td>
</tr>
<tr>
<td>Knowledge of assistance from GF</td>
<td>5.6</td>
</tr>
<tr>
<td>Don't know how to apply</td>
<td>75</td>
</tr>
</tbody>
</table>

**Fig. 46: An analysis on CBOs’ ability to apply for Global Fund grants**

The capacity of CBOs to carry out their programs was viewed by policy and coordination partners in the implementation of malaria programs. The DOMC felt that low capacity among CBOs was the major tumbling block in the implementation of Global Fund supported projects in Kenya.

Specific areas of requirements of the Global Fund were found to be challenging for CBOs. One such area is the performance based funding (PBF) system. Based on this mode of expenditure and accounting, organizations are eligible for continuous funding, only when they account for previous allocation according to the agreed budget and work plan. Between the implementing bodies, there should be a responsive system for fast reporting on project implementation and feedback. If this reporting is not timely or lacking, then the whole funding process gets out of gear, and funds disbursement gets delayed.

A previous study showed that a lack of adherence to PBF requirements has caused delays on the ground, and instead of timely and accountable reporting, there have been slow and out-of-time reports from implementers, which has dragged down even those organizations that have implemented their programs effectively. (See Odindo 2008) Organizations have delayed their reports, often merging one year’s report with the next. Policy and coordinating bodies noted that the GFATM is one of the most user-friendly grants providers. The GFATM does not lay any pre-conditions, and the funds are meant to go directly to the beneficiary communities, according to the needs and deficiencies identified by the country disease agencies and systems. The requirements are clear and based on two factors, i.e. performance and delivery. Therefore it is the responsibility of the implementing agencies and organizations to ensure the timely implementation of programs, provide credible reports on inputs and outputs, and show cause for further expenditure on the programs.

### 8.5 SUMMARY

In this chapter issues that are pertinent on the programming and performance of malaria projects at the country level were presented. The policy and coordination bodies are confident that with improvement in these areas, CSOs can fully benefit from GFATM grants in the future.
CHAPTER 9
SYSTEMS TO SUPPORT MALARIA PROGRAMS AMONG COMMUNITY BASED ORGANIZATIONS

9.1 SUPPORT THROUGH INTERNATIONAL ORGANIZATIONS

International organizations can have key roles in the implementation of malaria programs at community level: on the one hand, they play a key role in the mobilization of resources for CBO programs and funding of development projects in Kenya. On the other hand, they often cooperate with partner CBOs in implementing programs in the field.

CBOs have a strong role to play in the implementation of projects supported by the Global Fund to fight AIDS, TB and Malaria. Some international organizations of the UN such as the World Health Organization and the United Nations Childrens Fund are represented in the CCM, and are aware of the problems that have beleaguered the implementation of GFATM supported malaria projects in Kenya at community level. Many of these international organizations are also already involved in the assistance of health programs at various levels, and provide financial, logistic or technical support to CSO activities. They are also aware of the barriers CSOs face when accessing Global Fund grants and other shortcomings in the malaria programs.

The International Organizations were willing to provide technical support in areas of need, provided that support was factored into the Global Fund budgets. This support through the provision of technical support when specifically requested, particularly from UN agencies such as the WHO and UNICEF, has been available for some time now and will need to be taken up by the relevant authorities to form an integral part process of fostering applications and implementations of GFATM supported malaria projects in Kenya.

The PR for the civil society organizations including the CBOs is no longer the Ministry of Finance, civil society organizations themselves now have this responsibility: CARE Kenya for HIV/AIDS and AMREF for TB and Malaria. The onus now falls on these two organizations to show the way and advocate for capacity building among CBOs through the support of the international organizations willing to provide this training.
In order to see the KeNAAM’s of a malaria-free Kenya, the PRs, through the CCM, will have to take up the key responsibility of ensuring that GFATM projects for malaria in Kenya run efficiently and effectively even among the Community Based Organizations. They need to ensure that a system is put in place for proper and prompt implementation of field programs as laid down in the GFATM system. They must also play their leadership role in directing the programmatic and financial timelines for all sectors that receive GFATM resources in Kenya.

9.2 SUPPORT THROUGH THE DOMC

The Division of Malaria Control is the key policy formulation and implementation organ of the Government of Kenya with regard to malaria management and control. Their opinion was sought with regard to CSO and the Global Fund.

The DOMC acknowledged CBOs as key partners in carrying out community-based activities at grass roots level. They expressed the need for capacity building at CSO level to strengthen their capacity to effectively participate in malaria management programs.

9.3 SUPPORT THROUGH KENAAM

KeNAAM’s principal aim is to supplement the efforts of the Kenya government through the Ministry of Health to reduce and altogether eliminate the burden of malaria in the country. KeNAAM is a national network of NGOs, FBOs and CBO networks with its headquarters in Nairobi.

KeNAAM has over 65 active members spread throughout the country. Furthermore in an effort to foster partnership, KeNAAM has an associate membership drawn from private sector groups and organizations (PSOs). KeNAAM also collaborates closely with the Ministry of Health through the Divisions of Malaria Control (DOMC) and Child and Reproductive Health (DCRH) by implementing the National Malaria Strategic Plan. Other stakeholders include major bilateral and multilateral organizations that are keen on fighting malaria in Kenya and the Ministry of Education (KeNAAM, 2006).

KeNAAM suggested a new and revolutionary system for managing and strengthening CSOs – the Open Mindset. This is a new strategy for implementing and developing partnership. The strategy would aim at improving CBO performance and oversight, and would define specific roles at CSO level. The CSOs would have their specific roles in areas of comparative advantage, i.e. social mobilization and community change advocacy. The strategy would also define the roles of KeNAAM and the DOMC within this community based strategy, and tackle the often-difficult to implement area of supervision.

KeNAAM noted that the current malaria programs have been directed towards children and pregnant women. However, under the new malaria implementation policy of universal coverage, malaria control will open up to include all sectors of the community.

On psychosocial and cultural issues and malaria control, KeNAAM acknowledged the need for grassroots organizations to own processes of malaria control, including the use of LLINs, ACTs, and to actively participate in health seeking behaviours. A strong social mobilization process would eliminate some of the challenges experienced at community level, including “the talking nets” of Kilifi (people refused to cover themselves with ITNs because those who used the nets would “hear voices at night”), and would also cover the use of LLINs among migrant communities such as the Maasai, Samburu, and the Turkana in the Kenyan northern districts.
There would also be a strong advocacy on access of medical facilities by communities. Community Based Health Workers (CBHWs) would bring services closer to the people, bearing in mind the fact that 52% of the communities live outside the 5 km boundary of medical facilities. Communities also need training on syndromic management of malaria, and recognition of what is likely to be malaria. They need advice that not all fevers are malaria. The Ministry of Health should give guidance on how to use Rapid Diagnostic Testing (RDTs) in the community. Communities will also need guidance on the use of ACTs, including the training shopkeepers and other community outlets.

When it comes to socio-economic issues, KeNAAM recognizes that the community structure for programming (CBOs, FBOs, youth groups, women groups) needs to get involved in advocacy. There is need for capacity building of these organizations to enable them to participate fully and directly in their projects. Furthermore for continuity and advocacy, the community organizations need to be linked to national income generation programs and micro-finance institutions, as well as the Constituency Development Fund, the Ministry of Youth Affairs, the Ministry of Gender and Sports, the Kenya Youth Business Trust, Faulu Kenya and the Equity Bank, among others. Political good will in each project area is also necessary, hence the need for advocacy at project sites.

KeNAAM's key activity was to assist NGOs implementing malaria projects to pass information to CBOs and other CSOs. The impact of this activity could be seen during the selection of teams to the CCM, it was clear to see that the CBOs were only represented due to the intervention of KeNAAM. However, there are resource requirements for implementing these coordination activities.

KeNAAM shares information on the Global Fund with CBOs which regard coverage, interventions and institutional support. In Round 9, KeNAAM downloaded R9 forms and made them available to their members. The challenge faced in performing this task was the capacity of CBOs to receive/download, synthesize and use information from the internet.

A Solution suggested by KeNAAM was that if the "KeNAAM model" (bridging community groups into an umbrella organization at community level) was to work, then any programming information would be passed to the coordinating organization at community level which in turn would pass it to their members.

Concerning the CCM, KeNAAM felt that this institution has been playing a conflicting role, with a conflicting agenda. There have been restrictions on KeNAAM members’ proposals for the GFATM under a closed bidding system. Other challenges faced by KeNAAM were:

• Difficulty of communication with CBOs based outside Nairobi,
• Difficulty of linking CBO capacity to fill in GFATM Form A from the CCM,
• CBOs feel alienated due lack of opportunities
• The CCM needs to come up with a more participatory process of selection and awarding
• Need to involve more CSOs in representation

The appointment of a new PR for malaria (and TB) will open up new prospects for CSO participation in GFATM programs in Kenya.
9.4 SUMMARY

In this chapter, the possible role of International Organizations in the strengthening of capacity of community organizations in the application and implementation of malaria programs in Kenya was discussed. The part that International Organizations and UN agencies can play in mobilizing the resources that are required for the successful application of CBOs for funds, and in the application for and implementation of Global Fund programs for Malaria in Kenya was examined. The strengthening of capacities of CSOs to apply for funds, effectively run programs and report on the outcome of malaria control projects and the financial status was identified as being important for the success of projects run by community organizations and other civil society bodies. International organizations agreed on delivering technical assistance by participating in training programs for strengthening CSOs at country level. KeNAAM and the DOMC have critical roles to play in creating an environment in which CBOs will feel they have a role in malaria control and management.
CHAPTER 10
COMMUNITY BASED ORGANIZATIONS INITIATIVES TO STRENGTHEN MALARIA CONTROL: SOME FIELD EXPERIENCES

10.1 INTRODUCTION

The capacity assessment conducted on Community Based Organizations in Kenya was based mostly on the responses by the key personnel and individuals engaged in the programs of the organizations - managers, project implementers, or members of the various community groups. The assessment also targeted health leaders, heads of national and international organizations and global bodies, policy leaders and international scientists involved in malaria control in Kenya. The un-recorded side of the assessment was the field experience of the personnel. About 18 Research Assistants participated in the interviews in some 24 districts from Nyanza, Western and Nyanza Provinces. In this Chapter, the experiences of some of the interviewers during this survey, and their observations from western Kenya (Emuhaya and Vihiga Districts) and the Coast Province (Malindi District) are presented.

