AIDS PREVENTION AND CONTROL IN KENYA : ACTIVITIES OF THE NATIONAL BODIES AND OTHER GAP-BRIDGING INITIATIVES

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In Kenya, AIDS was first recognized in 1984. The number of new AIDS cases reported in one year has been on average 12,000 since 1990. However, due to under-reporting, missed diagnosis and delays in reporting, these figures are not accurate. The epidemic is more advanced in Nyanza, Western and parts of Rift Valley provinces where HIV prevalence rates among pregnant women are 15% to 30%. Sexual contact accounts for up to 90% of AIDS cases in Kenya and heterosexual contact is the main mode of transmission. Mother to child transmission together with exposure to infected blood accounts for about 10-20% of AIDS cases in Kenya[1].

HIV prevalence in adults increased from less than 1% in 1984, to 3% in 1990, 5% in 1992, and about 7% in 1995. By June, 1997, there were over 75,000 reported cases, and over 200,000 estimated actual cases with 100,000 deaths leaving behind many infected and uninfected orphans. The number of persons in Kenya infected with HIV/AIDS is currently estimated to be 1.2 million and is expected to reach 1.7 million in the next four years ; according to the National AIDS Control Programme Statistics (1997). Although remarkable efforts have been made in Kenya to control the spread of HIV and to reduce the impact of AIDS on individuals, families, communities and the nation as a whole, the epidemic remains powerful and dynamic, evolving with changing and unpredictable patterns in different communities[2].

HIV/AIDS prevention and control activities

Activities of the National bodies

A multitude of organized prevention and control efforts have been planned and implemented at the national, district and local community level in Kenya ever since the HIV/AIDS epidemic became evident. These efforts and the development of an infrastructure for HIV/AIDS prevention and control (HAPAC), has only to a limited extent been effective at the local community level in terms of changing attitudes and behavioral modes of members of the general population. A gap can now be documented between the national structure for HAPAC, and the real problems, facing the most vulnerable groups of the population. An improvement is needed in the current situation

1 *AIDS in Kenya, Background projections and impact interventions*. National AIDS and STDs Control Programme. Ministry of Health. 1996.
2 *Sessional Paper No. 4 of 1997 on AIDS in Kenya*. Government Printer. Nairobi. 1997.

of the local community's own initiatives and efforts, to address the existing gaps in AIDS programme implementation in Kenya.

In order to overcome the AIDS challenge, the government of Kenya has taken urgent steps to reduce the rate of spread of the AIDS virus. The Ministry of Health established the National AIDS Committee in 1985 to advise the Government on all matters related to the prevention and control of AIDS. The role of the donor agencies focuses on supporting the World Health Organisation (WHO), and through it supporting the development of national programs especially with funds, medical facilities and expertise. In this case, the WHO was invited to provide technical assistance and mobilize funds from donors and international organizations and the AIDS Programme Secretariat (APS) was established in the Office of the Director of Medical Services to co-ordinate programme activities.

This culminated in the establishment of Kenya National AIDS Control Programme in April, 1987. This was created as a government institution under the auspices of the Ministry of Health. It assumed a role of national super-structure for a number of vital elements in prevention and control. It was established to contain the situation through a series of activities, aimed at halting the spread of HIV and mitigating the impact of AIDS. NACP set up the AIDS programme secretariat, with several sub-committees addressing various components of AIDS control namely: Information, Education and Communication (IEC) sub-committee; Scientific Steering sub-committee; Laboratory & Blood Safety sub-committee; Epidemiology sub-committee and Clinical & Patient Care sub-committee. Its areas of concern include public awareness campaigns, co-ordination of HIV prevention and AIDS care activities and implementation programs, capacity building, promotion of broad-based political and social mobilization and advocacy for greater political commitment in allocating adequate resources.

This was then followed by the development of a five year strategic plan, Medium Term Plan (MTP) (1987-91). This plan focused on developing a national public awareness campaign on AIDS, published guidelines on testing and counselling, blood safety, clinical management of AIDS, opportunistic infections and capacity building for management of AIDS control programme at national level. The main strategies pursued were the prevention of sexual transmission, prevention of transmission through blood, prevention of mother to child transmission and disease surveillance.

