STRENGTHENING LINKAGES AND COLLABORATION BETWEEN CIVIL SOCIETY ORGANISATIONS (CSOs)/ COMMUNITIES AND THE FORMAL HEALTH SYSTEM

A STEP-BY-STEP GUIDE

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FOREWORD

Grass root Civil Society Organizations (CSOs) and the communities they work in are key players in the delivery of health services, as they have unique advantages in advocacy, demand creation and linkage of communities to services. However, their inadequate involvement in the formal health system continues to weigh down effective responses to priority health challenges including HIV and AIDS, tuberculosis, malaria, and maternal and child health, as revealed by assessments conducted by the African Medical & Research Foundation (AMREF) in Kenya in 2005 and 2008 in Nyanza, Rift Valley, Western and Eastern provinces.

Since 2009, AMREF *Maanisha* programme has been implementing a linkages framework for strengthening health systems and coordination environments in the HIV response in selected districts in 4 regions in Kenya and aimed at strengthening linkages between communities and health facilities through more than 700 CSOs. The framework, which places the community at the centre of the health system, has successfully been used to gauge working relationships amongst health stakeholders, providing a basis for concrete actions towards strengthening linkages and collaborations while monitoring for results.

Through the implementation of the framework, AMREF and her partners, the CSOs, Government of Kenya (GOK), have learnt that increased synergy between the formal health system and the community leads to sustainable improvement of service delivery and health outcomes. This has been evidenced through increased client referrals and quality of care offered to People Living with HIV as well as Orphans and Vulnerable Children. In addition, AMREF has witnessed increased recognition of CSOs by GOK structures through involvement in government led planning, implementation and review processes including Health stakeholders' Fora (HSF), annual operational planning and implementation of the community strategy.

In a bid to consolidate the gains made in this endeavour, AMREF has developed this guide that offers practical steps to forging synergistic linkages among players in the health system using a linkages framework. The guide has been developed in line with the Kenya Health Policy framework (2012-2030), that recognizes the different roles of various stakeholders, including CSOs, in its implementation at the national and county levels. This augments AMREF's Business Plan's (2011-2014) approach to transforming communities by building the skills, knowledge and resources required for sustainable health change and by enhancing their integration with the formal health system.

The guide is ideal for application during community, county and national fora aimed at enhancing coordination of the health system within a single disease or multiple disease programming. This is key to improvement of service delivery as well as ensuring that resources are not wasted and actions are not duplicated.

As you adapt and apply this guide, we invite you to share your lessons and suggestions for improvements with us, as well as with your colleagues and most importantly the clients you serve.

Dr Lennie Bazira S Kyomuhangi

Country Director, AMREF Kenya

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Glossary of Terms

Civil Society Organizations: Civil society organizations (CSOs) are non-profit organizations that aim to further the interests of the communities they serve and are driven to protect and empower the vulnerable. They include non-governmental organisations (NGOs), faith-based organisations (FBOs), community-based organizations (CBOs) and self help groups.

Community: A group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships which the community has developed over a period of time (WHO, 2004).

Health System: The World Health Organization defines a health system as "organizations, people, and actions whose primary intent is to promote, restore or maintain health". It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, and care and support to people in need of these services

Linkages: Refers to the social, policy, programmatic, services and quality assurance synergies between stakeholders in the health system

Stakeholders: Organisations, groups or individuals who have a direct or indirect stake or commitment in the programme / project design, implementation, benefits or its evaluation

Systems: A system is a set of elements where each element interacts with, or is related to, at least one other element. A system is characterized by linkages between its elements, as well as the internal nature of the elements. A system has primacy over its elements.

Abbreviations and Acronyms

AMREF:	African Medical and Research Foundation
AOP:	Annual Operational Plan
BIDII:	Benevolent Institute of Development Initiatives
CACC:	Constituency AIDS Control Committee
CDC:	Centers for Disease Control and Prevention
COBPAR:	Community Organizations Programme Based Report
CSO:	Civil Society Organization
DFID:	Department for International Development
DHSF	District Health Stakeholders Forum
GoK:	Government of Kenya
HCBC:	Home and Community Based Care
HIS:	Health Information Systems
ICAP:	International Centre for AIDS Care and Treatment Programs
JAPR:	Joint HIV and AIDS Programme Review
KNASP:	Kenya National HIV and AIDS Strategic Plan
KEPH:	Kenya Essential Package for Health
KHPF:	Kenya Health Policy Framework
MARPs:	Most at risk populations
M & E:	Monitoring and Evaluation
MoMS:	Ministry of Medical Services
MoPHS:	Ministry of Public Health and Sanitation
NACC:	National AIDS Control Council
NASCOP:	National AIDS and STIs Control Programme
NHSSP:	National Health Sector Strategic Plan
Sida:	Swedish International Development Cooperation Agency
UNITID:	University of Nairobi Institute of Tropical and Infectious Diseases

PART 1: INTRODUCTION

1.1 Background

Weaknesses and gaps in health systems continue to hamper effective responses and scale-up of priority health challenges including HIV and AIDS, tuberculosis, malaria, and maternal and child health services hence constraining the achievement of health-related Millennium Development Goals. A major gap is weak coordination and linkages among the various players in the health system with a big disconnect between communities and the formal health system.

AMREF has been catalyzing processes aimed at enhancing partnerships between people, as part of civil society and the formal health system for improved health outcomes. This has been done through one of her programmes, *Maanisha,* a community focused initiative to control HIV and AIDS in Kenya implemented in collaboration with Government of Kenya (GoK) structures and over 700 CSOs and Private Sector Organisations (PSOs) in 4 provinces.

Since 2009, AMREF *Maanisha* has been implementing a Health Systems Linkages, Collaboration and Coordination Strengthening Framework in 18 districts. This followed a needs assessment in 2005 and baseline survey in 2008 in Nyanza, Rift Valley, Western and Eastern provinces, which revealed weak coordination and inadequate involvement of communities among other gaps, as hindrances to effective HIV response. The framework, which was developed in consultation with the National AIDS Control Council (NACC) and Ministry of Medical services/Ministry of Public Health (MoMS/MoPHS) staff, outlines actors in the health system as well as linkages necessary for creating a vibrant coordination environment amongst the various players; which are trust, meaningful involvement, information systems, capacity building, quality assurance, referral system, and community health care financing.

Operationalization of the *Maanisha* Health Systems Linkages, Collaboration and Coordination Strengthening Framework in these districts in Kenya has proven useful in linking grass root CSOs and the communities they work with, with the formal health system and creating synergies between all sectors contributing to health including other government ministries and larger NGOs that mainly provide funding, technical assistance and quality assurance. AMREF and her partners have learnt that increased synergy between the formal health system and the community leads to sustainable improvement of service delivery and health outcomes through increased referrals, linkages and quality of care offered to affected individuals. These experiences, together with lessons learnt, have inspired the need to develop a guide that will offer practical steps to forging synergistic linkages among players and enhance coordination and harmonization for improvement of service delivery and health outcomes.

1.2. Purpose of the guide

While there have been attempts to create stronger linkages and improve coordination among the different players in the health system, there lacks clear guidance on how these efforts can be initiated, developed and sustained to achieve desired changes at community, regional and national levels.

The purpose of this guide therefore, is to provide practical steps to forging synergistic linkages within the health system, which can be applied to a wide range of health responses and at different levels of the health system. The guide aims at stimulating dialogue and guiding the various actors to:

- Take leadership for the health systems strengthening process.
- Formulation of terms of reference for coordination mechanisms/fora.
- Participatory gap analysis and action planning.
- Moving improved coordination across the different levels of the county health system
- Implementation and tracking of progress.

1.3 Intended Audience

This guide is designed for use by all stakeholders in health who may be considering strengthening linkages, coordination and collaboration at community, Sub County or county levels including Government ministries and agencies, Community units, community based organizations (CBOs), Non Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and Private sector Organisations (PSOs).

1.4 How the guide was developed

This guide is heavily based on experiences from piloting of the AMREF *Maanisha* Health Systems Linkages, Collaboration and Coordination Strengthening Framework in 18 districts in Kenya. It is also based on a wide-ranging review of AMREF materials and GoK policy documents among others.

The final product reflects feedback from stakeholders including AMREF, CSOs funded since 2009, GOK structures such as NASCOP, NACC and other ministries including Ministry of Education; Ministry of Gender, Children and Social Development and Ministry of Youth Affairs, UNITID, as well as other NGOs working in the same regions where Maanisha Programme is implemented and have participated in the linkages and coordination strengthening meetings. They include ICAP, Mild May international, BIDII, Plan International and Liverpool VCT.

These experiences and consultations have greatly shaped the development of this guide, as they also revealed the need to expand on the applicability of the linkages framework beyond HIV & AIDS response to cover other health interventions that require sector wide approaches including Malaria, TB, Reproductive health and Maternal, Newborn and Child Health (MNCH).

1.5 How the guide is organized

The rest of this guide is divided into six main sections:

- **The Health System**: Provides a summary of health systems strengthening, including definitions of the health systems, gaps in coordination while highlighting the roles that CSOs play in the health system

- **The Health System Linkages, Collaboration and Coordination Strengthening Framework:** Explains in details the linkages framework that forms the thrust of this guide; describing the different players in the health system, the linkages and illustrations of the score card used to assess the status of linkages

- **Application of the Framework:** Provides step-by-step guidance on the application of the framework from stakeholder identification/mapping, gap analysis process, results discussion, validation and action planning. The section goes ahead to discuss the various fora in which the score card can be applied

- **Monitoring and Evaluation:** This section discusses mechanisms for monitoring and reviewing progress towards desired results, highlighting some of the indicators for expected results based on experiences of its application

- **Case Studies:** Covers case studies from 3 districts in which AMREF has successfully implemented the linkages and coordination strengthening framework, discussing the processes, key results as well as lessons learnt.