10.2 FIELD EXPERIENCES

10.2.1 PERSONAL EXPERIENCES OF A FIELD INTERVIEWER

Personal experiences present a vivid view on the field situation. In the Box below, the views of an interviewer are presented on his personal experience during the interaction with community groups, and discussions with community organization leaders.

Box 1: Field experience of Julius Okullo, Interviewer in Emuhaya and Vihiga Districts, Western Province, Kenya

I carried out the survey in Vihiga and Emuhaya Districts. It’s target was to assess the capacity of Community Based Organizations, Non Governmental Organizations, Faith Based Organizations and other Civil Society Organizations to implement Global Fund supported Malaria programs in Vihiga and Emuhaya District: the Experience of Julius Okullo

Among the groups that I managed to access and interview, most of them were willing to give their information with only a few objecting. They also looked forward to some possible support from the organization collecting this kind of data. This may involve training of the members in malaria control and the application procedures needed for GF funding. They also demanded to know how they can be able to get in touch with the organization's offices, but so far I could only give them the contact details of the Headquarters in Nairobi. They need to know if the organization can get involved and open its offices at the district level. At certain points I was compelled to offer both the phone number of the organization as well as yours.
Among the groups I interviewed, a few were solely involved in controlling malaria within the community while others were involved both in the control of HIV/AIDS within the community but with a larger percentage of them involved in implementing projects that are geared towards economic welfare. Among these groups a part from those involved entirely in malaria control, minimal efforts are directed towards the control of malaria.

The interviewed groups within these two Districts are either covering the Sub-location, Location, Division or District levels with only a few of them covering more than one District. The Community Based Organizations are still young as most of them have been formed in the last 1.5 decades. Older Community Based Organizations complained about the poor communication channels with their previous partners. This has resulted in very minimal efforts from the members and these groups are almost loosing their members. Among these groups, there are those that are involved in the planting of herbal medicine such as Moringa oleifora, which they then use to treat the patients at home. These groups complained about poor training among the members, the lack of drugs and equipment to use in the home management of malaria.

There is also the lack of support from the health facilities within these areas as the staff is not willing to work with them. At times referrals are difficult as roads are poor and muddy in the rain season. There is also the lack of effective means of transport. People also have to walk long distances to get medications. At the health facilities, patients are at times advised to buy drugs from the local chemist who sells them at high cost. Due to the rampant poverty it is difficulty for the people to afford them. This is why the members need trainings in the effective administering of herbal medicines which can be used effectively to boost the home management of malaria.

Concerning the Global Fund funding and if the groups have ever applied for this: no groups had effective knowledge about the GF and its activities. The members would appreciate if the organization could be able to strengthen their capacity and capability to apply for GF grants for malaria control.

So far, the groups had only heard about the GF it in workshops but did not know how it actually works. These groups therefore did not know the possible areas of GF funding. They said they needed training on how to apply for GF grants, on the possible links to GF agencies and they indicated that they need to build the capacity to be able to write proposals which can be accepted in order to get funding. They look forward to possible trainings on how to apply for GF grants.

All these groups had no partner or donors to support them but rely only on the members’ contributions, merry-go-round and table banking for them to facilitate their malaria projects. These groups have never applied for GF money for malaria projects and would appreciate if mechanisms can be employed to boost their capacity. This can be through training in application procedures, proposal writing, writing project reports, and financial management and all that in malaria control.

Concerning the organizations’ knowledge and ability in managing malaria projects: community involvement, work plan development, implementation of projects activities and HMM are very high. Other activities such as proposal and budget development, ICT use in malaria programming, M&E, verification of data quality and both programmatic and financial reporting are still very low.

As a researcher, I would suggest to involve all groups interviewed in any kind of trainings, if there are to be any.
The community groups in Emuhaya and Vihiga complained about what the rest of CBOs all over Kenya complain about. They illustrate the difficulties CBOs face in their quest to implement malaria programs. The challenges include:

- Poor training among the CBO members
- Lack of malaria drugs and equipment to use in the home management of malaria
- Lack of support from the health facilities within these areas - the staff is not willing to work with them.
- Referrals are difficult as roads are poor and muddy in the rain season.
- Lack of effective means of transport
- Walking long distances to access medications
- At the health facilities patients are at times advised to acquire drugs from the local chemist which sells them at high cost.
- Due to the rampant poverty, it is difficulty for the people to buy the drugs.
- Need for the training of the members in the effective administering of herbal medicine (and other related alternative approaches), which can be used effectively to boost the home management of malaria
- Concerning the funding and the question whether the groups have ever applied for it: no groups had effective knowledge about the Global Fund and its activities. The members would appreciate if the organization could strengthen their capacity and capability to apply for GFATM grants for malaria programs.

The message is that CBOs have been forgotten by those that ought to seek their involvement in implementing programs in their turf. They are crying out for recognition and participation in national malaria and other health programs.

### 10.2.2 EXPERIENCES OF A COMMUNITY BASED ORGANIZATION IMPLEMENTING PROJECTS FOR MALARIA CONTROL IN MALINDI – WITH HELP FROM FRIENDS

In some cases encountered in the field, Community Based Organizations have taken on the task of mosquito and malaria control to the next level. PUMMA in Malindi is one such organization. Their story is shown below.

**PUMMA**

The community based groups in Malindi have come together to form a single unit, the Punguza Mbu Malindi, or PUMMA. This is an umbrella body that brings together various CBOs that are involved in activities that would lead to the reduction of mosquito populations in Malindi. This umbrella body which is registered with the Ministry of Social Services also collaborates with various stakeholders in Malindi - organizations that benefit from the reduction of mosquito...
infestation levels in Malindi - including the Municipal Council of Malindi, the Malindi Residents Association, the Malindi Hotel Owners Association and local business communities.

PUMMA is now a recognized organization in malaria and mosquito control in Malindi, offering the much needed support to the efforts of the Municipal Council in mosquito control. PUMMA recognizes the value of a clean environment and therefore has encouraged its members to join hands in the efforts to keep Malindi mosquito-free.

The organization has managed to be recognized by the authorities in Malindi, including the Ministry of Health through the District Health Management Team (DHMT), the District Medical Officer of Health (DMOH), the District Public Health Officer (DPHO), and the Municipal Council of Malindi. Due to this close liaison with the Municipal Council, PUMMA has been allocated space within the Municipal Council of Malindi (MCM) offices that it uses for meetings and coordination of its activities.

PUMMA participates actively in the various fora organized at local, regional and national levels. For example, on Malaria Day which is celebrated nationally to sensitize communities on good practices for malaria control each year, PUMMA is given an audience and space in the exhibition centre to articulate its programs and achievements.

COMMUNITY GROUPS PARTICIPATING IN THE MALINDI PROJECT

The individual groups that form PUMMA are as follows:

**Maweni Community Group**
A community based group that has among its activities awareness creation, environmental cleanliness, and income generation activities for its members

**Shela Women Group**
A women group started in 2002 and involved in cleaning the environment and removal of plastic containers that litter the environment and act as breeding sites for mosquitoes. The group makes mosquito nets as an income generation activity.

**TujaSaaidie Women Group**
This women group is also involved in environmental cleaning, and was started in 2002. They have moved their activities a step beyond environmental cleanliness to using the plastic papers to produce women’s handbags. They collect and clean the bags, and weave them into beautiful bags that they sell. The bags have been taken to exhibitions at Malaria Day, and won trophies locally, nationally and regionally.

**Ngala Site and Service Group**
The community group is involved in environmental cleanliness, cleaning septic tanks and running a merry-go-round for its members.

**Maweni Self Help Group**
The group has been operating for about a year and is involved in promoting cleanliness in the community, net use, and advocacy for mosquito control through drama.

**Maweni Primary Health Care**
The group is involved in covering septic tanks, and income generation activities.
Malkia Women Group
The group was formed in 2004. It is involved in community cleanliness, ITN distribution, and community education on removal of mosquito breeding sites.

Barani Community Health Workers
Started in 2005, this group has 15 members. They are promoting environmental cleanliness in the community

Kisumu Ndogo Youth Group
This group has 40 members, and is composed of youth and the young-at-heart. They are involved in cleaning the habitat, advocacy for HIV/AIDS activities, sports activities, and job creation for its members.

Genesis Youth Group
This group was formed in 1999. Its activities include drama, HIV/AIDS awareness, orphan support, and environmental cleanliness. They also train communities on mosquito control.

Maisha Mapya Solid Waste
This group was formed in 2005, and is involved in community mobilization for development, sensitization and training of communities on environmental cleanliness, and collection of cans and bottles for sale.

The CBOs are generally young, and lack resources to implement their programs. All the community groups expressed the wish to be assisted in getting tools for their activities in the communities where they are engaged, and the need for further training and capacity building for their members.

10.3 ACHIEVEMENTS OF THE MALINDI PROJECT

The project has shown several achievements:

- The project has demonstrated that it is possible to implement programs that are community driven with direct participation by the communities
- Continuous education of communities is beginning to bear fruits as the communities begin to adopt methods of vector control
- The project has gained support from the local health administration, including the District Health Management Team, the Medical Officer of Health, and the District Public Health Officer
- The Municipal Council of Malindi has given fully recognized PUMMA, and acknowledges the importance of the role it plays in mosquito control in Malindi
- Through the influence of PUMMA, the Municipal Council of Malindi has introduced a budget item for mosquito control among the line budgets for the township programs

10.4 CONSTRAINTS AND CHALLENGES

The constraints and challenges met by the project implementers, including the research team, the mosquito scouts and the CBOs during their activities include the following:

- The project is set in an urban environment, with diverse cultures and different income levels. This makes it difficult to find a common level of operation and engagement that would bring all target groups together.
- Literacy levels of communities in Malindi are different, and the level of understanding of vector management issues is different
• Finding a common convergence point in community projects is gradual and takes time, thus lengthening the period of project implementation
• The community members need to contribute their time voluntarily, and with little immediate reward, which requires dedication from participants
• Some household owners still do not understand the importance of vector control and the need to remove mosquito breeding sites from their environment
• Mosquito scouts face difficulties in influencing people to change their old ways
• The community sees mosquito scouts as employed people performing their duties for a fee - not directly concerned with the task of reducing mosquito populations and malaria at a voluntary level.