A Second Medium Term Plan (1992-96) was developed following external review of the first one, to pursue the same strategies but in addition emphasized the need to involve all sectors in HIV prevention in order to mobilize broader National response against the epidemic. IEC activities carried out during the first MTP revealed that about 80% of people in Kenya knew something about AIDS and therefore concentrated on controlling the sexual transmission of HIV. The new plan also emphasized the need to provide care and social support to people infected with HIV, their families and community; the need to reduce the social and economic consequences of HIV/AIDS and the strengthening of national and district capacity to respond to the epidemic.

The major challenges facing the second MTP were identified to include the need to promote changes in sexual behavior to reduce the spread of HIV, mitigation of socio-economic impact of AIDS as a consequence to a large number of Kenyans dying from AIDS, and financial resources to

support proposed activities. Recognition that STDs facilitated the spread of HIV led to integration of STD control into AIDS Control thus establishing the National STDs and AIDS Control programme (NASCOP) in 1992. NASCOP is a division within the department of prevention and promotion of health services in the Ministry of Health, dealing with STI, epidemiology and research, IEC, financial administration and clinical services. To achieve all this the government needed to mobilize resources and it has received considerable support from multilateral and bilateral donors in the financing of STDs/AIDS control activities, although this support is rapidly declining.

Because of the severe impact of AIDS on the economy, the government in 1993, during the mid-term review of Population III and IV credits, requested IDA (International Development Association) that US $15 million be reprogrammed from civil works to STD drug procurement and IEC activities on AIDS/STDs. In August, 1993, IDA jointly with ODA (Overseas Development Agency), led a mission to review the AIDS situation in Kenya and to work with the Government on developing a national response to the epidemic. An STI project was undertaken in June, 1994. AIDS was now recognized as a development issue and a whole chapter in the Seventh National Development Plan and the Fifth District Development Plans was devoted to it.

The STI project involved strengthening of institutional capacity at the national and district levels to design, implement, monitor and evaluate interventions ; promotion of preventive measures to reduce the risks of spread of STIs ; to enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate socio-economic consequences of AIDS. The implementing agencies were the Ministry of Health, NGOs, CBOs, while the beneficiaries were men and women at risk of STI in their reproductive age groups and their dependents (approx. 5 million people) through a program of targeted interventions.

The need for a multi-sectoral strategy had been foreseen at the inception of the NACP in 1987. However, appropriate framework for full realization of this strategy has been lacking. Lengthy and complicated bureaucratic procedures at the Ministry of Health headquarters inhibit the smooth flow of funds for initiatives at the provincial and district levels. Effective district inter-sectoral AIDS committees are few and where they exist lack capacity to implement an effective HIV prevention programme. NASCOP cannot receive donor funds directly and has to rely on the slow disbursement of funds through the Ministry of Health. For example, under the STI project, NASCOP has a provincial, a district liaison officer and NGO liaison officer WHO liaise with the PMO's and District Ministry of health's offices. The role of these offices is mainly co-ordination, supervision, mobilization, management and distribution of resources, interpretation of policies, monitoring and evaluation, training and to ensure standards are kept in the province/district.

According to the Sessional Paper No. 4 of 1997, the establishment of a National AIDS council, based in the Ministry of Health is vital to enable the Government to overcome most of these constraints. The creation of the National AIDS Council (NAC), expediated HIV prevention and controlled activities through formulation of appropriate policies ; and establishment of appropriate institutional framework for a multi-sectoral AIDS control programme ; strengthening of institutional capacity at all levels ; leadership in resource mobilization for AIDS control including care of people affected and co-ordination of all actors which include Government departments, NGOs, CBOs, Religious organizations, private sector, and donors among others. NAC operates within a reasonable degree of autonomy, receives and accounts for funds from the

Government, private sector, and international donor agencies. The Chairman is appointed by the President of the Republic of Kenya, and the Council served by a full time secretariat headed by a Director (who is a medical doctor with postgraduate training), and assisted by two deputy Directors. The Secretariat carries out the day to day activities of NAC, provides administrative support, and liaisons with other agencies and organizations.