- **Lessons learned:** Presents reflections of AMREF staff and partners actively involved in the linkages, collaboration and coordination strengthening efforts on factors that hindered or fostered success of the process and outcomes

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PART 2: THE HEALTH SYSTEM

2.1 What is a Health System?

2.1.1 Systems:

A system is a set of elements where each element interacts with, or is related to, at least one other element. A system is characterized by linkages between its elements, as well as the internal nature of the elements. A system has primacy over its elements.

2.1.2 Health Systems:

A health system is the sum total of all the players and resources whose primary purpose is to improve health. The World Health Organization defines a health system as "organizations, people, and actions whose primary intent is to promote, restore or maintain health"[1]. This definition includes the full range of players engaged in the provision and financing of health services including the public, non-profit, and for-profit private sectors, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities. The World Health Organization identifies the six building blocks of the health system in their 2007 report titled *Everybody's Business: Strengthening health systems to improve health outcomes.*

WHO Health System Building Blocks

1. Service delivery
2. Health workforce
3. Health Information system
4. Access to essential medicines
5. Healthcare financing
6. Leadership and governance

2.1.3 The Kenya Health System

The promulgation of a new constitution for Kenya in August 2010, provided an overarching conducive legal framework for ensuring a more comprehensive and people driven health services, and a rights-based approach to health is adopted and applied in the country. This calls for a reorganization of the current health system to facilitate health care provision within the devolved system of government, which comprise the national and county government, as provided for in the Constitution.

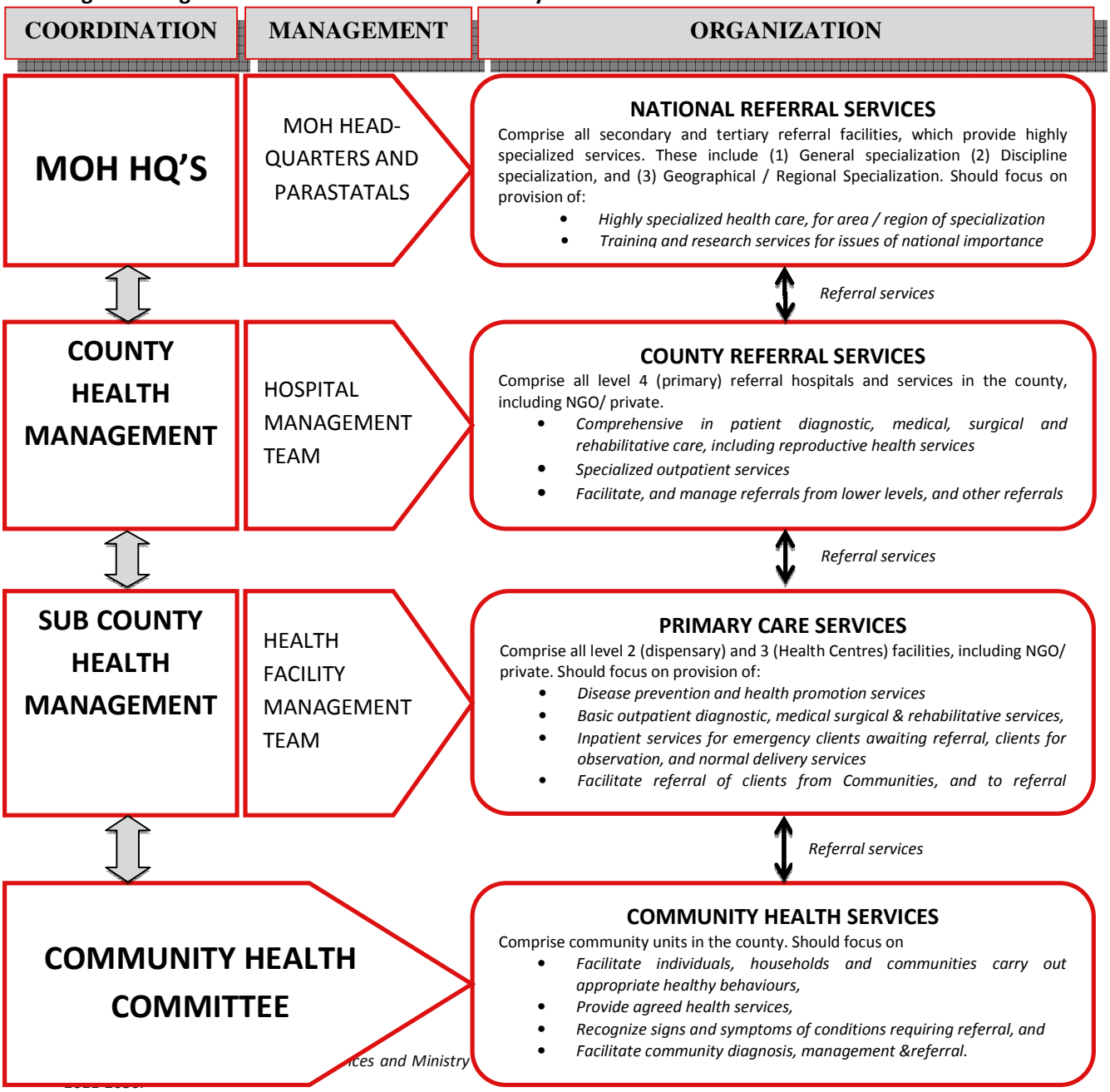
Under the new constitution, delivery of health services will be organized around a four tiered health system; County health services shall be organized around 3 levels of care: Community, Primary care, and Referral services. Level 1 (Community level) shall focus on organizing appropriate demand for services, while levels 2 and 3 (Primary Care and primary referral services) shall focus on responding to this

[1] *Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva, World Health Organization, 2007. Available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

demand. The county levels shall be well linked with Level 4 (National referral services) comprising of all secondary and tertiary referral facilities, which provide highly specialized services[2]. (Fig. 1)

This guide appreciates these changes and seeks to facilitate grass root CSOs participation in the reorganized health services in line with the devolution.

Figure 1. Organization of health services delivery



[2] Kenya health policy framework 2012-2030

2.2 The Gap between Communities and the Formal Health System

"….Until people become engaged with their own health care, we will continue to wipe the floor while the tap continues to leak." –Professor Miriam K. Were

As the world moves back to Primary Health Care, community participation in the health system has risen to the fore as a foundation principle, and is one of the underpinning values of primary health care outlined in the Alma Ata Declaration[3]. However, for this shift to become a reality, communities in their different forms need to be empowered and recognized as agents of change and leaders in promoting their own well-being, rather than just targets of intervention.

While communities are increasingly being recognized as an integral link in any health system set up to serve them, this has not always been the case. In many communities, there continues to be a disconnect between them and the rest of the health system, causing dysfunction in health promotion, prevention and health care service delivery and thus contributing to worsening health status especially among the poor, vulnerable and marginalized populations.

The gap between communities and the rest of the health system is reflected in the following ways:

- Barriers to communication that compromise the ability to share information and a reluctance to guarantee communities a voice in decision making
- A disconnect between the informal health sector (e.g., community-based health care workers and traditional service providers) and those in the formal sector
- Missed opportunities to increase health promotion and preventive care efforts in communities
- Attendant problems of access to, and utilization of quality services
- Weak data collection and research on community health needs, strengths and weaknesses for appropriate policy formulation
- Compromised or ineffective referral systems and access to specialised services

The overall goal of AMREF's strategy (2007-2017) is to reduce the gap between communities and the rest of the health system[4], in line with government policies and strategies including the Kenya essential Package for Health (KEPH) and the Kenya Health Policy Framework 2012-2030. Through her programmes, AMREF has been catalyzing a community movement for better health in Africa through enhanced partnerships with civil society and through capacity building in communities to increase demand for quality and efficient service delivery. The AMREF Business Plan (2011-2014) restates AMREF's commitment to empowering communities by helping them connect and integrate with the formal health systems, acting as a powerful catalyst for lasting health change from within.

The AMREF *Maanisha* programme, has been contributing to this process by strengthening community health care initiatives through grant making and capacity building of CSOs involved in HIV and AIDS activities. This has resulted in enhanced community voices and participation in health service planning

[3] *Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Available at: http://www.who.int/publications/almaata_declaration_en.pdf*

[4] *AMREF (2009), Enhancing Capacity and Participation to close the gap in Health Systems, Strategy 2007-2017, Nairobi*

and delivery including implementation of the community health strategy (See Appendices for case studies). This also follows the recognition of the role of CSOs in the health system. In the HIV response for instance, CSOs carry out a range of activities such as Home and Community Based Care (HCBC), Orphaned and Vulnerable Children (OVC) support, adherence support to PLHIV, nutritional support to PLHIV, widows and OVCs, Behaviour Change Communication (BCC), as well as educating the community on HIV and AIDS cross cutting issues using a variety of information, education and communication (IEC) materials and approaches[5].