10.5 FUTURE PLANS

The project recognizes that there is still some way to go before Malindi can be called mosquito-free. Data from national malaria programs and the Malindi District Hospital point to the fact that the level of malaria infection has gone down, and it is now a rare thing to diagnose active malaria among patients admitted in the hospital. However resurgence of malaria only requires a few areas as sources of infection, and the presence of mosquitoes will see to the rest. Therefore there is the need to keep vigil and continue with community programs on controlling malaria through plans to strengthen activities towards community involvement. The capacity to access Global Fund grants would be of immense value to the PUMMA cluster of CBOs.
11.1 INTRODUCTION

Community programs on malaria are implemented within the framework of the national policy on health – the Kenya National Strategic Plan III (KNASP III). This is in line with the Strategic Pillar 3 of KNASP III on capacity building, grant-making and mobilization support under the community/area-based health programs. This strategic pillar will further build competence at community level and strengthen community systems to address each of the individual, relationship, communal and structural causes of vulnerability. It will also strengthen their governance and financial management systems.

In contribution to the KNASP III Health and Community Systems Strengthening outcomes, CSOs have the chance to invest in strengthening both institutional and human resource capacity as well as coordinated structures for its members. The key players in this effort will be health administrators through the DHMT, local administration, community leaders, and the community itself. In this Chapter, the field observations and experiences with some of these key players in capacity building among CBOs are presented.

11.2 OBSERVATIONS FROM NYANZA PROVINCE

The field observations were carried out in 6 districts which are known to be malaria endemic areas in Nyanza Province. These were Bondo, Siaya, Nyando, Rachuonyo, Migori and Homa Bay. Medical facility heads and persons working closely with communities on programs were interviewed.

11.2.1 MEDICAL OFFICER OF HEALTH – BONDO DISTRICT

The District Medical Officer of Health (DMOH/MOH) is the health administrator of any district. Medical issues, including programs, are channeled through his/her office, and he/she gives the authority for the implementation of programs by CSOs in the district. In Bondo District, a meeting was scheduled and held with the MOH to get his views on implementation of GFATM projects in the areas under his jurisdiction. After the purpose of the meeting was explained, the MOH indicated that so far the hospital (institution) was not involved in any GFATM projects on malaria.

He also indicated that there were no CBOs in the area involved in malaria projects that were collaborating with the institution. The Ministry had not done any advocacy campaigns on the GFATM among the CBOs in the district, and was not providing any kind of support to communities in any kind of projects. CBOs that apply for funds from donors, including the GFATM, do so on their own.

However, he expressed the plans that the institution was willing to work with communities on projects including malaria, should such opportunities arise.
11.2.2 PUBLIC HEALTH OFFICER - SIAYA DISTRICT

Discussions with the District Public Health Officer revealed that the groups in the district are not aware of the GFATM and what it offers. The officer confessed that even the Ministry is not aware of any GF funds available to the community and does not know when calls for proposals for the GFATM are usually made. He confirmed that there were several groups in the district that would be willing to carry out activities in malaria prevention and management should there be an opportunity. He also indicated the Ministry’s willingness to act as a focal point for the communities with regard to provision of information and assistance to communities on the GFATM. So far, the institution was working closely with CBOs especially on HIV/AIDS activities through the CACC.

11.2.3 PUBLIC HEALTH OFFICER – RACHUONYO DISTRICT

A discussion was held with the Public Health Officer and some of his team members at Rachuonyo District Hospital. The facility carries out malaria programs within the communities. Some of the activities they are involved in include community mobilization and education and ITN distribution. Global Fund

Community groups in the area do not apply for GFATM grants despite the fact that the outline and application forms are normally shared with them in good time. Some of the factors that contribute to the CBOs not applying for GFATM grants as explained by the team at Rachuonyo District Hospital included:

- Lack of technical ability to apply for GFATM grants
- The GFATM proposal development process is too complicated for the CBOs to accomplish
- Lack of ability to report on activities
- Restricted number of applicants per district discourages CBOs to apply, for example only nine applicants were to be funded during the last call
- Wrangling among CBOs once funds are available also discourages the CBOs to apply
- Other challenges faced by CBOs
- Level of follow up on the little money provided under the GFATM discourages the CACC from fully participating in helping CBOs access funds
- Some of the medical facilities staff uses the nets as chain link fence around their kitchen gardens. This is a bad example to the communities who are supposed to participate in the malaria prevention advocacy in the communities. The communities thus do not value the connection between using the nets for mosquito prevention when they can use the same for other purposes.

11.2.4 MATATA HOSPITAL – RACHUONYO DISTRICT

A discussion was held with the Director of Matata Hospital in Oyugis, Rachuonyo District to find out why communities do not apply for and access GFATM grants. In response to this question, he indicated that the grassroots groups are disadvantaged when it comes to the GFATM. The money is handled at a higher level without involving the communities and it really never trickles down to such groups. His feeling was that the government has not done much to help the CBOs access GFATM grants. Some of the factors that hinder application of CBOs for GFATM mentioned by him were:

- Lack of knowledge among the CBOs about what the GFATM is or does
- Lack of capacity by CBOs to apply for GFATM grants. The proposal is lengthy and complicated
- Lack of knowledge of the calls from GFATM. Advertisements are done in the newspapers, yet very few CBOs in the rural areas access newspapers. The government needs to change the mode of advertisement if the information is to reach the CBOs
• The persons/organizations in charge of the GFATM money give it selectively to their organizations where they directly benefit or to befriended groups, thus neutral organizations rarely get a chance to access the funds, regardless of the quality of the proposal
• The GFATM is generally not felt on the ground, it does nothing for people at grassroots level
• The relevant persons never realize that it is the CBOs that are in touch with the communities and that they are the ones who can help make an impact with programs at community grassroots level. Thus the CBOs are always ignored when plans are made at a higher level, and money is consumed largely at management level while there is no impact on the ground
• There is negativity and a lack of enthusiasm from government staff in providing support to community groups or community workers unless there is direct gain for government staff, hence they do not support the community groups including in applying for and accessing GFATM grants for malaria
• The monitoring is currently being done by NACC (for HIV/AIDS). This is not effective. Independent persons/organizations should be appointed to carry out the monitoring

11.3 MALINDI DISTRICT

Various government officials and persons were interviewed in order to get their views concerning community application and access to GFATM grants. Some of the findings from the discussions are as follows:

11.3.1 MEETING WITH THE HOSPITAL SUPERINTENDENT

Discussions were held with the Medical Superintendent, Malindi District Hospital. The Superintendent indicated that there were a lot of activities on malaria prevention such as net distribution going on in Malindi. Community groups under the umbrella of PUMMA (Punguza Mbu Malindi) have been set up for malaria control and supported by KEMRI.

However, funds from the Ministry of Health are usually allocated directly to activities and the communities have no say at all on how such money is used. He felt that the communities should be included in the planning process. According to him, there were no formal linkages (agreements) between the communities and the Ministry and there is the need for a linkage between stakeholder groups with specific responsibilities and the Ministry.

Global Fund
The superintendent said that although malaria programs were being implemented in Malindi through the GFATM, there was no recognition that the GFATM has contributed towards malaria programs in Malindi. He said this is because the GFATM is more towards services in general. He suggested that it might be a good idea if the GFATM started a specific service, let it run continuously for a while for its impact and its contribution towards malaria control to be felt. Otherwise, at the moment, there is nothing tangible that can be attributed to the GFATM directly.

Gaps
The superintendent pointed out a gap in the management capacity of the hospital. He indicated that the hospital is growing day by day and that there is the need to build the capacity of persons holding management positions, particularly the middle management level, to ensure effective management of the hospital resources.

Willingness to work with communities
The superintendent however indicated that the hospital will be most willing to work with the communities on programs including those that aim at reducing malaria incidences in the district.
11.3.2 DISCUSSIONS WITH THE DISTRICT AND DEPUTY DISTRICT PUBLIC HEALTH OFFICERS

The District Public Health Officer (DPHO) indicated that his office had no excuses as to why they were not working closely with the communities towards malaria control and other programs in the district. He felt that some of the officers working on malaria issues and with the communities were not appropriate and needed skills development. For example, malaria control and the government strategy on empowering communities are handled by the Public Health Education Officer. He felt that this is a completely un-ideal situation. The DPHO confessed that he did not know much about the GFATM.

The Deputy PHO however indicated that a lot is being done by the communities in malaria prevention in the district and malaria is no longer really a big problem in Malindi. There is the PUMMA, a group of CBOs that operate under the support of KEMRI. KEMRI has been training these groups on how to control malaria.

The community groups in the district have not been sensitized on the GFATM, how it works and how to apply for its grants. Besides, the groups that can apply are very few. The process of the GFATM application is complicated and needs to be simplified. Information on GFATM also does not reach the communities, for example the call for proposals is always done on newspapers. Very few community members have access to the newspaper on a regular basis, hence they miss the announcements. The information should trickle down through a systematic channel such as through the DC, public health office, and to the community groups if the information is to reach the communities at grassroots level. He indicated that there is also the need for capacity building within the community groups. If educated and given the opportunity, most groups will be able to apply for GFATM funding.

There is also the need to decentralize the financial management for malaria under the GFATM just like in the case of the HIV/AIDS component which is managed through the CACCs. An accounting officer can be put on the ground to assist the groups with the accounting process because this is also a challenge to community groups.

This can be done by public health officers who are available in every location in the district. Formal linkages need to be created between the public health office and the community groups. The public health offices within the district already work with some community groups on programs such as community clean-ups and providing training to communities on various areas including sanitation.

11.3.3 DISCUSSION WITH A KEMRI MALARIA CONTROL SCIENTIST AMONG MALINDI COMMUNITY GROUPS

KEMRI works closely with community groups (PUMMA) in Malindi on malaria control activities.

Successes of the implementation of malaria programs in the district
Some of the successes that have been achieved through working with communities on malaria control activities include:

- Community acceptance of the program making it possible to pass on information on malaria control to the communities and making malaria control a success in the district
- KEMRI works with the scouts in the area, this makes it possible to pass on scientific messages on malaria control to the communities
- Through the malaria program, KEMRI has trained more than 400 people within the groups affiliated to PUMMA. The number of persons reached with information on malaria control is
• even higher.
• There is a strong collaboration with the stakeholders. This has been further strengthened by the regular joint meetings with the stakeholders
• The strong collaboration has resulted in program support by the stakeholders.