Among the most notable achievements of the national bodies since HIV was recognized are : infrastructure for screening of blood for HIV has been established in most district, provincial, mission and private hospitals. This includes supply of HIV testing reagents, maintenance of HIV screening machines, training of laboratory personnel and education of blood donors. This has ensured that 98% of blood for transfusion is screened for HIV in Kenya. They carry out national surveys ; for instance, in 1993 it revealed that 90% of women and men (15-49) years, were aware of sexual transmission of AIDS irrespective of urban-rural residence, level of education or provinces of residence. However, misconceptions about the modes of transmission of HIV was very high (50%).

The National AIDS programme have been instrumental in advocacy on critical issues pertaining to law, ethics, culture, vulnerability of women, and youth among others. The programs have developed partnerships with NGOs, Community Based Organizations (CBOs) and international agencies working in the area of AIDS, human rights and development. It has established surveillance systems for monitoring the trend of HIV/AIDS cases. The HIV/AIDS case sentinel surveillance programme and epidemiological database on AIDS are reliable for the whole country. District Capacity to implement HIV prevention has been realized through the establishment of District Inter-sectoral AIDS coordinating Committees which bring together representatives of Government departments, NGOs and CBOs. The Ministry of Health has since 1995 decentralized AIDS activities to the districts by issuing authority to incur expenditure to District Medical Officers for AIDS control. These activities include IEC programme, training of traditional birth attendants (TBAs), traditional practitioners and health care staff at health centres and dispensaries. It recently began focusing on an integrated community response, initiatives related to the development of national structures for appropriate home-based care systems.

Looking at examples from Kisumu, it is easy to see government involvement in the area through several district initiatives. The District AIDS Planning Committee (DAPC), has brought together various agencies in `AIDS control efforts' within the district. Over 50 organizations and individuals are involved in seven commissions that cover the following aspects: education, counselling, care, ethics, research, condoms distribution, and traditional healers. Under this, there is also the District Information Education and Communication (DIEC) sub-committee in which NGOs and several governmental ministries meet monthly. The forum is used to share experiences and to monitor AIDS/STDs activities within the district. It has a co-ordination committee which facilitates the `zoning' of operation areas within the district to avoid the problem of duplication and has a directory to help utilize skills within the district effectively.

Secondly, the District AIDS Surveillance Control (DASCO), is the district branch of the National AIDS Control Programme (NACP), and promotes the involvement not only of the mass media, but also of interpersonal means of communication – such as women's movements, religious organizations and social support groups – in educating the public about AIDS. It also provides an opportunity to look beyond the narrow confines of the fragmented health system and is an

attempt to develop a comprehensive approach to dealing with the HIV epidemic in a manner that encourages " grassroots " ownership and builds on the collective expertise within the District.

DASCO concentrates more on epidemiological surveillance, providing hospitals with equipment for blood screening, and health education and training of home-based care counsellors, and provision of home kits. Although not many activities are carried out at this level. It also exercises a supervisory role over the AIDS-related activities of other governmental and non-governmental organizations. It gives update/feedback on the status of HIV/AIDS epidemic and organizations have to liaise with DASCO. Unfortunately, external assistance for AIDS control and prevention is dwindling, and local organizations have to come up with ways to generate income to support their groups. Apart from the committee, DASCO has a clinical officer and a nurse in the STD clinic, a nurse in Maternal and Child Health clinic (MCH/FP) and a laboratory technologist. These are the people who choose the 1000 cases of Antenatal clinic (ANC) and STD clients under a study done at the Nyanza Provincial General Hospital.

Another district initiative, is the HIV/AIDS Prevention and Control (HAPAC), a project within NASCOP, managed by the Futures Group International U.K. Its goal is to decrease the risk of HIV transmission in the project areas on a sustainable basis by improving access to high quality, cost effective STI services. It also provides a forum for the stakeholders (NGOs, CBOs, private sector organizations or PSOs and religious organizations) at the district level to express their needs and concerns about STI/HIV/AIDS issues within their communities. HAPAC implementation mechanism includes organizations with an already established track record or already undertaking donor, funded grassroots projects and a few other organizations with weaker institutional capacity. to analyze existing interventions and to determine activities which represent priorities for the district within Nyanza province. This strategy guides and unifies the implementation activities designed to achieve the projects output : to increase capacity within the Government to manage all HIV/AIDS services and donor projects, to increase and improve NGO and private sector provision of STI services, to provide safer sexual and treatment seeking behavior promoted and re-enforced among selected target group, and to provide effective and efficient services, aimed at supporting and assisting people living with HIV/AIDS.

