FREE PENTECOSTAL FELLOWSHIP IN KENYA

"Preaching The Gospel To All Nations"

FINAL REPORT

FOR

THE END TERM EVALUATION OF THE HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014)

PRESENTED TO

THE FREE PENTECOSTAL FELLOWSHIP IN KENYA

BY
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EXECUTIVE SUMMARY

Operating through a 27 region structure FPFK has a total of 1044 churches with a combined membership of over 200,127 that is diverse and spread all over Kenya among different ethnic groups. PYM Norway has partnered with FPFK in the HIV and AIDS Awareness Project since 2000. The initial FPFK intervention on HIV & AIDS was during the period 2000-2004 followed by a second phase from 2005 -2010 consequently leading to the just ended phase from 2010-2014. The just ended phase was a scale up from previous interventions to include the HCD, HRBA and Advocacy approaches. The approaches aimed at promoting ownership of the interventions by building the capacity of communities to take a lead in responding to emerging concerns therefore contributing to sustainability of community based initiatives. FPFK prides itself as being one of the first ecumenical organizations to openly speak about HIV & AIDS within church circles and designing interventions that enhance discussion of the once forbidden conversations in the community.

At the end of the 2010-2014 Phase an evaluation was conducted looking back to the 15 years of project implementation with more focus on the third Phase. The evaluation sought to assess the impact of the project over the funding cycle with respect to change that has occurred in the lives of the targeted communities and learning drawn from project implementation at organizational level.

The evaluation methodologies included an in depth desk review of documents relevant to the project as well as field visits, and meetings at the national headquarters with Board and PSC, General Secretary as well as key project staff and a validation workshop. Among the limitations included the fact that it was not possible to visit all groups due to the large geographical coverage of the project target area, some support group members that were selected to participate in the exercise did not avail themselves especially in Meru and some of the local administration leaders and local partners were not available due to breakdown of communication. Due to time and resource constraint, it was not possible to carry out field visits to Nyanza and Coast regions which were the target areas for the 2000-2004 and 2005-2009 phases.

The following is a summary of the key results, key findings and recommendations:

Key Findings

1. The evaluation established that HCD approach through SALT teams were key in stimulating behaviour and attitude change that encourage spread of HIV and provide care between relatives or neighbours and community(for PLWHIV & OVCs). The findings indicated that all the 82 support groups formed SALT teams whose main activity was home visits and facilitating community conversations to address community concerns key being prevention and management of HIV&AIDS. The evaluation also revealed that all support groups had PLHIV as well as those who were not HIV+. The same trend was noted in the composition of the SALT teams. The total number of support group members is 3280. Of the 57 support groups formed in Mt. Kenya region reaching out to 2280 members, 684 members were HIV+, likewise in Maasailand region out of 25 support groups reaching out to 1000 members, 400 were HIV+. Through the SALT teams knowledge was received at house hold level that contributed to change in attitudes and behaviours that are considered high-risk to infection as well as acceptance of PLHIV.

2. The approaches were effective in reducing harmful traditional practices such as *moranism* and early girl child marriages. The evaluation also established that, to a great extent, the intervention contributed in reduction of stigma against PLHIV and OVCs. Targeted communities were sufficiently equipped with knowledge on HIV&AIDS observed through their increased openness in discussing their HIV status and the communities' initiative in supporting PLHIV. The findings also pointed towards communities' level of understanding the rights of PLHIV and other vulnerable groups. Majority of the beneficiaries interviewed were able to enumerate the rights of PLHIV.

3. FPFK had intended to use its position as a respected church organization as well as its other ecumenical networks to influence national policies in HIV & AIDS. The findings revealed that members of the PSC who are key government officials in the health sector contributed towards updating the project on important government

policies relating to HIV and AIDS in order to enrich the interventions at community level. However it was noted that effective advocacy to influence policy at the national level needed a concerted effort with other players among them the network organizations that FPFK was affiliated to such as the Evangelical Alliance of Kenya (EAK) as well as Act Kenya Forum.

4. The evaluation established that the FPFK HIV and AIDS Policy ratified in March 2006 was widely shared within the church leadership from National, regional and local level. The findings established that the Policy guidelines were useful in decision making processes where action needed to be taken such as solemnizing marriages. It was noted that distribution of the policy was mostly done during the Phase two of the project. The evaluation also established that the Policy had not been reviewed since its ratification in 2006.

5. Introduction of HCD, awareness on human rights through HRBA and Advocacy produced distinctive outcomes that make the approaches worth replicable in other communities. HCD through systematic SALT visits and capacity development resulted to life changing experiences for PLHIV where they have been transformed into productive members of the society and their integration in the community. HRBA and Advocacy has built the capacity of marginalized communities to stand up and advocate for their rights in all aspects of their social lives.

6. From the evaluation findings the project significantly contributed to the improvement of the socio-economic and environmental welfare of PLHIV and the community in the target areas. Of the 82 support groups established within the targeted regions all of them conducted SALT/Home, 54 had merry go round/table banking, 52 had income generating activities, and 28 had environmental care activities. The findings revealed that some of the groups were participants in the FPFK Tuinuane Economic Empowerment Project. The evaluation further revealed that these activities contributed towards increased income at the household level and created employment opportunities within these communities.

7. From the findings the project promoted gender equality in the target areas. From the Focus Group Discussions it was indicated that women can now participate in discussions pertaining to community development agenda together with the men. This

was ascertained by *Mzee Mohammed* in Loruko who noted that before the intervention, it was taboo for women to join discussions in which men were part. This is a significant contribution of the FPFK intervention in promoting gender equality. However the evaluation also revealed that male participation in support groups was a paltry 33% as compared to 67% female.

8. From the findings the approaches have been sufficiently localized within the communities targeted. Commitment and ownership to the project approaches and initiatives was evident. In Maasailand the number of local facilitators trained surpassed the initially planned target which was 20, by 22 from 25 support groups with a total membership of 1000. This is an indication that there is a sufficient pool of local facilitators that can sufficiently play their role in sustaining the continuation of activities in Maasailand. On the other hand Mt. Kenya region which has 57 support groups with a total membership of 2280 had 38 active local facilitators. This number of active local facilitator in Mt. Kenya if sustained may sufficiently contribute towards sustaining the continuation of the activities.

9. During the evaluation it was established that FPFK has many PSC's overseeing different projects resulting to compartmentalization of projects. From the Key Informant Interviews with the members of the PSC for HIV and AIDS and the General Secretary it was established that the PSC meets four times in a year. It was also established that PSC plays a critical role in project oversight as outlined in its functions as follows:

    - Review of project progress reports
    - Monitoring of project budgets vs expenditure
    - Review of financial reports
    - Staff recruitment
    - Staff performance appraisal
    - Staff discipline and motivation issues
    - Policy Implementation.

Some of the above functions were confirmed as the contents of PSC deliberations vide Minutes of the PSC Meeting for 12th December 2014.

Recommendations

1. FPFK should fundraise for more resources to expand HCD, HRBA and Advocacy approaches in marginalized communities, specifically replicating activities that have added value in support groups such as SALT team visits, merry go round/table banking, income generating activities and environmental care. These approaches are effective in the holistic development of marginalized communities especially in developing capacities in taking a lead in harnessing local resources and advocating for their rights.

2. FPFK through existing networks such as the Evangelical Alliance of Kenya and ACT Kenya Forum should enhance efforts in advocating and lobbying the Government to keep on its international obligations on HIV&AIDS and advocate for policy change and implementation on HIV&AIDS at both National and County level.

3. FPFK should review its HIV&AIDS Policy to incorporate latest information and strategies that the Church has embraced with regards to influencing Policy at the National and County level. The revised version should be widely distributed to the church membership and beyond and ensure its implementation.

4. In future FPFK projects, strategies should be put in place to ensure more men are encouraged to join and participate in community development initiatives while at the same time ensuring active participation of women.

5. In future FPFK should ensure that it has enough project staff commensurate to geographical area of coverage support to ensure support to community based initiatives.

6. FPFK should have only one PSC and establish the position of Head of Programmes in order to provide effective oversight, supervision and coordination of projects. Additionally FPFK should establish a monitoring and evaluation unit for close follow-up, quality and timely reporting and support.

7. Considering that HIV & AIDS is still a major challenge in Kenya, FPFK should consider identifying specific Counties with high prevalence rates for maximum impact in future projects. Specifically considering the fact that this was the first time

that the HCD, HRBA and Advocacy approaches were being implemented it is recommended that areas which are highly marginalized, needy and characterised by retrogressive cultures that drive the prevalence rates for HIV and AIDS such as Loruko and deep Maasailand be incorporated in future interventions in order to build on the gains achieved in the last phase and for more impact to be achieved. In addition according to a report on 'The National HIV and Aids Estimates', by National AIDS Control Council and the National AIDS and STI Control Programme (2014) over 105,500 new HIV infections were reported in Kenya last year. The Survey showed that only five counties accounted for the new cases in the report, with Homa Bay having the highest rate of new infections with 12,940 people, followed by Kisumu 10,350, Siaya, Migori and Kisii each have 9,870, 6,790 and 4,890 respectively. The five counties also have the leading number of deaths linked to HIV illnesses. It is important for FPFK to take this scenario into perspective considering that some of these areas were part of Phase One (2000-2004) of FPFKs HIV and AIDS Project.

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ACRONYMS

ABC	Abstinence, Behaviour Change & Condom Use
AIC	African Inland Church
AIDS	Acquired Immune Deficiency Syndrome
ARV	Ante Retroviral
FGD	Focus Group Discussion
FPFK	Free Pentecostal Fellowship in Kenya
HCD	Human Capacity Development
HIV	Human Immuno-Deficiency
HRBA	Human Rights Based Approach
IGAS	Income Generating Activities
KAIS	Kenya Aids Survey
KII Key	Informant Interview
OAIC	Organization for African Instituted Church
OVC	Orphaned and Vulnerable Children
PD	Project Document
PSC	Project Steering Committee
PLHIV	People Living with HIV
TOR	Terms of Reference
SALT	Support, Appreciate, Learn, Transfer
SPSS	Statistical Packages for Social Scientists
VCT	Voluntary Counselling Centre
WASH	Water Sanitation & Hygiene

SECTION I: INTRODUCTION

1.1 About FPFK

The Free Pentecostal Fellowship in Kenya (FPFK) is an evangelical church registered in Kenya as a corporate body. It operates in 27 regions in Kenya and has in total 1044 churches with a combined membership of over 200,127 that is diverse and spread all over Kenya among different ethnic groups. FPFK was established independently by the Norwegian and Swedish missionaries in the 1950s and 1960s respectively, after a merger of the operations of the two missionaries in 1997.

As part of the civil society, FPFK is an active member of member of Evangelical Alliance of Kenya (EAK), an umbrella body for Pentecostal churches in Kenya. its mission is "To preach the word of God to all nations in preparation for the second coming of the lord Jesus Christ by reaching out and establishing churches which can meet the spiritual Economic and social needs of the people through evangelism, Education, training &socio economic activities based on Christian values."

FPFK's governance structure consists of three levels which include the National Board, Regional Councils and Local Councils. The National Board is the principal policy making body. The National Secretariat headed by the General Secretary is responsible for the day-to-day operations of the church. The General Secretary is also the secretary to the National board. FPFK has regional councils who are responsible for managing and coordinating the activities of the churches in the 27 regions.

In its work with communities, FPFK runs programs such as the HIV&AIDS Program, Child Rights, Anti-FGM, Tuinuane Women Empowering Program, Conflict Prevention and Peace Building, and Emergency Humanitarian Relief Projects funded by diverse financial partners such as PMU Interlife Sweden, PYM Aid Norway, DiakonieKatastrophenhilfe (DKH) and InstitutfürAuslandsbeziehungen (IFA) Germany which are managed by a professional staff based at national, regional and field offices.

