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### Making aid effective at the community level: the AMREF experience

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# Making aid effective at the community level: the AMREF experience

*David Ojaka, Elizabeth Okoth, Sam Wangila, Meshack Ndirangu, Naomi Mwangi, and Festus Ilako*

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*Effective use of donor aid is critical in achieving the sixth Millennium Development Goal – reversing the HIV/AIDS epidemic by 2015. The Paris Declaration of 2005 identified five key principles for aid effectiveness: ownership, alignment, harmonisation, mutual accountability and managing for results. As civil society organisations play a critical role in implementing HIV/AIDS interventions, it is important that they adhere to these principles. Often, however, they fail to implement interventions conforming with the principles, leading to duplication and inefficiency. Two case studies from AMREF in Kenya demonstrate how the principles of aid effectiveness can be applied to increase the impact of HIV/AIDS interventions.*

## ***Rendre l'aide efficace au niveau communautaire : l'expérience d'AMREF***

*L'utilisation efficace de l'aide apportée par les bailleurs de fonds est cruciale pour atteindre le sixième Objectif du Millénaire pour le développement – inverser l'épidémie du VIH/sida d'ici à 2015. La Déclaration de Paris de 2005 a identifié cinq principes clés pour l'efficacité de l'aide : l'appropriation, l'alignement, l'harmonisation, la redevabilité mutuelle et la gestion en vue de résultats. Comme les organisations de la société civile jouent un rôle crucial dans la mise en œuvre des interventions en matière de VIH/sida, il est important qu'elles adhèrent à ces principes. Cependant, souvent, elles échouent à mettre en œuvre des interventions conformes aux principes, ce qui aboutit à des doublons et à l'inefficacité. Deux études de cas d'AMREF au Kenya démontrent la manière dont les principes de l'efficacité de l'aide peuvent être appliqués pour accroître l'impact des interventions de lutte contre le VIH/sida.*

## ***Tornando a Ajuda Efetiva no Âmbito da Comunidade: A experiência da AMREF***

*O uso efetivo da ajuda dos doadores é crucial para se alcançar o sexto Objetivo de Desenvolvimento do Milênio – reverter a epidemia do HIV/AIDS até 2015. A Declaração de Paris de 2005 identificou cinco princípios-chave para a efetividade da ajuda: apropriação, alinhamento, harmonização, responsabilidade mútua e gerenciamento para resultados. Como as organizações da sociedade civil desempenham um papel crucial na implementação de intervenções relativas ao HIV/AIDS, é importante que elas tenham adesão a estes princípios. Frequentemente, porém, elas falham na implementação das intervenções de acordo com os princípios, levando à duplicação e ineficiência. Dois estudos de caso da AMREF no Quênia mostram como*

os princípios da efetividade da ajuda podem ser aplicados para aumentar o impacto das intervenções relativas ao HIV/AIDS.

### **Una ayuda más eficiente a nivel comunitario: la experiencia AMREF**

*Para alcanzar los Objetivos de Desarrollo del Milenio y conseguir que la epidemia del VIH/SIDA retroceda para el 2015, es de vital importancia que la ayuda de los donantes se utilice con más eficiencia. La Declaración de París de 2005 enunció cinco principios clave para que la ayuda sea eficaz: apropiación, alineación, armonización, rendición de cuentas mutua y gestión basada en los resultados. Debido a que las organizaciones de la sociedad civil desempeñan un papel fundamental en la lucha contra el VIH/SIDA, es necesario que éstas respeten los cinco principios. Sin embargo, a menudo éstos no se aplican en la práctica ocasionando duplicidades y falta de eficiencia. Dos estudios de caso de AMREF (siglas en inglés de la Fundación Africana de Medicina e Investigación) en Kenia muestran cómo estos principios de eficacia en la ayuda son útiles para aumentar el impacto de la lucha contra el VIH/SIDA.*

