

Chapter 4

Kenya case study

Chapter overview

This chapter provides a case study of the collaborative situation in Kenya. First it provides a brief overview of the religious-health landscape in that country, in the context of the HIV and AIDS epidemic. Then it presents the country-specific findings, followed by recommendations arising from the research.

4.1 Kenya country context

Country Information¹¹²

Geography: Eastern Africa, bordering the Indian Ocean, between Somalia and Tanzania, 582,650 km²

Capital: Nairobi

Language: English (official), Kiswahili (official), numerous indigenous languages - Kenya's social diversity is reflected in various ethnic groups. They are divided on a linguistic basis into Bantu, Nilotic and Cushitic groups.

Politics: Kenya has been politically stable since independence in 1963. After nearly 30 years of single party rule, the country introduced multi-party democracy in 1991. An election-related conflict situation developed in 2008.

Administration: 7 provinces and 1 area.

Urban Rural Split: 80% of the country's population lives in remote rural areas.

Religion in Kenya¹¹³

Protestant 45%, Roman Catholic 33%, Muslim 10%, indigenous beliefs 10%, other 2%. A majority of Kenyans are Christian, but estimates for the percentage of the population that adheres to Islam or indigenous beliefs vary widely.



¹¹² CIA 2007, Molonzya 2003

¹¹³ CIA 2007

WHO Mortality Summary ¹¹⁴	Year	Males	Females	Both Sexes	Top ten causes of death all ages - Kenya 2002 ¹¹⁵	Deaths (000)	Years Life Lost %
Population (millions)	2005	17.2	17.1	34.3	All causes	376	100
Life expectancy (years)	2004	51	50	51	HIV/AIDS	144	40
Under-5 mortality (per 1000 live births)	2004	129	110	120	Lower respiratory infections	37	11
Adult mortality (per 1000)	2004	477	502		Diarrhoeal diseases	24	8
Maternal mortality (per 100000 live births)	2000		1000		Tuberculosis	19	5
					Malaria	18	6
					Cerebrovascular disease	14	1
					Ischaemic heart disease	13	1
					Perinatal conditions	13	5
					Road traffic accidents	7	2
					Chronic obstructive pulmonary disease	6	1

Other Health Information ¹¹⁶	Year	%
Total expenditure on health as % of GDP	2005	4.5
Per capita expenditure on health at ave exchange rate \$US	2003	20

4.1.1 Religious-health landscape in Kenya¹¹⁷

Kenya is home to a significant number of religious entities, and is often seen as the hub of regional development and health efforts. Speaking of the AIDS response in East Africa, Parry notes:

Kenya hosts numerous faith based Associations, Councils, Organizations, Secretariats, Consortiums and Networks that are not only national but also regional and international. Because they are umbrella organizations, or have chapters in many countries, they represent a huge constituency of some millions of believers and as such have the potential for enormous influence.¹¹⁸

A. The history of religious involvement in health

In Kenya, the mainline religions have historically set up health centres and hospitals as missionaries arrived in Kenya. For example, Catholic health care in Kenya has a long history, dating back to pre-independent Kenya in the early 1900s and continuing to present day.

Less is known about the historical involvement of non-mainline religions in health, such as the historical role of traditional religions and healers, other minority religions, as well as the more recent growth of Christian charismatic religious entities. What we know of mainline facility-based REs is that they have traditionally provided health services to communities in remote areas where other health providing agencies do not have infrastructure.¹¹⁹ There are also records of Islamic hospitals and health centres being established in Kenya during the colonial period.

B. Religious entities in the Kenyan health sector (or system)

Although less is known about community-based projects run by religious entities, especially congregational activities, the facility-based health-providing religious sector has a strong and organized presence in the Kenyan health sector. Secondary literature states that faith-based

¹¹⁴ UNAIDS 2006a, WHO-Afro 2006

¹¹⁵ WHO-Afro 2006

¹¹⁶ WHO-Afro 2006

¹¹⁷ Unless otherwise indicated, this summary is from the Schmid et al 2008 landscaping study

¹¹⁸ Parry 2002

¹¹⁹ Schmid et al 2008

organizations and networks currently provide more than 40% of health services in Kenya. This is depicted by the following statements:

- “The present Minister of Health, Hon. Mrs. Charity Ngilu, recently recognized the work of FBOs and singled out the Catholic Church as contributing up to 40% of the national struggle against HIV/AIDS.”¹²⁰
- In Kenya there are 974 faith-based facilities, 964 belonging to the Kenya Episcopal Conference (KEC) and the Christian Health Association of Kenya (CHAK), together providing 40% of national health services.¹²¹ “KEC and CHAK together have an allocation volume of 10 million - of whom about 1.5 million are inpatients and about 700,000 actual admissions per year.”¹²²

Figure 4.1: Kenyan Health facilities by ownership - source KEC participant 2008

Facility type	Government	Private	CHAK/KEC	KEC	CHAK
Hospital	147	42	68	44	24
Health centers	460	15	139	92	47
Dispensaries	1630	391	592	281	311
Medical centers	-	592	-	-	-
CBHC programs	-	-	98	46	52
TOTAL	2237 (51%)	1220 (28%)	896 (21%)	463 (11%)	433 (10%)

As can be seen from this table, just CHAK and KEC hold and manage a significant percentage of the total facility-based health assets and efforts. Adding to this are the number of undocumented religious entities, including those more spontaneous or community-based efforts. The religious-health ‘sector’ can thus be considered as significant.

4.1.2 The HIV and AIDS epidemic in Kenya¹²³

HIV and AIDS Estimates ¹²⁴	Estimate
Number of people living with HIV	1 300 000
National HIV prevalence among adults (ages 15-49) ¹²⁵	(1997/8) 10% (2006) 5.1%
Adults aged 15 and up living with HIV	1 200 000
Women aged 15 and up living with HIV	740 000
Deaths due to AIDS	140 000
Children aged 0 to 14 living with HIV	150 000
Orphans aged 0 to 17 due to AIDS	1 100 000

¹²⁰ CHAK 2008

¹²¹ Mwenda 2007

¹²² Mandi 2006

¹²³ This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008

¹²⁴ Unless otherwise stated, these come from UNAIDS 2006a

¹²⁵ These are 2007 readjusted surveillance stats from NACC 2008 (the UNGASS update report)

A. State of the epidemic¹²⁶

Kenya has a mature HIV epidemic¹²⁷ that demonstrates one of the region's most notable trends in decreasing HIV prevalence. National adult HIV prevalence is estimated to have halved in a decade (10% in the late 1990s to about 5.1% in 2006)¹²⁸ - "a dramatic and sustained decline that has rarely been seen in Africa."¹²⁹ This decline is seen as notable even with these newly adjusted estimates of 2007 and 2008.¹³⁰ This decline has been attributed in part to critical HIV services being scaled up, resulting in increased awareness and behavioural change, as well as a lower incidence of new infections and higher death rates as Kenya's epidemic moves into its 'death phase' (mortality rates are now double the rate of 1998).¹³¹

- **Location:** Current estimates place infection levels among urban residents twice as high as those among rural residents (8.3% to 4.0%). In Kenya, rural prevalence rates are historically lower than urban prevalence rates, but rural populations continue to trail behind urban ones in the pace at which infection rates drop.¹³²
- **A gendered epidemic:** In Kenya, women face considerably higher risk of HIV infection than men, and also experience a shorter life expectancy due to HIV and AIDS. One of the major challenges identified in the recent UNGASS 2008 update was the extensive differences in the risk of infection faced by different population groups. "Young girls are 5.5 times as likely as young men their age to become infected."¹³³ In the past, weak linkages in the planning and implementation of programmes addressing women's issues have been noted, with data often not disaggregated by gender.¹³⁴ However, recently HIV prevalence among young pregnant women declined significantly by more than 25% in both urban and rural areas.¹³⁵
- **High risk groups:** It has been suggested that because Kenya was previously categorized as a country with a generalized epidemic, this resulted in little attention being given to collecting data on HIV prevalence and behavioural indicators among the most-at-risk groups such as intravenous drug users (IDUs), Men who have sex with men (MSM), truck drivers, commercial sex workers (CSWs) and youth. It is of concern that high-risk social groups have been neglected in programming, treatment and care. "Limited data indicates that the high prevalence in some of these groups confirms that the epidemic pattern in Kenya indeed is concentrated in them. Kenya is preparing to model modes of transmission that it will use in the mid-term review of the HIV and AIDS strategic plan."¹³⁶
- **OVC:** Currently, it is estimated that there are 2.4 million orphans in Kenya. Half are orphans caused by the AIDS pandemic.¹³⁷ This remains an area of critical concern in Kenya. "The OVC situation is a deepening crisis as funding and programming fail to keep pace with the 2.4 million orphans who need care and support from their extended families

¹²⁶ This section acts as an introduction to the case-study to follow, and therefore not all HIV and AIDS statistics and issues are presented. See NACC 2008 for a more complete update of the Kenyan epidemic and national response

¹²⁷ Also sometimes termed 'severe and generalized'. See PEPFAR 2008, UNAIDS 2007

¹²⁸ UNAIDS 2007, with updated estimates says the adult prevalence has decreased from a high of around 14% in the mid-1990s to 5% in 2006.