In the Strategic Plan 2014-2023, FPFK has established a systematic effort in the identification of strategic priority areas of concern during the Strategic Plan period that were informed by the contextual, stakeholders and SWOT analyses undertaken as part of the process. Key among the strategic objectives was to design innovative and responsive social ministry

programs to alleviate poverty and all other forms of human suffering. This included mainstreaming HIV&AIDS and Gender among other cross cutting issues at all levels of the church.

1.2 An Overview of the FPFK HIV & AIDS Projects

For the last 15 years FPFK has implemented several HIV and AIDS projects using various approaches and methodologies targeting an array of Kenyan communities within the Church's area of operation. These projects include:

i. Maasai HIV & AIDS Project
ii. Youth HIV & AIDS Project
iii. HIV and AIDS Project Phase 1(2000-2004)
iv. HIV and AIDS Project Phase 2(2006-2009)
v. HIV and AIDS Awareness and Preventive Project Phase 3 (2010-2014)

These projects have worked in different geographical locations in Kenya to avoid duplication of services and to ensure a wider coverage.

1.2.1 Overview Maasai HIV & AIDS

The Maasai HIV&AIDS project being implemented in Narok focuses on building the community's capacity to identify and address with community concerns in relation to HIV&AIDS. The project addresses issues facing women and girls relating to harmful cultural practices and gender perspectives, awareness on HIV&AIDS, Human Capacity Development Approach to encourage community conversations and instil behaviour change and linkages to referral facilities. So far the project has reached over 23156 people in the targeted area.

1.2.2 Overview of Youth HIV &AIDS

The Youth HIV Awareness Project began in 2011 and is supported by PMU Interlife Sweden. The project aims at improving the youth understanding in HIV&AIDS and covers Taita Taveta, Nandi, Nakuru, Nairobi and Kwale Counties. The key approach used by this project is Abstinence, Be faithful to one uninfected sexual partner and proper use of Condom (ABC) .The main strategies include school visits, forming HIV&AIDS clubs in schools, edutainment activities through drama, poems and songs, community outreaches in collaboration with Ministry of Health for VCT services and in Taveta networking with blood donor organizations during community outreach. A peer educators' manual was developed in 2011

with input from youth and NASCOP as well as through the review of other manuals from partner organizations such as CHAK, AMREF International and MAP International. The project had targeted to reach 6000 young people but has so far reached over 10000 young people.

1.2.3 HIV & AIDS Awareness Project Phase 1(2000-2004)

The project on HIV&AIDS Awareness started in 2000. The initial inspiration towards creating awareness in HIV&AIDS resulted from a sense of compassion for the people at a time when the prevalence rates of HIV&AIDS were at its peak and the pandemic had been declared a natural disaster in the country. At the time it was necessary for FPFK to speak about HIV&AIDS in order to demystify the misconceptions about the pandemic within the church circles where it was taboo to speak openly about the issue that was perceived as having emanated from immoral behaviour. There was therefore the need to break the silence within the church fraternity. The key strategy used then was mass campaigns in awareness creation through Soul Winning Teams during crusades and school visits. Methodologies such as films, drama and music were used in these forums to educate people on HIV&AIDS in addition to seminars and training trainers on HIV&AIDS Awareness and Prevention. The project targeted regions in the country that had highest levels of prevalence which included South Nyanza, Kisii, Western Kenya and Coast.

At the end of Phase I of the project there were reservations expressed by NORAD with regards to the strategy used through crusades. This was after a visit by a Norwegian Media Company that picked on the wrong perceptions of the project and highlighted these aspects in the Norwegian Media. It was perceived that FPFK was utilizing funds as a strategy to win more followers to the church. It was however explained that the FPFK operated in the context of the community thus had to use outreach strategies that would ensure more people were reached with HIV&AIDS awareness and crusades presented this opportunity due to the mass attendance in such forums. Following this concern, FPFK decided to embrace a development approach in its project design that would clearly separate development work in communities from evangelism.

1.2.4 HIV & AIDS Awareness Project Phase 2 (2006-2009)

The project transited to Phase 2 (2006-2009) with one of its aims being the development of a Policy on HIV&AIDS that would guide the organization in addressing the various challenges that the pandemic was posing to the church and community at large. Some of the challenges included compulsory testing for HI, especially for youths planning marriage, whether or not to use condoms for prevention considering FPFK is an FBO, the need to support orphans and vulnerable children (OVCs) due to HIV&AIDS and stigma and discrimination by the clergy. This Phase of the project also included a scale up in its approaches to encompass further awareness on HIV&AIDS using the ABC approach mainly targeting youth between the ages of 15-24 and building the capacity of church leaders and community leaders so that they can support behaviour change. FPFK was also faced with the challenge of "what next" after awareness creation. It emerged that due to the awareness creation in Phase I of the project people who were HIV positive begun accepting their status and needed to go the next step in search for treatment. Due to high levels of stigma most of them were not willing to visit health clinics close to where they lived as most of them did not adhere to the rules of confidentiality. They travelled to other areas to access health services in order to avoid stigma and discrimination. FPFK thus included in Phase Two of the project a component on HIV Testing and Counselling to further support attitude and behaviour change. In this component FPFK partnered with the National AIDS and STD Control Programme (NASCOP), who provided technical training for VCT Counsellors. In addition FPFK negotiated with their churches in the targeted regions and health facilities for room/physical facility to establish VCT Centres. The regions that were targeted in this phase were Nyanza where the HIV&AIDS prevalence was still high and Kajiado which was vulnerable to increased HIV prevalence due to harmful cultural practices such as polygamy and female genital mutilation.

1.2.5 HIV&AIDS Awareness and Preventive Project Phase 3 (2010-2014)

In 2008, FPFK became part of the BN (now Digni) supported process that involved 5 organizations in sharing experiences in working with HIV&AIDS. The process was led by the Salvation Army and included Organization of Africa Instituted Churches (OAIC), Africa Inland Church (AIC) and CORAT Africa. The Salvation Army shared their experiences in working with the Human Capacity Development (HCD) with the participating organizations feeling they would include the approach in their future programming. FPFK took the challenge and developed a new project document that was going to work with HCD, HRBA

and Advocacy different previous phases. The inclusion of the HRBA and advocacy approaches became necessary, as HIV&AIDS was not only a health and development challenge but also a human rights issue that required intervention in respect of rights and advocacy for upholding and respecting those rights.

The just ended phase started in 2010 through 2014 and it targets Mt. Kenya and Maasailand regions. The project carried out a midterm evaluation in 2012 and the findings and recommendations informed the way of working in the remaining period to strengthen the already formed support groups. Among the key recommendations were:

1. **Strengthening the local facilitation team:**

   Comment: This was done through further trainings of the local facilitation teams in HCD, HRBA and Advocacy approaches. This has strengthened their facilitation role of the SALT teams and home visits.

2. **Inclusion of church leaders and local leaders in the response:**

   Comment: FPFK has made a commendable effort to include church leaders in the interventions at community level. The church leaders were trained in the project approaches and have been instrumental in support group formation as well as spiritual and psychosocial counseling during SALT team visits. In some areas such as Isiolo, Iltilal, Ol'kalau and Meru local leaders have closely worked with the project and provided necessary support for community entry during support group formation and transfer to neighboring communities

3. **Scaling up the response in the local community:**

   Comment: FPFK has been able to provide catalytic opportunities for community conversations through the local *barazas* – public meetings organized by local leadership as well as utilizing church leadership for entry into homes during SALT visits. In Kimana, Maasailand the public meetings were key in ensuring involvement of the wider community in mitigating the impact of HIV & AIDS.

4. **FPFK should develop monitoring and evaluation tools to ensure proper monitoring and reporting on progress and impact of interventions at the community/local level and national levels.**

   Comment: This still remains a concern and has formed the basis of one of the recommendations in the end of project evaluation.

1.2.5.1 Project Goals and Objectives

The long-term goals/development goals of the project were to improve the wellbeing of people infected and affected by HIV&AIDS, as well as improve the economic welfare, public health and the environmental quality in the target areas.

The main objective of the project was to stem the spread of HIV&AIDS by increasing the capacity of the Communities to respond effectively to the challenges posed by the epidemic using their inherent human and social strengths.

The intermediate objectives are:

i. Mobilize communities through SALT teams to change behavior and attitudes that encourage spread of HIV and provide care between relatives or neighbors (for PLHIV & OVCs)
ii. Achieve policy change and legal repeal so that the Human Rights of women and vulnerable children affected by HIV&AIDS and the indigenous rights of the communities especially the Maasai are respected and upheld.
iii. Ensure that the government keeps its national and international commitments concerning HIV&AIDS and exercises transparency and accountability in handling of funds for dealing with the pandemic as well as encourage the government to embrace Human Capacity Development Approach to HIV&AIDS response as opposed to service provision/top – down interventions response.
iv. Improve the socio-economic and environmental welfare of the target communities by initiating environmentally sustainable income generating activities targeted at those affected and infected by the HIV&AIDS pandemic and also the general public.
v. Promote learning through inter-group transfer of experiences gained during SALT activities and document replicable experiences from the participating communities
vi. Measure activity outcomes (qualitative and quantitative) in order to determine those activities that add value with a view to replicating them among participating target groups.

1.2.5.2 The Project's Planned Outputs:

i. HCD Framework for Action, HRBA and Advocacy strategies are set up for Mt. Kenya region and Maasailand;

ii. Fifty (50) HCD facilitators are trained (20 from Maasailand and 30 from Mt. Kenya region);

iii. Key actors (FPFK Church, other institutions and leaders) are introduced to HCD approach and their HIV&AIDS competence assessed;

iv. Local demonstration centers are established to act as facilitative presence in target areas for communities to take care of their own concerns;

v. Community care coalitions are formed as a basis of home-based care and prevention as well as agitating for better products from service providers;

vi. Conduct advocacy campaigns aimed at advancing the human rights and the indigenous rights of the target groups;

vii. Train community members in alternative and environmentally sustainable means of income generating such as fish farming etc.;

viii. Train community members in ways of conserving their environment such tree planting, re-use and recycling of materials in their homes etc.;

ix. Instill in leaders through mentoring qualities necessary for effective local responses

x. Using FPFK position as a respected church organization and also its affiliations with bodies such Evangelical Alliance of Kenya, ACT Kenya Forum and other ecumenical bodies the project will articulate policy and advocacy positions that yield clearly defined roles and responsibilities on the part of the government and also build strong leadership support for dealing with the epidemic, and;

xi. On the grassroots vigorous targeted activities will be undertaken to educate people on their rights and the obligations of the state so that they can agitate themselves for these rights.

1.2.5.3 Target Groups

As outlined in the project Document the project targeted the following groups:

i. Communities in the target regions,

ii. Churches in the target regions,

iii. Community Leadership,

iv. Health Facilities and Service Providers in the target region,

v. Churches and Faith Based Organizations at the National Level

The findings in the report further highlight how FPFK worked with the above mentioned target groups in line with the various aspects of the TOR.

1.3 Objectives of the End of Project Evaluation

After 15 years of implementing three phases of the project on HIV & AIDS Awareness (2000-2004, 2006-2009 and 2010-2014), FPFK sought to carry out an evaluation with a specific emphasis on Phase three of the project. This was based on the following overall and specific objectives:

1.3.1 Overall Objectives

The End of Project Evaluation had the following overall objectives:

i. Measure the overall effectiveness and performance of the project against planned objectives and expected results, and;
ii. Measure the project results taking into consideration unanticipated results both positive and negative.