Undoubtedly, CSOs contribute to a wide range of health system functions as summarized in Table 1 below warranting greater recognition and meaningful engagement. The table has been adopted and modified from the WHO 2001 discussion paper titled "The Role of Civil Society in Health". Examples of CSOs role in the health systems are drawn from the experience of AMREF Maanisha supporting over 700 CSOs to design and implement quality HIV&AIDS interventions through institutional capacity building and grant making. Specific examples on how different CSOs have contributed can be found in Maanisha Programme reports. The examples are further drawn from a report of a rapid assessment conducted by AMREF Maanisha on how the programme has enhanced community voices in demanding for their health rights as well as other socio economic rights. These documents are referenced for further reading

[5] *Mwaura N. "CSO as an untapped resource in the implementation of the Community Strategy: The experience of AMREF Maanisha programme. Nairobi; 2010*

Table 1: Roles of CSOs in a health system

Health System Function	Examples of CSOs Roles	AMREF *Maanisha* Experience[6], [7]
Health Services	Service provision	*Maanisha* supports over 700 CSOs to deliver HIV&AIDS services in the community including HIV counseling and testing, Home and Community Based Care, condom education and distribution, education on HIV risk reduction and psychosocial support to PLHIV and OVC
	Distributing health resources such as condoms, bed nets etc	
	Facilitating community interactions with services	More than 300 *Maanisha* funded CSOs are linked to health facilities near them, resulting in increased referrals of clients for quality HIV&AIDS services including HIV testing, ART initiation and follow-up, TB screening and treatment, PMTCT and family planning services
	Building health worker moral and support	111 *Maanisha* funded CSOs are implementing the community health strategy through training of community health workers (CHWs), working in community units as CHWs, participating in Community and Facility Health committees, hence easing the pressure on health workers occasioned by heavy work load.
Health Promotion and Information Exchange	Obtaining and disseminating health information;	*Maanisha* supports 340 CSOs to promote HIV prevention among the general, most at risk and vulnerable populations in the community through: IEC materials, peer education, small group discussions and community outreaches to share HIV risk reduction messages.
	Building informed public choices on health;	
	Implementing and using health research;	In Siaya district, CSOs, health workers and other stakeholders are implementing Youth Friendly Services based on findings of an operational research carried out by AMREF in 2011. This is aimed at improving sexual and reproductive health outcomes among the youth in the intervention sites.
	Helping to shift social attitudes	In its support to CSOs, *Maanisha* has continued to mainstream cross cutting issues including stigma & discrimination, gender inequalities and harmful cultural and social norms, resulting in reduced social vulnerabilities among PLHIV, OVC and PLWD
	Mobilizing and organizing for health	Funded CSOs promote uptake of HIV&AIDS services through participation in world AIDS and World TB days campaigns, Rapid Results Initiatives (RRI) to accelerate HTC, Community action and dialogue days under the community strategy
Policy Setting and influencing	Representing public and community interests in policy	*Maanisha* has strengthened community voices by advocating for and supporting CSOs engagement in policy dialogue through participation in government led fora including: health stakeholders' fora, annual operational planning and Joint HIV and AIDS Programme Review. They are mentored to align their interventions with national policies such as the Kenya National AIDS Strategic Plan (KANSP III) and other policies and guidelines for service delivery in the different HIV thematic areas
	Promoting equity and pro-poor policies	
	Negotiating public health standards and approaches	
	Building policy consensus, disseminating policy positions	
	Enhancing public support for policies	
Resources mobilization and allocation	Financing health services	CSOs have continued to mobilize resources to promote access to healthcare especially among the poor and vulnerable members of the community. One such CSO, Oogo in Nyanza, has sensitized and mobilized its members to participate in income generating activities. The proceeds go towards contributing to the National Health Insurance Fund (NHIF) hence providing medical insurance to group members and their families
	Raising community preferences in resource allocation	
	Mobilizing and organizing community co-financing of services	
	Promoting pro-poor and equity concerns in resource allocation	
	Building public accountability and transparency in raising, allocating and managing resources	
Monitoring quality of care and responsiveness	Monitoring responsiveness and quality of health services	*Maanisha* funded CSOs are increasingly being represented in health management committees at the community and facility levels, and participating in community dialogue days under the community strategy. CSOs use these opportunities to voice community priorities in health, demand for quality services, while promoting mutual accountability in management of health and resources
	Giving voice to marginalized groups, promoting equity	
	Representing patient rights in quality of care issues;	
	Channelling and negotiating patient complaints and claims	

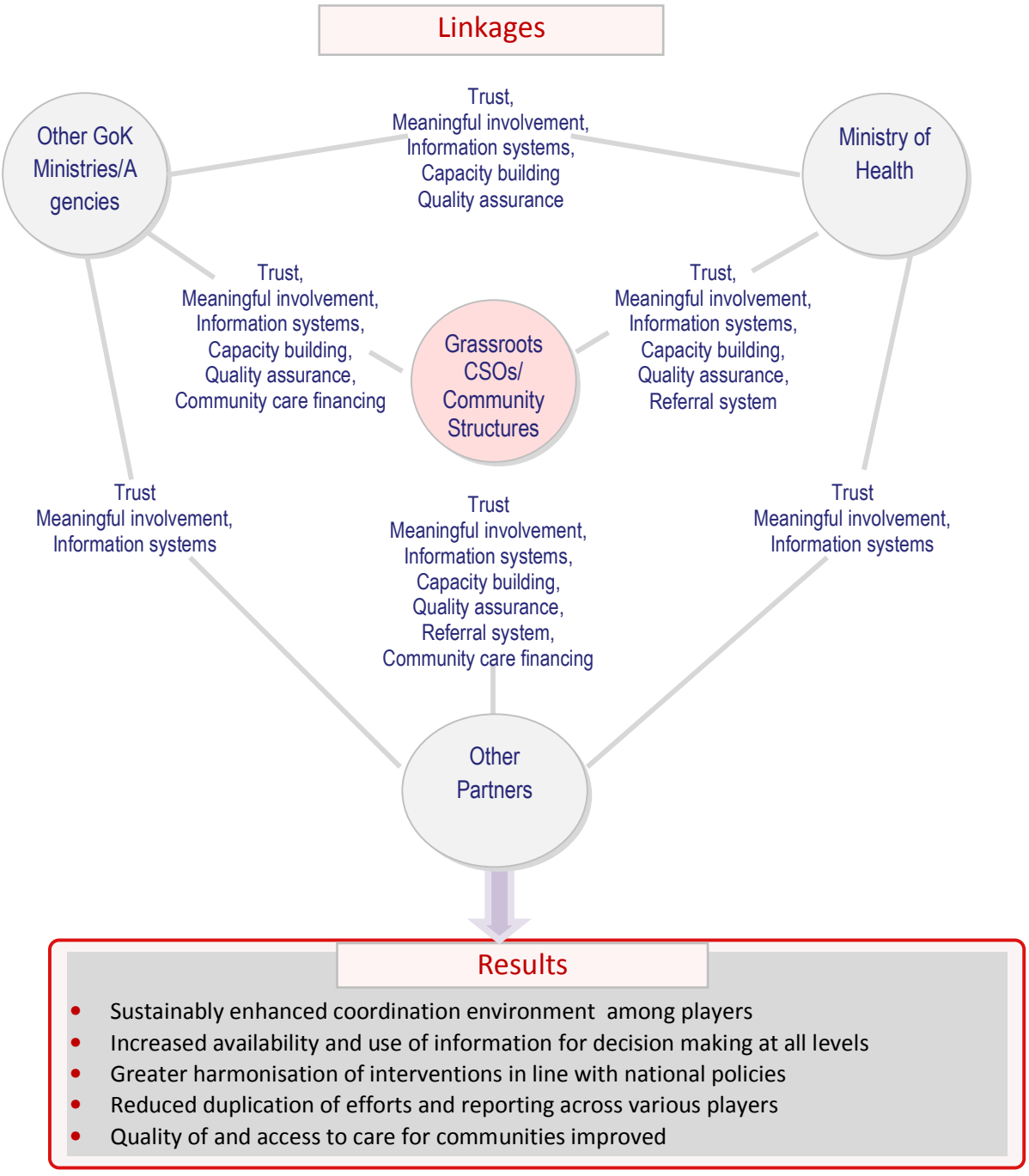
Adopted and modified from: *WHO 2001, Strategic alliances: The role of civil society in health, Discussion Paper No. 1, Civil Society Initiative*

[6] AMREF (2011), *Fourth Bi-Annual Report; Maanisha Community Focused Initiatives to Control HIV and AIDS in Kenya*, Nairobi

[7] AMREF (2012), *Implementing HIV Interventions with a Community Lens: How AMREF Maanisha Program Enhances Community Voices*, Nairobi

PART 3: AMREF HEALTH SYSTEM LINKAGES, COLLABORATION AND COORDINATION STRENGTHENING FRAMEWORK

Figure 2: The Linkages Framework



3.1 Development of the Framework

In order to inform *Maanisha* programme strategies, AMREF conducted a needs assessment in 2004 in the Lake Victoria Basin Region of Kenya and a baseline survey in 2005 and 2008 in Nyanza, Western, Eastern, and Rift Valley provinces. Findings from these assessments, together with consultations with NACC and MoMS/MoPHS staff in Nyanza province revealed that gaps in the health system coordination environment weighed down effective HIV and AIDS response. Further, initial meetings by AMREF *Maanisha* in a bid to bring together CSOs and government stakeholders for consultations at district levels identified factors affecting linkages between health facilities and the community. These include lack of recognition of CSOs by health workers, inadequate involvement of GOK staff in implementation by CSOs, CSOs not submitting reports to MoH and NACC, poor information flow from both parties, lack of regular meetings and non-cordial relationships between NACC and MoH.