KEY WORDS: Aid; Civil society; Social sector; Sub-Saharan Africa

## **Introduction**

Ensuring aid effectiveness in high HIV and AIDS-burdened countries is critical to achieve the sixth Millennium Development Goal (MDG) of reversing the epidemic by 2015 (United Nations Economic Commission for Africa 2005). Various resolutions have been reached by a number of countries on how the effectiveness of aid in the HIV/AIDS response could be enhanced for maximum impact. For instance, in September 2003, during the 13th International Conference on AIDS and STIs in Africa, a set of guiding principles for '*optimizing the use of resources and improving the country-level response to AIDS*' was approved (UNAIDS 2005: 7). Further to this, April 2004 marked the endorsement of and commitment to the 'Three Ones' principles by governments, donors, international organisations and civil society. The principles stipulate that firstly, each country should have '*one agreed AIDS action framework that provides the basis for conducting the work of all partners*'. Secondly, countries should have '*one national AIDS coordinating authority, with a broad-based multi-sectoral mandate*'. Lastly, there should be one agreed country-level monitoring and evaluation system for all HIV interventions (UNAIDS 2004: 7).

A high-level agreement on mechanisms for improving aid effectiveness was reached in Paris in March 2005 and dubbed the Paris Declaration (Paris Declaration on Aid Effectiveness 2005). This declaration outlines key issues that donors, development partners, and governments from developing countries need to put in place to enhance the effectiveness of aid. The declaration resolved that for aid effectiveness to be enhanced there is an urgent need to address issues of ownership, harmonisation, alignment, managing for results, and mutual accountability. Following this, in September 2008, the Accra Agenda for Action was released at the 3rd High-Level Forum on Aid Effectiveness, outlining ways to better implement the Paris Declaration. As part of the Accra Agenda for Action, there was an invitation to civil society organisations (CSOs) to '*reflect on how they can apply the Paris principles of aid effectiveness from a CSO perspective*' (Accra High-Level Forum 2008).

The principles on aid effectiveness in Sub-Saharan Africa are of urgent importance, owing to the fact that the region is the epicentre of the AIDS pandemic. In 2008, Sub-Saharan Africa accounted for 71 per cent of all new HIV infections (UNAIDS and WHO 2009). In Kenya, over 1.4 million people aged 15–64 years of age were living with HIV by 2007, and the national HIV prevalence for those aged 15–49 stood at 7.4 per cent (NASCO 2009). The prevalence of

HIV varies by region, with two of the eight provinces (Nyanza and Rift Valley) accounting for half of all the HIV cases in Kenya (NASCOP 2009).

This paper documents the experience of two AMREF Kenya projects that have applied the principles of the Paris Declaration in HIV interventions at the community level in Kenya. The paper also demonstrates the benefits of applying these principles, and highlights some key lessons learned in HIV and AIDS interventions at the community level using these principles.

### *The need for research*

Despite the noble resolutions and plan of action contained in the Paris Declaration of March 2005, there is limited information on the role of CSOs in the implementation of these principles. While an Advisory Group on Civil Society and Aid Effectiveness (under the Working Party on Aid Effectiveness) examined the critical role of CSOs in contributing to aid effectiveness, and the limitations with the Paris Declaration in recognising the role of CSOs (Advisory Group on Civil Society and Aid Effectiveness 2007), there is limited research identifying concrete examples of how aid effectiveness principles can be translated and applied at the community level, particularly in addressing HIV and AIDS in high-burden countries. The current paper fills this gap.

Kenya's national response to the HIV pandemic has fallen short in applying the key principles on aid effectiveness at the both national and community levels. AMREF conducted a needs assessment in 2004 (AMREF in Kenya 2004) in Nyanza and Western regions in Kenya. Baseline surveys and gap analyses were also carried out in 2005 (AMREF in Kenya 2005) and 2008 (Nyamongo and Nzioka 2009) in a total of four provinces in Kenya. Findings from these assessments show that the situation in Kenya is worsened by many constraints, including: weak coordination and facilitation; low capacity of communities; inadequate involvement of communities; low quality of care for most-at-risk populations (MARPs) and vulnerable groups; limited availability of resources to communities; and factors underlying the high prevalence and negative impact of HIV among MARPs and vulnerable groups (AMREF in Kenya 2005).