1.3.2 Specific Objectives

The specific focus of the evaluation was guided by assessing the planned long term goals and objectives of the project emphasizing the following aspects:

i. To determine whether communities were mobilized through SALT teams to change behaviour and attitudes that encourage spread of HIV and provide care between relatives or neighbours (for PLHIV & OVCs);

ii. To find out what impact the project had in the target areas.(Both positive and negative, and in what ways have the project has been able to achieve its objectives. How effective was this approach in positively impacting the behaviour and attitudes of the target group towards curtailing the spread of HIV? To what extent did it contribute to stigma reduction for both the PLHIV and OVCs? Are the targeted communities sufficiently equipped with HIV&AIDS knowledge?);

iii. To determine whether the project ensured that the government keeps its national and international commitments concerning HIV&AIDS and exercises transparency and accountability in handling of funds for dealing with the pandemic. To assess the extent to which the project influenced the government in embracing the Human Capacity Development Approach to HIV&AIDS response as opposed to service provision/top – down interventions response;

iv. To assess how has the project contributed towards improving the socio economic and environmental welfare of the lives of those affected and infected by HIV & AIDS in the target areas;

v. To find out whether the policy has been used (if so to what extent has the policy changes impacted on the rights of women and vulnerable children affected by HIV & AIDS as well as the rights of the indigenous communities?);

vi. To Measure activity outcomes (qualitative and quantitative) in order to determine those activities that add value with a view to replicating them among participating target groups;

vii. To assess the element of sustainability – In what regard has the project been able to train local facilitators so that they will be able to continue the activities even when the project has phased out? Support groups (ownership/sustainability) – In which ways are the support groups operating as resources in their communities;

viii. To find out how the project has promoted gender equality and women's empowerment;

ix. To find out what FPFK as a church has gained from this project; are the approaches owned by the church? And how is this strategy working;

x. To determine how coordination has been undertaken between the different FPFK HIV&AIDS projects and different partners of FPFK, and;

xi. To assess in what regard networking has contributed towards future sustainability? (both when it comes to other FPFK projects, other NGOs and governmental institutions) and WAA, Uganda).

SECTION II: EVALUATION METHODOLOGY

2.1 Introduction

This section describes how the requisite data was sourced, processed, analysed and interpreted to fulfil the evaluation objectives. The items described in this section include target population, sample procedures, data collection methods and data processing and analysis.

2.2 Target Respondents

The target respondents were project beneficiaries, staff at both National and Field level, local facilitators, members of the Board and PSC, pastors, local government representative and health facility representative.

2.3 Data Collection Methods

The data was collected through Focus Group Discussion (FGDs), Interviews with beneficiaries, Key Information Interviews and Observation (home visit).

2.3.1 Data Collection

Secondary data was sourced through a desk review that involved a study of the relevant project documents and other FPFK organizational documents such as: Project Document, Project, Baseline Survey report, Mid Term Evaluation report, Annual Plans, Policies and other external material on HIV & AIDS. Primary data was sourced through questionnaire administration on staff, beneficiaries, FGD with beneficiaries and key informant interviews with Board, PSC, Pastors, local facilitators, representatives of government health facilities and representatives of local government.

2.4 Data Analysis and Report Writing

The study applied both qualitative and quantitative approaches to process, analyze and interpret data. In qualitative dimension, the consultant reviewed project reports to concretize and validate primary data. The next step involved description of qualitative responses: areas that required additional information were identified and the requisite data source through follow ups. The second step involved systematic analysis and interpretation of qualitative data which was then integrated with quantitative data to form this report.

2.5 Limitations of the Evaluation Process:

1. It was not possible to visit all groups due to the large geographical coverage of the project target area.

2. Some support group members that were selected to participate in the exercise did not avail themselves especially in Meru and some of the local administration leaders and local partners were not available due to breakdown in communication.

3. Due to time and resource constraint it was not possible to carry out field visits to Nyanza and Coast regions which were the target areas for the 2000-2004 and 2005-2009 phases.

SECTION III: FINDINGS OF THE EVALUATION

3.1 Introduction

This first part of this section highlights findings of the last two Phases of the project from 2000-2004 to 2006 -2009.The second part presents detailed findings of the evaluation carried out for 2010-2014 project based on the TOR:

3.2 HIV&AIDS Project 2000-2004 and 2006-2009

Through key informant interviews it was revealed that some of the results of 2000-2004 and 2006-2009 were:

i. 200 Counsellors were trained on Voluntary Counselling and Testing and these were linked to the District AIDS and STD Control Programme (DASCOP) that provided support to the VCT centres in terms of equipment and materials and technical support to ensure the facilities are operating within the requirements

ii. FPFK set up 30 VCT centres collaboratively with churches and the government to offer VCT services

iii. FPFK supported the construction of a clinic in Ukwala, Siaya County that has a VCT centre. In addition in order to strengthen community support, community members were trained to undertake door to door visits to encourage counselling and testing. They were supported with a bicycle to facilitate the visits.

iv. Staff mobility towards monitoring of project interventions was supported by providing 2 motorbikes in Nyanza and 1 in the Coast region.

v. The development of the FPFK HIV&AIDS Policy in 2002 was a milestone in FPFKs effort towards addressing the HIV&AIDS pandemic and its effect on both the infected and the affected. The development of the policy included all church members-men, women, and youth as well as church leadership from the regions to the national level. The development of the policy was commended by WHO and FPFK was lauded for being one of the first religious institutions to come up with such a document.

vi. Interventions by FPFK in addressing HIV&AIDS were appreciated by community leadership and in Kisii a Member of Parliament lobbied for the allocation of Constituency development Funds to FPFK trainers to establish a VCT Centre and train Counsellors in the Constituency in order to enhance availability of services in this area.

vii. The change of strategy from mass approach through crusades in the first phase to working with groups through seminars and conventions in the second phase enabled building of closer relationships with communities thus building a foundation for community ownership of interventions. This strengthened community empowerment in areas such as resource mobilization and in Nyanza some of the groups were able to martial resources from other partners such as AMREF.

From these findings it is evident that FPFKs strategy in addressing the HIV&AIDS pandemic has grown progressively from one stage to the next taking into cognizance the context of the local environment in the targeted regions in relation to the community needs in as far as access to HIV&AIDS counselling, testing and treatment services is concerned.

It is also evident that there was strong collaboration with the government through NASCOP at the national level and DASCOP at the constituency level in ensuring that there was capacity to facilitate attitude and behaviour change through VCT in the targeted regions. The training of VCT Counsellors by NASCOP is commendable especially realizing that concerted efforts with strategic partners towards reducing HIV prevalence in the targeted regions is critical. In addition a number of the trained counsellors were absorbed as staff by the government in some of the government owned facilities.

Setting up of VCT centres in existing church facilities and health centres was a sustainable strategy as these continue to provide the required services to date. It emerged that the VCT facility at Thesalia in Muhoroni continues to offer VCT services to the community members in Muhoroni to date.

The scaling down of the Coast region after the first phase and Nyanza region after the second phase reduced the gains that had started being felt at the end of Phase I and Phase Two of the project respectively. The capacity of the local communities had not sufficiently been built to the level of sustaining the interventions. It was however noted that FPFK through the just ended project continued to provide trainings on request for the youth, women and church leaders during specific forums organized by the regions. In Nyanza awareness interventions are still ongoing though at a lower scale.

3.3 Findings from the Project 2010-2014 Based on TOR

The evaluation for this phase mainly concentrated on the two target areas which were Mt. Kenya and Maasailand regions. In this section the findings presented are according to the terms of reference and the objectives of the evaluation.

3.3.1 Community Mobilization through SALT teams

Whether communities were mobilised through SALT teams to change behaviour and attitudes that encourage spread of HIV and provide care between relatives or neighbours (for PLHIV & OVCs).

The Human Capacity Development Approach is aimed at strengthening local communities' response towards HIV&AIDS by integrating home care and prevention through home visits (private) and broader neighbourhood conversations (public) through a process facilitated by SALT teams. SALT teams were part of larger entities known as a support groups that were formed to enhance community care coalitions as well as serve as a foundation for harnessing economic, social, spiritual and physical support. The SALT teams offer accompaniment, support and stimulus to the community so that it grows in competence for caring for relatives and neighbours in their homes.

The evaluation established that SALT teams were key in stimulating behaviour and attitude change that encourage spread of HIV and provide care between relatives or neighbours (for PLWHIV & OVCs). The findings indicated that all the 82 support groups formed SALT teams whose main activity was home visits and facilitating community conversations to address community concerns key being prevention and management of HIV&AIDS.

Table 1 Support Groups

Region	Support Groups	Members	SALT Teams	HIV+ Members
Mt Kenya	57	2280	57	684
Maasailand	25	1000	25	400
Total	82	3280	82	1084

The evaluation also revealed that most of the support groups had PLHIV as well as those who were not HIV+. The same trend was noted in the composition of the SALT teams. Of the 57 support groups formed in Mt. Kenya region reaching out to 2280 members, 684 were HIV+,

likewise in Maasailand region out of 25 support groups reaching out to 1000 members 400 were HIV+.

The SALT teams were able to train community members on the need to accept PLWHIV and support OVCs in order to achieve gains against the spread of HIV&AIDS. The key highlight of the SALT Team intervention was in Ol'kalau, Rurii, where Njambi, a beneficiary of the intervention has become part of the team that drives peer counselling among PLWHIV. She is also an advocate of the rights of PLWHIV. Njambi said:

> *"I was at my death bed when the salt team visited me. The community had abandoned me and treated me as an outcast. I had lost all hope in life. The salt team counselled me, provided food and care for me and took me to a VCT. I was put on ARVs which I use to date. I am now physically strong and economically empowered through the intervention of FPFK. I am now an ambassador of the fight against HIV&AIDS. Even though I still encounter stigmatization from some community members, we have been able to achieve much in terms of reductions in new infections. We distribute condoms to people we visit apart from advocating for safe sex and abstinence."*

The study established that SALT teams visit homes at least three times a week and also when called upon by families who have ill relatives. During SALT visits, beneficiaries visited were given foodstuff. They were also trained on the need to use condoms in order to reduce chances of infections. Whenever a SALT team visited and found a person bedridden and unable to go to hospital, they would take the initiative of taking him/her to hospital. In Ol'Kalau, for example, Njambi narrated that from the home visits and others who have approached her as an individual, she has referred at least 50 seriously ill patients to hospitals. This information was corroborated by the Clinical Officer in charge of HIV&AIDS at the Ol'Kalau District Hospital who indicated that the partnership between the hospital and the FPFK intervention has been able to introduce many people to counselling and ARVs. She stated that since the inception of the project, new infections have reduced in the area. She noted that risk factors to HIV&AIDS spread like prostitution, deliberate spread of the virus by those infected, and ignorance of condom use among those infected have significantly reduced.

The evaluation also revealed that initially the SALT teams especially in Maasailand were not well received by the community members when they conducted home visits. However after

relatives of households became ill from opportunistic infections as a result of HIV the same families looked for the SALT teams to assist on how to take care of the sick ones and advise them on where to seek for treatment. This has tremendously elevated the importance of the SALT teams within the communities, thus created community support of the initiative. A member from Naretoi SALT team enthusiastically had the following to say:

> *"We are so grateful to be part of the SALT team and to make a difference in our community. Just as the name SALT suggests our role is to preserve our community through knowledge that will protect them against the deadly disease and ensure long life to those who are already infected by encouraging them to take ARVs and to access good nutrition. As SALT we must bring hope to the lives of the people."*

The SALT teams use forums such as the Chief's public meetings and churches to encourage discussions on HIV&AIDS prevention and positive living. Those who are living positively with HIV take the opportunity to speak about their experiences and this has encouraged many more to accept their status and begin to live healthy lives.

The evaluation established that the intervention was able to change attitudes and behaviours that are considered high-risk to infection. In Naivasha, one of the beneficiaries noted that two of her children are positive because she did not observe measures that would reduce mother-to-child transmissions. However, upon joining a support group started by FPFK, she was encouraged to observe ways of reducing the risk of mother-to-child infection. She currently has a young boy who is HIV negative. This is a clear indication of a behaviour change that has curtailed an infection.