Challenges in the implementation of malaria programs in Malindi District
However, despite all these successes, there are also some challenges. Some of them include:
• Program implementation is a slow process. One has to go at the community’s pace
• Resources are also a challenge. Communities have beautiful ideas and plans but are unable to implement them due to a lack of resources
• Lack of information is another challenge faced by the communities. Limited or no information reaches the communities
• Sometimes the community priorities are completely different from the ones of the program and this poses a challenge to the program implementation
• As Malindi is a tourist town, community members migrate to their rural homes or to other places to look for jobs during low tourism seasons. This poses a challenge for the program implementation because when the community migrates, there is no one to work with
• Despite the work done, a lack of knowledge by the communities on malaria control still is a challenge. For example, their inability to associate mosquito breeding grounds to the mosquitoes in their houses
• Culture and tradition also hinder development and program development in the district
• Information flow is very poor. Management of information from groups/stakeholders to the ministry of health and vice versa is not there

Way forward
Some of the suggestions given by the KEMRI representative as possible way forward in successful implementation of malaria programs in the district are as follows:
• There is still the need for community sensitization on the GFATM
• Communities should be educated on how to get funding, where to get such funding, how to apply, how to do budgeting, prepare work plans and reporting
• The community groups should be formalized with proper structures for proper management and accountability of resources
• There is the need to build the capacity of community groups on proposal development to enable them to apply for funding (GFATM, women fund, youth fund, etc.)
• There is the need to put in place a proper information channel between the stakeholders and the Ministry of Health for the ease of information flow
• The capacity of all persons at all levels in the system should be built to enable them to work together on program implementation and on information sharing
• The first point of contact for the Community Health Workers (CHWs) with the Ministry of Health is at the dispensary level. However, perception of the CHWs by the dispensary personnel is negative. This discourages proper collaboration between the two groups in provision of effective health services to the community because it is the CHWs who are in direct contact with the communities at grassroots level
• There is also the fear of medical facility staff that if the capacity of the CHWs is built, their roles/jobs might be at stake
11.4 KILIFI DISTRICT

DISCUSSION WITH A KEMRI SCIENTIST

Discussions were held with senior scientists at KEMRI in Kilifi district in order to determine facts and get to know his thoughts on the lack of active participation of communities in applying for funds and implementing malaria activities through the support of the GFATM. Some of the information he provided were as follows:

- There is the need to provide information on the GFATM, and any other relevant and correct information to the communities. The communities lack the necessary information to be able to apply for GFATM grants. The communities should then be guided to make decisions based on correct information.
- There is a lack of community involvement in the implementation of GFATM programs. Communities should be involved in malaria programs right from the beginning, i.e. planning stages of program through to implementation. This may take time but with patience, it is possible to fully involve the communities. It is advisable to involve the communities as they are, and not discriminate against them due to their lack of ideas or education.
- There should be capacity building/training on the GFATM and other programs at all levels. The communities believe that the government will do everything for them, which is a misconception. They need to understand what is theirs and take up the necessary responsibility to make it work.
- There should be full participation of the public health office. The public health office is not well equipped with information to train the communities on the GFATM.
- There is the need to close the gap between the public health office and the community.

Global Fund

The representative indicated that he has had some negative experiences with the GFATM and categorically said that he would never again apply for GFATM funds. His main concern was the disbursement process followed by the GFATM which is too long and not appropriate for operational research projects.

11.5 MEETING WITH COMMUNITIES

Some community members were also interviewed and discussions were held with them at individual level in order to gain an insight into their views on why they did not apply for GFATM grants. The majority of the persons interviewed did not know about the GFATM and had never applied for any funds from the GFATM. Most of them indicated that they did not know when calls for proposals are usually made or how to access the application forms. They also indicated that they lacked the technical capacity to apply for the funds. The communities felt that project funds are blocked at a higher level and do not reach the communities at grassroots level. If they do, then they are given to befriended organizations or organizations owned by the persons responsible for managing the funds, hence the other CBOs with no godfathers within the system get nothing. This is another factor that discourages CBOs from applying for funds that are channeled through the government system.
11.6 DEDUCTIONS FROM THE INTERVIEWS

Calls for proposals
From the discussions held with various medical facilities representatives, it was clear that most of them do not have much information regarding the GFATM. Most of them are never aware of when the calls are made. Even those who can access the forms are normally discouraged by the complicated and long application process. They are also discouraged by the fact that they believe the funds are given to specific CBOs and institutions based on relationships with the persons responsible for selecting the proposals at the CCM and also when it comes to funds distribution at lower level.

Information flow
Community Based Organizations, especially in the rural areas, neither know what the GFATM is, nor are they normally aware when calls for GFATM proposals are usually made and published. This is mainly a consequence of the media chosen to announce the proposals – the newspapers. Most of the rural communities rarely have access to newspapers. Due to poverty, they would often rather put food on the table than buy a newspaper, thus most of the time they miss to see the GFATM advertisements calling for proposals. Those who hear about it are not able to access the application forms and/or do not have the technical capacity to apply for the funds.

Internet accessibility
The other method of channeling GFATM announcements and the application forms is through the CCM website. Not many CBOs have access to computers with the internet through which they can download the forms. Many of them also do not have the capacity to download such forms on their own (especially if they are PDF files), fill them out as required and submit hard copies. Unlike the HIV/AIDS component of the GFATM where there are CACCs at each district level, there are no similar structures put on the ground to assist the CBOs to access the information, application guidelines and forms for GFATM funding for malaria projects. Sometimes the CBOs approach people or organizations which are assumed to have the technical know-how to apply on their behalf at a cost, but such applications never go through. This also discourages the CBOs to continue applying.

Linkages with public health offices
There are no or limited direct links between the medical facilities at district level and the CBOs on the ground, hence the level of support to CBOs by such facilities is limited or does not exist at all. Through the District Public Health Officers, the district medical facilities would be an appropriate source of information, education and provision of technical support to CBOs on the GFATM and the application process. There is the need to sensitize the district public health officers in each district to support communities in accessing and providing technical support where necessary to communities in applying for GFATM grants or any other projects that can be channeled through the medical facility. Linkages should be formed and sustained between the district public health office and the CBOs in each district if the support for CBOs is to be achieved from that office.

Transparency and accountability
During further discussions with the CBO representatives, it became clear that there is no transparency concerning the government representatives responsible of helping the community groups to access application forms, provide technical support and disburse funds to the community groups. This has greatly discouraged many CBOs who do not even try to apply for GFATM funds on HIV/AIDS which is a much more simple process and where forms are readily available through the CACC offices.
The general feeling of most of the community stakeholders is that funds are handled and mismanaged at higher level, and this is part of the reason why the funds cannot trickle down to benefit communities at grassroots level.

11.7 OVERCOMING THE CHALLENGES

Some of the ways through which the challenges faced by the CBOs in applying for GFATM grants for malaria may be overcome include but are not limited to:

• Awareness creation on the existence of the GFATM among the CBOs
• The application process and format should be made simpler to enable the CBOs to apply for GFATM grants for malaria
• The reporting format for the GFATM should also be simplified
• The need to use methods of advertising or calling for proposals other than the newspaper that can be easily accessed by CBOs including, also the ones in the rural areas. Radios have a wider reach compared to newspapers and may be used for the calls. Liaison can also be made with the CACC offices in each district to assist in informing the CBOs, providing application forms and providing technical support to CBOs on application for GFATM grants for malaria
• The capacity of CBOs on GFATM proposal development, reporting and accounting should be build to enable them to access and manage the funds more efficiently. In order to do this, sufficient information should be passed on to the public health officers and/or the capacity of the relevant officers should be built. The trained officers in turn should provide information and technical support to the CBOs on the GFATM for malaria.
• Umbrella groups that can act on behalf of the CBOs at grassroots level with regard to the GFATM (i.e. be a voice for the CBOs) can be formed. The umbrella organization should create awareness on the GFATM among CBOs at grassroots level, provide information on the GFATM to the CBOs, access and provide application forms on the GFATM to the member CBOs and also provide technical assistance to CBOs on applying for the funds
• There is the need for the relevant persons in the system to realize that the CBOs should not be ignored during the implementation of programs that target the communities in order to feel an impact. It is the CBOs that are in direct contact with the community members
• Levels of providing and monitoring of funds should be decentralized systematically into different levels up to the community level. For example, for malaria the channel could be:
  - AMREF as the main group (PR)
  - Sub-groups to provide capacity building, manage grants, take care of the CBOs’ interest, i.e. ensure funds are fairly disbursed and monitored (do follow-ups) use of funds by CBOs
  - CBOs

11.8 SUMMARY

In this Chapter, the views from various levels of stakeholder groups in the field were presented. It was shown that there is the need to sensitize and mobilize communities on GFATM in order to strengthen their participation in the area of GFATM malaria application and implementation. Not many people understand how the GFATM works, including Ministry of Health officers. At first, the public health officers should be sensitized and educated on what the GFATM is all about. The trained public health officers in turn would educate the communities on the GFATM in the locations where they work. Unless all the relevant persons and government officials take other people’s problems seriously and deal with them as if they were their own, there will never be any progress.
CHAPTER 12
DISCUSSIONS

12.1 INTRODUCTION

The role of CBOs and CSOs is well recognized by the Global Fund (www.theglobalfund.org) as well as by the Kenya’s national strategy for health delivery. For example, the National Health Sector Strategic Plan II (2005-2010), which defines the Essential Health Package that the health sector will deliver to Kenyans - the Kenya Essential Package for Health (KEPH) - was developed through the consultation of stakeholders in the sector, including CSOs and CBOs, to help revitalize the community health services in Kenya.

The Kenya Director of Medical Services has stated: “One of the key innovations of KEPH has been the recognition and introduction of Level One services that are aimed at empowering Kenyan households and communities to take charge of improving their own health”. The strategic plan document, “Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services” clearly defines the type of services to be provided at level one services, the type of human resources required to deliver and support this level of care, the minimum commodity kits required and the management arrangements to be used in implementation.

Two of the targets to be realized under the strategy are: a comprehensive well trained Community Owned Resource Person (CORP) and a Community Health Extension Worker to support the CORP. CBOs are therefore part of the Kenyan medical system, recognized by the health policies. The challenge now is to use these existing policy structures to strengthen the community systems, and provide the necessary tools for community organizations to move their agenda on malaria control forward.