Survey data from the AMREF studies conducted in 2004 and 2005 (AMREF in Kenya 2004, 2005) further revealed that only a handful of civil society organisations (CSOs) had monitoring and evaluation (M&E) frameworks that are nested within the national M&E strategic framework. Likewise, the extent to which stakeholders in HIV and AIDS programming are harmonising and aligning their activities to the nationally agreed HIV and AIDS action framework, as articulated in Kenya's national HIV/AIDS plan, remained mixed. In particular, the 2004 needs assessment (AMREF in Kenya 2004) revealed that one third of stakeholders were not following the national guidelines while implementing HIV and AIDS activities. The survey also identified ownership, mutual accountability and sustainability as areas that needed strengthening in order to enhance capacities of communities and CSOs. The lack of systematic harmonisation in the implementation of HIV/AIDS activities, as well as non-alignment of the activities to existing national guidelines, is an indication of inefficiency and duplication, which consequently undermine the effectiveness of programme aid. To the extent that the two case studies from AMREF have applied these principles, this study is unique: the experiences and lessons documented in this paper can form a firm basis for applying best practices in aid effectiveness which conform to the Paris Declaration.

### *Background information about the two AMREF in Kenya case studies*

AMREF was established in 1957, and is an independent non-governmental organisation (NGO) with its headquarters in Nairobi, Kenya. AMREF in Kenya is one of the semi-autonomous country offices leading AMREF's programmes and projects in Kenya. AMREF in Kenya has

implemented and evaluated two key projects that have applied the five principles of the Paris Declaration on Aid Effectiveness.

The **Maanisha** programme works in 129 of Kenya's districts. The word *Maanisha* is a Swahili word that translates to 'giving meaning to'. The programme started in two Nyanza and Western Provinces in 2004, and now has been scaled up to four provinces in Kenya. The programme gives technical support and grants to over 740 CSOs that are designing and implementing HIV/AIDS interventions in the four provinces. These organisations range from small community-based organisations, to larger non-governmental organisations, and to networks of CSOs. Maanisha focuses on the most-at-risk populations (including men who have sex with men, intravenous drug users, and commercial sex workers) and vulnerable groups (such as orphaned and vulnerable children and widows or widowers) for HIV/AIDS. The project is expected to end in October 2012.

The **AIDS Population and Health Integrated Assistance Program (APHIA II Eastern)** is designed to support the government health policies and outcomes for HIV/AIDS, tuberculosis, maternal and child health and reproductive health in Kenya in a comprehensive and integrated approach. AMREF is responsible for improving and expanding care and support for people and families affected by HIV/AIDS in 20 districts of Eastern Province in terms of support for orphaned and vulnerable children, home-based care, and stigma reduction. The project supports 11 Local Implementing Partners: established NGOs that work with hundreds of community structures including grassroots orphan and vulnerable children committees, community-based organisations, orphan guardian groups, groups of community health workers, and persons living with HIV/AIDS (PLHIV) groups. The programme commenced in 2006 and was implemented up to December 2010; it has now been continued as a new phase named 'APHIA plus'.

These projects both work in areas with particularly high prevalence of HIV. The two projects provide capacity building to CSOs and local implementing partners in both technical, governance and management areas. The management capacity component includes provision of small grants. In addition, both projects strengthen health systems for effective HIV/AIDS programming and encourage strong networks among CSOs and the formal health system for a comprehensive and sustained HIV response.

## Methods of data collection

A systematic search of the two project databases and progress reports was conducted to analyse the progress made with regard to the five principles on aid effectiveness (ownership, alignment, harmonisation, mutual accountability, and managing for results). These databases contain quantitative data from various sources. The APHIA II Eastern data is from the evaluation cycle documents that are collected. The Maanisha data include different data sources from their information system collected throughout the evaluation cycle, including survey data from CSOs on capacity levels in various areas.

In addition, key reports, including a recently released external review of Maanisha (Khasiani 2009); the most recent annual reports for both projects (AMREF in Kenya 2009, AMREF Kenya 2010); the most recent monthly report for APHIA II Eastern for AMREF's results area (APHIA II Eastern 2010); and mid-term reviews for both projects (AMREF in Kenya 2007, APHIA II Eastern 2009) were reviewed for relevant findings.

## Results: AMREF strategies in fostering the principles on aid effectiveness

The two HIV and AIDS projects are guided by the five principles on aid effectiveness. The aim of this paper is to share how these projects are implementing the Paris Declaration principles, and the achievements made as a result.



## Ownership

Consensus reached at the Paris Declaration (Paris High Level Forum 2005) calls upon developing countries to ‘*set their own strategies for poverty reduction, improve their institutions and tackle corruption*’. For CSOs, this ownership is reflected in ensuring that communities, district teams, and people living with HIV (PLHIV) own the interventions. These AMREF projects enhance ownership by supporting a wide range of stakeholder involvement in planning, implementation, monitoring and evaluation processes.