While there are positive gains through the SALT teams, the evaluation also revealed that there were challenges faced. Among them is the fact that they have to walk long distances to be able to reach populations that are hard to reach. In Maasailand members of Naretoi SALT team explained that most of the homesteads were a distance apart in areas where road network was poor thus they had to walk long distances to reach most of the affected households. The same was expressed in Loitoktok where the SALT teams have had to walk long distances to reach out to households that were far away. In addition the evaluation also

revealed that the SALT teams sometimes lacked basic training materials such as the model reproductive health dummies and home based care kits that they could use for demonstration while visiting families with ill relatives.

It is evident from the above findings that despite the mentioned challenges the SALT teams sufficiently mobilised communities and influenced behaviour and attitude change that encourage spread of HIV and provide care between relatives or neighbours (for PLHIV & OVCs). It can also be concluded that both the support groups and SALT teams contributed significantly to the reduction of stigma and discrimination against PLHIV. The fact that SALT team members who are living positively with HIV were called upon to be a source of encouragement to others who had given up hope and that homes are opening their doors to their interventions is an indication of acceptance of PLHIV and the contribution they are making towards promoting quality life for families that affected by the pandemic. From the findings it can be confirmed the project achieved the expected results for this objective.

3.3.2 Effectiveness of the Approaches

How effective was this approach in positively impacting the behaviour and attitudes of the target group towards curtailing the spread of HIV? To what extent did it contribute to stigma reduction for both the PLHIV and OVCs? Are the targeted communities sufficiently equipped with HIV&AIDS knowledge?

FPFK HIV&AIDS Awareness project used three distinctive approaches in addressing HIV&AIDS in the targeted communities. The HCD approach emphasizes on the capacities or strengths of communities to respond to their own concerns. The HCD approach lays more emphasis in working with the people at local level, affected and infected by HIV and AIDS as opposed to working for them while the HRBA approach encompasses working towards fulfilment of the human rights of the target group rather than their needs. The third approach was Advocacy which was aimed at articulating policy and advocacy positions that would result into clearly defined roles and responsibilities on the part of the government in addressing HIV & AIDS.

The evaluation established that the intervention was successful in contributing towards the reduction of the spread of HIV&AIDS. In Loitoktok, one of the pastors of a local church is a converted *moran*. He informed us that *moranism* was for a long time a hindrance in the fight against the spread of the disease. He noted that *moranism* allowed the *morans* to pick girls

from the community and go with them to their *manyattas*. They would then engage in sex without protection. This act led to the spread of HIV&AIDS. However, he indicated that with this intervention in Maasailand, the *morans* now have knowledge on risk factors associated with multiple partners and unprotected sex. With reduced cases of risk factors (*moranism* and early marriages) most parents now prefer to take their sons and daughters to schools and have adopted alternative rites of passage.

In a *manyatta* in Iltilal, the *morans* interviewed corroborated the findings from the pastor that they were equipped with knowledge on HIV and AIDS and were aware of the negative consequences of having multiple sex partners and unprotected sex. The visit to the *manyatta* confirmed that the project had been able to positively influence and change die hard cultures and traditions that have been the drivers of the spread of STDs, HIV and AIDS in this specific community.

The study further established that the intervention positively impacted on attitudes and behaviours that lead to the spread of HIV&AIDS. In Loruko, one *Mzee* Mohamed said:

Kiswahili version

"Sisi ni nyani. Hii FPFK imekuja na kutufundisha kukaa kama binadamu. Siku hizi tunapeleka watoto wetut shuleni. Tumegundua kwamba kuoza wasichana wakiwa wadogo sio haki kwao. Serikali imetuacha lakini FPFK imekuwa na sisi na kutufundisha vizuri. Mila ya kuridhi wanawake pia imepunguka hapa kwetu."

English Version:

"We in this part of the world are like monkeys living in the wild. But FPFK came and taught us how to live like human beings. We now take our children to school. We have learnt that early marriages for our girls are a violation of their rights as children. The government has neglected us but FPFK has been here to teach us well. Widow Inheritance has also tremendously reduced in our village."

From this finding, the evaluation ascertained that retrogressive cultural practices among the Turkana and Samburu in Loruko, Isiolo County have greatly reduced. In effect we can

conclude that the intervention was effective in positively impacting the behaviour and attitudes of the target group towards curtailing the spread of HIV&AIDS.

The evaluation also established that, to a great extent, the intervention contributed in reduction of stigma against PLHIV and OVC. In Naivasha, the evaluation established that the community church had fully embraced PLHIV and OVCs. Most of the beneficiaries here were women living with HIV. The pastor at this church noted that church members had been made aware of the Church's HIV&AIDS policy and they had welcomed it. However, the church still experiences a lot of challenges in addressing stigmatization especially from church pastors. In Ol'Kalau, the local pastor mentioned to us that one of the pastors from a neighbouring FPFK church had refused to accept a congregant simply because she is living with HIV&AIDS. The affected person has been given accommodation and refuge at the church in Ol'Kalau.

From the finding it is evident that communities targeted are sufficiently equipped with knowledge on HIV&AIDS observed through their increased openness in discussing their HIV status and the communities' initiative in supporting PLHIV. The findings also pointed towards communities' level of understanding the rights of PLHIV and other vulnerable groups. Majority of the beneficiaries interviewed were able to enumerate the rights of PLHIV.

However while the findings established that the project had positively impacted on the behaviour and attitudes of the target group towards curtailing the spread of HIV and contributed to stigma reduction for both the PLHIV and OVCs as well as sufficiently equipping them with HIV&AIDS knowledge, there were some areas where retrogressive and unhealthy practices that contribute to the spread of HIV&AIDS are still widely practised. In Naivasha it was observed that there were still call girls in the streets while in Maasailand some of the '*morans*' have not fully embraced safe sex practices. In some of the local churches it emerged that some of the members are yet to fully embrace PLHIV.

3.2.3 Government National and International commitments concerning HIV&AIDS

Whether the project ensured that the Government keeps its national and international commitments concerning HIV&AIDS and exercises transparency and accountability in handling of funds for dealing with the pandemic. To assess the extent to which the project

influenced the government in embracing the Human Capacity Development Approach to HIV/AIDS response as opposed to service provision/top – down interventions response.

The findings revealed that members of the PSC who are key government officials in the health sector contributed towards updating the project on important government policies relating to HIV and AIDS in order to enrich the interventions at community level. However it was noted that effective advocacy to influence policy at the national level needed a concerted effort with other players among them the network organizations that FPFK was affiliated to such as the Evangelical Alliance of Kenya (EAK) as well as Act Kenya Forum.

In Isiolo, the evaluation established that the project team had involved the County Government. The local MCA (Member of County Assembly) representing Loruko (he is also the majority leader in the County Government) was fully aware and involved in the implementation of the HIV&AIDS project. Through this partnership, the local MCA was able to advocate for funds from the County Government for supporting beneficiaries. In Isiolo a slaughter house has been established by beneficiaries through the help of these funds. The evaluation also revealed that in Loruko the Chief, a young man, is a member of the Larbarshereki support group and therefore he works very closely with the community members in ensuring that awareness on HIV&AIDS prevention is undertaken.

Though the evaluation established that there were strong linkages with leaders at the grass root in some areas, in other areas there was need to create strong linkages with the local leadership in order to build local ownership of the intervention. In Loitoktok in Iltilal the Assistant Chief interviewed indicated that the local administration had not been deeply involved in FPFK project activities the area but they were aware and appreciated the ongoing activities in HIV&AIDS Prevention and environmental clean-ups by the support groups. From these findings it is clear that attempts to work with policy makers have been made and can be built upon.

3.3.4 Impact of FPFK Policy on the Rights of Women, OVCs and Indigenous Communities

Whether the policy has been used and if so to what extent has the policy changes impacted on the rights of women and vulnerable children affected by HIV&AIDS as well as the rights of the indigenous communities?

The FPFK Board in March 2006 enacted a policy as part of its response to HIV&AIDS among her members. The policy objectives were;

i. To provide guidelines to FPFK leadership and members on how to respond to HIV&AIDS within the organization and community.
ii. To demonstrate the love of Christ by proactively involving the church in HIV/AIDS pandemic through a standard framework to ensure uniformity and consistency (Matt 22:39).

The evaluation revealed that the development of the Policy was a major achievement and demonstrated FPFK's commitment towards addressing HIV&AIDS. It emerged that its development involved a consultative process that brought on board a diverse group of members from the local level to the national level of the church structure. A series of workshops and forums were held towards this process as follows:

i. FPFK's Key Leaders Policy Workshop whose participants were Project Steering Committee, National board members, institution representatives, women leaders, youth leaders, Trustee representative and Regional Leader Representative. A total of 25 participants;
ii. Policy Formulation-Women's Workshop. A total of 37 participants;
iii. Policy Formulation workshop-Regional Councils. A total of 25 participants;
iv. Policy Formulation-Youth Workshop. A total of 48 participants;
v. HIV Policy Document Workshop (Staff and Regional Pastors). A total of 38 participants.
vi. Consensus Workshop on HIV Policy (Board, PSC and Key National Leaders). A total of 29 participants.

The evaluation findings from interviewing the Board, PSC and General Secretary revealed that upon its enactment the Policy was widely shared within the church leadership from National to regional level. The Board members and members of the PSC interviewed confirmed that the Policy Statement clearly provides guidelines on the stand of the church with regards to prevention of HIV&AIDS, Care and Support, Mitigation as well as its obligations as an employer.

From the evaluation it was established that the Pastors in Meru, Ol'Kalau and Iltilal use the Policy Statement as a reference point in decision making when faced with the issue of HIV&AIDS among their congregants. In Iltilal the local Pastor affirmed the response from the Board and PSC that the Policy guidelines were useful in decision making processes where action needed to be taken such as solemnizing marriages. Among the sections of the Policy that he adheres most to was the one that states..." HIV status will not be a deterrence of solemnization of marriage ..."[1]

Concerning the policy impact on the rights of women and OVCs, the evaluation findings indicated that most local church leadership in the two regions had embraced its provisions and encouraged and supported the formation of support groups through which women and OVCs would access economic and social support as well as access information on prevention, care and treatment which are their fundamental rights. This is as carried in the Policy under the section on Prevention, Care and Support and Mitigation. The number of support groups in both regions attests to this fact.

However the findings revealed that there was need to share the Policy widely especially among community members. It was noted that the policy was mainly circulated during Phase Two of the project. The findings also indicated that even though the regional and local pastors have the Policy Document they were still not adhering to it. This was evident in Ol'Kalau where in one of the local churches a Pastor disallowed one member from attending church because she was HIV+:

"A pastor in one of our local churches discriminated against a HIV+ member. He refused to allow her participate in church activities. He told the lady that she was immoral and that is why she had contracted the virus. He publicly preached in the church that congregants should not associate with such people. The lady approached me and told me her plight. I took her in and we have given her accommodation at our local church."

Despite this challenge, the fact that most of the local FPFK churches provided space for support group meetings and that a local pastor took in an HIV+ member is an indication that the local church leadership in some of the churches had well understood the position of the church on HIV&AIDS, which is stipulated in the HIV&AIDS Policy and were adhering to it.

[1] FPFK HIV&AIDS Policy 2006

Further the evaluation established that the Policy Document needed a review to incorporate latest information and strategies that the Church has embraced with regards to influencing Policy at the National and County level. From the above findings it is evident that the FPFK Policy Statement on HIV&AIDS has played a big role in institutionalizing HIV&AIDS as a cross cutting issue in its work with communities and development partners at National and local level. However, there is need to update the policy in order to fill in the gaps that have arisen while operationalising the policy at all levels and to develop monitoring mechanism in order to ensure adherence.