Health System coordination gaps:

- Poor information flow among health players
- Weak monitoring and Information systems
- Low capacity of communities to design effective responses;
- Inadequate involvement of communities
- low quality of care for vulnerable groups
- Limited availability of resources to communities/CSOs (AMREF *Maanisha*, 2010)

Following above findings, AMREF initiated consultations with NACC and MoMS/MoPHS in 2009, to find solutions and innovations for reducing identified gaps in the health system and fostering trust and harmony among the various actors. The proceedings of these meetings greatly shaped the health systems linkages, collaboration and coordination strengthening framework that has since been operationalised within the AMREF *Maanisha* programme regions. The framework is a "self analysis tool" that outlines the seven major linkages that need to be strengthened in a County, sub-county or community setting in order to have a strong health system within a vibrant coordination environment as well as categories of key players in the health system. It is a generic framework that is adaptable to any health system, and can be applied in single or multiple disease programming situations

The linkages framework is a "self analysis tool' that outlines the seven major linkages that need to be strengthened in a County, sub-county or community setting in order to have a strong health system within a vibrant coordination environment

During this same period, AMREF and her partners have learned more lessons about how best to apply the linkages frame work, to ensure a multi-sectoral approach that recognizes other ministries beside the ministry of health. This is also in line with the KHPF (2012-2030). The policy framework proposes adoption of a "Health in all Policies' approach, which ensures the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions including Education, Gender and Social services, Youth affairs, Agriculture among other sectors[8].

[8] *Kenya, Ministry of Medical Services and Ministry of Public Health and Sanitation (2011), Comprehensive National Health Policy Framework 2011-2030*

3.2 Players and Linkages

3.2.1 Players:

This framework deliberately outlines four players of the health system namely,(1) Ministry of Health (MoH), (2)other government ministries, (3) "other partners" and (4) CSO/community. The MoH, other government ministries and 'other partners' constitute the formal sector, while communities are the different organized groups of civil society constitute the informal sector. This is further elaborated below:

Four (4) players:

1. Ministry of Health
2. CSOs/community
3. Other government ministries/ agencies
4. Other partners such as NGOs, FBOs, Learning Institutions

(i) The **MoH** element includes decentralized structures such as the Health Management Teams (HMTs) at county and sub-county levels as well as health facilities at all levels.

(ii) **Other government ministries and agencies** include those other than the ministry of health but which are equally important in attaining the overall health goals. These included such ministries as education, youth, agriculture, as well as the Ministry of Special Programmes under which **NACC** falls.

(iii) The **'other partners'** includes all other players in the health field excluding government ministries and agencies, and grassroots CSO/Community - these other implementers include NGOs operating at the county and sub-county levels and private sector organisations among others.

(iv) The **community** element refers to level one of the health care system including community units, grassroots CSOs targeting several villages or sub-locations, village health committees and households serviced by these structures. This framework puts the community at the centre of the health system and hopes that it will literally be so - *whatever players do in terms of health systems linkages and coordination strengthening, it needs to significantly improve the wellbeing of targeted communities – if it does not, it is simply not worth investing resources in it*.

3.2.2 Linkages:

The framework outlines seven linkages necessary for creating a vibrant collaboration and coordination environment amongst the various county, sub-county and community health actors; these linkages are trust, meaningful involvement, information systems, capacity building, quality assurance, referral system and community health care financing. Each of these linkages is defined below.

Seven (7) Linkages:

- ✓ Trust
- ✓ Meaningful involvement
- ✓ Information systems
- ✓ Capacity building
- ✓ Quality assurance
- ✓ Referral system
- ✓ Community care financing

(i) Trust: Trust is the confidence and strong belief in the genuineness, integrity, ability and reliability of another person. In an environment of trust, one can rest assured of the other person's friendship and support. In the context of this framework, trust exists when each of the four players believe in the genuineness, integrity, ability, and reliability of the other three elements and vice versa. For example, does the community believe in the goodness of MoH, NACC and other implementers, and do these three believe in the goodness and inherent ability of the community. Although past health systems frameworks have not recognised trust as a key entity, AMREF's experience has shown that trust forms the basis for all other linkages to work, and is therefore a key pillar for sustainable strengthening of health systems collaboration and coordination environments.

(ii) Meaningful involvement: Involvement means adequate engagement of the four players in Planning, Implementation, and Review mechanisms. It is about each of the players actively adequately engaging with the other three players in processes that are within the latter's sphere of interest, or that have an effect on the latter's desired end results. For example, how well does NACC involve MoH in JAPR processes? Or how well does NACC involve MoH in certain technical aspects of HIV and AIDS programming? Or how well does MoH involve communities/CSOs in the AOP process, or community strategy planning and implementation? And it needs to be meaningful involvement – as in the player being involved is given adequate leeway to add value to the process – for example, when NACC involves communities in JAPR, are the communities given adequate leeway to voice their opinions and are these captured in a way that allows the communities voice to get to the policy and programming dialogue at county and national levels? There is always the risk of making involvement a public affairs gimmick, but it need not be, and should never be!

(iii) Capacity building: The AMREF Strategy (2007-2017) defines capacity building as 'the process by which individuals, groups, communities and organizations increase their ability to perform core functions'. In the case of *Maanisha*, this definition sums up the programme's efforts and resolve towards increasing the ability of CSOs/PSOs to design and implement HIV & AIDS interventions. Diverse methods can be used to enhance the capacity of CSOs, including training, mentoring, exchange visits, and review meetings. Other partners, MoH and other government ministries need to ask the question - how well are we building the capacity of CSOs/communities?

While AMREF - *Maanisha* as necessary applies training, the capacity building approach lays a lot of emphasis on mentoring (what AMREF calls *'walking with CSOs/communities')* and exchange visits that foster intense and sustained capabilities amongst CSOs

(iv) Quality assurance: Quality assurance includes all systematic actions taken to ensure that set procedures are adhered to and that delivered products or services meet technical standards. Key methods that programmes can use in order to assure quality include ensuring that: approved guidelines are available to implementers including communities; trainings are facilitated by accredited facilitators; implementers adopt a client perspective in service delivery; mechanisms to check adherence to standards e.g. supervision visits. NACC, MoH and other implementers need to put together mechanism in place to ensure adequate quality assurance of interventions in addition to enhancing capacity of community implementers to regularly measure and improve the quality of their interventions. Notably, integration of services helps improve the

quality of services provided, and the players need to ask *'what services are currently disintegrated and need to be integrated (put under one roof or delivered by the same care provider etc)?'*

(v) Referral systems: Referral is a process in which a service provider at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a client, seeks the assistance of a better or differently resourced facility or organisation at the same or higher level to assist in, or take over the management of the client. An effective referral system ensures a close relationship between all levels of the health system and helps to ensure people receive the best possible care closest to home. Being a system, a referral system requires consideration of all its components.

Important components of a referral system include:

1. ***Initiator*** of referral either at community level or health facility level
2. ***Receiving*** facility or organization
3. **Key *referral supports*** namely referral protocols, referral forms, transportation, information / communication to client on the need and process of referral, referral registers, client management protocols, feedback from receiver to initiator
4. ***Supervision and capacity building*** on referral by the local health authorities including training staff and monitoring documentation and efficiency of referral.

(vi) Health information systems (HIS): An HIS is 'a set of components and procedures organized with the objective of generating information that will improve healthcare management decisions at the various levels of the health system'. For an HIS to work effectively, key prerequisites need to be in place namely: information policies that relate to national standards e.g. tools that should be used by stakeholders; financial resources to support data **C**ollection, **C**ollation, **A**nalysis, **I**nterpretation, **D**issemination, and **U**se (**CCAIDU**); people who are adequately trained/skilled to manage information at different levels of the health system; communication infrastructure for transfer and management or storage of information; and coordination and leadership mechanisms to effectively lead the HIS. Weaknesses anywhere in the CCAIDU continuum can render an information system less useful e.g. if information is collected or if one player has new useful information (emerging information, lessons learned, or best practices) but is not shared (disseminated), it will at best lead to marginal benefits for the health system as a whole.

Whenever reviewing the HIS in a given setting, criteria could include:

- ***Integration and inclusivity****:* often, several stakeholders in a given district or province rely on different sub-HIS e.g. the COBPAR reporting system of NACC and the HCBC and reporting system of MoH (the community strategy reporting system). The level of integration between different sub-HIS is a key determinant of the overall value of an HIS in enhancing decision making. The level of integration can be analyzed by asking the following questions: *is there dialogue between stakeholders who use the different sub systems? Do they share information/data? Do they coordinate their work to avoid duplication of efforts? Do they use the same coding classifications for specific conditions; what is the level of inclusivity - does the HIS include communities (including grassroots CSOs) as well as other implementers?* Greater integration of HIS subsystems can be accomplished by increased demand by stakeholders for data from other subsystems
- ***Completeness:*** completeness of the HIS can be assessed by asking and answering the question: what percentage of all cases or events are captured and represented in HIS e.g. are we through COBPAR capturing all the human rights work done in a certain district? Improving the coverage of the HIS could include activities such as: inclusion of communities and civil society in the HIS; and capacity building and support supervision to improve compliance to HIS requirements.
- ***Timeliness:*** a HIS that cannot Collect, Collate, Analyze, Interpret, and Disseminate data within a time frame of the data's Usefulness (i.e. within the time frame of the decision making processes) is probably of little value. Timeliness of the CCAID part of CCAIDU process could be improved by activities such as: capacity building and support supervision to improve compliance to HIS requirements; improved communication at all levels to facilitate timely data flow; and improved means of data handling and analysis (where possible and appropriate, this could include computerization)
- ***Use for decision making:*** stakeholders need to ask the critical question: other than 'clearing and forwarding' this data to the provincial and /or national level, do we use the data do make decisions at our level of jurisdiction?