Working closely with communities is crucial in developing ownership of interventions. As has been identified though, many CSOs in Kenya have limited capacity and limited resources to implement effective HIV/AIDS interventions. Hence, a key component of these two AMREF Kenya projects is to work closely with CSOs to build capacity in such areas as leadership, project management, governance and sustainability.

The importance of capacity building to build community ownership is illustrated in the results from implementation of the Maanisha programme. In 2009, Maanisha, in collaboration with decentralised government structures, strengthened the capacity of 536 CSOs through mentoring, training, and exchange visits. This resulted in 92 per cent of the CSOs showing an increase in organisational capacity. This included 40 per cent of CSOs having a person living with HIV/AIDS (PLHIV) as an office bearer, 93 per cent of CSOs being led by elected leaders, and 58 per cent of CSO office bearers being women (AMREF Kenya 2010). In Nyanza and Western provinces, where Maanisha has been in place the longest, 81 per cent of CSOs mobilised resources outside Maanisha, a key factor for sustainability (AMREF Kenya 2010).

APHIA II Eastern also used capacity-building, to build community ownership of the interventions. It provided technical assistance for HIV-related institutional capacity-building to the local implementing partners that received grant money, as well as providing ‘system strengthening’ interventions on monitoring and evaluation, financial management, and programme management to this same group (AMREF in Kenya 2009).

## Alignment

The principle of alignment in the Paris Declaration stipulates that ‘*donor countries align behind these objectives and use local systems*’. From the point of view of AMREF and CSOs, implementing this principle entails ensuring that the programmes implemented in communities ultimately align with: Kenya’s AIDS framework (National AIDS Control Council 2009), the work of the national AIDS coordinating authority in Kenya (the National AIDS Control Council, or NACC), and one agreed country level monitoring and evaluation system for all HIV interventions (National AIDS Control Council 2005). Kenya’s AIDS framework document and Kenya’s health sector strategic plan (Government of Kenya 2005) are both anchored on two key national development strategies (Government of Kenya 2007a, b).

AMREF has been among the key stakeholders involved in the consultation, design and roll-out of the above national strategic plans. The involvement spans from the community, district, provincial and national level consultations – involvement that ensures the resultant plans are owned by all. At the community level, AMREF works with partners to ensure that their activities are implemented against clear work plans and targets. For instance, the two AMREF projects translate the above national strategic plans through working closely with various government players at national and local levels in preparing and implementing health plans. The APHIA II and Maanisha project plans fit in to support district plans based on the gaps as agreed with government staff. The two AMREF projects also support CSOs to ensure that their activities address

key priority areas in health in general, and HIV in particular, as articulated by the national strategic plan, and that their activities are aligned to those at the national level.

Concretely, Maanisha continues to advocate for involvement of CSOs in key government-led processes. In 2009, 65 per cent (346) of funded CSOs participated at various levels in the Kenyan government review process of the country's overall AIDS framework, and 18 per cent were involved in the implementation of the community strategy, a Kenyan government process in health (AMREF Kenya 2010).

Additionally, in an independent review of Maanisha completed in 2009, it was found that:

As part of harmonisation and coordination to achieve the 'Three Ones' principle, Maanisha promotes stronger linkages between decentralized NACC and Ministry of Health (MOH) structures and CSOs . . . Through such linkages, Maanisha improved the quality of services jointly delivered by the Ministry of Health and CSOs to HIV/AIDS clients within communities. Closer partnerships between CSOs and MOH has also enhanced information sharing and exchanges, particularly on protocols, policies and strategies on delivery of services and is promoting CSOs adherence to national guidelines. CSOs are also increasingly participating in fora at district and provincial levels for policy making and planning and reviews. This is a sustainable approach to implementing HIV/AIDS interventions. (Khasiani 2009)

One of APHIA II Eastern's main activities is the promotion of compliance to national strategies and guidelines in HIV/AIDS. In 2008–09, this translated into establishing partnerships between the various government ministries at a national, provincial, district and community levels to plan jointly and ensure involvement in facilitation and coordination (AMREF in Kenya 2009).