¹²⁹ NACC 2008

¹³⁰ See NACC 2008, UNAIDS 2007

¹³¹ See UNAIDS 2006a and NACC 2008

¹³² NACC 2008

¹³³ NACC 2008

¹³⁴ UNAIDS 2006a

¹³⁵ UNAIDS 2007

¹³⁶ NACC 2008

¹³⁷ NACC 2008

and communities ... There is a marked bias favouring the urban in delivery of services, which means that the percentage of support for rural children is significantly lower.”¹³⁸

B. Timeline of significant events in Kenya’s AIDS epidemic

This timeline does not depict every AIDS-significant event in Kenya, but rather is an amalgam of events important to the participants, in government documentation, and participant documentation. It therefore contains events important to religious entities too.¹³⁹

- | | |
|------|---|
| 1984 | First public case of AIDS-death in Kenya |
| 1991 | Re-introduction of multiparty democracy |
| 1998 | The Great Lakes Initiative on AIDS (GLIA) signed by countries of the great lakes region of Africa (Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania, and Uganda). The mission of the GLIA is to contribute to the reduction of HIV infections and to mitigate the socio-economic impact of the epidemic in the great lakes region by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country. |
| 1999 | The Government of Kenya (GoK) declared <i>HIV/AIDS a national disaster</i> - following the publication of sessional paper number four of 1997 on AIDS in Kenya. |
| 1999 | Kenya formally adopted a multisectoral approach to combating HIV and AIDS. The multisectoral approach formed the foundation for the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005 and KNASP 2005/06-2009/10, which seeks to engage and mobilise all key social and economic sectors in the national response. |
| 2000 | The <i>National AIDS Control Council (NACC)</i> was established. |
| 2000 | The development of the <i>Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005</i> , which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners. |
| 2000 | Introduction of ARVs in Kenya |
| 2001 | The Ecumenical Response to HIV/AIDS in Africa (EHAIA). <i>Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa</i> . Nairobi, Kenya, 25-28 November 2001 |
| 2002 | Pan-African Lutheran Church Leadership, <i>Breaking the Silence, Commitments of the Pan-African Lutheran Church Leadership Consultation in response to the HIV/AIDS pandemic</i> . Nairobi, Kenya, 2-6 May 2002 |
| 2002 | Council of Anglican Provinces in Africa (CAPA). <i>Statement from CAPA AIDS Board Meeting</i> . Nairobi, Kenya, 19-22 August 2002. |
| 2002 | NASCOP established a National Antiretroviral Therapy Task Force to guide the way forward to scaling up the provision of antiretroviral therapy across the country. The policy involves both the private and public sector. |
| 2003 | East-Central Africa Division of Seventh-day Adventist Church. <i>East - Central Africa Division (ECD) of Seventh-day Adventist (SDA) Church Regional Workshop on HIV/AIDS. The Nairobi Declaration</i> . Nairobi Kenya, 10-13 November 2003. |
| 2003 | Just before the 2003 ICASA conference the Government of Kenya announced that it would start providing ARVs through public health facilities. Thereafter, multilateral donors led by the Global Fund and PEPFAR assisted Kenya in the provision of ARVs. |
| 2003 | International ICASA Conference on AIDS and Sexually Transmitted Infections in Africa <ul style="list-style-type: none">▪ Among other African nations Kenya adopts the Three Ones principle |

¹³⁸ NACC 2008

¹³⁹ Sources: NACC 2008, NACC 2005, UNAIDS 2006a, Webster 2005, WHO 2005, participant workshops and questionnaires

- 2003 In March 2003, President Mwai Kibaki declared 'total war' against HIV/AIDS (TOWA)
- 2003 The NACC devolved to the grassroots with the introduction of Constituency AIDS Control Committees (CACCs). By 2007 there was a CACC in each of Kenya's 210 constituencies.¹⁴⁰
- 2004 Formation of Kenya Inter-religious AIDS Council (KIRAC) by the government of Kenya.
- 2005 The development of the *Kenya National HIV/AIDS Strategic Plan (KNASP) 2005-2010*, which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners.
- 2005 Free ARV delivery
- 2005 The National Health Sector Strategic Plan 2005-2010 guides the health sector response. The health sector response to HIV/AIDS is addressed primarily through the National AIDS and STDs Control Programme (NAS COP) located within the Ministry of Health.
- 2006 Mainstreaming HIV into development instruments and key sectors prioritized.
- Progress made with regard to the Emergency Recovery Strategy, Medium-Term Expenditure Framework, Education sector and Home Affairs sector (Children's Department and Prisons).
- 2007 International Women's summit on Women leadership in HIV, sponsored by the YWCA, 4 July 2007.
- 2007 1st national Catholic AIDS Conference in Kenya 2007
- 2007 Joint Annual Review Programme (JAPR)
- 2008 It has been reported that the post-election crisis in early 2008 could have had an affect on the epidemic as thousands of Kenyans dropped out of their HIV treatment programmes in January. According to NACC, at least 15,000 out of the original 600,000 people initially displaced by the violence were HIV-positive. By late February 2008, fewer than half of them had access to treatment, but analysts now say most patients are back on treatment.¹⁴¹

C. Kenya's HIV and AIDS national policy: KNASP 2005¹⁴²

NACC (National AIDS Control Council). 2005. *Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/06-2009/10, (A Call to Action)*. Nairobi: NACC.

*Advances in understanding, better national coordination and growing international support and resources have created an unprecedented opportunity to prevent new infection and reduce the impact of HIV and AIDS in Kenya. To grasp this opportunity and build an effective, enhanced national response, all stakeholders need to work together within a common action framework. The KNASP 2005/06-2009/10 provides that framework. The KNASP articulates a set of common targets and results agreed upon by all stakeholders. As such, the KNASP enables all partners, both national and international, to make best use of their individual and collective resources in support of an effective and efficient national response.*¹⁴³

Commitment to the Three Ones: KNASP commits Kenya's strategy to the principle of the Three Ones. The KNASP document constitutes the one agreed HIV and AIDS action framework specified; the National HIV and AIDS Control Council (NACC) provides the one national coordinating authority, and one national monitoring and evaluation system is set in place.

¹⁴⁰ NACC JAPR 2007 in NACC 2008

¹⁴¹ PlusNews 2008b

¹⁴² Unless stated otherwise, all quotations in Section C come from the NACC 2005 KNASP policy document under discussion.

¹⁴³ NACC 2005

Commitment to a multisectoral approach: KNASP is described as a 'Plan of Action' for a deliberately multisectoral response to HIV and AIDS. In fact, the first Core Principle that underpins the strategy is, "A multisectoral approach, which enhances advocacy, builds strategic partnerships and mainstreams HIV/AIDS within key sectors". KNASP states that earlier responses to HIV and AIDS were largely centralised and health sector led.

With increased recognition of HIV/AIDS as a development problem affecting every aspect of life, there occurred a shift to a multisectoral response guided by one coordinating authority, M&E framework and strategy. Implementation of HIV/AIDS interventions devolved to individual sectors and decentralised levels in order to reach affected communities, families and individuals effectively.¹⁴⁴

The KNASP 2005/06-2009/10 employs three strategies to enhance the multisectoral approach: "strengthening existing and developing new strategic partnerships; mainstreaming HIV and AIDS in all sectors; and strengthening NACC's capacity to coordinate across sectors."

Commitment to a participatory process: It is stated in the KNASP policy that it was developed out of a participatory process in which many stakeholders took part. The stakeholders were drawn from a cross-section of public, private, civil society, faith-based organizations and international institutions.