(vii) Community health care financing: community health care financing is the mobilization and management of funds by a community to finance some of its health needs. It includes different mechanisms of mobilizing resources such as microcredit, community health funds, and micro insurance. Their common features include: voluntary involvement of community members in revenue generation in the spirit of self reliance; marked community cooperation in revenue generation, collection, pooling, and allocation; and pre-payment (i.e. payment before episode of illness occurs). Factors for success of community financing include: organisational capacity of the community group, including financial management systems and skills, networking and linkages with external organisations and institutions (e.g. NACC, MoMS/MoPHS, other CSOs), financing linkages with donors and/or microfinance institutions, diversity of funding, and relevance of the group in addressing a broad range of issues (rather than just focusing on health, the groups addresses development, including health), and agility (ability to adapt to a changing environment).

Within the context of the health system strengthening framework, players can enhance community care financing by: enhancing ability of CSOs to attract funding from diverse funding agencies through organisational development mentoring, proactively linking CSOs with funding agencies, and supporting sustainable income generating activities by CSOs. This way, communities have access to financial resources for health care e.g. transportation to health facilities, enrolment into the national health insurance fund, and other development

PART 4: APPLICATION OF THE HEALTH SYSTEM LINKAGES, COLLABORATION AND COORDINATION STRENGTHENING FRAMEWORK

4.0 Introduction

This chapter presents key steps in strengthening linkages, collaboration and coordination among health stakeholders in a given setting, be it at the community, sub-county or county levels of the health system. The section begins by discussing suggested leadership mechanisms for the process, stakeholder identification, and formulation of Terms of Reference (TOR), gap analysis, action planning and follow up mechanisms for tracking progress.

4.1 Leadership for the Process

Leadership is the art of motivating a group of people to act towards achieving a common goal. Health systems strengthening processes at all levels of service delivery need leadership for them to take off and remain airborne. While "Other partners" such as NGOs may catalyse the processes, leadership for the process needs to be from the government players for it to be sustainable. The source of this leadership should be determined by context. For example, in current Kenya's health development environment, and specifically the HIV and AIDS programming arena, NACC leads processes aimed at strengthening the overall coordination environment, while MoH, through the National AIDS and STI Control Programme (NASCOP) leads in coordinating implementation efforts focusing on specific HIV prevention, care and treatment services such as Home and Community based Care (HCBC), Anti retroviral Therapy (ART), HIV counselling and Testing (HCT), Prevention with Positives (PWP) among others.

4.2 Stakeholders Identification

4.2.1 Who is a stakeholder?

Stakeholders are individuals, groups or agencies who have direct or indirect interest, some aspects or rights or ownership in a given project, can contribute in the form of knowledge or support, or can impact or be impacted by the project, its work or outcomes, (Walker and Rowlinson, 2008).

4.2.2 Stakeholder engagement

The first step in the process of stakeholder engagement is stakeholder identification which entails determining who your project stakeholders are including their key groupings and sub-groupings. Here, it is important to keep in mind that not all stakeholders in a particular group or sub-group will necessarily share the same concerns or have unified opinions or priorities. This means then that different stakeholders are entitled to different considerations. A key consideration is having a more in-depth look at stakeholder group interests, how they will be affected and to what degree and what influence they could have on your project. The answers to these questions will provide the basis from which to build your stakeholder engagement strategy.

Key health stakeholders at a community level may include Ministry of Health and other GOK line ministries at the county or sub county levels, Community based organisations including groups of people living with HIV, community units, faith based organisations and other non-governmental organizations implementing or supporting health programs in the area.

4.3 Terms of Reference

Linkages, collaboration and coordination strengthening mechanisms/fora require terms of reference (ToR) that explicitly include all the linkages between the various players. Often, these can be adapted from existing generic ToRs such as those in the District Health Stakeholders Forum (DHSF) guidelines or NACC guidelines for Constituency AIDS Coordination Committees (CACC) and District Technical Committees (DTC), and deliberately tailored to context. Initial meeting/fora should spend adequate effort in designing clear ToRs that have the understanding and buy-in of players. The importance of ToRs cannot be overstated – it is one way to keep the process focused and at the same time foster institutional memory needed to manage the risk of high staff turnover among many players.

Participants need to be realistic to only recommend practical actions i.e. those that are doable or within their scope of influence; otherwise the whole process becomes a 'wild goose chase'

4.4 Gap Analysis

This is a highly participatory self analysis exercise in which members of the health stakeholders in a given forum use this framework as a guide in assessing the situation at the beginning of the health systems strengthening process.

Steps in conducting the gap analysis exercise:

1. Divide the participants into groups of 4-6 individuals and have each group handle the linkages between at least two players. Group membership needs to include members of the players being assessed by the group, as well as members of other players, to ensure the discussion is rich in context yet not too subjective
2. Each group should select a team leader and a rapportuer to record the group's deliberations.
3. Give each group copies of the relevant gap analysis tools according to which linkages they are assessing e.g. a group that is assessing MoH-CSO linkages should get a matching tool (see appendix 2)
4. Group members discuss and agree on the linkages between each set of players based on the current state of affairs. They could add or modify the specific linkages if necessary – for example, they could decide to add 'quality assurance' to the linkage between Other GoK Ministries and 'other partners'.

If number of participants allow, it is advised that for every set of outer and inner linkage, there are two groups .This will allow comparison of opinions and importantly ensue that each group is assessing linkages with communities as well as linkages between other players

4.5 Scoring

Each group proceeds to assess the linkages, collaboration and coordination environment using the following as a guide:

- Each linkage between any two players can get a score of 0 to 4, where 0 = nonexistent or very poor, 1 = poor, 2 = fair, 3 = good, and 4 = excellent.
- The group then discusses each linkage, giving it a

The whole purpose of scoring is not so much the score itself, rather it is to prompt the group to dialogue - before members agree on a score, there needs to be adequate reasoning behind it.

score between 0 and 4, and reasons for the score- (*Before members agree on a score, there needs to be adequate reasoning behind it).*

- Participants in group work then outline actions needed to achieve a score of 4 for each element. *(An example of information generated by a group discussing the linkages between Ministry of Health and CSO held in Rarieda district in April 2010, is provided in table 2 below).*

Table 2: Baseline Group Discussion Findings for the MoH and CSO Linkages in Rarieda District in April 2010

Players: CSOs -MoH		**District:** Rarieda	**Date:** 7th December 2010
Linkage	**Score**	**Reasons**	**Action**
Trust	2	-CSOs view MoH staff as having unclear motives when called to facilitate trainings -Perceived poor time management by MoH -CSOs concerned about drug shortages at the health facilities, without clear explanations by MoH	-Include CSO representatives in community and facility meetings where service delivery issue are discussed -Train the CBOs on some technical issues -Promote open communication between the two parties
Meaningful involvement	2	-Involvement is in writing but not in action -Weak linkages between CSOs and MoH -CSOs not always open with information regarding their projects	-The two parties need to involve each other in the following: AOP; community strategy; DHSF, CSO activities including trainings
Information systems	1	- Poor coordination and sharing of information by both MoH and CSOs - CSOs not supplied with adequate reporting tools - Inadequate knowledge of how to use reporting tools by CSOs	- Improve on information sharing and strengthen linkages - MoH to supply CSOs with necessary reporting and referral tools - Proper mentorship and more training of CSOs on proper use of reporting tools
Capacity building	3	- CSOs receive Supervision by MoH and NACC in some areas of intervention e.g. HCBC - CSOs receive training and updates from MoH especially during Quarterly review meetings organised by Maanisha	-Continue with review meetings and supervision
Quality assurance	2	- Some of the policy guidelines are not available to CSOs	- Strengthen access to and use of policies and guidelines by CSOs
Referral Systems	2	-Poor referral linkages between MoH and CSOs -"Ownership" of project and clients by CSOs and partners affects client referrals to local health facilities	- Improve on regular integrated meetings and consultations
Total	**13**		
Average %	**54%**		

From table 2, coordination between CSOs and MoH scored 54%, meaning it was fair (*on a scale where 0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent***). The reasons for this score are clear from the third column. The average % score (in this case 54%) was arrived at by dividing the total score for the group (13) by the maximum total score (24 i.e. 4 per score x 6 linkages).**

4.6 Results Presentation and Validation

- After each group has completed the gap analysis tool, deliberations are then taken to plenary, where all groups present and participants validate the opinions regarding scores, reasons, and recommended actions.
- During plenary participants expand the possible reasons and actions to represent the feelings of the forum so that the final scores, reasons for each score and required actions reflect the entire team's true position. This will foster ownership and collective responsibility.

4.7 Action Planning

This is done in plenary whereby the entire team of the stakeholders are guided on concrete actions towards improving the linkages, collaboration and coordination environment with assigned timelines and responsibilities.

- The action plan should include: the vision for the stakeholders with regard to health systems/coordination strengthening; key objectives; actions; timeline for key actions; and persons/organisations responsible (see appendix 3)
- With the example in table 2 above, the county/sub county could set a goal to reach a score of 80% in 2 years, with specific objectives to strengthen weak linkages.
- *Notice that when all groups have presented, it is possible to have a scorecard showing where the district is with regard to the health system/ coordination environment (see Figure 3 for sample of completed scorecard). This is achieved by dividing the six percentage scores by six.*

It is useful to have a visual display of the findings, for all stakeholders to come to terms with the reality. Indeed, the various partners could take the completed scorecard and post it in their offices for reference

Table 3: A sample action plan from a Linkages and Coordination strengthening meeting for Makueni District held on December 2010

ACTION	PERSON RESPONSIBLE	TIME-FRAME
Ensure participation of all active stakeholders in DHSFs including CSOs and other GOK ministries such as Education, Youth Affairs, Gender, children and social services and agencies such as NACC	Chairperson – Makueni DHSF steering committee	Quarterly
Share COBPAR tool with the MoH staff and other partners increased information sharing	CACC coordinators	January-March 2011
Create forum/platform for sharing of new information	Makueni Health Information Systems Improvement committee	Before next DHSF
Make a presentation on KNASP III targeting all stakeholders and possibly distribute copies	Makueni and Kaiti CACC Coordinators	Next DHSF forum
Hold joint HIV and AIDS related advocacy events e.g. World AIDS Day, World TB Day	All stakeholders	As frequently as are the events
Share information on funding with other stakeholders	CSOs, NACC, AMREF and other donors	Next DHSF and as frequently as possible thereafter
Distribute client referral tools to CSOs	MoH	January-March 2011

4.8 Possible Fora for application of the Linkages Framework

The framework is ideal for application during health systems strengthening /coordination fora such as County health stakeholder fora, community dialogue days and other fora whose aim is to enhance coordination of the health system within a single disease or multiple disease programming.