3.3.5 Activity Outcomes

To Measure activity outcomes (qualitative and quantitative) in order to determine those activities which add value with a view to replicating them among participating target groups

HCD CAPACITY BUILDING ACTIVITIES	**OUTCOME**
Training of staff and the main actors in HCD.	✓ A facilitator manual/guide on HRBA and Advocacy had been adopted. ✓ Integration of human rights issues in the HCD process to HIV & AIDS programming.
Hold workshops in the target regions with key actors to introduce them to the HCD approach.	✓ Communities' capacity for change, care, hope leadership and transfer improved. ✓ Increased communities' roles in stigma reduction through care coalitions. ✓ New linkages and partnerships formed ✓ Increased confidence in sharing information on community led responses with other actors
FIELD BASED ACTIVITIES	**OUTCOME**
Start local response demonstrations in the selected target areas	✓ Increased openness and disclosure on HIV related issues by the community members. ✓ Increased transfer of knowledge and experience from replication of support groups. ✓ Communities empowered to identify their own strengths and concerns. ✓ Competent local facilitators ✓ Increased awareness and knowledge by the Maasai on their rights as an indigenous community. ✓ Increased agitation for the fulfilment of the rights of the Maasai by government
Work with health facilities especially VCT centres to ensure that they learn from local	✓ Increased visitations of VCT centres, reduced morbidity and mortality rate in the target areas.

responses and adjust their operations accordingly.	✓ Efficiency in the utilization of locally available resources to combat HIV&AID.
Facilitate and accompany the community in gaining competence in taking care of orphans, vulnerable children and women affected by AIDS as well as start community wide conversations on promoting the human rights of these vulnerable groups	✓ Increased cases of women inheriting their husband's properties. ✓ Reduced cases of disinheritance by relatives of widows and OVCs ✓ Reduced cases of FGM and early marriages. ✓ Increased linkages with authorities in addressing cases of human rights violations. ✓ Increased competence within local communities in taking responsibility for their own development needs in view of HIV&AIDS. ✓ Increased openness in discussing HIV&AIDS.
Establish demonstration centres for income generating activities e.g. fish farming.	✓ The support groups have the capacity to manage IGAs ✓ Improved livelihood among support groups members from the IGAs
Establish tree nurseries and distribute seedlings to community members	✓ Increased environmental care and conservation

From the above activities the evaluation established that HCD introduction, sensitization and awareness for human rights holders and the responsibility of the rights bearers and advocacy should be replicated among participating target groups. The outcomes of these activities were an indication of the long term impact they have on the community in their overall development.

The outcome of HCD introduction through systematic SALT visits and capacity development is illustrated in Lydia's story. From the story SALT has increased openness and disclosure on HIV status by beneficiaries:

"I am a Kenyan lady aged 42yrs old I am a mother of four kids and four grandsons, I live in Kimana, Loitokitok I got tested in the year 2004 and turned positive I started my ARV's immediately My cd4 count was 47 and I weighed 37kgs I went public in the year 2007 during Aids day where I was introduced by Pastor Karachi Matongo from FPFK Kimana church. We started a support group by the name KIPFAT where we were trained on HCD by a team from FPFK led by Pastor Kefa and Alice Sintoya. After going public, I started teaching the community about HIV. I try to tell the infected people that they can live their lives as before they were infected. Our group meets on every Wednesday. By now I'm 82kgs my cd4 is 1082 my viral load is less than 200 my wish is to be trained in community development or a VCT course so that I can serve my community. Thanks F P F K for your support may God bless you!"

Before

After

KCDF & NACC SEMINAR HELD AT BONTANA HOTEL NAKURU KENYA ON 28TH-31ST AUG 2012

From Lydia's story we can conclude that Capacity development, referral and SALT team visits should be replicated among participating target groups in order to empower PLHIV.

The outcome of sensitization/awareness on HRBA and advocacy in communities is illustrated through the increased awareness and knowledge by the Maasai on their rights as an indigenous community as well as increased agitation for the fulfilment of the rights of the Maasai by government:

Participant from Kimana

"The training from FPFK on human rights based approach and advocacy has really opened our eyes and us the Maasai we are now fully aware of our rights. As we attempt to change our lifestyle from pastoralism to agriculture based activities we have faced many challenges in our community. The water we have used to irrigate our farms is being re routed to flower farms owned by a well known politician and this has affected our harvest. We have now decided to organize for a demonstration that will involve presenting our petition on the issue to the Chief's office and if he does not address our issue we will move to the office of the County Commissioner."

From this illustration sensitization and awareness through HRBA and Advocacy are activities that should be replicated among participating groups in order to empower local communities and PLHIV to agitate and demand for their rights from right bearers.

3.3.6 Socio-Economic and Environmental Welfare

How the project has contributed towards improving the socio economic and environmental welfare of the lives of those affected and infected by HIV&AIDS in the target areas.

Economic dependency and insecurity are at the core of the gender dynamics of HIV&AIDS. For both married and unmarried women, their comparatively limited access to and control of economic assets increase the likelihood of their: 1) inability to negotiate safe sexual practices; 2) likelihood of exchanging sex for money (survival sex); or 3) pressure to stay in a relationship that they perceive to be violent or risky.[2]

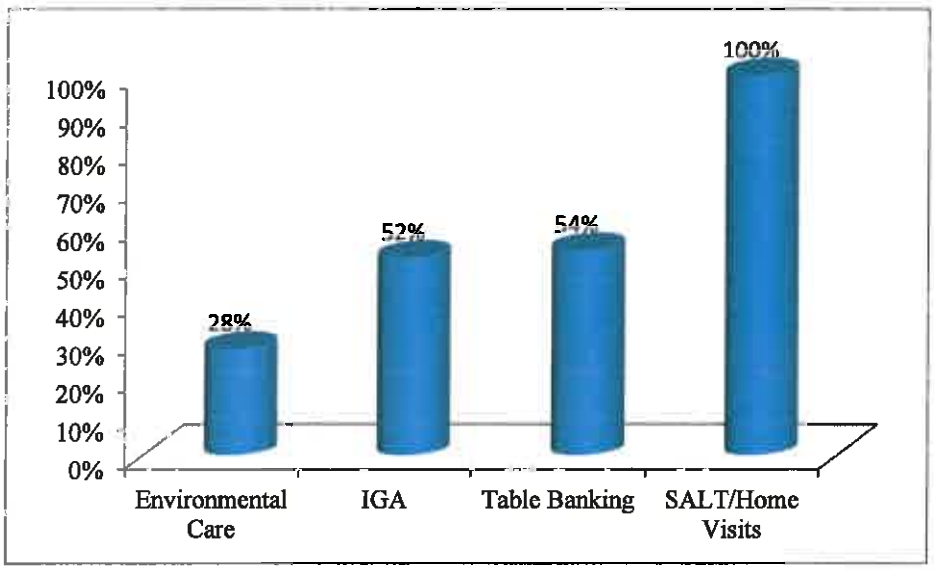
[2] Gender And Development Group, World Bank, 2007

The evaluation established that the greatest impact of this intervention was the improvement of the socio-economic and environmental welfare of PLHIVs in the target areas. More than 80 groups were established across 52 places within the target areas.

The project contributed towards improvement of the social lives of the targeted communities. Through SALT visits communities' level of acceptance of PLHIV has increased therefore leading to positive relations among community members. It has led to increased productivity among targeted groups that had lost hope as a result of HIV related illnesses and the very marginalized community members. Community members have been economically empowered through the initiation of income generating activities within the support groups. These included merry go round/table banking slaughter house, poultry farm, tree planting, rabbit keeping, pig keeping, vegetable farming, potato farming, dairy goat keeping, and bead work among others. With income generating activities established for the groups, a majority of the group members were assured of an income at the household level. Activities such as green house farming, slaughterhouse and fish farming have also created employment opportunities.

Whereas a majority of these activities transformed the socio-economic status of the beneficiaries positively, others improved the state of the environment in which these beneficiaries lived. These were noted through establishing tree nurseries and tree planting that contributed towards environmental conservation.

Figure 1: Activities That Add Value to Support Groups



3.3.7 Gender Equality and Women Empowerment

How the project has promoted gender equality and women's empowerment.

Gender equality is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including economic participation and decision-making, and when the different behaviours, aspirations and needs of women and men are equally valued and favour.[3]

Gender equality and women's empowerment is critical in the fight against HIV&AIDS. Young women are disproportionately vulnerable to infection; elderly women and young girls are disproportionately affected by the burden of care-giving in the epidemic's wake. Gender inequality and poor respect for the human rights of women and girls are key factors in the HIV&AIDS pandemic: both from the point of view of effectiveness and from the call for social justice, HIV/AIDS programming must take account of the gender dimensions of HIV&AIDS and its processes.[4]

According to the latest (2008) WHO and UNAIDS global estimates, women comprise 50% of people living with HIV.[5] In sub-Saharan Africa, women constitute 60% of people living with HIV. Sex workers and their clients are among those most-at-risk for HIV, but the proportion of women living with HIV has been increasing in the last 10 years.[6]

The struggle against HIV&AIDS requires a far greater focus on women. The UN Secretary General's Special Envoy on AIDS, Ms. Mataka, noted that "Unless we empower women not just economically, but with technology that they can initiate and control to protect themselves against infection, we will remain with very limited success." [7]

On the other hand the need to involve men in the response to HIV/AIDS cannot be underscored. Men must partake fully in dialogues, actions and policies to deal effectively with gender inequalities and the resulting vulnerability that fuels the spread of HIV. They have a responsibility for their own bodies and can help peers to understand the forces that

[3] Irish Department of Justice and Equality (n.d., paragraph 1)

[4] HIV&AIDS Fact Sheet-UNICEF

[5] WHO and UNAIDS, 2008

[6] Ibid.

[7] Africa Renewal, 2015

push them to sometimes put themselves as well as others at risk, and they can point to the benefits gained by accepting responsibility. Men in their different roles can engage as role models in society by advocating positive attitudes towards women and people living with HIV/AIDS. They can also promote prevention such as condom use. As fathers, men can offer positive role models for their sons and daughters by respecting women and themselves. Men and women benefit from open communication that can help build equal and safe partnerships. It is therefore important to learn what men want and need, and to empower them to be able to take responsibility for their behaviours.[8]

The evaluation through the focus group discussions established that gender inequality contributes to the spread of HIV. It can increase infection rates, and reduce the ability of women and girls to cope with the epidemic. Often, they have less information about HIV and fewer resources to take preventive measures. They face barriers to the negotiation of safer sex, because of unequal power dynamics with men. Sexual violence, a widespread violation of women's rights, exacerbates the risk of HIV transmission.

From the evaluation, it was established that the intervention had succeeded in promoting gender equality in the targeted areas. Most of the women who participated in the Focus Group Discussions indicated that through awareness creation among their male counterparts, women could now be engaged in discussions together with men even in areas where culture deemed women as subordinate such as in Maasailand and Isiolo. One *Mzee* in Loruko noted that before the intervention, it was taboo for women to join discussions in which men were part. He lauded the FPFK intervention as having turned this culture around such that women and men can now discuss issues in support groups without one looking down upon the other.

The evaluation findings however also indicated that male involvement in the project activities was lower compared to that of women. This was attested by the statistical records that show gender disaggregated data for support groups as well as the local facilitators. This was corroborated by the local Pastor in Naivasha who was concerned by the low number of men joining support groups. He mainly attributed this to the fact that most men are not available during the day time as a result of work commitments but also social groups for self help are mainly associated with women and the male ego in effect discourages men from joining such groups. To mitigate this, he indicated that he had made efforts to start men only discussion

[8] HIV&AIDS Fact Sheet -UNICEF

groups in the evening within the church facility and this worked well. Among the issues discussed are HIV&AIDS prevention and possible economic investments.