Fourth, is the Home-Based Care Unit (HBC) under the Ministry of Health which evolved as an effective strategy for involving and empowering the family and community to care for and cope with persons having AIDS and HIV infection. It is also a response to the problem of how to manage the increasing number of patients and maintain routine hospital services at the same time. The family is said to provide the greatest strength and support and many patients prefer to die at home. There are community health workers (CHWs) from different organizations and hospitals who go to visit the patients at homes and also educate the family members on how to accept the patients and take care of them at home.

Organizationally, the programme is run by a multi-disciplinary home care team made up of personnel from the medical, nursing, education, counselling, pastoral care and the AIDS prevention and control units of the hospitals. The home care support network is in charge of assessing the needs of seriously ill and dying patients in their homes and providing for their needs where possible ; assessing educational impact both in the hospital and between successive visits to the home ; and contact tracing (although there is a problem of coverage of all patients).

And as part of efforts to control the HIV epidemic in Kisumu, the Ministry of Health has also created AIDS training and information centres in conjunction with other NGOs. These centres have trained many volunteer AIDS educators and lay counsellors. School education programs have been launched ; for example drama is being used to educate the youth in schools and out-of-schools. Promotion through pictures, posters such as "*Stop AIDS*" "*Do not be fooled- AIDS is not witch craft*," "*Be faithful to your partner*," and other AIDS-related signboards in Kiswahili, English and dholuo, the local language, can be seen everywhere to supplement advertisements in the radio, newspapers and television.

The Ministry of Health offers MCH/FP services to members in all clinics. This includes routine examinations, tests, diagnosis, treatment, management of factors which pose a risk to women clients, conduct blood tests, serological tests, annual pap-smear tests for a nominal fee and free provision of contraceptives to acceptors. The integration of HIV/AIDS campaign into Primary Health Care has proved to be an effective way to target women. Lastly, the Social Welfare Department, the district office of the Ministry of Social Services is also very involved in child survival and development. It supervises and admits a small number of children to their orphanages and refers the others to other volunteer homes. This is done through the District Children's Advisory Committee (DCAC). Workshops continuously held have brought together government bodies, NGOs, private sector, donor and beneficiary representations of STI/AIDS management, Home-Based Care and Information, Education and Communication (IEC) projects. Trained workers are able to provide technical and management skills necessary for management of a comprehensive AIDS and STDs programme ; to do rapid appraisal participatory researches to enable them to undertake a situation analysis of STI/IEC in their districts and to co-ordinate these activities at district level.

However, major constraints exist in AIDS control including the slow pace of change of sexual behavior, resource limitations, poverty, harsh effects of structural adjustment programs on vulnerable groups, rapid increase in the number of people developing AIDS and needing medical care and social support, officials lack of credibility, and a lack of a clear policy framework to guide implementing agencies.

Role of NGOs and CBOs

Kenya is still heavily dependent on the contributions of NGOs to its health sector. Currently, most of these NGOs are involved in HIV prevention and care activities. There is a consortium of NGOs working in HIV prevention and care. The Kenya AIDS NGOs consortium (KANCO) was established in 1990 with the goal of strengthening the HIV/AIDS prevention and care initiatives of its members. Some, but not all NGOs are affiliated with KANCO, the AIDS umbrella organization which aims at coordinating, networking, improving collaboration, and facilitating the work of the individual groups ; for instance, in avoiding duplication of efforts.

KANCO is made up of a group of NGOs, religious organizations, government agencies and individuals working in AIDS related activities and has more than 300 active members. Many of these groups are involved in direct activities, others are involved indirectly. In addition, there are other organizations and loosely structured associations not registered with KANCO, but have projects running at the regional, district or local community level. The Government and external

donors closely control the activities of these organizations, in order to mobilize and strengthen their capability for active involvement.