### *Harmonisation*

The Paris Declaration defines harmonisation as '*donor countries coordinate, simplify procedures and share information to avoid duplication*'. How does this apply on the ground? At the CSO level, harmonisation calls for use of common arrangements or procedures in programme implementation and is also one of the 'Three Ones' key principles (UNAIDS 2004). This principle as applied to HIV and AIDS programming entails ensuring that CSO activities fit within the HIV and AIDS national strategic framework, including the use of nationally approved guidelines for HIV implementation.

AMREF projects and all the AMREF-supported CSOs in the two projects implement HIV and AIDS activities following the national strategic guidelines on HIV prevention, care, treatment and support. Aligned guidelines range from those on work with orphaned and vulnerable children, home-based care, voluntary counselling and testing, prevention of mother to child transmission of HIV, and community-health facility strengthening, to strategies on condoms, male circumcision, and gender mainstreaming.

Further, AMREF also directly works with the Kenyan government structures in developing HIV guidelines. For instance, the APHIA II Eastern project was among the key stakeholders involved in the consultation, design, and roll-out of the National Home Based Care Framework. Both projects have also been involved in training in technical areas (e.g. orphan and vulnerable children and home-based care), and these training documents have been made available to partners.

In addition, as much as possible, CSOs and other stakeholders at the district and community levels coordinate their activities to minimise duplication of efforts and wasting of scarce resources. In contributing to harmonisation, the two AMREF projects work closely with the

Kenyan government and other major HIV stakeholders to provide financial and technical support to implementing partners through the formation of committees that meet regularly for harmonisation of plans, operations, and funding arrangements. This is aimed at averting double funding, duplication of efforts, parallel and conflicting HIV strategies. Further, these harmonisation committees serve the complementary role of providing support in areas of resources, technical support, and logistics. Stakeholders' forums are also held where best practices are shared.

### *Mutual accountability*

Mutual accountability in the Paris Declaration focuses on '*donors and partners (being) accountable for development results*'. At a community level, this is about AMREF, the CSOs, and the communities themselves being accountable for results by ensuring transparent financial management, participatory monitoring and evaluation, annual audits, and annual programme reviews by external agencies.

The two AMREF programmes apply this principle through strategies like conducting periodic client satisfaction surveys, stakeholders' feedback forums, and regular programme review forums. In addition, AMREF programmes undergo programme, data, and financial audits. The projects have quarterly reporting and meetings with donors and with sub-grantees. AMREF and the sub-grantees also circulate reports, papers, magazines and other documentation to a wide number of stakeholders.

In addition, AMREF does capacity assessments and builds the capacity of its partners in financial management, compliance and accountability. The results of this capacity building show that this work continues to develop mutual accountability. In 2009, Maanisha mentored, in an ongoing way, 536 CSOs on financial systems strengthening, and trained 284 of them in financial management. As a result, 95 per cent of the CSOs were using finances as per the approved work plan, and a similar percentage were complying to requirements for reporting (AMREF Kenya 2010). Partners submit quarterly technical and financial reports, which provide details on use of funds for HIV related activities.

### *Managing for results*

In the spirit of the Paris Declaration, managing for results entails that '*developing countries and donors shift focus to development results and results get measured*'.

Managing for results also entails overseeing the provision and use of aid in a manner that aims to achieve the desired programme results. The AMREF projects have results frameworks or log frames, which clearly define the overall goal, the desired outcome for each programme area and for each specific service areas, as well as indicators, and targets. These are further guided by guidelines for programme areas that define principles and an essential package for each service area. For instance, the AMREF-led component of the APHIA II project has set a standard which requires that each child that receives services as an orphaned or vulnerable child must be supported in at least three out of the seven essential areas: health, education, nutrition, psychosocial support, shelter, adult care, and protection based on a child's specific priority. In terms of home-based care for people with HIV/AIDS, each client must receive the full package of care, ranging from clinical and basic nursing care, to life skills development, to food and nutrition.

Furthermore, each service provider, including staff from the ministries of health, primary caregivers, community health workers, and volunteers, receive training and ongoing support and mentoring.



Other ways in which the two projects manage for results is in participating in district operational plans, where mutually agreed upon health indicators are adopted by all to track progress in priority health issues affecting their districts. Both programmes have also been instrumental in advocating for CSOs' use of the nationally recommended reporting tool for HIV activities. Consequently, CSOs funded by Maanisha report progress made in HIV programming to the Kenyan government using the nationally recommended community-based AIDS reporting form (12 per cent were using the form at baseline; 87 per cent were using the form by year two) (AMREF Kenya 2010). The AMREF monitoring and evaluation framework, and that of supported CSOs in both the APHIA II Eastern and Maanisha projects, are nested or aligned in the overall national HIV and AIDS monitoring and evaluation framework.