The KNASP 2005/06-2009/10 evolved through a highly consultative, broad-based process launched in July 2004.

The KNASP ensures the effective engagement and participation of all stakeholders in the design, implementation and monitoring of strategic interventions. It is particularly important that vulnerable and/or underrepresented groups, such as PLWHA, women and young people, people living with disabilities (PWD), and nomadic and pastoralist groups, are empowered to make an effective and constructive contribution.

Commitment to one national M&E system: KNASP highlights the importance of monitoring and evaluation as "critical for the success of the KNASP." In line with the Three Ones principles, the establishment of a common national M&E framework to track the overall performance and impact of the national response is ensured.

All partners involved in the implementation of KNASP shall report progress in their specific areas and receive feedback on the overall progress of the national response within the framework set out by the national M&E system.

The NACC UNGASS 2008 report notes that this national M&E system faces some challenges. For example, "some partners still rely on their parallel M&E systems ... [although] most stakeholders are willing to buy into the national M&E framework. M&E training should be conducted at local levels ... information is useful if used at the source, but there is weak competence in data use at all levels."¹⁴⁵

Commitment to the Joint Annual Review Programme (JAPR): The NACC UNGASS 2008 report sees JAPR as the tool to reinforce the Three Ones principle.

Civil society activities are the backbone of the national response to HIV and AIDS while development partners underwrite a major portion of these programmes. It is difficult to monitor and coordinate the diverse spectrum of budgetary and programmatic planning.

¹⁴⁴ NACC 2005

¹⁴⁵ NACC 2008

This is why JAPR was created in 2002... The JAPR embodies the Three Ones principle and gives it a solid foundation ... JAPR has enjoyed seminal achievements.¹⁴⁶

What is also of interest is that as of 2008, DfID and the World Bank will only commit funding to programmes that come through the national JAPR system.¹⁴⁷ The broadening of the national multisectoral collaboration is currently based on a process of decentralization of NACC's structures and the annual JAPR to district and community levels.¹⁴⁸

The coordinating structures named in KNASP: The National AIDS Control Council (NACC) was established by the Kenyan government in 2000 to coordinate the multisectoral response. The structures named in the report are:

- NACC: which operates under the Office of the President with the Cabinet Sub-committee on AIDS being the oversight body. The NACC board consists of permanent secretaries drawn from a range of ministries as well as representatives from civil society organizations, people living with HIV and AIDS (PLWHA) groups and the private sector.¹⁴⁹ NACC coordinates all Kenyan programmes, policy and interventions in the AIDS sector. A UNAIDS country profile states that NACC "has been able to establish itself as the one national coordinating authority on HIV, with a substantially enhanced public image and credibility."¹⁵⁰
- Other structures named in KNASP are: DTC District Technical Committees, CACCS Constituency AIDS Control Committees, ICC Inter Agency Coordinating Committee in NACC, and MCG Monitoring and Coordination Group for each priority area.
- NASCOP (The National AIDS and Sexually Transmitted Diseases Control Programme) of the Ministry of Health is stated as the lead agency in most of the Results Framework in the KNASP document.
- Key faith-based partners identified in the implementation of the KNASP policy are identified as 'KIRAC/FBOs'

4.1.3 A brief survey of the state of collaboration in Kenya

Kenya is implementing a successful multi-sectoral response to HIV/AIDS ... There is an increasing understanding and willingness to cooperate among stakeholders across Government, civil society, the private sector and development partners ... But progress cannot be taken for granted; enormous challenges remain.¹⁵¹

We will briefly consider some of the key issues emerging from secondary literature on the state of multisectoral collaboration in Kenya - relevant to this research.

A. Collaboration with government

¹⁴⁶ NACC 2008

¹⁴⁷ NACC 2008

¹⁴⁸ NACC 2008

¹⁴⁹ NACC 2008

¹⁵⁰ UNAIDS 2006a

¹⁵¹ NACC 2005

There is little secondary literature that provides a balanced picture of what the state of collaboration is between Christian religious entities (CREs) and the Kenyan government, hence this research. What literature there is points to two avenues for CREs' collaboration with government, the first is through health-services collaboration (for example between CHAK, KEC and the Ministry of Health), and the second, as part of 'civil society' through NACC.

From CHAK and KEC organizational documentation, there appears to be a strong collaborative relationship with government - not surprising considering their ownership of about 40% of the national health infrastructure¹⁵² - built around health more generally (rather than specific to HIV and AIDS). This literature does speak of some tension in the past, but more strongly of developing collaborative structures and channels between CHAK, KEC and the Kenyan government - mainly around working groups, such as the *Technical Working Group, Ministry of Health-Faith Based Health Services (MOH-FBHS-TWG)*. For example, during a recent HR crisis when nurses from the CREs were being recruited into the government health facilities, swift advocacy on the part of CHAK and KEC appeared to generate dialogue and have satisfactory results.¹⁵³

Beyond these health-providing facilities, CREs in Kenya are assumed to be part of 'civil society' involved in multi-sectoral collaboration around HIV and AIDS. Government documentation states that "the inclusion of (civil society organizations) CSOs in AIDS policy, planning and programming has improved."¹⁵⁴ UNAIDS agrees that NACC has been proactive in ensuring that civil society engages in key national planning processes and mechanisms.¹⁵⁵ More research is needed to know exactly how inclusive such collaboration with government is, and in particular, *which* representatives of civil society (and CREs) are included, and which are not.

B. Interfaith and ecumenical collaboration

Again, there is not much clarity on the ways CREs collaborate together around HIV and AIDS - and what we do know is from the documentation of the mainline Christian health providers who appear to have strong collaboration in their health-provision services. For example, CHAK and KEC jointly own the *Mission for Essential Drugs and Supply (MEDS)*, which provides essential drugs and medical supplies, as well as training of church and other not-for-profit health facilities in the management and appropriate use of drugs.¹⁵⁶ Of ecumenical or interfaith collaboration around HIV and AIDS little has been reported, apart from the formation of the *Kenya Inter Religious AIDS Consortium (KIRAC)*.¹⁵⁷ A World Council of Churches (WCC) study says of Kenya:

It is our considered opinion that genuine networking among churches and ecumenical organizations needs to be nurtured for them to benefit from the networks. The study has demonstrated that the Inter Religious AIDS Consortium of Kenya (IRCK) has been formed at the initiative of the National AIDS Control Council and not that of the member

¹⁵² See 4.1.2 above

¹⁵³ CHAK 2008, CHAK 2007, CHAK 2006

¹⁵⁴ NACC 2008

¹⁵⁵ UNAIDS 2006a

¹⁵⁶ GHC 2007, CHAK 2006

¹⁵⁷ Molonzya 2003

religious organizations therefore raising questions of genuine ownership of the consortium by the religious organizations.¹⁵⁸

This same study notes that the avenues for networking for churches and ecumenical organizations in Kenya are: the Kenya AIDS NGOs Consortium (KANCO), the Kenya Inter Religious AIDS Consortium (KIRAC), the Christian Health Association of Kenya (CHAK) and the Ecumenical Pharmaceutical Network (EPN).¹⁵⁹

It was briefly mentioned above that Kenya is a 'hub' of regional and international REs. Although this has not been investigated, it seems logical that this might have an effect on the degree of collaboration between REs - given an increased access and presence of a variety of national, international and regional representatives. For example, CHAK was recently appointed to host the first secretariat for African Countries CHAs, a platform intended to support and coordinate networking, communication, sharing of information, experiences and planning for the African CHAs.¹⁶⁰ Working out of the CHAK office, it is possible that such a platform function increases CHAK's own collaborative network and functioning.

C. Collaboration between funders

Literature suggests that collaboration between donors remains a challenge in Kenya - even in the multisectoral context of HIV and AIDS response. UNAIDS notes that "harmonizing and aligning donor activities in support of a nationally owned agenda with defined priorities remains a challenge."¹⁶¹

However, NACC and the WHO point out that coordination among partners has recently improved with the establishment of coordinating committees.

Government, international partners and agencies, civil society and the private sector influence strategy and policy through the *Interagency Coordinating Committee for HIV and AIDS* (ICC-AIDS), the *Joint Interagency Coordinating Committee* (JICC) and the *Country Coordinating Mechanism* (CCM). ICC-AIDS is the primary forum for convening stakeholders to deliberate on the national response to AIDS. It presents decisions on Global Fund issues at the CCM.¹⁶²

This suggests that the structures are in place for funding organizations to meet and collaborate.