12.2 GLOBAL FUND INVESTMENT IN MALARIA BEGINS TO BE FELT AMONG 2.3 MILLION PEOPLE

88 MILLION BED NETS DISTRIBUTED FOR MALARIA CONTROL

On 8th July, 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria announced from Geneva that there has been positive progress in the fight against malaria, with a cumulative total of 88 million insecticide-treated bed nets delivered through its funded programs to families at risk of contracting the disease. These figures show that there has been an increase of 49% from 59 million nets distributed by mid 2008.

The Global Fund provides around 23% of international resources to fight AIDS, 57% of international funding to fight tuberculosis and 60% of international funding to fight malaria. In the area of HIV/AIDS, some 2.3 million people living with HIV have been reached with lifesaving antiretroviral (ARV) treatment through GFATM supported AIDS programs, a 31% increase over results reported a year ago. Furthermore, Global Fund-supported tuberculosis programs have so far put more than 5.4 million people on effective TB drugs treatment. Tuberculosis is the leading cause of death among HIV-infected people; the World Health Organization estimates that TB accounts for up to a third of AIDS deaths worldwide.
Giving an overview of the Global Fund and its fight against the three major global diseases, Dr. Michel Kazatchkine, Executive Director of the Global Fund noted that in less than eight years, the Global Fund has gone from a concept to a driver of change. He said that when the GFATM was started in 2002, Malaria was a neglected disease and only a few people in developing countries were being treated for AIDS or tuberculosis. Many countries simply did not have the resources to fight these diseases effectively. He noted that the picture had changed dramatically and that now, the benefits of the Fund are beginning to be felt.

Importantly, Dr. Kazatchkine noted that “there is still much to be done, but we are making real progress and I am proud that the Global Fund is a leader in this global effort”.

### Table 21: Performance of the Global Fund from Mid 2008 to Mid 2009 on HIV/AIDS, TB and Malaria

<table>
<thead>
<tr>
<th>Global Fund results June 2009</th>
<th>Mid 2008</th>
<th>Mid 2009</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people currently receiving ARVs</td>
<td>1.75m</td>
<td>2.3m</td>
<td>31%</td>
</tr>
<tr>
<td>Number of people receiving treatment under DOTS</td>
<td>3.9m</td>
<td>5.4m</td>
<td>38%</td>
</tr>
<tr>
<td>Number of nets distributed (ITNs and LLNs)</td>
<td>59m</td>
<td>88m</td>
<td>49%</td>
</tr>
</tbody>
</table>

The reported data showed combined results from individual programs supported by the Global Fund in 140 countries. The report indicated that performance-based funding is the core of the Global Fund performance-based financing system which only disburses money based on targets reached. The quality of the results is assured through the work of the Global Fund verifying agency in each country and independent data and systems reviews.

The report noted that the Global Fund closed this years call for new grant proposals last 1 July, 2009, and that the scale-up in Global Fund supported programs has led to an unprecedented increase in new high-quality proposals for grants being submitted. It is anticipated that there will be an equally high level of demand this year as well. The Board of the Global Fund is expected to approve new grants under this round at its Board Meeting in November 2009.

Civil Society Organizations are a core partner group in the success of the GFATM implementation, and the GFATM Board recognizes this major contribution of the CSOs to performance of the GFATM in all implementing countries. For this reason, the Global Fund stipulates that at least 40% of all the financial resources allocated to each country should go to the country’s civil society groups, including Community Based Organizations and Faith Based Organizations.

Sadly though, at least in Kenya, various impediments and bottlenecks appear to be in the way of community organizations to participate in this extremely important program.
12.3 CHALLENGES FACED BY COMMUNITY BASED ORGANIZATIONS

Problems faced by community organizations can be classified into three major areas:

12.3.1 GAPS IN PROJECT MANAGEMENT SKILLS

Project Management is the process that provides a framework for information gathering, analysis, planning, implementation, monitoring and evaluation of a project. It is a dynamic process using the appropriate resources of the organization in a controlled and structured manner, employed to achieve a change clearly defined within specific objectives identified as strategic needs. Project management is therefore a powerful tool for improving the effectiveness and efficiency of a project by helping an organization to set project goals and objectives; and to guide implementation, monitoring and evaluation of a project.

Project management provides a framework within which projects are implemented and ensures that scarce resources are used for project activities that address the defined objectives. It also helps to establish a link between proposal preparation, review and approval mechanism, and ensures that the project is completed within defined scope, quality, time and cost limits. For an organization to implement its programs in an effective and efficient manner, the staff implementing the project needs to have knowledge and skills in various elements of project management. Project staff of the largest majority of CBOs say that they lack such skills, a factor that has been an impediment in the ability of CBOs participating in implementing malaria projects to attain the objectives of their programs.

12.3.2 GAPS IN LOGISTICS MANAGEMENT

Logistics entails planning on availability and utilization of resources and commodities in order to achieve the set targets effectively. Wikipedia defines Logistics as:

“....the management of the flow of goods, information and other resources, including energy and people, between the point of origin and the point of consumption in order to meet the requirements of consumers (frequently, and originally, military organizations). Logistics involves the integration of information, transportation, inventory, warehousing, material-handling, and packaging, and occasionally security. Logistics is a channel of the supply chain which adds the value of time and place utility”

and Logistics Management as:

“...the part of the supply chain which plans, implements and controls the efficient, effective forward and reverse flow and storage of goods, services and related information between the point of origin and the point of consumption in order to meet customer [and] legal requirements. A professional working in the field of logistics management is called a logistician“.

Community Based Organizations lack the training in logistics management to control the in-flow and out-flow of resources placed at their disposal, and to produce supportive documentation to assist their groups to effectively run their projects.

12.3.3 GAPS IN ADMINISTRATION AND GOVERNANCE

Administration and governance issues have been stumbling blocks in the running of community organizations. The roles of various office holders in the organization are often muddled and unclear, which ultimately affects the performance of the CBO. Furthermore communication channels within the organization are often lacking and internal conflicts are frequent.
Administration and governance were not covered in this survey, but it was clear that, with a skeleton staff, the CBOs often have one person playing dual roles. For example on the question on who provides financial services in the organization, it was clear that most CBO Leaders/Chairpersons were also involved in keeping project accounts and reporting on project activities. Such multiple roles often lead to a lack of transparency, for example in reporting on project finances.

12.3.4 LACK OF OPPORTUNITIES FROM THE IN-COUNTRY GLOBAL FUND

On paper, the role of CBOs in the national health system is clearly defined, and the relationship between CBOs and the medical authorities at the district level is clearly defined. Policy documents and national strategic plans also acknowledge this role. Formally, the Ministry of Health (MOH) welcomes the involvement of NGOs, FBOs and CBOs in health policy and care delivery at all levels. In reality, there is lack of linkage between the CBOs and the district services - yet it is at the community and district levels where many of these stakeholders are mostly engaged. The District Health Management Team (DHMT) through the District Health Forum should be involving all stakeholders, including CBOs, in a consultative process of preparing the district health plan and budget and planning for malaria control.

The vision in this process is that all stakeholder views are taken on board during decision-making in health matters affecting the communities and that during this process of preparing the district annual health work plan and budget, many health stakeholders can make maximum impact on future Government plans and spending in their areas of interest, such as malaria.

12.3.5 THREATS FROM POOR INFRASTRUCTURE

Rural Kenya is known for its poor infrastructure, for a lack of roads, a lack of appropriate communication for information and education technologies, a lack of electricity, low levels of telephone lines and very long distances to be travelled by project implementers to get to their clients.

12.4 AREAS THAT CBOS HAVE A COMPARATIVE ADVANTAGE IN ADMINISTERING AT COMMUNITY LEVEL

Advocacy and Mobilization of Communities on use of LLITNs
Kenya has been associated with high ownership of ITNs – some 63% of Kenyan households are reported to own nets. At least 80% need to use a net in order to achieve the desired reduction in malaria morbidity. Of the 63% households reported to own nets, it is unknown how many people actually use the nets on a regular basis, and how many of these are children under 1 or 5 years, and how many are pregnant mothers. Therefore, a universal net coverage (defined as one net for two people) approach, which is essential for a malaria free Kenya, still needs some time to really be achieved. Here lies the opportunity for CSOs, particularly Community Based Organizations. CBOs are close to the people, and can readily mobilize men, women, and children to take up use of LLINS, and enhance their use at community level. Community Own Resource Persons (CORPs) can be trained to take up certain responsibilities in community training, act as linkage points between the communities and the medical facilities, as well as to the DHMTs.

Participation in epidemic preparedness and response (including indoor residual spraying) among communities
Indoor residual spraying (IRS) is an effective intervention to mitigate malaria epidemics, and has been conducted by the Ministry of Health. The annual spraying did not take place in March-April
2009, due to the late release of the Global Fund Round IV. Combined with ITNs, IRS reduces the population of mosquitoes drastically and has been a key in the reduction of mosquito populations and malaria incidence in Kenya. Community organizations’ role here would cover the sensitization of communities for IRS, and advocacy for the support of IRS programs among the target groups.

**Early recognition of malaria and access to effective case management and accurate malaria diagnosis**

Communities need to support the efforts that have targeted the implementation of Home Management of Malaria programs. The major constraints with this intervention have been inadequate stocks of ACTs as well as poor prescription practices by the health workers not yet trained on the application of the new treatment guidelines. This intervention has been mainly donor funded and Kenya needs about one million doses every month to meet its ACT needs. Government should allocate adequate financial resources to meet this need.

A new malaria treatment policy in Kenya aims at taking health services to Level one (grassroots), which was approved in 2005 and officially launched in late 2006. Community resource persons can be involved in the training of health workers on the new treatment guidelines to the public, mission/NGO and selected private sector health workers at all facility levels. Since the program began in 2006, many health workers, particularly from the non governmental sectors were not reached with this government-initiated training. The DOMC estimates that one half of all health workers from all sectors have not been trained to date. As a result, case management in accordance with the new treatment guidelines remains weak. This offers an opportunity for the better-placed CBOs, and NGOs to follow the approach used by DOMC, which is to conduct three-day trainings through a cascade approach employing trainers of trainers (ToTs) at community level.

Such projects implemented at community level would support and contribute to Kenya’s commitment to scale up access to treatment services to universal coverage, which implies that Kenya is committed to ensuring that all persons suffering from malaria have prompt access to affordable and appropriate treatment within 24 hours of onset of symptoms. To achieve this target, the national malaria control strategy recognizes the importance of scaling up Home-based Management of Malaria (HMM). Home Management of Malaria with ACTs has been piloted in various parts of the country with promising results. This again is an area of opportunity for CBOs with knowledge and skills to participate in.