Figure 2: Support Group Membership by Gender

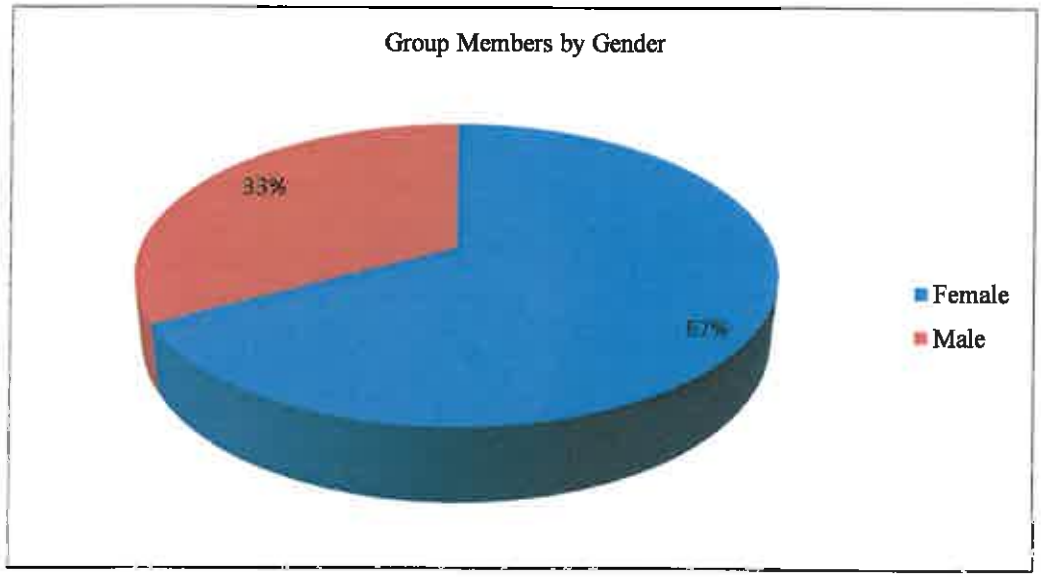
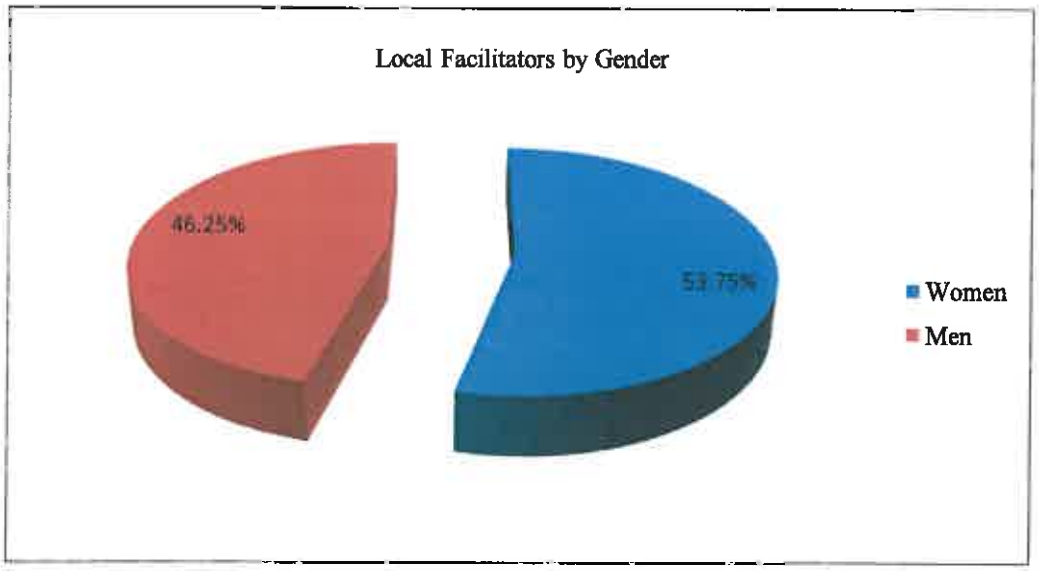


Figure 3: Local Facilitators by Gender



The aspect of gender norms surrounding masculinity can discourage men's use of HIV testing and other health services. The evaluation findings from one on one interviews with two beneficiaries in Naivasha and Ol'Kalau respectively indicated that the women were the first ones to gather courage to go for testing and to access treatment in a situation where both the couple were ill and suspected they were HIV positive. It had to take some convincing from their wives for the men to go for testing. In one of the instances for fear of

stigmatization, the man opted to share the wife's ARVs even though they knew this was not right, rather than him visiting a health clinic to access treatment.

The HRBA has also contributed further to promoting gender equality in ensuring equitable access to care, treatment and support for those infected and affected by HIV&AIDS. The approach has partially addressed gender inequalities and promoted access to information and services as a right regardless of marital status or gender. The approach advocates for HIV & AIDS responses that include strategies for ensuring equal access of men and women to their full rights as citizens. The FPFK HRBA Advocacy Guide; Chapter Four on Gender, HIV and Human Rights provides the foundation for capacity building in ensuring a gender responsive HIV&AIDS prevention strategy.[9] The project has succeeded in promoting women's participation and their empowerment and encouraged male involvement in the fight against HIV&AIDS. This effort needs to be sustained going forward.

3.3.8 Impact of the Project in the Target Areas

The Impact of the Project in the Target Areas and Ways in Which the Project Has Been Able to Achieve its Objectives

The overall impact of the project in the target areas was its contribution in the reduction in the rate of new HIV&AIDS infections. In Ol'Kalau, for example, the officer from the health facility indicated that new infections had reduced by 45% according to Government statistics.[10] She attributed this decrease partly as a result of the awareness campaigns carried out by FPFK.

It has also effectively contributed to attitude and behaviour change in the communities targeted.

A notable impact is the improvement of the quality of life especially among PLHIV participating in this project in the two regions. This was evident through increased support and care of PLHIV and people living with chronic illnesses and mental illness. PLHIV in the community that were bedridden are now productive members of the community and increasingly self-reliant with enhanced self esteem and confidence. In Naivasha one of the

[9] FPFK HRBA and Advocacy Guide: A facilitators Guide 2012

[10] NASCOP Report, 2014

local facilitators living positively with HIV is attached to the District Hospital where she assists in the counselling other PLHIV in the Comprehensive Care Centre.

There is marked improvement in household nutrition and economic empowerment evident in the fact that most of the support groups have started income generation projects that are agriculturally based. Some of the harvest is for subsistence use while some of it is sold to earn income.

Stigma reduction at household and community level is evident by the positive attitude in relation to people's beliefs and behaviour. This was evident through acceptance in support groups, openly discussing their status.

The HCD approach that encouraged formation of support groups has been localized and owned by the communities both in Mt. Kenya and Maasai land. The support groups have continued to seek ways of improving their livelihood through identification of locally available resources that will lead towards economic and social empowerment. This was evident in Loruko, where a slaughter house has been established by Ong'an Women Group. Given the pastoralist way of life of the Samburus and Turkanas who are the predominant population in Loruko, a slaughter house serves the needs of the community based on the context with regards to their major economic and social activity.

Other than the slaughter house being a sustainable income generating activity at the house hold level it has created employment opportunities and reduced despair among the beneficiaries. At Gikoe, Gikoe Poultry Group was established as a result of the HCD approach. This is yet another sustainable income generating activity whose impact is the overall economic empowerment of members as well as employment creation. At Shamata, the impact was economic empowerment which was achieved through the establishment of poultry farming and tree seedling business by the Aberdare Group.

A total of 52 areas in the target communities were sufficiently reached with a total of 82 groups created.[11] A majority of these groups each had a sustainable income generating activity. On the other hand more than half of the groups were involved in SALT Team visits.

[11] FPFK Field Reports, 2014

Through the HRBA approach the capacity of communities have been built to demand for/ and exercise their rights and engage decision makers at the local level to ensure those rights are upheld. Community members have gained skills in advocacy and learnt to hold their leaders accountable to ensure that the rights of the marginalised are upheld.

The evaluation established that PLHIV have been empowered to demand for quality services in health facilities. In Ol'Kalau there was a case where the medical personnel refused offer treatment to one of the community members because he had stopped taking his ARVs for a period of time. The SALT team members took the member back to the hospital and demanded that he be treated because it was his right. Indeed he was put back on treatment. This is an indication that knowledge learnt was being put in practice for the benefit of the marginalised people who may have no voice to speak out. This was also evident in Meru where the group intervened in a case where one of their members was denied land ownership. The group organised a public demonstration and closed the local lands office and demanded intervention by the minister for Lands. It had to take a visit by the Minister for Lands to the area for the case to be resolved and due to the irregularities that were brought to light by the group the Minister ordered land offices in other areas to be closed for audit.

Overall, the project has been able to economically empower beneficiaries through the establishment of sustainable income generating activities in various target communities. In addition the project empowered the communities on their rights and contributed reduction in stigma and discrimination.

3.3.9 Assessment of the Project Sustainability

Assess the element of Sustainability – In what regard has the project been able to train local facilitators so that they will be able to continue the activities even when the project has phased out? Support groups (ownership/sustainability) – In which ways are the support groups operating as resources in their communities.

The HCD approach was mainly aimed at entrenching sustainability of interventions at community level. Through key informant interviews with the FPFK management it was established that at the National level there was training of the national facilitating team which was mainly field staff who participated in a one year HCD process and further training on HCD was subsequently done for other staff, pastors and the PSC.

Training of the HCD approach was then cascaded down to the community level. The local facilitation teams are made up of support group members who have demonstrated full understanding of the HCD process. This is the basis upon which they were recruited. These are people who have good influence within their support groups and local communities with some of them being community health workers (CHW), under the Ministry of Health community health extension program. Their main roles are training support group members on HCD, HRBA and Advocacy approaches as well as mentorship. They also network and establish linkages with other local actors such as the local leadership, health facilities and community based organizations. It was established that their role is voluntary a key ingredient towards local communities ownership and support of the process.

The evaluation established that the project trained local facilitators in each of the regions as planned in the Project Document. The evaluation also established that there are 80 active local facilitators against a target of 50 as indicated in the project document.[12] There were 38 in Mt. Kenya and 42 in Maasailand. An interesting observation is that while Mt. Kenya region has the highest number of support groups compared to Maasailand it has fewer local facilitators. On the other hand Maasai has fewer groups against a higher number of local facilitators compared to Mt. Kenya region. It was further established that in Mt. Kenya region, initially the number of local facilitators was higher but came down due to the fact that some of them relocated to other areas taking up new jobs and some because their expectations on remuneration was not met.

Table 2: Number of LFs by Region

Category	Frequency	Percentage
Mt Kenya	38	47.5
Maasailand	42	52.5
Total	80	100

The local facilitators are also part of the SALT teams who are engaged in community outreach and training in prevention, care and support of PLHIV. In Naivaisha and Ol'Kalau it was evident that the local facilitators played a key role in creating linkages between the

[12] FPFK Project Document

government health facilities and communities especially in ensuring that PLHIV accessed counselling and treatment services as required.

From the findings the approaches have been sufficiently localised within the communities targeted. Commitment and ownership to the project approaches and initiatives was evident. In Maasailand the number of local facilitators trained surpassed the initially planned target by over 100% from 25 support groups that have a total membership of 1000. This is an indication that there is a sufficient pool of local facilitators that can sufficiently play their role in sustaining the continuation of activities in Maasailand. On the other hand Mt. Kenya region which has 57 support groups with a total membership of 2280 had 38 active local facilitators. This number of active local facilitator in Mt. Kenya if sustained may sufficiently contribute towards sustaining the continuation of the activities.