4.1.4 A brief survey of the state of funding in Kenya

This research did not set out to provide a full funding breakdown for Kenya or for CREs in Kenya. Nevertheless, there are a few themes that emerge:

- CREs experienced a period of funding crisis in the 1990s in Kenya "much of the support FBOs were getting from the big congregations, churches and donors, as well as the assistance received from the government from as far back as the fifties and sixties, came to an end."¹⁶³

¹⁵⁸ Molonzya 2003

¹⁵⁹ Molonzya 2003

¹⁶⁰ CHAK 2008

¹⁶¹ UNAIDS 2006a

¹⁶² NACC 2008

¹⁶³ Mandi 2006

- Major funds are channelled through NACC, such as the Global Fund, the United States Government, the World Bank, and the United Kingdom's Department for International Development.
- Kenya is one of PEPFAR's 15 focus countries. Under the Emergency Plan, Kenya received nearly \$92.5 million in Fiscal Year (FY) 2004, more than \$142.9 million in FY 2005, approximately \$208.3 million in FY 2006, \$368.1 million in FY 2007, and is expected to exceed \$500 million in 2008.¹⁶⁴
- CREs (e.g. CHAK) are part of the Global Fund country coordinating mechanism for Kenya, and are PEPFAR recipients.
- International funding for HIV and AIDS initiatives has increased in Kenya, with 98% of currently available funding coming from international donors.¹⁶⁵
- This heavy reliance on donor funding makes long-term sustainability a challenge.¹⁶⁶
- While support seems to be aimed across the spectrum of prevention, treatment, care and support - NACC notes that development partners have favored supporting ART rollout over less costly prevention measures.¹⁶⁷
- In Kenya, the demand for ARV is on the increase and delivery is almost entirely supported by development partners. "The recent emphasis on treatment has overshadowed programmatic activity in prevention and is becoming costly ... This raises concerns about the long-term sustainability of ART."¹⁶⁸
- NACC has called for development partners to align their programmes and funding to national response priorities, saying "they must refrain from implementing systems parallel to the Three Ones for M&E and reporting. PEPFAR should follow the example of other development partners and observe the principle of basket funding."¹⁶⁹
- Similarly, the civil society perspective in the UNGASS report¹⁷⁰ mentions the following challenges in collaboration with development partners:

While some development partners recognize the importance of civil society, this does not yet translate to optimal engagement with civil society as equal partners ...

Development partners should harmonize the way they work with civil society. The different approaches and requirements of individual donors create confusion among CSOs and increase their workload. The requirements related to calls for proposals and reporting should be simplified so that all applicants are able to meet them ...

Donors tend to focus their support in the same geographic areas ...

Because civil society is often represented by big NGOs, development partners tend to overestimate CSO capacity. Development partners could help strengthen CSO capacity by allocating a percentage of each grant for that purpose.

Development partners' funding of civil society would be more effective if disbursements were direct rather than through the government.

¹⁶⁴ NACC 2008, UNAIDS 2006a

¹⁶⁵ UNAIDS 2006a

¹⁶⁶ NACC 2008, UNAIDS 2006a

¹⁶⁷ NACC 2008

¹⁶⁸ NACC 2008

¹⁶⁹ NACC 2008

¹⁷⁰ NACC 2008

See box 4.1 below which contains an extract from the 2008 UNGASS report, specifically the civil society perspective on funding and the financial situation in Kenya.

Box 4.1: The civil society perspective on the financial situation in Kenya

Increase government funding: Civil society is responsible for the majority of Kenya's programmes. For instance, FBOs deliver almost 40% of health care services. However, they receive little or no government funding. Exacerbating this problem is the fact that when the government does a survey or sets a target it includes and relies on our programmes but still does not contribute to our operations. The government should give us a formal commitment to work with civil society and to allocate funds to us.

Increase donor funding: We believe that clear expressions of partnership with civil society should be incorporated into all calls for proposals.

KNASP 2005/6-2009/10: CSO budgets should be aligned with KNASP 2005/6-2009/10. Donors should allocate funding to operational research as outlined in KNASP 2005/6-2009/10.

More transparency in funding allocation: Decisions about the allocation of funds are made without clear criteria or proper consultation. Civil society representation in decision-making forums is ensured on paper, but in reality our voices and contributions are often ignored.

More effective regulation of claimant organizations: Organizations that are eligible for grants should be better regulated. It is also important to take note of local mobilization constraints. Regulation should not inhibit genuine applicants from poor and vulnerable groups who are sincere in their intent but find it difficult to meet the demands of bureaucratic procedures.

Promote coordination of funding allocation: Funding mechanisms such as the World Bank's programme of support, constituency development funding and various multilateral and bilateral initiatives must coalesce around one coordinating body to avoid multiplicity of funding to singular components, geographic areas or implementers.

Source NACC 2008

4.1.5 The key players in the Kenyan HIV and AIDS context

We provide here a listing of some of the key organizations that secondary literature shows are working in the Kenyan multisectoral context. This is in no way a comprehensive listing.¹⁷¹

Government structures: National AIDS Control Council (NACC), National AIDS Control Program (NAS COP), Interagency Coordinating Committee for HIV and AIDS (ICC-AIDS), the Joint Interagency Coordinating Committee (JICC), the Country Coordinating Mechanism (CCM) ...

Collaborative networks or networking organizations: Kenya AIDS NGOs Consortium (KANCO), Kenya HIV/AIDS Private Sector Business Council, the Kenya Inter Religious AIDS Consortium (KIRAC), the Christian Health Association of Kenya (CHAK) ...

Multilaterals, bilaterals and major donors providing support to address Malawi's HIV and AIDS epidemic: AUSAID, British Council, Canadian International Development Agency (CIDA), Church World Service (CWS), CIDA, DANIDA, Department for International Development (DfID), European Community (EC), Family Health International (FHI), FIDA International, Global Fund to fight AIDS, TB, and Malaria, Government of Finland, GTZ, Hope Worldwide, JICA, Joint United Nations Programme on HIV/AIDS (UNAIDS), Médecins Sans Frontières, Norwegian Church Aid (NCA), Pathfinder, Population Services International (PSI), President's Emergency Plan for AIDS Relief (PEPFAR), SIDA, U.S. Agency for International Development (USAID), UN family (e.g. UNAIDS, UNDP, UNICEF), United States Centers for Disease Control and Prevention (CDC), World Bank (WB), World Health Organization (WHO)...

¹⁷¹ See NACC 2008, UNAID 2006b, Webster 2005, WHO 2005, World Bank 2008

Christian religious entities engaged in HIV and AIDS: secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in Kenya. In 2003, the WCC study concluded that in Kenya there is a, "...glaring lack of involvement of many churches, ecumenical and secular organizations in the mitigation of the socio-economic impacts of HIV/AIDS and also the lack of proper monitoring and evaluation of their HIV/AIDS programmes."¹⁷²

The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.1. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in Kenya. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in Kenya, and is a working document that can be utilized and developed further in Kenya.



Figure 4.2 Nairobi, Kenya - 2008

4.2 The findings of the research in Kenya

The participatory research process was designed to identify findings in four key areas:

1. Concerning the context in which Christian religious entities (CREs) are working
2. Concerning the work of CREs in the promotion of Universal Access
3. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
4. Concerning the challenges and potential of collaborative partnerships between CREs and other stakeholders

¹⁷² Molonzya 2003

Within these four areas, the participatory research process produced the following six findings in Kenya:

1. CREs in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV and AIDS epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.
2. CREs in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women
3. In their contribution to Universal Access CREs in Kenya are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration
4. CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the clarity of the national policy, the collaborative structures that have been established, and the increased funding for CREs. (2) The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.
5. CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of CREs, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.
6. There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation of a range of stakeholders in formulating national policy and donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national M&E process.

We now examine each of these findings in greater detail, drawing from the evidence that emerged in the workshops and questionnaires. Supporting commentary and evidence from secondary literature can be found in the footnotes. The chapter concludes with a set of clear recommendations based on these findings.

4.2.1 Findings concerning the context in which Christian religious entities are working

Finding 1: Christian religious entities in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV and AIDS epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.