The NGOs are very visible in the delivery of health care in Kenya. At district or community level, Community-based organizations (CBOs) are commonly found, and these projects are usually funded by the local or international NGOs and could be said to be championing this HAPAC effort. These Non-governmental, CBOs are very active and contribute greatly in the delivery of basic and appropriate services to the general population, targeting the vulnerable groups especially in relation to HIV/AIDS. Some of them work as an extension of already on-going health related work, and are often integrated into family planing programs to assist the marginalized and the underprivileged populations in Kenya. However, other CBOs have been formed in direct response to the HIV/AIDS epidemic to serve the local communities. These CBOs are firmly rooted in the local community and are closest to the people. They have developed sustainable, culturally and socially appropriate strategies for small-scale interventions, which try to involve the vulnerable members of the community. In Kisumu such involvement was targeted at women with no formal education, or means of supporting themselves, unemployed youth and marginalized population groups (*e.g.* street children, orphans and teenage mothers among others), as members of these groups were categorized as potentially at risk in relation to HIV/AIDS.

A wide range of inter-personal communication approaches including drama, puppetry, songs and poems have been used by these CBOs to achieve a high level of HIV/AIDS awareness and peer education through locally acceptable channels of communication. This has been achieved through mobilizing community groups in churches, social welfare association, chiefs barazas and institutions of learning. Their staff are particularly better placed and have a potential to deal with sensitive issues of HIV/AIDS prevention and control. However, despite the good work being done by these organizations , majority of their activities lack long term planning and clear objectives, are sometimes, developed in isolation and lacking in monitoring and evaluation criteria. While some of them deliver high quality services when and where they are needed, others, particularly the newly emerging CBOs suffer from administrative, lack of infrastructure, technical skills and experience to sustain their efforts independently. This hampers potential donors from offering assistance ; especially in regard to accountability and sustainability.

There are also no major variations in most of their community activities. Most of these CBOs seem to carry out similar activities. They mainly concentrate their activities around IEC, support services, training, clinical services and condom distribution. From study findings, research, surveillance, logistic support and data collection were said to be a major constraint for most organizations. They were non-existent in some or ranked last in their activities listing. In addition, the organizations lack in-built monitoring and evaluation mechanisms. Nevertheless, NGOs/CBOs have a better placed staff and a potential to deal with sensitive issues of HAPAC activities, as their range of experience and skills is wide. Conclusively, the NGO/CBOs key priority areas, visions and planned activities include IEC, networking, capacity building, logistical support, sustainability, monitoring and evaluation, care, support and data collection, to deal with the HIV epidemic in Kenya more effectively.

Role of Community Initiatives

Other important small grassroots groups with significant contribution to the national struggle against HIV/AIDS are the formal and informal women groups/associations. In Kenya there are a substantial number of NGOs, CBOs, a few advocacy and civic bodies, and many loosely structured women's associations ; all active at the local level. These groups have greatly contributed in AIDS fight through mobilizing community support for, and involving themselves in HAPAC initiatives such as IEC, social support, counselling, gender relations etc. For instance, women have joined together in groups, to be able to communicate with each other, to support each other in daily life and to contribute to community development at village level ; under the spirit of *harambee*. All these associations are highly committed to their goals and have started income generating activities, revolving funds, they contribute in health education, IEC campaigns, caring of orphans, caring for persons with HIV/AIDS, and vocational skills.

Many of these women associations act on their own initiatives. Others have joined together to receive support from the government, NGOs or are on volunteer basis and are non-profit making. Many NGOs/CBOs have already realized their hidden potential and are giving them funds, basic training in peer education, home based care, supportive activities, and to some, counseling skills.. However these women groups experience constraints such as limitations of continuous financial support, cultural and technical skills (e.g. training, supervision, capacity building) which prevents them from realizing their full potential in HAPAC programs.