Although application of the framework may appear somewhat subjective, the gains in terms of ownership of recommended actions far outweigh the losses due to any perceived subjectivity. Furthermore, different counties could have different actions and ways of conceptualising desired change, as long as it is within existing national frameworks. For example, the linkage elements between certain partners could be increased to match unique situations

4.8.1 *From County to Sub-county and Community level*

- A good way to ensure that health systems Linkages, collaboration and coordination environments are being strengthened is to see the county as provider of guidance to the sub-county, and the sub-county and community levels as the key implementation environment. Sub-county level players should meet at county level to undertake this analysis for the county. This serves also as learning fora for sub county level players. Thereafter, sub-county staff go back and undertake the same analysis for their respective sub counties within the context of health stakeholders fora, technical committees, and other relevant health fora

If it is not happening at the sub-county and community level, it is not happening at all!

- The framework can be also applied by a sub county or a community unit 'in isolation', without having to wait for county intervention. This could be useful in situations where piloting applicability before scaling up to more sub counties or to entire counties is thought to be necessary.

PART 5: MONITORING AND EVALUATION

5.1 Implementation and Tracking Progress

- The action plan forms the basis for implementation and regular review by the coordination fora in a given setting.
- During subsequent meetings or stakeholders' fora, participants review progress in linkages between the various players towards set goals and adjust plans as necessary while highlighting any challenges experienced.
- In order to measure progress made in the period since the last meeting, the same method of analysis and scoring is followed i.e. groups focus on assessing progress made, exploring new challenges, and deliberating on actions to enhance progress. For example, from table 2 above, with regard to involvement, the group will assess how well players are involving each other as well as commitment from each side, explore new challenges with that linkage, give a score for that linkage (for example, it could have moved from 40% to 60%), and explore further actions needed. As you can see, it is a monitoring as well as planning process, and it is up the facilitators to guide the process so that it is fruitful.

Note: Facilitators need to figure out the best way to document and communicate gaps and agreed upon actions to all players. Meeting reports therefore need to at least include: participants; process followed; gaps identified and reasons for the gaps; action plan; and completed scorecard. In addition to having the completed scorecard as part of the report, it could be translated into A2 or A1 print out on manila but with the score boxes empty. After the exercise, stakeholders can take copies of completed ***scorecard*** *to their offices together with the* ***action plan*** *for easy reference and sharing with colleagues of the respective stakeholders.*

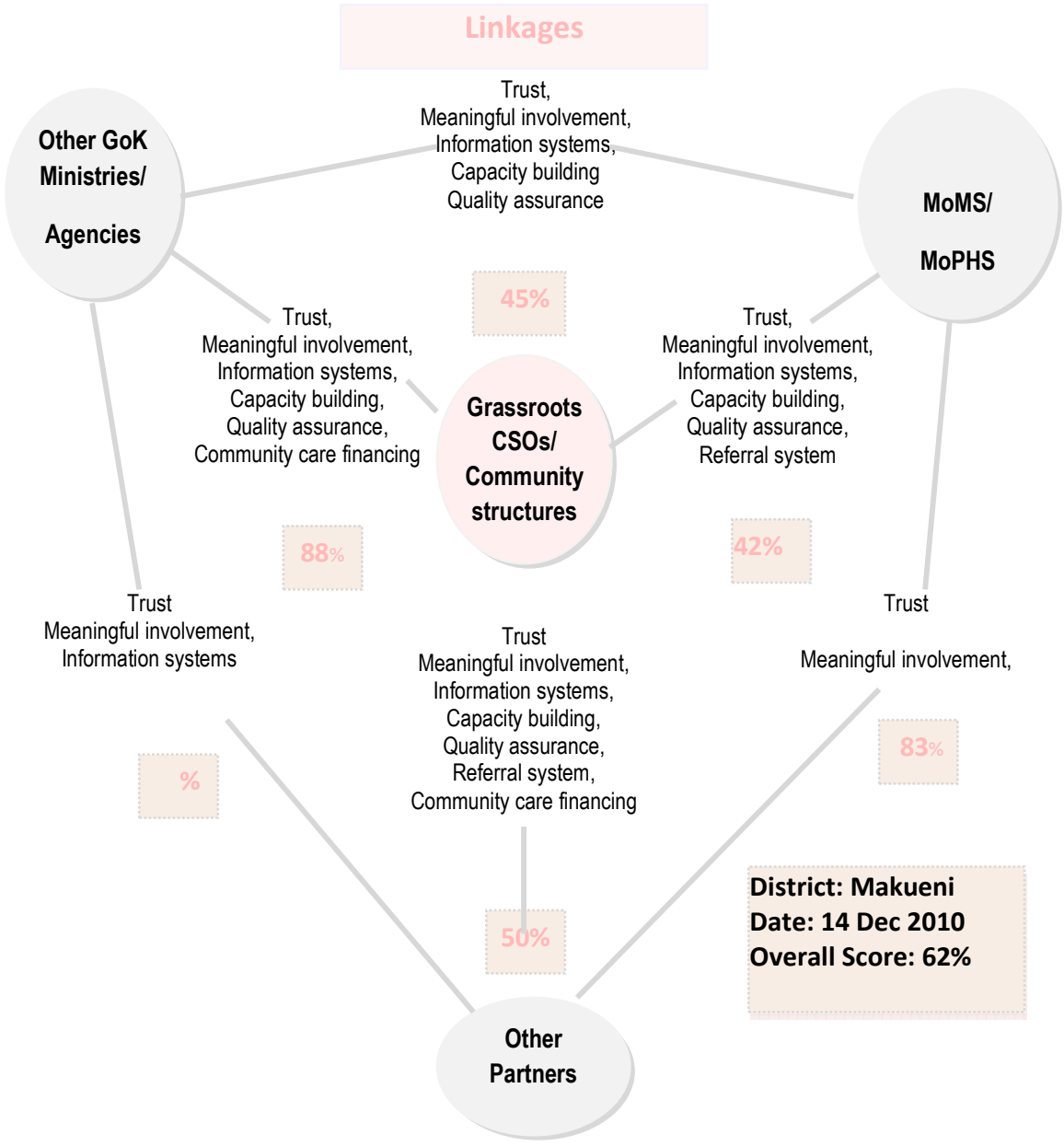
Example of a completed score card:

Makueni District:

The coordination strengthening meeting held on 14th December 2010 was the first one in the district after several months of consultations with the Makueni DHMT and CACC coordinators and sensitization of CSOs on the importance of mutual involvement in each other's activities processes for a harmonized and coordinated environment. The meeting brought together health stakeholders including the Ministries of Health, Ministry of Youth Affairs, NACC decentralized structures, CSOs and other development partners supporting HIV and AIDS interventions in the district.

During this meeting, linkages among all the partners were assessed except one; NACC and "Other Partners" due to the limited number of NACC representatives. An average score for the district was arrived at, forming a basis for concrete actions towards further improvement.

Figure 3: Sample completed score card from a linkages and coordination strengthening meeting for Makueni district:



PART 6: CASE STUDIES

Case Study 1: How enhanced coordination improved service delivery in Rarieda District

Situation before the intervention

The AMREF Maanisha project has been working with over 700 CSOs since 2004 to implement a community focused HIV program in Nyanza, Western, Eastern and part of the Rift Valley Provinces. Supported by Sida and DFID, the programme works with Key partners such as the MoH, NACC devolved structures and CSOs. Initially, the CSOs did not have a smooth working relationship with CACCs and MoH. CSOs were apprehensive in being supervised by CACCs due to mistrust. Further, some CSOs preferred working with CACCs with no involvement of MOH which caused tension between CACCs and MOH who felt that the former were usurping their responsibilities. AMREF knew that for effective coordination, there was need for a closer working relationship between CSOs, CACCs and MoH.

Strategies used to strengthen coordination

One of the key objectives of the program is to strengthen facilitation, harmonization, and coordination mechanisms between CSOs/PSOs and GOK structures. In order to accomplish this, AMREF initiated a pilot health system linkages, collaboration and coordination strengthening framework in Rarieda in Nyanza province in 2009. Generally, the AMREF approach aimed at enhancing local solutions in addressing community needs, promotion of inclusiveness, efficiency and effectiveness among stakeholders for quality HIV services. To ensure the project buy in, AMREF held meetings with provincial heads namely the PASCO, PHCBC and NACC field officer. The DHCBC, CACC and DASCO who are critical in implementation of HIV activities also attended these meetings. It was agreed that the CACC should be the link person in coordinating CSO engagement with other GoK structures, while the DHMT arms of DASCO and DHCBC would be the focal technical assistance persons. The meeting also agreed that there should be joint supervision of CSOs by CACCs and MOPHs and that information sharing sessions should be enhanced.