In the participatory workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in national and social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

Many of the CREs involved in responding to the epidemic have a long presence in Kenya, some dating back to the nineteenth century such as the Anglican Church of Kenya (1844) and the Presbyterian Church of East Africa (PCEA 1891). Many others pre-date Kenyan independence in 1963 such as the Young Women's Christian Association (YWCA 1912), CRS (1943), CHAK (1946), KEC (1950), St Johns Community Center (SJCC 1957).

Furthermore, Kenya has been a centre for wider Christian involvement for a long time. In 1973 the Protestant churches of Africa established the offices of the All African Council of Churches in Nairobi, and in 1984 the Pope visited Kenya.

CREs perceive themselves to have responded quite early to the HIV and AIDS epidemic, with participants agreeing that there was already a response to the epidemic in the late 1980s and early 1990's. In 1986 the Presbyterian Church of East Africa had a symposium to deal with the emerging crisis and invited the government to partner with them.¹⁷³ In the same year the first Catholic bishop wrote a pastoral letter on HIV and AIDS. The Anglicans held a conference in 1997 in Mombasa, where they produced a draft policy on AIDS for the Anglican Church. In 2006, The Kenya Episcopal Conference (Roman Catholic) celebrated 20 years of involvement in responding to HIV and AIDS. Participants in the workshop noted that not only were more CREs responding to HIV and AIDS, but that there had also been a boom of new AIDS-engaged religious entities emerging in Kenya from around 2000.¹⁷⁴

There is furthermore, a perception amongst CREs that they pioneered in part the response to HIV and AIDS in Kenya.

CHAK and others started working against HIV and AIDS much earlier, in 1990 CHAK started working in HIV/AIDS ... but the truth is that the churches started much earlier than the government ... in fact some of the programs the churches were running were borrowed by the government¹⁷⁵

When HIV/AIDS was first recorded in Kenya, in the 1980s, we were in denial, only the churches got involved, saying we have a problem, we have to do something about it, and because of the action of the churches, the government got involved - in 1999 - so the church actually took a lead in lobbying and advocacy to get the government [to respond]

¹⁷³ This perception is supported by secondary literature - see Molonzya 2003

¹⁷⁴ This boom appears to have happened in most SSA countries. See chapter 3 for further discussion

¹⁷⁵ All in-text quotations from here on, in this chapter, are from participants in the two Kenyan workshops. Anonymity was assured in order to provide a more participatory discussion

There is also recognition that when the government declared HIV and AIDS a national disaster in 1999, this enabled the churches to find a stronger sense of direction. As access to funding from PEPFAR and the Global Fund became possible, a number of new CREs emerged. Many of these do not have a national footprint, but work locally. However, it was felt that while the government initiative assisted in focusing the energy of the CREs, not much has come from this partnership.

In 2003 the government called all churches together and we thought more would come from that, that there would be more commitment ... but not much has happened. There hasn't been the finance.

Participants were also very aware of the relationship between the social context and public health, and how this impacts upon the HIV and AIDS epidemic. Two clear periods were identified. The first had to do with the impact of structural adjustment on health care in Kenya as the epidemic was growing. The following statements illustrate this point:

1985-1986 structural adjustment took place and poor people suffered. Health collapsed and there was the spread of HIV/AIDS [general agreement]. This opened the floodgates; the poor were laid off, there was expansion of informal settlements, and disease spread.

Companies closed down and donor funding became scarce, and people became poorer.

Fee payment at hospitals started which meant that many people could not access health facilities.¹⁷⁶

At the same time a drought happened, and people were laid off...

There was a gender dimension; that is when the feminization of poverty happened...when the funds laid off the staff ... mostly mothers laid off, and led to risky sex behaviour ... in our context the women and children ended up suffering more ... at the hospital, if you did not have money you could not go.

[This led to] urbanisation as people moved in search of jobs.

The second period was more recent, with the violence and turmoil following the election in December 2007. This research was not in a position to gain any long-term perspective on the impact of this turmoil, but it was clear that it has disturbed relationships and unsettled many people. Participants were reluctant to speak in much depth about the current violence after the elections, but statements such as the following indicated that the current context needs to be taken seriously for any future initiatives to strengthen multisectoral collaboration.

We are a very peaceful people ... we have wondered in the past, what do we have to do to make [Kenyans] react? ... this goes against the grain of 47 years, revealing things about ourselves ... it was a shock.

I'm still crying ... we have not said happy New Year this year...it has been a tearful time.

From the faith community ... some of our colleagues took sides, and the church never took a position before this ...

¹⁷⁶ Kenya introduced user fees in early 1990s but rescinded them in late 90s in response to steeply declining utilisation stats for govt health facilities and inability to administer the user fee system fairly and efficiently

It is clear therefore that within the context of Kenya, CREs perceive themselves to have a well established participation in national and social life, including responding to the HIV and AIDS epidemic. They understand themselves to be key stakeholders in the national response to HIV and AIDS, and that their contribution and insights should be taken seriously in that response. Furthermore, they are aware that there are a range of factors within in the national and social life of the nation that drive the epidemic.

4.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

Finding 2: Christian religious entities in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women.

The desk review as well as the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic (see Appendix 6).

While not each and every entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole, CREs in Kenya perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived:¹⁷⁷

Prevention	Treatment	Care	Support	Other
CHAK	CHAK	CHAK	KEC	KIRAC
KEC	KEC	CCSMKE	CCSMKE	ADRA
CCSMKE	DOSS ACK	YWCA	DOSS ACK	NCKK
(ACK)	CRS	SJCC	YWCA	EAA
DOSS (ACK)	PCEA	ADRA	SJCC	
KIRAC	SDA	CRS	CRS	
YWCA		SDA	PCEA	
SJCC		NCKK		
ADRA		EAA		
PCEA		ITK		
SDA				
NCKK				
EAA				
ITK				

Figure 4.3: Depiction of participatory exercise, Kenya 2008

A. Prevention

Four kinds of prevention activities predominate:

- The most predominant activity is education and awareness work. Prevention messages tend to focus on abstinence and behaviour change, particularly among the youth. There is,

¹⁷⁷ See Appendix 1 for acronyms. Those in italics in the table above did not have representatives at the workshop, but were added on the strong suggestion of participants.

however, also some reproductive health peer education. Some have adopted a Trainer of Trainers approach and developed training manuals in this process.

- Some organizations are involved in prevention of mother to child transmission (PMTCT). Of note is KEC who indicated that their programme had reached over 100,000 mothers in the last four years.
- In addition, voluntary counselling and testing (VCT) is undertaken. KEC is involved through 170 centres, while PCEA operates 70 centres.
- Capacity building among health workers is recognised as important by CHAK who see this as a way of strengthening their ability to carry out HIV and AIDS education.

B. Treatment

CREs are involved in treatment through a range of church medical facilities in the country. A key aspect is the provision of anti-retroviral treatment (ART) as well as treatment for sexually transmitted infections. Thus for example:

- CHAK is involved in: service delivery, treatment and care of PLWHA through health facilities using ARTs. Management of opportunistic infection (OIs) through health facilities, nutritional care, providing treatment at a national level.
- CRS is involved in: increased access to ARVs. It has 24 mission hospitals where among other things, ART is administered and the management of opportunistic infections takes place. PCEA is involved in treatment through 3 main church hospitals: Kikuyu, Dumutumu, Chogoria. From these hospitals, ART is administered.
- DOSS of the Anglican Church of Kenya also operates hospitals and health centres in which STI's are treated as well as ART administered.

KEC is significantly involved in treatment through 45 hospitals. They estimate that through their programme about 35 000 people are receiving ART which constitutes 16% of the national figure of 180 000, 3 000 of which are children.

Participants noted that the network of mission hospitals have been key to the roll-out of ART in Kenya. They are recognised as having started this work prior to the government with MEDS having started training in 2002.

In this country, mission hospitals are very important ... mission hospitals started ahead of the government roll-out.

A lot of health facilities are faith based and they have some of the best care for HIV and AIDS patients. The church has pushed treatment more than the government.

Treatment is seen by CREs to be an area in which there is significant collaboration with government who use the mission hospitals for training and for the distribution of ART.

The mission hospitals are very important ... that is where we collaborate with the government...and distribute a lot of ARVs here.

C. Care

With regard to care, two activities predominate:

- The home based care networks which provide opportunities for assisting people living with HIV and AIDS.
- Care for orphans and vulnerable children.