From their income generating activities, credit facilities or revolving funds, these groups can only manage small initiatives such as assisting affected families with basic necessities like clothing, food, shelter, soap, blankets and in some cases, fees for the orphans. Some of these groups are engaged in activities concerning education of adolescents and youth within and outside of school, training of skills for income generation, orphaned children, caring, giving social support and providing informal education to orphaned children and PLWAs. Other organizations deal with rehabilitation programs of children from commercial sexual exploitation, teenage mothers and girls, street children, and provide them with income generating activities (*e.g.* selling vegetables, jua kali goods, collecting garbage and scrap metal) and offer vocational training skills such as tailoring, handicrafts and carpentry, among others ; with the aim to make them economically independent, thereby reducing their risks of being HIV infected, and if already infected, to avoid further re-infection and spreading of the virus.

Although these grassroots level initiatives generally have limited coverage and are encumbered with numerous limitations, they to some extent, have an effect in the prevention of further spread of HIV. If these are promoted, mobilized and sustainability of projects ensured, they can act as a missing link between local community and the government initiatives in HAPAC activities, which the primary health care sector and NGOs alone can not effectively do. We can understand better the importance of these grassroots initiatives and their diffusion effect, by looking briefly at an example of a community initiative, whose members joined together to support each other and fight against AIDS. Women fighting AIDS in Kenya (WOFAK), began as a small-scale initiative and now has similar associations in different parts of the country.

In August 1993, this group of women who were HIV+ came together informally to give support to one another. They all had common psycho-social problems due to their HIV status. At this time HIV was a highly stigmatized social problem and no one talked openly about it. These women had come to know one another through participation in KEMRI research projects and through being members of the Kenya AIDS Society (KAS). It was soon realized that there was a need for a more formal organization which could reach further to other women who were experiencing the same problems and could not be reached by this informal group nor by support groups that targeted mixed populations.

They realized that women were more vulnerable than men and that they needed a different and special approach because of the different socio-cultural and biological factors that make women more vulnerable to HIV infection. The Women Fighting AIDS in Kenya (WOFAK) organization was therefore borne. The view of WOFAK at this time was that it would provide a platform where women could address issues of women's vulnerability to HIV/AIDS and for those who were HIV+ or affected, to be able to find psycho-social support within support groups. Since then, WOFAK has evolved into a dynamic organization registered under the NGO Coordination Bureau and mandated to operate fully as a women's support organization. It has branches in all the most affected districts especially in Nairobi, Nyanza and Mombasa.

In view of the spirit of utilizing the experiences of HIV+ women who are living positively with the virus, some of the counsellors are themselves HIV+. This not only gives them an economic base from which to earn a living, but also to gain support themselves by knowing that they can help someone else who is experiencing the same problems as themselves. Clients get counselling from trained and experienced counsellors who can empathize with the situation that the clients faces. They are trained and have had experience in the field of counselling of PWHIV/AIDS.

For instance, when WOFAK first went to Homa-Bay in Nyanza province, people with HIV/AIDS* were being abandoned by their families. The programme started by first training 35 community leaders (all women) in HIV/AIDS education. The trained women, then went out and educated other people within their locations in churches, schools, and during social and political functions. By late 1996, the women had sensitized their communities enough that WOFAK went a step further to train them in home-based care. They trained them on care of HIV/AIDS patients, including basic counselling, nutrition, basic nursing care (especially for opportunistic infections), counselling for the dying and skills to train community members in home care. This was greatly in need as the hospitals had limited in-patient facilities and as a result the patients were discharged within a few days of diagnosis or admission. When they were discharged, there was no plan to care for their needs - either physically or psychologically. Through the multiplier effect, these women have now trained more women, and more people with HIV/AIDS are now being accepted and cared for.

WOFAK continues to reach out to other women, families, schools, the general population, health workers, private sectors in Kenya as a whole. Their outreach efforts have since expanded to include training on income generating activities, pre, post and continuous counselling, home-based care, supporting affected/infected people, training implementers, primary health care, ethics, laws and human rights, advocacy, networking, AIDS in the work place and IEC. Their overall goal is to educate the public at large on matters relating to HIV/AIDS, and to encourage the already affected persons to live positively with the disease.

However, they encounter numerous constraints which they continue to fight even today such as negative cultural beliefs and practices, inability of patients to access drugs for opportunistic infections, lack of support or role modelling from opinion or political leader, stigmatization of people with AIDS and traditional and religious ways of treating the sick people ; delaying or denying them the opportunity to seek proper medical services.