**Involvement of CBOs in Management of malaria and anemia in pregnancy**

There is a strong need to involve community organizations in the management of malaria and anemia in pregnancy. The groups would be involved in the enrollment and advocacy of pregnant mothers for IPTp. Present data shows that there is a low uptake of IPTp among the target groups. Although there is high ANC attendance (87%) as well as high awareness about the IPTp strategy, only 24% of pregnant women had received two or more doses of IPTp according to the MIS 2007. This level is far less than the 60% stated in the Abuja target, and communities will have to be involved in behaviour change strategies if it were to be successful. Through their wide membership, CBOs would mobilize their members to pass appropriate messages to their communities.
CHAPTER 13
CONCLUSIONS AND
RECOMMENDATIONS

13.1 INTRODUCTION

The assessment of the capacity of CBOs to apply for and implement GFATM supported programs for malaria control has been presented in the previous sections. In this chapter, the study provides conclusions and recommendations based on the findings and the analysis of data from community organizations and other key malaria stakeholders.

13.2 CONCLUSIONS

This review has brought out the precarious position in which the Kenyan CBOs find themselves today. Several factors stand out clearly:

- CBOs are low in capacity in most areas - from financial resources, to trained personnel, to materials and equipment.
- CBOs lack knowledge in specific areas of project management, including application processes, monitoring and evaluation, financial management skills, and reporting.
- CBOs are keen to learn new techniques and methods on malaria control, and how to manage disease – and their resources.
- CBOs are enthusiastic and ready and willing to participate in community development, and lifting the standard of living of their members.
- CBOs do not get sufficient contact and information from relevant authorities that would enable them to apply for and acquire the funds for running their projects.
- Some CBOs have taken the initiative to seek application for funds, but a lack of support from the local authorities has discouraged them to a point of never seeking to apply again.

Throughout the organizations covered by this survey, there was lack of one resource or the other that is required for implementing malaria programs. On the one hand, the CBOs lacked the people to run the programs – most of their staffs are volunteers. They lacked equipment and materials to run the projects with, and they lacked the finances to help them run the programs. Probably most important, they lacked the skills that would give them the capacity to apply for and implement the programs. On the other hand and probably even more important, they lack the voice to speak for them where it matters, and where their voice needs to heard – the CCM. If there was a voice in the CCM for CBOs, someone would have listened to the cry for proper representation and involvement of CBOs in equitable sharing of the funds that are available for controlling malaria in Kenya.

Is there hope for true CBO participation in malaria programs in Kenya for the future? Yes, and the hope must lie in the planned policy change so that from Round 10 on, Global Fund Malaria programming will not be based on proposals handed in at the end of a one-month proposal writing exercise, but will focus on the Strategic Plan for the respective diseases.
13.3 LACK OF A COORDINATING MECHANISM FOR CBOS

CBOs have lacked a single authoritative body to give them guidance in matters of project planning, application implementation, review and reporting. Whereas NGOs have several experienced and strong bodies to give guidance in disease management and control, sourcing for project opportunities, and sometimes even applying for project on behalf of their members (such as the Kenya AIDS NGOs Consortium (KANCO) that applies for Global Funds for HIV/AIDS programs on behalf of its members), an equivalent CBO body is absent. No such applying opportunities exist for community organizations, and application chances for CBOS come and go, with a minimum of applications being received from any CBOs, even those in relevant areas and could have benefited from the call for proposals.

13.4 RECOMMENDATIONS

There are many capacity gaps among Community Based Organizations in the application process for and implementation of Global Fund supported malaria projects. With some efforts and cooperation between the various stakeholders, these can be overcome.

13.4.1 LACK OF RESOURCES

Project programming starts with the concept and goes to the final accounting for resources used in the implementation and reporting on the outcomes. It is therefore essential that an organization that plans to implement programs has the capacity to implement them effectively and efficiently. CBOs lack the resources to effectively run their programs.

Recommendation

It is recommended that the resource base of CBOs is strengthened by building their governance base and by restructuring the organizations that are involved in malaria programs. There is also the need for the provision of basic equipment to enable CBOs to participate strongly and effectively in GFATM programs.

13.4.2 CAPACITY BUILDING THROUGH TRAINING

The program implementation of any organization depends on its ability to run its programs, based on the staffing level of the organization. By definition, community organizations depend on volunteerism for staffing to implement its programs. However, professionalism can not be replaced by mediocrity. Therefore, CBOs have to find a training strategy to raise their capacity and their level of implementing their programs.

Community training and re-training was mentioned repeatedly as an area of need among CBOs. The training demanded covered the application processes; training in proposal writing; training in writing project reports; training in financial management, training in monitoring and evaluation; and training in malaria control.

Recommendation

It is recommended that CBOs that wish to apply for GFATM grants for their malaria projects are trained to enhance their capacity to implement these programs. Specifically such trainings should include:

- Application processes for the Global Fund
- Proposal development,
• Budget development,
• Work plan development,
• Development and selecting indicators for monitoring and evaluation,
• Monitoring project activities,
• Evaluation of project activities,
• Impact assessment,
• Programmatic reporting,
• Financial reporting
• Verification of data quality,
• Compliance with GFATM requirements, including Performance Based Funding (PBF) and GFATM Procurement and supply chain management (PSM).

13.4.3 COMMUNITY SYSTEMS STRENGTHENING

Community Systems Strengthening (CSS) strategies, is an aspect of Health System Strengthening at community and grassroots levels. CSS refers to initiatives that contribute to the development and/or strengthening of community-based organizations in order to improve knowledge on, and access to improved health service delivery.

There is a weak link at present among community organizations to implement community programs. Thus community systems strengthening (CSS) is required if communities are to benefit from malaria programs targeting participation of community groups. In common with other donor funding programs, the GFATM system requires efficiency, transparency, accountability, and effective systems that would drive programming. These must be reflected in efficient use of resources, timeliness and directed implementation, distinct and discernible output/outcomes, and clear channels for reporting and feedback.

Recommendation

Systems of Community Based Organizations should be strengthened and their roles and tasks within the communities where they are active should be defined and documented, and be made to account for those responsibilities.

CBOs should be strengthened to ensure that the CSS component operates within the framework of the community health strategy for implementation of the KEPH. They can be assisted in the following areas:

• Support the establishment of community units in line with the national community health strategy especially in areas of Kenya with high triple burden - high prevalence, low access, inadequate coverage and quality of public health facilities.
• Conduct training of CORPs on KEPH, equipping them to (1) undertake BCC activities aimed at malaria control services, demand creation and enhancing utilization of services and interventions like LLINs, IRS, and AL; and (2) Provide treatment services for malaria at the community level.
• Promote health awareness through IEC on control and prevention of common diseases, particularly malaria, HIV/AIDS and TB.
• Promote community initiatives for behaviour change including improving BCC capacity of community-based organizations.
• Sensitize, mobilize and organize communities to ensure leadership support and awareness of their rights and responsibilities in health.
• Build partnerships between Community Based Organizations, public and private health facilities, and other local level systems, to improve coordination, enhance impact, and avoid duplication of service delivery.
13.4.4 GAPS IN THE APPLICATION PROCESSES

Proposal preparation is the first step in application of Global Funds, and has to follow the guidelines provided by the GFATM. Yet many organizations fail to follow the stipulated instructions, leading to the outright removal from the application process. The assessment exposed capacity gaps among CBOs in various levels of preparation for and the application for Global Funds on Malaria – including access of guidelines from GFATM or CCM, proposal preparation itself, setting indicators, monitoring and evaluation, to reporting. Most of the community organizations indicated the need for capacity building in one or more of these areas. Although CCM has in the last few years simplified the application process, and has provided instructions on-line on the application requirements, it appears there is still a long way to go with regard to community organizations. Recommendation

Community organizations should undergo training on the application process for Global Fund grants. These could include the awareness for the announcement for GFATM grants for malaria projects, accessing information from the Kenya Global Fund and CCM websites, and preparation of a proposal according to the Global Fund instructions and requirements.

13.4.5 GAPS IN QUALITY ASSESSMENT

Often, many proposals are dropped at a very early stage. In Round IX applications released in May 2009 for example, only 17 organizations were shortlisted to receive Global Fund grants out of some 67 civil society organizations that applied. If there was a quality assessment process before the applications were forwarded to CCM, the final authority in receiving Global Fund applications, this number would surely be much higher. In an earlier review of proposals submitted for Global Fund grants for malaria projects, Odindo (2008) determined that individual proposals did not fair too well either in terms of adherence to good practice in proposal writing, and assessment of the quality of the proposals and grant application. At least one proposal had a score of 0 – meaning that it had no business even attempting to apply for GFATM grants.

Recommendation

Community organizations need a body with the authority to advice the government on civil society participation on malaria control in Kenya. The Kenya NGO Alliance Against Malaria’s principal aim is to supplement the efforts of the Kenya government through the Ministry of Health to reduce and eliminate the burden of malaria in the country. KeNAAM is a national network of NGOs, FBOs and CBO networks with its headquarters in Nairobi.

KeNAAM has more than 65 active members spread throughout the country. Furthermore, in an effort to foster partnership, KeNAAM has an associate membership drawn from private sector groups and organizations (PSOs). KeNAAM also collaborates closely with the Ministry of Health through the Divisions of Malaria Control (DOMC) and Child and Reproductive Health (DCRH) by implementing the National Malaria Strategic Plan. Other stakeholders include major bilateral and multilateral organizations that are keen on fighting malaria in Kenya and the Ministry of Education (KeNAAM, 2006).

It is recommended that KeNAAM should have a strong quality control section to deal with the quality of malaria proposals that ultimately go to the GFATM. It should engage qualified quality control personnel to review the proposals that finally get to the GFATM for funding.
13.4.6 STRENGTHENING GOVERNANCE AND ORGANIZATIONAL STRUCTURES AMONG CBOS

A CBO coordinating body such as KeNAAM can play a major role in building the structures that would enable CBOs to be accountable and transparent, and build a strong system in leadership and partnership among the CBOs. The same structures can be used to strengthen the process of proposal development for the Global Fund among CBOs. Announcements of the Global Fund come in March, with a deadline and closing date coming four months later. This offers sufficient time and opportunity for the coordinating body to select the themes around which it will develop proposals.