The area of caring for orphans consumes much of the energy of CREs.

We have been abandoned with the children ... we do not have the resources ... we are overwhelmed ... we have no choice ... there is no one else [to do this work].

There is another aspect, the churches sponsor schools - and these children are in these schools, and when the teacher says there are these children, the church takes on the responsibility ... so you have these children in your institutions ... you are sharing the same comfort.

Participants also noted that CREs do not always make a clear distinction between care and support.

D. Support

CREs are involved in a range of 'support' activities for people living with HIV and AIDS, and particularly for orphans and vulnerable children (OVC) and widows.

We are spending a lot of time and money making sure communities know how to support orphans ... and that children have vocational training.

These activities include:

- Promotion of good nutrition
- Education (support for orphans and vulnerable children)
- Credit support
- Agricultural support
- Economic empowerment
- Vocational training
- Psycho-social support

E. Other

The key other aspects that CREs are involved in are:

- Radio Programmes and information and communication technology (ICT) in order to do HIV and AIDS prevention
- Organizational capacity building and support
- Targeting issues of stigma and discrimination
- Advocacy work

Participants admitted that while they were involved in various forms of advocacy work, most were not involved in policy development.

F. Beneficiaries

In promoting Universal Access to Prevention Treatment Care and Support, CREs work with a wide range of beneficiaries.

In terms of **location** while these national entities have their offices in Nairobi, there is a strong commitment to a focus on rural areas.

We have health facilities in rural centres where there are no government facilities ... the government have not been there.

In areas that are very remote with poor infrastructure, even now after 40 years the government has not been able to do much there and only the FBOs are there.

There was also recognition that Kenyan society is characterised by ongoing **migration**. The HIV and AIDS epidemic is strongly felt amongst people on the margins of society, many of whom are rural people, who have moved to the urban slums around cities like Nairobi.

In terms of **gender**, while participants in the research recognised that it is crucial to work with men, they acknowledged that most of the work is with women. When participants at the workshop were asked if any organization had ever run programs for men only, all admitted that they had not saying, "we are not doing much work with men". But they recognised the crucial role men played in curbing the epidemic, and acknowledged that in some areas men often did not go to church, but "sent their wives". They further acknowledged that women are bearing the brunt of care. "Most people [doing the] care are women," and training for HBC took place mainly with women.

In terms of the **religious** constituency and working with people outside the Christian faith, it is clear that CREs are committed, in terms of both principle and policy, to working with all people. However, in reality they recognised that they work mainly with Christians. As one participant said:

We do not discriminate but at the end of the day we work mainly with Christians, even though we do not discriminate.

Some of the CREs, such as CRS, have non-Christian staff in some of their projects. Furthermore, there is support from CRS for both KCS and CHAK. In addition, there is also direct intentional work together. One such example is the instance where KCS and CHAK run treatment programs together. Participants affirmed that treatment is a key area where collaboration takes place between Christian and non-CREs.

This section has supported our finding that CREs in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support. Four key prevention strategies are education and awareness, PMTCT, VCT and capacity building amongst health workers. CREs are involved in treatment through a range of church medical facilities in the country. A key aspect is the provision of anti-retroviral treatment (ART) as well as treatment for sexually transmitted infections to a large number of people. Care is focused on home-based care for PLWHA, and care for orphans and vulnerable children, the latter task consuming much energy. A range of support activities are undertaken including credit support, vocational training and psycho-social support.

In terms of beneficiaries, CREs are strongly committed to working with rural people. While they recognize the importance of working with men, most of the programmes work with women. There is limited engagement with non-Christians, predominantly in the area of treatment.

Finding 3: In their contribution to Universal Access Christian religious entities in Kenya are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

As discussed in chapter 3, religious entities are seen to have key strengths that offer leverage for the response to the HIV and AIDS epidemic. In the introduction above, we further presented some of the assets religious entities are said to hold in the Kenyan health system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this capacity was nevertheless clearly demonstrated throughout the discussion and in the organizational documentation collected through the desk review and questionnaire response.

In the workshop, when representatives of collaborative stakeholders such as government, donors and other religions were asked to reflect on the work of CREs they identified three major areas of strength.¹⁷⁸

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to 'grassroots people' and were therefore in a position to influence communities. Furthermore, they were in contact with large numbers of people within close proximity to their sphere of influence.

(2) This related to the second area of strength, namely their **legitimacy** within communities. This legitimacy stemmed from their history of work in the rural communities of Kenya, but also because they were available and willing to offer psychosocial and spiritual support. They represented a moral authority arising out of their values based on the Bible, which was the driving force behind the implementation of their programmes. Because of a religious imperative to be available to people and to care for them, they represented an important resource for curbing of the epidemic and offered immediate relief, particularly to orphans and vulnerable children. As a result of all of this, they enjoyed significant credibility within communities.

(3) The third area of major strength lay in their **resources**, both human and material. They had committed workers that were able to mobilise people easily. Their structures are defined and well organized which further assists in mobilisation processes, particularly in rural areas where, as it was acknowledged, "even the government does not have structures in the rural areas." Furthermore, human and material resources were plentiful through their large national and international networks.

CREs in Kenya are acknowledged by collaborative stakeholders as having key strengths in three areas: (i) their 'reach' enables them to serve a wide range of people; (ii) their legitimacy, owing to their history of work, their willingness to serve, and their moral authority; and (iii) their

¹⁷⁸ See chapter 3 discussion

human and material resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

4.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

Finding 4: Christian religious entities in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the clarity of the national policy particularly around the Three Ones, the collaborative structures that have been established, and the increased funding for Christian religious entities. (2) The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

Through the desk review and the snowballing approach to the identification of participants for the workshop, it was clear that CREs are involved in a range of collaborative partnerships. (See above and Appendix 5.2 for the selection of key collaborative stakeholders identified by advisors in Kenya.)

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs.¹⁷⁹

This was confirmed in an exercise carried out with representatives from CREs in which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with collaborative stakeholders. This exercise sparked much animated discussion over lunch and later in the day and indicated that in Kenya:

- Most CREs have a number of relationships with each other, government and donors, although some were not connected to coordinating bodies.
- In Kenya, there was some relationship between CREs and government. Some CREs were connected to several government structures (e.g. NACC, Ministry of Education (MoE), Ministry of Health (MoH), Children's Department).
- Donors in Kenya appeared to mainly work with government (through NACC) and did not seem to dominate this relationship.
- There was some interaction between the CREs present at the workshop and interfaith bodies, mainly CHAK, YWCA and DOSS.

¹⁷⁹ As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs.

A. Perceptions of Christian religious entities about collaboration

In seeking to understand the perceptions of CREs concerning collaboration, time was spent exploring their attitude towards government policy, government practice, and collaborative relationships with funders.

Interaction with Government Policy

The *Kenya National Aids Strategic Plan (KNASP)* was used as a basis for exploration of their perceptions of government policy with regard to the HIV and AIDS epidemic. At the beginning of the session the facilitator checked on the participant's familiarity with the KNASP policy document

Although all participants acknowledged familiarity, not all had actually read it, which meant that many of the responses were not coming from firsthand knowledge of the document. Nonetheless, there was **positive** agreement that the policy:

- Acknowledges the Three Ones as important for an effective response to the HIV and AIDS epidemic.

The Three Ones is very important...it has made it more effective, people know what they are doing, know what the CBOs are doing.

- Makes a clear statement regarding the impact of HIV and AIDS and what needs to be done to mitigate its effect.
- Lays out clear goals, objectives and targets.
- Makes provision for co-evaluation and includes a M&E framework
- Seeks to involve a number of key stakeholders.
- Puts a number of structures in place: NACC: National AIDS Control Council, DTC: District Technical Committees, CACCS: Constituency AIDS Control Committees, ICC: Inter Agency Coordinating Committee in NACC, MCG: Monitoring and Coordination Group for each priority area.

Further, also important was the issue of the participatory nature of the policy development process. Many participants asserted that there had been involvement in this process by organs of civil society as well as 'grassroots' communities. There were two participants who had directly been involved in workshops leading to the production of the document. When asked by the facilitator if there was a general feeling that people had been adequately consulted, most responded in the affirmative, commenting:

...we own the document ... it is ours.