With the support of Norwegian Church Aid, WOFAK has continued to work with the communities in various districts. Other CBOs/NGOs/PSOs and NASCOP provide counselling services, referral testing, distribution of IEC materials and supply of condoms. WOFAK has opened several offices to better serve the communities. Because of their efforts to change community attitudes and to improve the health of HIV/AIDS patients through HBC, the situation of people with HIV/AIDS in their programme areas is no longer so dire.

From this example, we agree that because women are responsible for most of the care for HIV/AIDS patients at home or institutions, they are a good target group for such an initiative, being in close contact all the time. The demand for care in these communities means that the project was of interest to and eventually owned by the communities, and therefore likely to be sustainable.

Conclusion

From the above example, we can see the potential role of community initiatives in health related and community support activities. However, not all cases, have been as effective as the above example, there are still gaps existing between the national programs and the reality at the grassroots level in most local communities. The CBOs efforts are sometimes not well implemented and to some degree still fail to reach the local community. For instance, some efforts in Kenya are not sufficiently culture-specific and appropriate to effect a behavioral change.

Perhaps most important is that there is minimal evidence that agencies – whether governmental or NGO/CBOs – make serious effort to evaluate the services and programs they offer. Most appear to be stuck in the rut, and either ignore the fact that they are getting nowhere or assume that clientele turnover or even increases in numbers are indicative of success. On the other hand, the government agencies are authoritarian in approach, have become disinterested and apathetic and most of the time they ignore the grassroots woman's problems. Whatever input, effort or contribution they could make towards solving their own problem is either lost altogether or else is severely under-exploited.

For these organizations to realize their potential and to be more successful in their activities, they need to have key priority areas which they can target and realize their fulfillment rather than taking a big loadful of activities out of which most are not actually realized. Organizations need to network and not compete or duplicate efforts. Under these priority activity themes (IEC, support services, clinical services, surveillance, data collection, research, logistics, training, and distribution of condoms), each organization should only deal with what they know they can manage to sustain and bring forth a positive output in HIV/AIDS prevention and control of the target areas.

However, CBOs that include women, men and the youth, act as a good point in bridging this gap. With a positive attitude and recognition by the government of their many contributions ; these initiatives could act as potentially powerful groups in the local community. If the national government and international organizations could delegate more problem solving approaches to these local community organizations, who are willing to take action to alleviate the huge burdens put on themselves by the HIV/AIDS epidemic, could prove to be very rewarding, as these groups are dedicated to community oriented development work[1].

At the same time, these organizations should recognize the call for empowerment of women in the context of the general situation prevailing in the area. While the case for women empowerment will be argued on its own merit, it is also true that the increasing inability of government to finance welfare programs gives added impetus to the search for (as well as the stated willingness to accept) alternative solutions. Activities such as income generating, revolving loans, cost-sharing should be encouraged at this point for these community initiatives to remain sustainable.

Generally, most of these official and non-official bodies are doing a remarkable job in HAPAC activities. However, those dealing with community-based health care (CBHC), in collaboration with health care sector should help initiate and widen the scope of the grassroots programs. For instance, Bamako Initiatives on essential drugs, care and treatment in AIDS control, is an area that should now be emphasized by these organizations. Adequate and maintained drugs and supplies on a community based initiating system will among others, curb STI and eventually the AIDS epidemic. This is because Bamako Initiatives are mutually beneficial initiatives through cost sharing, is a way to increase the community's resources at a low cost and ensures continuity for sustainability of the activities.

Finally, for all the NGOs, CBOs and community initiatives to meet the challenges and grasp the opportunities for constructive intervention and social support, this will require the involvement of everyone in the communities, from elders, parents, men, youth, women, health care professionals, affected/infected persons and leaders among others. In addition, organized efforts by government, national and international organizations are needed to strengthen the capacity and capability of these groups.

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1 Krantz G. & F. Staugard, " Identifying the Missing Links in HIV/AIDS Prevention and Control ", in C. Cabrera, D. Pitt and F. Staugard (eds.), *AIDS and the Grassroots : Problems, Challenges and Opportunities*, Nairobi, 1996.

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