The adoption of a new policy of basing the year’s GFATM application on the Malaria Strategic Plan may prove to be even more challenging for CBOs. However, such proposals can be developed in partnership between CBOs, under relevant themes. In close liaison with MICC and the CCM, appropriate national topics can be generated from the GFATM announcement for the year. In order for this process to be successful, the current coordinating body - KeNAAM - needs to strengthen its role and take up more challenges in bringing the CBOs implementing malaria programs closer together. They need to see the necessity of building partnerships for implementing GFATM projects.

Partnership is a relationship grounded in common values and mutual trust. It is a relationship where “goals, conditions, obligations, roles and responsibilities” are clearly defined and mutually acknowledged and respected, and where the parties show respect for each other and treat each other as equals. Malaria is a countrywide problem and with partnership and directed roles and refined responsibilities, GFATM activities would be implemented in a clear and time bound manner.

Recommendation

KeNAAM should restructure itself and take up fresh responsibility to lead the CBO GFATM system. It should then take a responsible position for directing the CBO agenda, providing linkage with other beneficiaries in malaria control.

13.4.7 PERSONNEL DEPLOYMENT BY CSOS

Under the current GFATM guidelines presented by the Kenya CCM, by awarding a grant to a CSO, the GFATM and its organs in Kenya presume that the organization has the capacity to implement the program. Judging by the present CBO assessment and the views expressed by the key policy and coordinating agencies, there is a critical gap in the capacity of CBOs in programmatic and financial management of the GFATM projects once the grant is awarded. Although capable of implementing the actual activities, according to the policy and coordinating agencies, this gap stems from the initial process of selection of partners for implementation by the sub-recipient. CBOs can be assisted in the decision making process to deploy their human resources within the implementation program.

Recommendation

CBOs should be strengthened to put in place systems that would enable them to build a staff with relevant qualification for running and managing the GFATM malaria projects. Such organizational capacity can be built on a regional/district basis. Significant areas that would require CBO expertise include:

- Malaria epidemiology and management;
- IT including internet use
- Anopheline mosquito biology and control,
- Project management including M&E,
- Data management and reporting; and
• Financial management including procurement and supply chain management, narrative and financial reporting, and performance based funding.

CBOs should also receive guidance on adherence to firm controls on GFATM awards and contracting for malaria grants.

13.4.8 STRENGTHENING OF COMMUNICATION CHANNELS

A significant outcome of this assessment is the described low level of communication between the CBOs and various agencies of the Global Fund, notably the CCM. None of the community organizations interviewed gave an affirmative response regarding an efficient and responsive system of communication between the organization and the various bodies of the GFATM, mainly the CCM.

Recommendation
Communication between CBOs and the local district health management teams as well as the CCM should be improved for easy information transfer. Such channels should be used on a frequent basis for access to information on the Global Fund.

13.4.9 COORDINATION OF CBO PROGRAMS

Community groups are facing a serious lack of capacities to handle programmatic or fiscal issues. There is no institution the CBOs can approach in case of break of communication between the single CBOs. Therefore, there is the need to create a clear and well defined route for channeling issues right from the start of the project implementation. Problems concerning the project implementation (data collection, records and record keeping, monitoring and evaluation, programmatic reporting) need to be directed to a program person, while those dealing with financial issues (disbursement of funds, financial reports, financial oversight) can be addressed by a financial lead person.

Recommendation
It is recommended that a coordinating body such as KeNAAM takes the responsibility of creating/strengthening, coordinating and facilitating the channels of communication - both bottom-up as well as top-bottom. This will focus on speedy and timely resolution of any conflicts, or solve relevant issues. Further, in this era of the digital village and fast information flow through the internet, the coordinating body should transmit some knowledge concerning the use of the internet to the CBOs that target GFATM application.

13.4.10 DUAL TRACK FINANCING

Dual track financing allows several organizations and institutions to present their proposals jointly for financing. It is a practice that is common for most externally-funded programs, and allows organizations to draw on the strength of some organizations that have resources - particularly capital and human - to take a lead role in managing the financial resources for project implementation. This partnership allows the recognition of roles of individual members of the coalition and their participation in achieving the final project objectives.

Recommendation
It is recommended to use this method in the future and CBOs should be encouraged to present their proposals as a group, in partnership with the more established and strong CBOs, in order gain from the experience and skills of these organizations. Gradually, these CBOs can be “weaned” and encouraged to prepare and present their own proposals for funding.
REFERENCES


KeNAAM Strategic Plan (2006)


The Global Fund to Fight AIDS, Tuberculosis and Malaria: Significant and obvious errors that have previously given rise to a successful appeal: http://www.theglobalfund.org/en/about/technical/appeals/preVIOUS/


ANNEX

Questionnaire

Questionnaire No. __________

DATE: ____________________

Capacity of Community Based Organizations, Non Governmental Organizations, Faith Based Organizations and other Civil Society Organizations to Implement Global Fund Malaria Programs in Kenya

Province and District __________________________________________________

City/Town   __________________________________________________________

Organization __________________________________________________________

Name of Respondent (Optional) ________________________________________

Name of Interviewer ___________________________________________________

Malaria is endemic to the poorest countries in the world, causing about 248 million clinical cases and about 880,000 deaths each year. In Kenya, 25 million out of a population of 35 million Kenyans are at risk of malaria. Malaria accounts for 30-50% of all outpatient attendance and 20% of all admissions to health facilities. Many organizations and private and public institutions are involved in the fight to control the disease in Kenya. This survey will assess bottlenecks and capacity needs of NGOs, CBOs, FBOs, and other civil society organizations, alliances and networks that are carrying out malaria activities in Kenya in terms of the Global Fund grant application and implementation.

This is a voluntary interview. The respondent will not be coerced to give information. The interview may be stopped at any time on request from the respondent. Information collected from this interview will be treated with discretion and only used for the purpose it has been collected for and will never be used against the respondent. The interview will be conducted only where the interviewee has given his/her consent.
## PRIMARY SECTION: SURVEY SCHEDULE

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<td>Age 15 and above</td>
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</table>
PART 1: CIVIL SOCIETY ORGANIZATIONS (CSO)

SECTION A. CSO Profile

1. Name of Organization:

2. Year of inception:

3. Organization headquarters in Kenya:

4. Type of organization (Tick one)
   a) N-NGO [   ]; b) I-NGO [   ]; c) CBO [   ]; d) FBO [   ]; e) PSO [   ]

5. Nature of work
   a) Health [   ]; b) Emergency [   ]; c) Other [   ]

If other, indicate which _________________________________________________________

6. Management and ownership of CSO (Tick one)
   a) Local/Community [   ]; b) National [   ]; c) International [   ];

SECTION B. Resource Base of the CSO

Human Resources

7. How many local employees (long-term) are engaged in implementing your Malaria project? (Tick one):
   a) 1-12 [   ]; b) 13 – 24 [   ]; c) 25 – 50 [   ]; d) 51 and above [   ]

8. How many international employees (long-term) are engaged in implementing your Malaria Project? (Tick one)
   a) None [   ]; b) 1 – 6 [   ]; c) 7 – 20 [   ]; d) 21 – 50 [   ]; e) 51 and above [   ]

9. How many of the long-term staff have the following qualifications (Give number in each category)
   a) No qualification [   ]; b) Certificate [   ]; c) Diploma [   ]; d) Graduates [   ];
   e) MS/MA/MPH [   ]; f) MD/PhD [   ]
10. How many temporary staff and volunteers do you engage in your Malaria program?
   a) None [    ]; b) 1 – 6 [    ]; c) 7 – 20 [    ]; d) 21 – 50 [    ]; e) 51 and above [    ]

11. How many of the temporary/voluntary staff have the following qualifications? (Give number in each category)
   a) No qualification [     ]; b) Certificate [     ]; c) Diploma [     ]; d) Graduates [     ];
   e) MS/MA/MPH [     ]; f) MD/PhD [     ]

Financial Resources

12. What are the sources of funding for your Malaria project/program? (Please tick all that apply)
   a) The Global Fund to Fight AIDS, Tuberculosis and Malaria [    ]
   b) Presidential Malaria Initiative [     ]
   c) Roll Back Malaria [     ]
   d) Bill and Melinda Gates Foundation [     ]
   e) Through partnership with NGOs/FBOs/CBOs [     ]
   f) Through CBO/FBO/NGO members and volunteers [     ]
   g) None [     ]
   h) Others (Please indicate) ______________________________________________________
   [     ]

13. What is the current annual financing budget for your Malaria Project(s)? (Please express in KShs)
   a) < 1,000,000 [    ]; b) 1,000,001 – 5,000,000 [    ]; c) 5,000,001 – 10,000,000 [    ]; d) >10,000,000 [    ]

14. What proportion of your annual budget for malaria project implementation does this represent?
   a) <25% [     ]; b) 25% - 50% [     ]; c) 51% - 75% [     ]; d) 76% - 99% [     ]; e) 100% [     ]

15. Who manages your project funds?
   a) Accountant (full time) [     ]
   b) Accountant (partime) [     ]
   c) Non financial employee [     ]
   d) Other (Specify) _____________________ [     ]

16. Who prepares your financial returns/report?
   a) Accountant (full time) [     ]
   b) Accountant (partime) [     ]
   c) Non financial employee [     ]
   d) Other (Specify) _____________________ [     ]

Material Resources

17. Does your organization posses any of the following items?

<table>
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<tr>
<th>Item</th>
<th>Number available</th>
<th>Age (Years)</th>
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<td>Photocopier</td>
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<td>Field vehicle</td>
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</tbody>
</table>

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SECTION C. Capacity of CSO to Carry out Malaria Projects/Programs

18. In which area(s) of malaria control does your organization work? (Tick all that apply)
   a) Advocacy and community mobilization [ ]
   b) ITN/LLIN distribution [ ]
   c) Training and capacity building [ ]
   d) Indoor Residual Spraying [ ]
   e) Treatment/Case management/referral [ ]
   f) Vector control [ ]
   g) Logistics management [ ]
   h) Procurement of commodities [ ]
   i) Systems strengthening [ ]
   f) Others (specify) ___________________ [ ]

19. Which of the following explains best the structure of your malaria activities?
   a) The organization has a program on malaria [ ]
   b) The organization has more than one malaria project (Please indicate number) [ ]
   c) The organization has only one malaria project [ ]
   d) The malaria project is based in a partner organization, we only implement some activities [ ]
   e) Other (Specify) ______________________________________________ [ ]