The evaluation established that ownership of support groups that have been created is with the group members. So far more than 80 support groups have been created. In these support groups, the intervention has been able to build the capacity of members in the HCD, HRBA and Advocacy approaches. This has enabled support groups to establish income generation activities using local resources and SALT teams for home visits and community outreaches. The establishment of these income generating activities has so far ensured that these support groups are not only self-sufficient but are also sustainable. The concept of community transfers to another community where successful groups that have attained level 5 in the HCD progression[13] start up new groups in neighbouring communities has been well received. In Mt. Kenya 20 groups have transferred their experiences to neighbouring communities while in Maasailand there were 8 transfers, an indication that support groups are indeed regarded as vehicles through which communities are able to support each other in socio-economic development.

The evaluation established that the support groups are resourceful to the target communities. Njambi in Ol'Kalau-Rurii support group explained that through their support group alone, they have been able to create another support group. This offshoot support group is now operational and self-sufficient. In Naivasha, members of a support group noted that they have been able to go to a district hospital that initially disregarded the rights of PLHIV and demanded that this stops. In yet another support group, a lady demanded that a girl who had

[13] HCD-Local Response Progression Diagram

been driven out of school by the school administration be accepted back and the head teacher obliged. From this illustration, the evaluation established that the support groups have been resourceful to target communities to the extent that they advocate for the rights of PLHIV and OVCs; conduct SALT Team visits; engage in economically productive activities, and conduct peer counselling in the community.

In Loruko the support groups have taken a lead role in fighting harmful traditional practises such as early marriages for the girl child and female genital mutilation. The support groups have taken lead in embracing new progressive cultures that came as a result of exchange visits to Meru and Maasailand. They have taken a lead in enhancing basic sanitation and hygiene in the community through construction of ventilated pit latrines. The support groups also initiated poultry keeping improving their nutrition and are planning to start agricultural activities using irrigation from the all season local water source (River Ewaso Nyiro).

The evaluation established that the project has trained both the beneficiaries and project staff as part of capacity building and exit strategy. Among the trainings conducted were for support group leaders on the Roles of Office Bearers, Group Leadership and Dynamics, Conflict Mitigation and Resolution in the groups and Networking Strategies. The local facilitators were trained on the project Approaches (HCD/HRBA and Advocacy) and how this will lead to sustainability. The stake holders' (mainly Pastors) were trained on the need for their continuous support to group activities, exit plan and the achievements of the project since its roll out.[14]

From the findings above it can be concluded that there was sufficient capacity building for local facilitators. This will ensure sustainability of the activities after project phase out. We can also conclude that local communities own these activities. This is an indication that the communities have the necessary skills, knowledge and capacity not just to carry on with these activities but also to sustain them.

3.3.10 Assessment of Contribution of Networking to Project Sustainability

To assess in what regard networking has contributed towards future sustainability? (both when it comes to other FPFK projects, other NGOs and governmental institutions) and WAA, Uganda.

[14] FPFK Annual Report 2014

The evaluation established that FPFK has continued to network with other actors namely APHIA Plus, Hope Worldwide, World Vision, Care for AIDS and AMREF in efforts to strengthen the platform for addressing HIV&AIDS in the targeted communities. The key area of collaboration is organizing the World AIDS Day; an annual event and in community forums.[15]

In Maasailand support groups have been networking with World Vision where the organization facilitated the digging of a water dam in Noosidan through the group's initiative. World Vision is also collaborating with communities in education sponsorship for needy and orphaned children in the groups.[16] At the institutional level there has been networking with Salvation Army to improve the project approaches that will enhance community led responses.

The evaluation also indicated that the project networks with the government especially at the local level. Again the World AIDS Day which is a government initiative has provided space for the project to be part of the ongoing government efforts in addressing HIV&AIDS. The government in organizing the World AIDS Day in Murang'a (Mt. Kenya region) and in Maasailand recognized the role the church was playing in spearheading the fight against stigma and discrimination in the community.

In Gikui, Loruko, Oyerata and Iltilal communities have good relationships with the local administration and the Chiefs are members of the support groups. This is an indication that the local administration values the benefits of the project thus ensures a conducive environment for the groups to carry out their activities.

The project has established a learning relationship with Women Against AIDS (WAA) Uganda that saw 4 FPFK support group members participate in an exchange programme in Uganda.[17] This was intended to facilitate learning for purposes of enhancing the HCD, HRBA and Advocacy approaches in the FPFK project. A further visit to WAA was by staff

[15] FPFK Annual Report 2013

[16] FPFK Annual Report 2014

[17] FPFK Annual Report 2013

whose result was the development of a standardized monitoring tool for the local facilitators to use as a reporting template.[18]

It was however noted that FPFK needs to utilize existing networks that they are part of such as Evangelical Alliance of Kenya and ACT Kenya Forum for further advocacy at the national level. FPFK is also at a vantage position of starting similar networks at the local level with other churches and faith based organizations working on HIV&AIDS to lobby County Governments for increased budgets on the health sector, specifically focusing on HIV&AIDS initiatives.

3.3.11 Gains from the Project

To find out what FPFK as a church has gained from this project; are the approaches owned by the church? And how is this strategy working.

Findings from the key informant interviews revealed that the church had a moral responsibility to ensure quality of life for communities. It was indicated that the project was timely as it came when most religious institutions did not talk about HIV&AIDS. It emerged that FPFK has been in the lead speaking openly about HIV&AIDS right from the time HIV was at its peak in year 2000. This has given FPFK an early lead in contributing to behaviour change and stigma reduction especially in the areas it implements the project. In Ol'Kalau, the Health Officer corroborates this when she mentioned that FPFK was the only church that had accepted to host meetings for support groups with PLHIV. In addition in Kimana and Naivasha, members of support groups who were not FPFK members narrated how their own churches do not give space for PLHIV openly to participate in church activities nor give space for meetings for support groups if they know some of the members are PLHIV.

FPFKs commitment to address HIV&AIDS especially using the HCD, HRBA and Advocacy approaches in areas that are highly marginalized where very few organizations operate such as Loruko and Maasailand has uplifted the image of the church and received appreciation from the local leadership. The Majority Chief Whip of Isiolo County Assembly expressed that the trainings by FPFK in Loruko had changed the face of the area as it was the only development organization that had built long lasting capacity for the community members.

[18] FPFK Annual Report 2014

There was also evidence that FPFKs initiative on HIV&AIDS had been embraced and was appreciated by other churches. In Iltilal, in Maasailand, FPFK was working closely with another Pentecostal church in awareness on HIV&AIDS and the church also provided space for support group meetings.

The evaluation established that the approaches were owned by the church in the sense that the Pastors were also trained in HCD, HRBA and Advocacy thus they are able to continue supporting the work on a long term basis. In addition, in all the areas we visited in Mt. Kenya and Masaailand the church was the entry point to these initiatives thus enhancing the ownership of the approaches.

3.3.12 Coordination between FPFK HIV&AIDS Projects

To determine how coordination has been undertaken between the different FPFK HIV&AIDS projects and different partners of FPFK.

The evaluation established that while different FPFK HIV & AIDS projects have their own Team Leaders and focus on different geographical regions, their linkage and coordination with the FPFK HIV&AIDS Awareness and Prevention Project is in the following ways:

i. The Youth HIV Awareness Project works closely with young people in the support groups formed under the FPFK HIV&AIDS Awareness and Prevention Project. This was confirmed by a youth member in a support group in Kimana who attested that staff from the Youth HIV&AIDS Awareness project involves them in training and discussions on how to further address issues they face while living with HIV.
ii. The Youth HIV&AIDS Awareness Project also uses the HRBA and in addition have a Peer Educators Training manual that compliments the manual on HRBA. Training on HRBA is conducted by staff from the FPFK HIV&AIDS Awareness and Prevention Project. The Maasai HIV Project also uses the HRBA especially the manual for its trainings.
iii. The Maasai Project has replicated the approach of formation of IGAs from Mt. Kenya Region for the groups in Narok region. This was after an exchange visit of the project participants in Narok to Mt. Kenya region.
iv. There are joint interventions for example the project leaders for the Maasai Project and the FPFK HIV&AIDS participated in a radio programme in Radio Nosim, a

vernacular radio station in Maasai language to speak about HIV&AIDS Management and Rights of PLHIV

v. Staff of the Maasai Project has participated in an exchange visit to Loitoktok to learn more on the approaches used and replicated best practises in Narok

vi. There are Joint workshops for project staff to build their capacity in project management.

vii. Exchange programmes were also organised for project participants from Narok to Kajiado. This provided a good learning opportunity especially in the implementation of the HRBA, HCD Approach and Advocacy especially given the fact that the two regions are similar in context with regards to culture and way of life.

viii. The three projects share one PSC thus facilitating learning within projects as well as information sharing.

However it was noted that FPFK also implements a number of other projects which have their own PSC's and this has resulted to compartmentalization of projects with very little opportunity for convergence that will facilitate knowledge sharing and information exchange among the projects.

3.4 Organizational Capacity

Whilst the evaluation process conducted an assessment of the organizational development process being undertaken by FPFK (Read *FPFK Assessment report on OD Process, 2015*) this section highlights the organizational structure of FPFK in relation to the project delivery.

The FPFK is governed by a three tier structure i.e. National Board, Regional Councils and Local Councils. FPFK has 27 regional councils responsible for managing and coordinating the activities of the churches in the regions.

The highest decision and policy making level is the National Board. The Board is elected at the church's National Annual General Meeting and has a membership of ten all men. The members, all of whom are Pastors, are legible to serve for a period of four years renewable for another four years. The Board meets 4 times in a year. It was established that Board's role in the project is to approve necessary policy documents that guide project implementation such as FPFK HIV&AIDS Policy (2006) that advocate non discrimination and FPFK Gender policy to address gender equity. The evaluation findings also established that the other main

function of the Board is to oversee the linkage and synergy between the project goals and the mission of FPFK.

The National Secretariat is headed by the General Secretary who is responsible for the day-to-day operations of the church. The General Secretary is elected during AGM and can serve for a period of four years. The current General Secretary came into office two years ago (2013). The General Secretary serves as the secretary to the National Board.

The PSC is main body that oversees project implementation. It is made up of 11 members out of which 4 are women and 7 are men. It is appointed by the Board. The Board is represented by two of its members in the PSC. Members of the PSC have various professional backgrounds, thus adding value to the implementation of the project. Currently members of the PSC are drawn from these professional: 3 members are public health practitioners and Heads of Departments in the different Counties, 3 Pastors and 1member is a women's leader in the Church.

From the Key Informant Interviews with the members of the PSC and the General Secretary it was established that the PSC meets four times in a year. Its functions include:

i. Review of project progress reports
ii. Monitoring of project budgets vs expenditure
iii. Review of financial reports
iv. Staff recruitment
v. Staff performance appraisal
vi. Staff discipline and motivation issues
vii. Policy Implementation

The above functions were confirmed as the contents of PSC deliberations vide Minutes of the PSC Meeting for 12th December 2014. The reports from PSC meetings are then presented to the Board by the General Secretary for deliberation and adoption.

The evaluation revealed that the organization provided opportunities for Board and PSC capacity building on project management on approaches used by the project to reach out to the target group as well as resources mobilization. This was further enhanced by monitoring visits to project sites by the PSC members. This was as indicated the Annual Project Report

for 2013 and 2014 and was corroborated during Key Informant Interviews with the PSC members.