### *Wider perspective*

The findings narrated above have focused on the practices of AMREF in Kenya with regard to the Paris Declaration on Aid Effectiveness. No comprehensive analysis has however been made here on what the other players such as the donor community and governments have done in the Kenyan context with the five principles. Research conducted among senior government officials and politicians in three countries in Sub-Saharan countries excluding Kenya (Wathne *et al.* 2009, 2010) suggests that indicators for the Paris Declaration and the Accra Agenda for Action are not only too narrowly defined, they also lack depth. Particularly singled out are the measures of predictability and transparency in aid, with donor and recipient countries reported to have different interpretations of the same terms. From the perspective of recipients of donor aid, three important behaviours of an effective donor are: the level of commitment to development, the flexibility to respond to dynamic circumstances, and support for country-led policy. In view of the rapidly evolving Kenyan national context (the existence of a long-term plan, 'Vision 2030' which seeks to transform the country into middle-income status; ongoing political reforms to enact a new constitution; a new five-year strategic plan for HIV/AIDS), it is time that a review of the implementation of the international accords on aid effectiveness in Kenya is conducted.

### **Conclusions and ways forward**

The results described above have been achieved by applying the five Paris Declaration principles in programmes jointly designed and managed between AMREF's local implementing partners and AMREF. A number of factors which have helped AMREF in Kenya to implement the five principles can be singled out. The first is that AMREF in Kenya undertook, as a deliberate policy, to meaningfully and realistically engage with the Ministry of Health and other state bodies involved in HIV/AIDS activities. Thus, AMREF in Kenya sits on a total of over 40 committees and technical working groups of the Ministry of Health, NASCOP, and NACC. A large part of this representation is from the Maanisha programme, and to a lesser extent the APHIA II Eastern programme. AMREF is also the founder member and host of the Kenya Health NGOs network (HENNET). With such broad representation, AMREF in Kenya is very visible and gets a hearing.

A second factor has been AMREF in Kenya's dedication over the years (since its foundation in 1957) to its mission statement: *'to ensure that every African has a right to good health by helping to create vibrant networks of informed communities which work with empowered health care providers in strong health systems'*. With this consistency and focus, AMREF in Kenya is trusted by communities; this trust is echoed at national and international levels. The third set of enabling factors which have contributed to successful implementation of the principles of aid effectiveness are the systems within AMREF in Kenya and the Maanisha

project in particular. AMREF in Kenya has a robust and accountable financial management system. At the country level, this is overseen by a senior management team (SMT) and an external advisory council made up of individuals with varied professional expertise. Within the Maanisha project, due diligence has been applied to ensure adequate management and oversight structures. Internal project management processes include monthly and quarterly review meetings of the Project Implementing Team (PIT). In the Maanisha project, there are governance structures that are dominated by external and objective membership but with AMREF staff represented as ex-officio members. These structures include the Technical Review Committees (TRCs) which reviews funding proposals from CSOs in each province and whose membership is drawn from expertise in the local universities, Ministries of Health and Constituency AIDS Coordinators; the National Grant Approval Committee (GAC) most of whose participation is drawn from selected NGOs, NACC and NASCOP; and the Program Steering Committee (PSC) in which representatives from the two donors (DFID and SIDA) sit.

Given the experiences articulated above, the Paris Declaration needs to be reviewed against the background of the rapidly evolving Kenyan environment to articulate the roles of different actors at various levels of application that will ensure aid effectiveness and achievement of development goals. These include national government, local government, CSOs, and community structures. Specifically, as has been noted elsewhere, the declaration needs to incorporate a broader set of stakeholders, including CSOs (Advisory Group on Civil Society and Aid Effectiveness 2007).

The principles of the Paris Declaration should be shared at sub-national forums (provincial, district, and community stakeholder meetings) in order to bring about greater ownership by the communities on the ground. Continued sharing of best practices and evaluation results of community programmes that have applied the Paris Declaration principles, such as APHIA II Eastern and Maanisha, is also key to learning how best to achieve better aid effectiveness.

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