20. In how many districts (of original/larger districts) does your organization operate its Malaria programs?
   a) 1-6 [ ]; b) 7-20 [ ]; c) 21-50 [ ]; d) 51 and above [ ]

21. What is the size of your target population for Malaria programs?
   a) <10,000 [ ]; b) 10,000 – 100,000 [ ]; c) 100,000 – 1 million [ ]
   d) 1 million – 10 million [ ]; e) >10 million [ ]

22. What percentage of your planned target population have you been able to cover with your activities?
   a) <25% [ ]; b) 25% - 50% [ ]; c) 51% - 75% [ ]
   d) >75% [ ]

23. Up to what level have you been able to achieve your targeted/planned activities for your Malaria program/projects?
24. What have been the successes in implementing your Malaria Project(s)? (Please tick only if mentioned)
   a) Timely reporting [ ]
   b) Timely completion of program activities [ ]
   c) Funds used prudently and reported efficiently [ ]
   d) Satisfaction with project expressed by beneficiaries [ ]
   e) Clear communication channels formed with all stakeholders [ ]
   f) Impact of implementation demonstrated (Name some examples) [ ]

   g) Other area of success __________________________________________________________

25. What were the challenges in implementing the Malaria Project(s)? (Please tick only if mentioned)
   a) Lack of qualified staff [ ]
   b) Low level of staff training [ ]
   c) Lack of funds [ ]
   d) Delay in funds disbursement [ ]
   e) Poor infrastructure [ ]
   f) Lack of commodities [ ]
   g) Lack of equipment [ ]
   h) Lack of transport [ ]
   i) Poor reporting and feedback [ ]
   j) Unsatisfactory communication with key partners and donors [ ]
   k) Other (Specify) __________________________________________________________ [ ]

26. What would you like to be put in place to enhance your success in implementing the Malaria Project? (Please tick only if mentioned)
   a) More qualified staff [ ]
   b) Further training for malaria personnel [ ]
   c) More funds for malaria programs [ ]
   d) Fast disbursement of malaria funds [ ]
   e) Improved infrastructure (roads, transport, electricity, telecommunications, internet) [ ]
   f) Improved logistics (purchase, distribution and stocking of commodities) [ ]
   g) Improved community mobilization and advocacy for project implementation [ ]
   h) Improved equipment [ ]
   i) Improved M&E, reporting and feedback [ ]
   j) Improved communication with partners/donors [ ]
   k) Other (Specify) __________________________________________________________ [ ]
SECTION D. Knowledge on GFATM and the Country Coordination Mechanism

27. Do you know about the Global Fund?
   a) Yes [ ]      b) No [ ]

28. Can you mention the major areas for which the GFATM provides funding (Please tick only if mentioned)?
   a) Malaria [ ];        b) HIV/AIDS [ ];        c) TB [ ]

29. Do you know who can apply for GFATM funding?
   a) Yes [ ]      b) No [ ]

30. If Yes, please mention them (Tick only if mentioned)
   a) Ministry of Health [ ]
   b) International organizations [ ]
   c) Local CBOs, FBOs and NGOs [ ]
   d) Private Sector Organizations [ ]
   e) Companies and Corporations [ ]
   f) Others (Specify) ____________________________ [ ]

31. Are there any other topics that you would like to know about the GFATM?
   a) Yes [ ]      b) No [ ]

32. If Yes, please mention some areas

33. Would you like to be provided with further information on these topics on the GFATM?
   a) Yes [ ]      b) No [ ]

34. Do you know about Kenya Global Fund Country Coordination Mechanism (CCM)?
   a) Yes [ ]      b) No [ ]

35. If Yes, do you know its role in GFATM malaria projects?
   a) Yes [ ]      b) No [ ]

36. If Yes, please mention some (Please tick only if mentioned)
   a) Harmonization of GFATM activities and programs in relation to other donor coordination mechanism in Kenya [ ]
   b) Lobbying for basket funding for GFATM [ ]
   c) Supporting collaboration among CSOs, private partners, GOK [ ]
   d) Enhancing policies and principles of the Kenya government on GFATM [ ]
   e) Providing catalyzing effect in entrenching and harmonizing GFATM in the national program [ ]
SECTION E. Experience on Global Fund for Malaria

37. Have you applied for GFATM for malaria before?
   a) Yes [ ]   b) No [ ]

38. Did you receive the funds?
   a) Yes [ ]   b) No [ ]

39. If you have not applied for GFATM for malaria, would you like to receive GFATM funding for your malaria projects/programs?
   a) Yes [ ]   b) No [ ]

40. If Yes, Do you know the procedures required for applying for the GFATM funds?
   a) Yes [ ]   b) No [ ]

41. Are you capable of applying for the GFATM?
   a) Yes, I am fully capable [ ]
   b) I am only partially capable [ ]
   c) No, I don't have the capability [ ]
   d) Other (Specify) ______________________ [ ]

42. In your view, in which areas could your knowledge and capability to apply for the Global Fund be improved? (Please tick only if mentioned)
   a) Training in application processes [ ]
   b) Training in proposal writing [ ]
   c) Training in writing project reports [ ]
   d) Training in financial management [ ]
   e) Training in monitoring and evaluation [ ]
   f) Training in malaria control [ ]
   g) Provided with personnel [ ]
   h) Provided with equipment [ ]
   i) Other (Specify) ______________________ [ ]

SECTION F. Organizational knowledge and skills in implementing GFATM projects

43. If your organization is already implementing a GFATM grant for a Malaria project, what are some of your successes in implementing the project?

44. What are your challenges in implementing the GFATM Malaria project?
45. What would you like to be put in place to enhance your success in implementing your GFATM for Malaria project?

46. Please indicate your organization’s knowledge and ability/skills/capacity to apply for and implement GFATM Malaria project in the following areas?

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<thead>
<tr>
<th>Area</th>
<th>High (&gt; 75% achievement)</th>
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<th>Low (1 – 44% achievement)</th>
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<td>Involvement of communities in project appraisals</td>
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<td>Proposal development</td>
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<td>Work plan development</td>
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<td>Use of Information Communication Technologies (ICTs) in malaria programming</td>
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47. Please comment briefly on the following areas that apply to your organization’s ability to implement your GFATM malaria projects. Specifically mention any challenges in the process.

a) Application for GFATM Malaria funds

b) Implementing the GFATM project (name specific areas of challenges)

c) Specific requests to meet the challenges and deficiencies in application and implementing GFATM Malaria projects

PART 2. INTERNATIONAL PARTNERS/ORGANIZATIONS

a) What have been your roles and responsibilities in implementing malaria projects in Kenya, particularly projects funded by the GFATM?

b) In your view, what can be done to increase the capacities of local CBOs to apply for GFATM funding?

c) In your view, how can local CBOs, NGOs and FBOs be strengthened to enhance their ability and efficiency to implement GFATM grants for Malaria projects/programs in Kenya?

d) Specifically in your experience, how would you rank the ability of Kenya CSO malaria programs to perform the following activities?

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<tr>
<th>Area</th>
<th>High (&gt; 75% achievement)</th>
<th>Moderate (45 – 74% achievement)</th>
<th>Low (0 – 44% achievement)</th>
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### Table: Malaria Project Implementation Activities

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<td>Work plan development</td>
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<tr>
<td>Compliance with Malaria requirements</td>
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</table>

**e)** In your opinion, how can the capacities of the CSOs to apply for GFATM grants be enhanced?

**f)** What actions are you willing to take to improve capacities of CSOs to apply for and implement GFATM grants?

**g)** In your view, in addition to issues discussed in other areas above, what direction would you like to see CSOs take towards strengthening their GFATM Malaria programs in the future?

**h)** What comments not covered above would you wish to make on CSO Malaria Projects in Kenya with particular regard to GFATM grant performance and increasing the number of CSOs applying for GFATM funding? (Please use back of this page if needed)

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### PART 3. IN-DEPTH INTERVIEWS: SYSTEMS AND Programs ON MALARIA (Policy makers, District Medical Officers of Health, DOMC, Ministry of Health, CEO-KeNAAM)

**Interviewer:** Use reverse of sheets if needed

**a)** Policy
  - What are the regulatory arrangements for strengthening the capacity of CBOs and other grassroots
organizations to apply for GFATM grants in Kenya?

- Does the government support CBOs’ capacity enhancement to apply for malaria programs?
- If yes, in which areas and how is the support effected at local, regional (district) and national levels?

b) Gender
- Does the current policy on CBO strengthening consider gender of the beneficiaries?
- What are some gender considerations to support CBOs to strengthen their capacities to apply for GFATM grants?

c) Psychosocial/Cultural issues
- Is language a factor in strengthening CBOs and other CSOs and their ability to apply for GFATM projects?
- What impediments are there in strengthening malaria programs among CBOs due to language and other customary barriers?
- In which ways are the impediments being curbed and challenges being met to strengthen these organizations’ capacity to apply for GFATM grants?

d) Socio-economic issues
- In which ways can CBOs and other grassroots organizations involved in malaria prevention and control identify its strengths, weaknesses, opportunities and threats, to enhance its ability to apply for and access GFATM grants?

e) Linkages and Networking
- Is there a regional cooperation focusing on synergies, sharing of best practices and cost savings with regard to malaria aimed at strengthening CBOs to apply for GF grants?
- What is the range of interventions in which linkages and networking in use are beneficial to CBO capacity strengthening?
- Is there a formal and established partnership between the government (e.g., Ministry of Health, Ministry of Gender), the private sector, and CBOs that improve and maximize the possibilities for providing advice to CBOs on malaria programming and capacity building specifically for the GF?

f) Coverage, Interventions, Institutional Support and Other Issues
- How does the DOMC support and strengthen CBOs to enhance their ability to apply for and implement GF Malaria projects?
- How does KeNAAM support and strengthen CBOs to enhance their ability to apply for and
implement GF Malaria projects?

- How does the CCM support and strengthen CBOs to enhance their ability to apply for and implement GF Malaria projects?
- How does the DHMT support and strengthen CBOs to enhance their ability to apply for and implement GF Malaria projects?

g) Other significant issues on GFATM
- In your view, which are the other areas relevant to CBO strengthening and capacity building that could lead to improvement in CBO performance in applying for GF Malaria programs?