AMREF also held similar meetings at the district level. This entailed conducting meetings with CACCs, MOPHs and CSOs to discuss on how collaboration and harmonization could be improved. The gaps identified by the stakeholders for an effective HIV response were many. These are summarized below:-

Gaps identified by CSOs	Gaps identified by NACC/MOH
• Intermittent drug supply • Inadequate supply of reporting tools • Favoritism in service delivery • Lack of recognition of CSOs work • High expectation for facilitation allowances from CSOs • Inadequate follow-up and technical support • Unavailability of GoK staff when and if in need of technical assistance • Support staff offering medical services	• Inadequate networking & involvement by CSOs • Weak linkages with health facilities • Low reporting rates to NACC/MoH • Some CBOs are closed and do not collaborate with MOH/NACC • Non-compliance to standards during HIV programming e.g. in HBC. • Inadequate skills in reporting, M&E and documentation • Inadequate understanding of district coordination structures

The discussions by stakeholders also resolved that in order to strengthen coordination and linkages, there is need for grassroots CSOs NACC, MOH and other partners to cultivate and promote trust, meaningful involvement, information flow/feedback, capacity building, ensure quality assurance, referral systems and community care financing. From these meeting it was agreed that joint supervision is of importance to help strengthen linkages and effective coordination. Since then, joint supervision has been conducted quarterly at divisional levels with the MOH and CACC namely the CACC, DASCO DHCBC Divisional HCBC and a PHO. In addition, the MOH team also included health facility in charges. The team visited both Maanisha funded and non Maanisha funded CSOs. Following the supervisory visit stakeholders meeting was held where feedback from the visits was given to individual groups on their activities and challenges facing the partners were discussed. to

Key results

To track the progress made in strengthening the linkages, AMREF developed and piloted a HSS score card. The scorecard tested the linkages between MOPHs and the grassroots CSOs, CACC and grassroots CSOs and other partners and CSOs.

The results of the baseline and the follow up survey done in April 2011 are as presented in the table below:-

Linkages	Baseline assessment	Follow up
MOPHS-CSO	54%	62%
CACC-CSO	29%	50%
Other partners and CSOs	61%	64%
NACC and MOMS/MOPHS	-	60%

An application of rapid assessment tools showed evidence of strengthened coordination:-

I. Stakeholders from MOPHs and CACCs said that joint supervision and the review meetings enhanced linkages between the CSOs, MOPHS and CACCs. The open discussion generated dialogue between the CSOs, NACC and MOPH leading to increased information sharing, trust and meaningful involvement.

II. Quality assurance improved especially in the joint monitoring and evaluation of CSOs.

III. As a result of strengthened collaboration and coordination, the overall score for the district improved from 58% to 62%.

IV. The trust among partners was exemplified by the formation of the **Rarieda PLHIV network** which has since been registered and is reaching a large pool of PLHIV with quality HIV services. According to the ***Rarieda DHCBC coordinator***, "this AMREF tool is good…it makes us dialogue and reason together and I will use it in the community unit for community dialogue days in the community unit". A ***CSO representative*** had this to say: "If you don't trust MoH then why do you go there when you are sick?" Other partners mentioned that the HSS strategy has been effective and efficient in that the joint supervisory visits by different officers are able to address the different needs of the CSOs and hence provide them with comprehensive technical support necessary for effective HIV programs.

Key Lessons

I. The linkages framework enhances dialogue among stakeholders making them understand themselves better and have meaningful collaboration in HIV programming.

II. It particularly made them understand that working together is a must for better health of the community. For instance during the discussion between MoH and CSOs, the former were able to understand themselves from the consumers point of view and the community was able to understand the MoPHS from the health providers point of view.

III. The buying in of top leadership is critical in project implementation and ensures success. For instance, the engagement of leaders at the province before rolling down the coordination strategy at the District level ensured support and active involvement of the stakeholders at the District level.

IV. The HSS score card has enabled different teams to score their relationships, become more open to each other and self evaluate them hence giving room for strengthened growth and partnership.

Case Study 2 – Makueni District

The situation before the intervention

Before roll out of the Maanisha Health System and Coordination Strengthening frame work in Makueni district, there were weak linkages between the MoH and CSOs, MoH and NACC and other Partners and CSOs. In particular, CSOs hardly reported to NACC decentralized structures using the nationally agreed HIV reporting tool popularly known as the COBPAR tool. The CSOs also lacked trust in the NACC decentralized structures and did not value the role of CACCs in coordinating all the HIV activities at the constituency level. The weak referral linkages between the other Partners, grass root CSO & health facilities undermined the quality provision of HIV services. Further, some CSOs did not implement HIV activities in line with the Kenya national AIDS strategic plan especially during trainings where national guidelines were not used. All these undermined the country's strategic approach for a multi-sectoral approach in HIV response and also undermined the national efforts in rolling down the three one's principle[9].

On the other hand NACC and MOH did not understand each other well. There was mistrust and lack of meaningful involvement in HIV implementation between MoH and NACC, MoH and CSOs and other partners and CSOs. Consequently, during joint national HIV events, the partners rarely pooled resources for efficiency and effective implementation of such activities. The MoH and NACC also hardly recognized CSOs role in HIV programming and as such hardly involved them in annual operational planning or in Joint Annual Program Review (JAPR) planning. This lack of harmonization and non-alignment of activities as per the strategic plan as well as lack of proper mechanisms for managing results undermined the District's efforts in embracing the principles of aid effectiveness[10].

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[9] *On 25 April 2004, UNAIDS, and other stakeholders while co-hosting a* ***Consultation on Harmonization of International AIDS Funding*** *formally endorsed the "Three Ones" principles, which advocates for the following components as it relates of HIV and AIDS Programming:-*

1. *One agreed AIDS action framework that provides the basis for coordinating the work of all partners.*
2. *One national AIDS coordinating authority, with a broad-based multisectoral mandate.*
3. *One agreed country-level monitoring and evaluation system*

[10] *The Paris declaration resolved in March 2005 that for aid effectiveness to be enhanced there was an urgent need to address issues of ownership, harmonization, alignment, managing for results and mutual accountability.*

The above gaps undermined the provision of high quality and timely HIV related services to the target beneficiaries. For instance, the CSOs and their clients did not access the technical support and services they needed from MoH and NACC due to lack of coordination and mistrust.

The strategies used

AMREF Maanisha program developed a health systems linkages and coordination strengthening framework with a view to strengthen linkages and coordination among key stakeholders for a better HIV response. This involved identification of the key stake holders/players as well as a gap analysis for each in so far as coordination and linkages was concerned.

AMREF Maanisha initiated consultative meetings with DHMTs and other stakeholders to initiate discussions on health systems strengthening for improved HIV response. This entailed providing financial support for the stakeholders meetings and including the DMOH's office for buy in of the framework.

In a meeting held in December 2010, a total of 36 persons attended the meeting; 3 AMREF staff, 7 Makueni DHMT members, 10 Health Facility (HF) in-charges, 9 Maanisha-funded CSOs, 2 CACC Coordinators and 1 representative each from the Ministry of Education, Ministry of Agriculture, ICAP-K, LVCT and BIDII. The HSS score card was first tested, revealing gaps in linkages among the different players in HIV and AIDs arena including NACC, MoH, grass root CSOs and other partners from GOK and NGOs. Concrete action planning during these meeting ensured stakeholders took responsibility to facilitate identified measures for strengthening coordination and linkages. The follow-up meeting in September 2011 reviewed progress towards implementation of actions agreed upon in the previous meeting while assessing changes in scores on the linkages.

> ***"I never knew what a COBPAR tool was until the last meeting organised by AMREF between NACC and MoH. Since then, the CACC coordinator now shares the COBPAR report with me and I now have a list of CSOs in the district including their areas of HIV interventions. This will help in linking the CSOs with the nearest health facilities for improved referrals and ART adherence support to PLHIV"..... Remarks by DMoH Makueni during a coordination strengthening meeting***

Impact resulting from the above strategies

Results of the linkages and coordination strengthening efforts in Makueni have been evidenced through scores gathered during follow up coordination meetings, as well as from the CSOs monitoring and supervisory and CSO reports. Implementation of agreed upon actions by stakeholders has resulted in:

- Increased dialogue leading to improved linkages between MoH and CSOs. The second coordination meeting revealed that the score for the CSOs-MoH linkages had increased from ***fair*** **(42%) to** ***good*** **(67%).**
- Increased information sharing between NACC and MoH; NACC is currently sharing COBPAR reports with MoH and are participating in DHSFs.

- Improved referral mechanisms as CSOs reported having been supplied with tools by MoH to facilitate client referrals to health facilities for ART services.
- Improved linkages between CSOs and Other Partners including other government ministries such as education and development partners; from 50% to 58% as a result of increased trust.