However, it became clear later in the discussion that there was a general lack of familiarity with the document. Towards the end of this discussion, a contradictory discussion arose where some participants voiced a concern that few representative organizations were involved in the policy formation, and that there was a lack of participation from the 'grassroots'. This contradictory response was further demonstrated by the lack of response when the facilitator probed participants about how the document addresses the African context and related issues.

Two major areas of **weakness** in the policy document were identified:

- That the policy assumed KIRAC to be representative of all inter-religious organizations and participants felt this was a misrepresentation of the situation on the ground. “The whole perception that KIRAC represents the interfaith community is a mis-representation ... it is referred to all the time like that, but [it is] not.” As a result of this assumption, they felt that problems arose around communication and support being channelled through this one structure.
- That the policy focuses on resource allocation without this being adequately linked to the national budget. Thus, it was felt, that the government is reliant on external funding which leads to gaps in service delivery.

It was noted by one participant that KNASP was not the only relevant document. Other policies such as the National OVC and HBC guides, Kenya Education Sector Strategic Plan, VCT National Policy, National Policy on Condom Distribution, and the Reproductive Health Policy were seen to be more helpful in determining particular strategies for areas of intervention.

Interaction with Government Practice

CREs appreciated the fact that there was a participatory approach to the work of government. As a result, they felt that there is a fair amount of networking with organizations. Important to the work of government was the fact that they recognised the need for information at a district level and invested time and resources into these programmes. Coordinating structures are in place which enable government to liaise with organizations. This resulted in an increasing sense of accountability in resource utilization by the NACC. What was particularly appreciated, was the rapid rollout of ART. This was seen as impressive with 180 000 people out of the 200 000 who need ART receiving treatment.

CREs did feel that there were negative points in government practice relating to the HIV and AIDS epidemic, mostly related to the bureaucratic nature of the NACC which made it difficult to pursue the Three Ones policy. This hampered resource allocation, and hindered open communication with the grassroots. They felt that there is poor implementation of monitoring and evaluation of programmes with channels of communication not being clearly outlined.

The channels for providing information are not clear ... we are happy to feed into the national system, but the problem is in the process.

Some participants felt it was unreasonable of NACC to expect CREs who do not receive national funds to nonetheless report to the national body. This was also related to the expressed concern that there were cases of corruption and incompetence in some parts of the national structures.

... we have given accounts three times, we give them the documents and after three months they ask again. I have actually told my people to stop accounting, because you don't know whether we are accounting for other organizations ... we give receipts for expenditure, and we have accounted three times.

Furthermore, it was felt that there are inadequate strategies to address the most vulnerable group, namely women in the 25-39 year group. This related to the fact that budget allocation from government seemed to 'lack conviction' in the face of the magnitude of the epidemic. In addition, it was felt by some that the HIV and AIDS agenda is not driven by government but by the global donors. This was seen as another form of 'colonial intervention'.

A key area of tension for CREs when working with government stakeholders was the emphasis on condom promotion as the main prevention tool. In the early years of responding to the epidemic, this issue clearly led to tensions between all religious entities and government.

We were involved [in responding to the epidemic], but not in a way that the government or funders recognize ... because of the condom issues ... the government and funders viewed the churches as a stumbling block. The condoms became an issue [between church and government] in that same period [around 1999]. Because I remember, Catholics, bishops and Muslims went to [Urubad] to burn condoms ... in 1995-1996 ... so donors and governments saw the church as a stumbling block, and yet we were doing our work, within our power ...¹⁸⁰

While participants recognised that promoting condom use is an important aspect of prevention, they were clear that CREs themselves generally do not promote condoms as part of their main prevention strategy.

We are promoting abstinence, but it does not mean we do not recognize condoms ... but it conflicts with our policies, so even though we cannot do promotion, we can do referral. This strategy gives room for those who are able to do the work ... for us to go around the issue ...

There did, however, seem to be a growing consensus that in the case of discordant couples, condoms could be promoted in the counselling situation.

... in the counselling sessions, correct information is given, and couples are allowed to make what our policy calls 'life-enhancing' choices ... and if you are clever you will realize what this means ... the couples have to do this for themselves.

Interaction with donors

Many participants acknowledged that having donors as collaborative stakeholders was invaluable, especially as they were increasingly recognising the importance of religious entities in mitigating the epidemic. They also acknowledged the substantial funding that had been given to their organizations over the years. They particularly valued long-term financial support from particular organizations which then enabled CREs to develop a long-term vision for their work. Several participants appreciated that technical support had been provided to build capacity within CREs.

PEPFAR and the Global Fund were recognised as being instrumental in bringing about great change for the better in HIV and AIDS service delivery carried out by CREs. They seemed relieved that these funders had recognised the role of abstinence with less focus on condom promotion. Furthermore, most felt that collaborative relationships were strengthened by partnerships that did not only involve funding, but included mutual sharing of resources, experiences, and ideas.

However, CREs felt that donors did not trust them, particularly in terms of financial management. This is demonstrated in the many instances of placement of their own personnel in project management. The participants also spoke of a perception that CREs lack capacity.¹⁸¹

¹⁸⁰ This is not only a past concern. Plusnews reports in 2008 that Muslim leaders in Kenya's North Eastern Province have resolved to actively preach against the use of and public promotion of condoms. PlusNews 2008d.

¹⁸¹ See chapter 3, secondary literature demonstrates this broad perception that religious entities particularly lack capacity in technical, financial and administrative areas.

They think FBOs have no capacity, they say these people have just done theology, they are not accountants

The feeling that FBOs can't account for money is wrong ...

Participants spoke strongly of a feeling of exploitation arising in some relationships, most notably in situations when particular donors collaborate to raise funds through the CREs for their own agenda and then abandon the original vision.

Agencies when they are in need they come to us, but when they win, they leave you out.

Yes, international agencies visiting FBOs to raise money for themselves, then you never hear from them again...we are very vulnerable.

Participants felt that often external agendas were forced onto local organizations and if they did not comply, financial support was withdrawn. Furthermore, agendas could change focus without warning and then so did the funding allocation. This was a source of frustration.

One minute they are talking about a thing, and then they shift to another and do not even tell us - shifting themes, our agendas get driven from outside.

(They) say what needs to be done and give no room for other options ... they threaten to pull out if what they want is not allowed.

A further concern was the way funds often have to be utilized within a short time-period which inhibits long-term planning. This situation was exacerbated by the expectation of elaborate and frequent reports which consume energy away from the actual work in communities. In addition, CREs found that procedures for funding applications are often complicated and require particular skills which they did not have. This made it difficult to access funds.

CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. On the whole, the collaborative relationships between CREs and collaborative stakeholders (or partners) appear to be well balanced and successful. Participants spoke of the strengths being the clarity of the national policy around the Three Ones, the collaborative structures that have been established, and the increased funding for CREs.

The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

4.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

Finding 5: Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of Christian religious entities, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

A number of key issues were raised in the workshops around the challenges and potential of partnerships.

(1) Asking the question, 'Is multisectoral collaboration happening in Kenya?' with the group of collaborative stakeholders resulted in a range of responses. Some felt that by virtue of the existence of KNASP, collaboration was taking place. However, the more general view was that collaboration was not taking place.

We share out the resources ... and then each goes their own way...each one runs their own programme.

It was further felt that resource allocation was divisive.

Different interests ... once you put resources in the middle, competition comes.

It was generally felt that while structures were in place to ensure collaboration, in practice it was proving difficult to implement.

At large but it seems elusive ... you have the structure ... but no one implements ... they do their own thing ... it's a challenge.

Because different sectors have their own mandate, collaboration around HIV and AIDS is an add-on.

(2) With regard to **inter-religious collaboration**, there was a feeling by some that this did seem to be working.

... it is in place, there is synergy, people do what they do best.

However, others acknowledged that there were real weaknesses in this aspect of collaboration which was manifest in competition between different religious groups who push their own agendas.

There is competition between the various interfaith collaborative structures and it is very difficult to include everyone.

A further issue was raised by collaborative stakeholders concerning the relationship that CREs had with their own regional Ecumenical bodies such as the AACC and the Ecumenical AIDS Initiative. They were seen to prioritise these relationships over their relationship with the Inter-religious Council of Kenya (IRCK). The IRCK representative had a refreshingly open attitude towards the limitations of the IRCK network and acknowledged similar weaknesses in this relationship.

In Kenya we have a problem of duplication of collaborations over HIV/AIDS

(3) The greatest challenge to collaboration was the perception of collaborative stakeholders that CREs display an ethos of **dogmatism and conservatism**. This manifests itself through their patriarchal and hierarchical structures. More importantly, these participants felt that CREs' conservative ethos resulted in their unwillingness to deal with particular high risk groups, such as commercial sex workers.

... challenge of working with the faith-based community working with vulnerable groups
... don't see it changing in the near future.

However, it was also acknowledged that CREs placed a 'theological' emphasis on the poor which was the flipside of their conservatism. Perhaps most significantly, they felt that at times CREs were misrepresenting the epidemic as a result of 'inappropriate theological understandings'. Christian Entity participants themselves, as was discussed in the previous section, acknowledged that the issue of condom promotion continues to be a source of tension between them and other collaborative stakeholders. Their unwillingness to promote condoms does emerge out of a conservative theological position which suggests that this would encourage promiscuity.

(4) Issues relating to organizational structures and functioning was another challenge facing multisectoral collaboration in Kenya. Collaborative stakeholders saw the major weakness of CREs as the **competition** that exists between CREs. This leads to a lack of credibility within their own collaborative relationships. On the other hand, CREs perceived parts of the national structures to be corrupt. There was, therefore, scepticism among Christian entity stakeholders as to how these structures function organizationally.

(5) Collaborative stakeholders indicated that another key weakness of CREs is their **lack of capacity**.¹⁸² They are seen to frequently operate with limited human and financial resources as well as with insufficient skills. This lack of capacity is manifested in their limited reporting to funders, leading to a lack of accountability.

It is a chicken and egg situation, they don't have the capacity to do it, and they don't have the financial resources to build this capacity.

These problems were exacerbated by the over-emphasis on the 'spiritual' by CREs, rather than dealing with difficult programmatic issues. An example given was the fact that staff appointments were made on the basis of the person being a 'good Christian' rather than a 'good administrator'.

They hold to a theological value that says the expression of faith is more important than skill.

Christian entity participants, however, saw this as a 'lack of trust' in their ability to deal appropriately with large sums of money. Collaborative stakeholders did acknowledge in this discussion that this 'theological valuing' did have a positive flipside, namely that it encouraged volunteerism. In addition, because of a theological commitment, often the work ethic of CREs is strong despite a lack of capacity. It was acknowledged that this was particularly true with regard to their substantial work with orphans and vulnerable children.

CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of CREs, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

¹⁸² See Chapter 3

Finding 6: There is an obvious commitment to strengthening the partnership between Christian religious entities and collaborative stakeholders from both sides around the Three Ones policy. From the Christian religious entities there is a desire for greater participation of a range of stakeholders in formulating the implications of this policy as well as donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national M&E process.

Despite the challenges noted in finding 5, a great desire was expressed by both sides, for opportunities to improve collaboration.

A. Hopes for stronger collaboration: Christian religious entities

CREs were able to reflect on their hopes for stronger collaboration in three areas, namely: government policy, government practice, and with donors.

In terms of **government policy**, the following were identified as a way forward for multisectoral collaboration:

- Criteria for funding should be more specifically noted in the KNASP document.
- A clear and more detailed policy and strategy on OVCs should be developed (e.g. including free education, free healthcare, and access to basic necessities).
- More obvious voices from people living with HIV should be included in the strategy.

In terms of **government practice**, the following were identified as key issues:

- National coordinating structures should be strengthened.
- Public-private partnership policy should be developed and applied more consistently.
- There should be open forums to discuss policy review.
- Government should involve CREs as partners when they put their policies into practice.
- There should be greater interpretation and dissemination of KNASP to grassroots agencies in the HIV and AIDS epidemic.
- More coordinated events should take place in order to ensure equitable resource allocation and an effective M&E framework.

Christian entity participants were clearly aware of the importance of coordinated efforts to mitigate the epidemic, demonstrated by the high energy-level during this discussion.

In terms of **donors** the following was identified as a way forward for the future:

- There should be a forum to share strategic issues and agree on funding structures and accountability.
- Such a forum should also ensure that resource allocation is equitable and measured according to extent of service delivery.
- Genuine and mutual partnerships should be encouraged with mutually agreed agendas. Financial support should be channelled directly through CREs, rather than through global bodies.

We have dealt with the hopes that CREs have for collaborative partnerships with government and funders. Now we turn to the hopes expressed by these other stakeholders, of working with CREs.

B. Hopes for stronger collaboration: Collaborative stakeholders

Collaborative stakeholders also reflected on suggestions for a way forward in strengthening multisectoral collaboration.

They recognised the need for further dialogue and greater networking between all the stakeholders. This would also facilitate improved channels of communication in relation to information sharing. In order for there to be 'mutual ownership and partnership', there needed to be both 'functional and sustainable coordination' as well as a willingness by all parties to cooperate with one another. This could perhaps be achieved through a forum, as suggested by the CREs, that would ensure 'common evidence based goals' leading to a 'clear vision' of the collaborative relationship to be established. However, the collaborative stakeholders expressed strong concern that an effective forum would only be possible if CREs were willing to engage the national M&E processes (the third of the Three Ones).

There was some disagreement as to whether an additional forum was necessary. Some recognised the weakness of having all communication and resource allocation being channelled through one structure such as KIRAC, while others felt that KIRAC was effective and appropriate and therefore no further forum was necessary.

In Kenya we need an agreed voice/structure of the faith-based sector.

Kenya Interreligious Council is doing a fantastic job...we have a structure for now.

Nevertheless, an enormous amount of willingness was expressed on the part of government and donor stakeholders to strengthen collaboration with CREs. Also particularly impressive in Kenya, was the willingness of the representatives of key organizations who are seen to be drivers of collaboration (i.e. NACC, IRCK and KIRAC), to openly admit weaknesses in their organizations and listen to the other participants without defensiveness. The researchers felt that this open attitude was itself a strong force in enhancing multisectoral collaboration, and speaks of both the Kenyan collaborative environment, and the importance of having the right people or personalities heading these collaborative efforts.

The potential for future collaboration was further demonstrated by the positive comments in this regard during the closure session of the workshop with CREs. One participant said the following:

I think that the conceptualization of the idea of having the faith organizations meet and also have this type of sharing of our experiences and what we are doing, and also trying to discover what the public sector thinks of what we are trying to do, and also of the facilitation, guided questioning which prompts us to think and reflect, to me is marvellous, to me this might be the first initiative of its kind - in the process of sharing we are learning from one another, and in this field of HIV and AIDS ... getting to this point ... that for me is a big beginning, it is a journey we are starting, and we are foreseeing what we could do, and look forward to the future.

Before I came, I did not realize that as partners we had been doing certain things, towards the reduction of the prevalence of HIV and AIDS - we did not know to what

others are doing, but through this process we have realized how much we are doing ... and to think about how we can make our programs more realistic and relevant.

This enthusiasm was further demonstrated by the fact that participants at the CREs' workshop chose to meet for an extended period afterwards to continue discussing a way forward for their collaboration with one another.

It is clear then that both CREs and collaborative stakeholders are committed to the principle and practice of greater partnerships in the struggle against the HIV and AIDS epidemic, and in promoting Universal Access. They have expressed hopes for ongoing participation in the formulation of policies, as well as a common commitment to the national monitoring and evaluation process.

4.3 Recommendations arising from the research findings in Kenya

4.3.1 For the attention of the Christian religious entities

- Assess effectiveness of the various faith-based collaborative structures (e.g. KIRAC and IRCK) and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Recognise culpability in hindering relationships with government stakeholders through conservative and dogmatic beliefs, particularly in relation to the condom issue, and be willing to compromise in certain instances.
- Strengthen the commitment to the 'one' monitoring and evaluation process, so that the work of CREs can have greater impact upon the national HIV and AIDS strategies.

4.3.2 For the attention of government

- Communicate the principles of the Three Ones more deliberately and engaging with the practice of CREs more effectively.
- Ensure better representation on coordinating structures used by government to relate to religious entities.
- Involve the faith-based organizations in ensuring that HIV and AIDS information is reaching grassroots communities.

4.3.3 For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of monitoring and evaluating procedures.
- Recognise the importance of long-term relationships with other collaborative stakeholders.

4.3.4 For the attention of all

- Utilize the principles of the Three Ones as an entry-point for greater collaborative efforts.
- Ensure adequate representation in all coordinating structures.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.