PART 7: LESSONS LEARNT

The following are some of the lessons that AMREF and her partners have learnt over the 2 years of implementing the Health System Linkages and Coordination Strengthening framework:

1. **Grass root CSOs play a significant role in the delivery and uptake of health services at the community level, as they have unique advantages in unique in advocacy, demand creation and linkage of communities to services.**

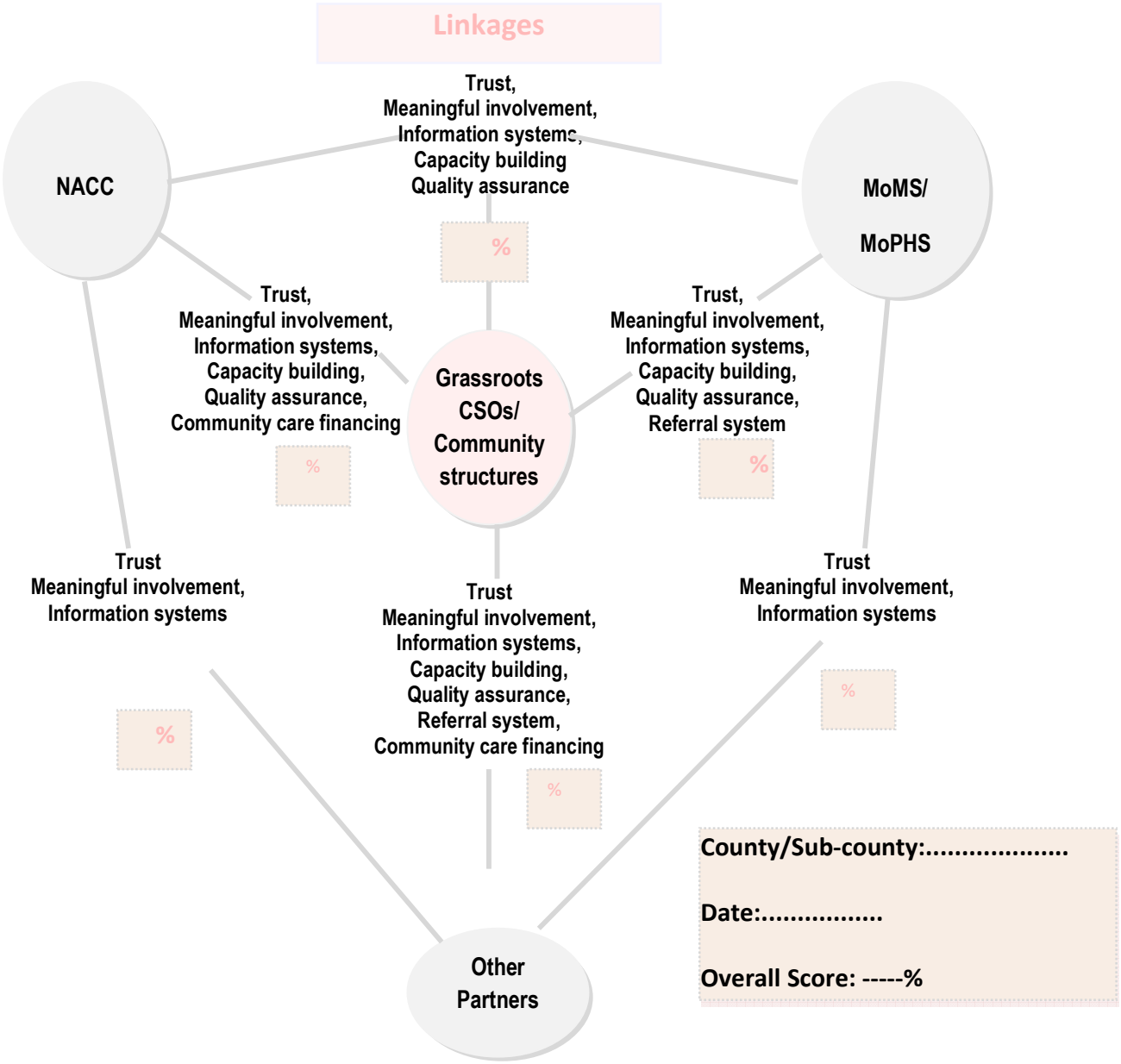
2. **Linking communities to health facilities through mechanisms that ensure ownership by both parties, such as community health committees, is key in strengthening community participation in the formal health system**

3. **Linkages, collaboration and coordination strengthening meetings should ensure inclusion of all partners at all times to enhance objectivity and promote meaningful dialogue.**

4. **Concrete action planning with clear goals and objectives are important conditions for success of linkages, collaboration and coordination strengthening efforts as they also enhance responsibility and accountability among players in the health system**

5. **Increased synergy between the formal health system and the community leads to sustainable improvement of HIV service delivery and health outcomes.**

Appendix 1: Health System Linkages Score Card



Appendix 2: Health Systems Coordination Environment Gap Analysis Tools

Maanisha

Community Focused Initiatives to Control HIV AND AIDS in Kenya

HEALTH SYSTEM AND COORDINATION ENVIROMENT GAP ANALYSIS TOOL

Date…… **County**……..

Forum……

Group Members: *(Please tick all applicable)* **per group (**Please fill in the box)	**Number of partners**
[ ] MoH	[ ]
[ ] NACC	[ ]
[ ] CSO/Community	[ ]
[ ] Other GOK Ministries	[ ]
[ ] Other partners (NGOs, PSOs)	[ ]

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

NACC - MoH

Linkage	Question	Score	Reasons for the score	Action Required
Trust	How can you rate the level of confidence that NACC and MoH have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well does NACC and MoH involve each other in their planning, implementation and review processes? e.g WAD, JAPR, AOP, community strategy, HSF?		•	
Information systems	How well is information/data shared between NACC and MoH in order to reduce duplication, aid in decision making, share lessons learnt etc?		•	
Capacity building	To what extent does NACC and MoH involve each other in building the capacity of CSOs to design and implement HIV&AIDS intervention e.g through training, mentorship, joint monitoring visits		•	
Quality assurance	Does NACC and MoH have an agreed upon mechanism for assuring quality of services provided by CSO? If yes, how effective is it?		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Players: NACC - Grassroots CSOs/Community				
Linkage	**Question**	**Score**	**Reasons for the score**	**Action Required**
Trust	How can you rate the level of confidence that NACC and CSO/community have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well does NACC and CSOs involve each other in their planning, implementation and review processes? e.g. JAPR, M&E, World AIDS Day, CSO trainings etc		•	
Information systems	How well is information/data shared between NACC and CSO/community e.g. through COBPAR, notice boards in the constituency, feedback meetings?		•	
Capacity building	To what extent does NACC build the capacity of CSOs to design, implement, monitor and evaluate HIV&AIDS intervention e.g. through training, monitoring, mentoring		•	
Quality assurance	How well is NACC supporting CSOs to implement quality interventions e.g. through availing approved guidelines, supervision, creating linkages with MoH?		•	
Community care financing	How well does NACC support CSOs in mobilizing resources to finance their health needs e.g through linkage with funding agencies, IGAs, mentoring?		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Players: Other GoK Ministries & Agencies - Other partners				
Linkage	**Question**	**Score**	**Reasons for the score**	**Action Required**
Trust	How can you rate the level of confidence that other GoK Ministries/agencies and other partners have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well do other GoK Ministries/agencies and other partners involve each other in their planning, implementation and review processes? e.g. JAPR, M&E, advocacy, joint activities , representation in CACC		•	•
Information systems	How well is information/data shared between other GoK ministries/agencie and other partners e.g. through COBPAR, notice boards in the constituency, sharing of lessons learnt and best practices		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Players: MoH - Grassroot CSOs/Community				
Linkage	**Question**	**Score**	**Reasons for the score**	**Action Required**
Trust	How can you rate the level of confidence that MoH and CSO/community have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well does MoH and CSOs involve each other in their planning, implementation and review processes? e.g. AOP, community strategy, training, DHSF etc		•	•
Information systems	How well is information/data shared between MoH and CSO/community e.g. through reports, sharing of best practices, accessing new information,?		•	
Capacity building	To what extent does MoH enhance the capacity of CSOs to design and implement HIV&AIDS intervention e.g. through training, mentoring, creating linkages between CSOs and CACC and other player?		•	
Quality assurance	How well is MoH supporting CSOs to implement quality interventions e.g. through availing approved guidelines, supervision?		•	
Referral Systems	How functional/efficient are the referral systems between MoH and CSO/community?		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Players: MoH - Other Partners				
Linkage	**Question**	**Score**	**Reasons for the score**	**Action Required**
Trust	How can you rate the level of confidence that MoH and other partners have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well does MoH and other partners involve each other in their planning, implementation and review processes? e.g. AOP, community strategy, training, DHSF etc		•	•
Information systems	How well is information/data shared between MoH and Other partners e.g. through reports, sharing of best practices, accessing new information.		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Players: Other partners - Grassroots CSO/Community				
Linkage	**Question**	**Score**	**Reasons for the score**	**Action Required**
Trust	How can you rate the level of confidence that Other partners and CSO/community have in each other's goodness, integrity, ability and reliability?		•	
Meaningful involvement	How well do other partners and CSOs involve each other in their planning, implementation and review processes? e.g. through networking, advocacy, World AIDS day etc		•	
Information systems	How well is information/data shared between other partners and CSO/community e.g. sharing of lessons leant and best practices?		•	
Capacity building	To what extent do other partners build the capacity of CSOs to design and implement HIV&AIDS intervention e.g. through training, mentoring		•	
Quality assurance	How well are other partners enhancing the capacity of CSOs to implement quality interventions e.g. through availing approved guidelines, supervision?		•	
Referral systems	How functional/efficient are the referral systems between other partners and CSO/community?		•	
Community care financing	How well do other partners support CSOs in mobilizing resources to finance their health needs e.g through linkage with funding agencies, supporting IGAs, mentoring?		•	
Total				
Average %				

Scale: *0% - 20% = very poor; 21% - 40% = poor; 41% - 60% =fair; 61% - 80 % = good; and 81% - 100% = excellent*

Scores: 0 = nonexistent/very poor; 1 =poor; 2 = fair; 3 = good; 4 = excellent

Appendix 3: Action Plan Matrix

Action Plan: Health System Linkages and Coordination Strengthening

County/Sub-County_____ Date: _____

Note:

- *The action plan forms the basis for implementation and regular review by the coordination strengthening fora at the county and sub-county level*
- *The team should agree on which issues to priorities out of all the gaps identified and come up with practical actions to address them*

Gap/Problem Identified	Actions to be taken to address the identified gaps/ problems	Time line	Persons Responsible	Progress / Remarks