At the staff level, the General Secretary is the Chief Executive Officer of the organization. The project has 6 staff, 3 women and 3 men, composed of:

- Project leader - responsible for the overall day-to-day management and coordination of the project activities.
- 4 field staff (two for the Mt. Kenya region and 2 for the Maasailand
- 1 driver

The evaluation revealed that most of the staff had sufficient experience in community development and project implementation ranging from 2 to 6 years in the project. Their competence was evident in the way they interacted with the support groups, local facilitators and local partners during the entire evaluation process. This was also a pointer towards their knowledge in project implementation approaches and understanding of communities' dynamics. It was also evident that the project provided opportunities for staff development through academic studies in order to enhance their skills in project design, management, monitoring and evaluation. Two of the staff are currently undertaking further studies in major Universities in Kenya. Opportunities for tailor made courses are also made available through the project such as the training on Do No Harm that the Project Leader attended in Uganda to boost her capacity in project design and management.

The evaluation findings indicated that FPFK has clear documentation, reporting and feedback processes from the local level to the National level. At the field level each support group keeps a record of the activities they are involved in including SALT visits, income generation activities and trainings conducted. The field staffs then compile monthly reports which they forward to the Project Leader in hard and soft copies. Once in a month the staffs have an opportunity to sit together at the Headquarters to compile the reports and discuss any emerging issues arising from the field as well as learn from each other. It was revealed that the monthly staff meetings have enhanced timeliness of reports. However in the key informant interview with the Project Leader capacity building needs to be enhanced in reporting for the Maasailand region.

Findings from the evaluation revealed that apart from the monthly staff meetings, FPFK has put in place sufficient mechanisms to provide information for critical decisions through reports from local facilitators who are the community contact persons, by phone and through monitoring visits.

It was however noted that the standardized reporting format for local facilitators that had been developed during the exchange visit with WAA had not yet been implemented. It was also noted that while the General Secretary is responsible of presenting the reports from the PSC meetings he was not a member of the PSC. This is an oversight as he cannot be held accountable for those reports. The evaluation also revealed that the number of staff compared to the area of project coverage did not match therefore leading to inadequacy in monitoring by staff. This was observed by beneficiaries that staffs monitoring visits to communities were inadequate.

While project staff rely a lot on local facilitators to link with the groups on their behalf the role of local facilitators in relation to monitoring and reporting are not clearly instituted within FPFK reporting structure. This is gap especially if local facilitators will be relied upon for continuity of activities at community level.

SECTION IV: CONCLUSION, LESSONS LEARNT AND RECOMMENDATIONS

4.1 Conclusion

The long-term development goals of the project were to improve the wellbeing of people infected and affected by HIV and AIDS, as well as improve the economic welfare, public health and the environmental quality in the target areas. From the outcomes established by the evaluation findings the project has achieved its intended development goals.

The model used by FPFK has promoted sustainability at household and community level by building the community member's resilience through the HCD, HRBA and Advocacy Approaches. The targeted communities have developed capacity to anticipate and adopt to change through clear decision making processes, collaboration and management of resources internal and external to the community. In Loruko community members' consciousness to demand for accountability from its elected leaders has been awakened. The formation of support groups was a means towards promoting sustainability through community empowerment especially in areas that are isolated due to poor infrastructure, lack of access to agriculture and other basic facilities such as Loruko and in Maasai land. The support groups have provided a mechanism for social gathering; personal development and community participation thus promoting the positive effects of neighborhood life that allows people to meet and build a network of relationships that creates a true community. Promotion of local income generating activities has created a local economy thus availing opportunities for wealth creation within these communities. This has further contributed to economic empowerment at the community level. The ability of the targeted communities' to address issues that face them and touch on their rights beyond HIV & AIDS has been built. A replication of this model in other communities that are marginalized and hard hit with HIV & AIDS with high poverty levels will lead to the long term sustainability of the affected communities.

The lives of people infected and affected by HIV & AIDS in the targeted areas have been positively changed through improved care and support at family and community level. PLHIV that were initially bedridden have become productive members of the community with increased self esteem and self confidence. The project has contributed to household nutrition and economic empowerment evident through income generating activities which have led to increase self reliance among group members. The project has led to opening up of

communities to positively accept and live with PLHIV. It also has contributed to community led responses to HIV & AIDS illustrated by the communities' understanding and exercising of their rights to local problems as witnessed in the case of Meru land issue and advocating for the rights of the girls child. The project has improved basic sanitation through WASH activities and enhanced care for the environment. However there is need for FPFK through the networks it is affiliated to, to influence policy at the National level that will sustainably impact on the well being of the affected and infected.

4.2 Lessons Learnt

1. The project has opened up marginalized communities to embrace PLHIV and empowered local communities respect the rights PLHIV;
2. The evaluation established that WASH activities, home visits, IGAs, peer counselling, and awareness creation & advocacy add value and should be replicated;
3. HCD, HRBA and Advocacy approaches are successful in community mobilization and capacity building at the local level;
4. HRBA has effectively contributed to increased awareness on and respect for the rights of women and girls in the targeted communities.

4.3 Recommendations

1. FPFK should fundraise for more resources to expand HCD, HRBA and Advocacy approaches in marginalized communities, specifically replicating activities that have added value in support groups such as SALT team visits, merry go round/table banking, income generating activities and environmental care. These approaches are effective in the holistic development of marginalized communities especially in developing capacities in taking a lead in harnessing local resources and advocating for their rights.

2. FPFK through existing networks such as the Evangelical Alliance of Kenya and ACT Kenya Forum should enhance efforts in advocating and lobbying the Government to keep on its international obligations on HIV&AIDS and advocate for policy change and implementation on HIV&AIDS at both National and County level.

3. FPFK should review its HIV&AIDS Policy to incorporate latest information and strategies that the Church has embraced with regards to influencing Policy at the

National and County level. The revised version should be widely distributed to the church membership and beyond and ensure its implementation.

4. In future FPFK projects, strategies should be put in place to ensure more men are encouraged to join and participate in community development initiatives while at the same time ensuring active participation of women.

5. In future FPFK should ensure that it has enough project staff commensurate to geographical area of coverage support to ensure support to community based initiatives.

6. FPFK should have only one PSC and establish the position of Head of Programmes in order to provide effective oversight, supervision and coordination of projects. Additionally FPFK should establish a monitoring and evaluation unit for close follow-up, quality and timely reporting and support.

7. Considering that HIV and AIDS is still a major challenge in Kenya, FPFK should consider identifying specific Counties with high prevalence rates for maximum impact in future projects. Specifically considering the fact that this was the first time that the HCD, HRBA and Advocacy approaches were being implemented it is recommended that areas which are highly marginalized, needy and characterised by retrogressive cultures that drive the prevalence rates for HIV and AIDS such as Loruko and deep Maasailand be incorporated in future interventions in order to build on the gains achieved in the last phase and for more impact to be achieved. In addition according to a report on 'The National HIV and Aids Estimates', by National AIDS Control Council and the National AIDS and STI Control Programme (2014) over 105,500 new HIV infections were reported in Kenya last year. The Survey showed that only five counties accounted for the new cases in the report, with Homa Bay having the highest rate of new infections with 12,940 people, followed by Kisumu 10,350, Siaya, Migori and Kisii each have 9,870, 6,790 and 4,890 respectively. The five counties also have the leading number of deaths linked to HIV illnesses. It is important that FPFK takes this scenario into perspective considering that some of these areas were part of FPFKs Phase One (2000-2004) HIV & AIDS Project.

ANNEXES

Appendix I: Picture Speak

Iltilal Support Group members doing clean up in line with promoting clean environment hygiene and sanitation

Project Staff (far end) putting gloves ready for clean up in the community

Goats bread by a Support Group

A pig reared by a Support Group

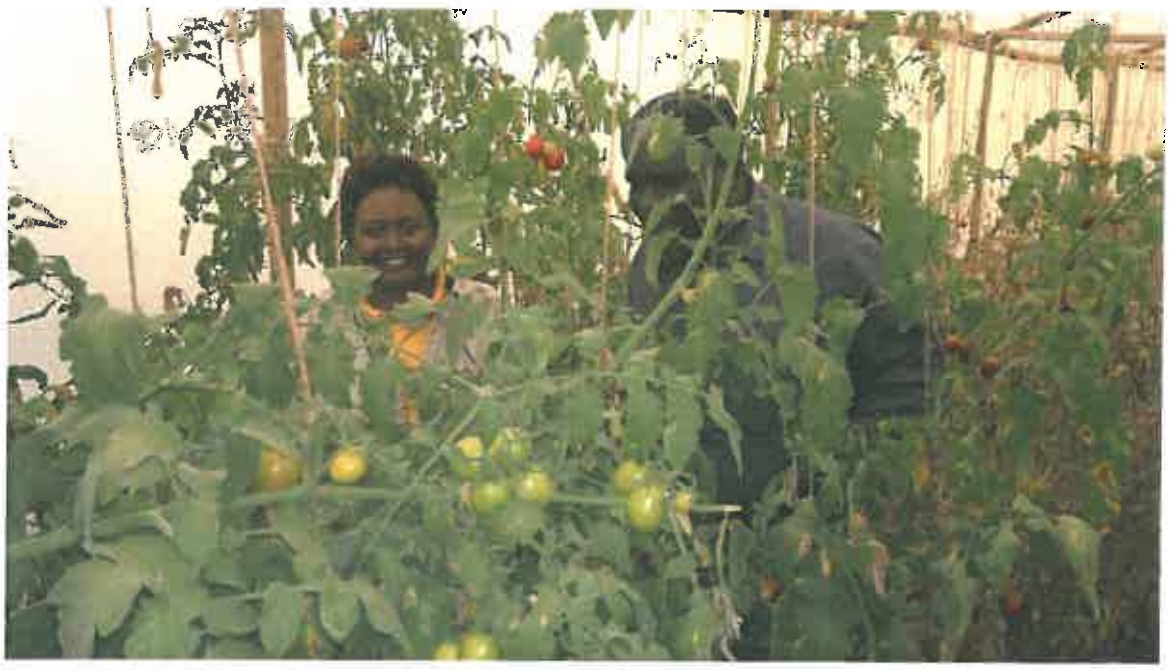
A homestead of one of the beneficiaries Loruko

An FGD Session in Naivasha moderated by Caroline Maneno, Evaluation Consultant

An interview with a local Pastor during the evaluation in Isiolo conducted by Chris Anuro, Research Assistant

A fish pond operated by a Support Group in Meru

During Evaluation with 'morans' in the 'manyatta'



Kimana Support Group green house

Appendix II: The Evaluation Schedule

The evaluation process will cover seven key steps for a total of 25working days, as indicated in the table below.

Main Activities	Sub-Activities	Work Days
1. Preparation	-Consensus-building meeting with FPFK staff/imbuement -Review project and policy literature -Develop data collection instruments and training materials -Develop data entry & management templates using SPSS -Produce instruments for training & for pretesting -Identify and recruit data entry clerks	7 Days
2. Training	-Train data collectors and data entry clerks	1Days
3. Data collection	-Coordinate data collection interviews by Data collectors, supervise & monitor performance; data quality control.	10 Days
4. Data processing and analysis	-Quantitative data coding, digitalisation, cleaning & transformation, where necessary. -Qualitative data transcription, verification, digitalization, analysis & interpretation	3Days
5. Report writing	-Interpret quantitative and qualitative data, and develop a coherent and factual report. -Submit first draft report and discuss findings with FPFK project team.	2 Days
6. Validation and dissemination	-Review the first draft to include comments, suggestions and positive critique. -Develop PowerPoint presentations. -Disseminate findings at the district, provincial and national levels	1 Day
7. Final review and editing	-Review the draft to incorporate workshop deliberations, edit the final draft and submit to FPFK	1 Day
TOTAL		**25 Days**

Appendix III: Focus Group Discussion Guidelines for Beneficiaries

(LOITOKTOK, ISIOLO, MERU, OLKALOU AND NAIVASHA REGION)

01 When did you start getting involved in the FPFK activities? Year

02 What do you do in activities organized by FPFK?

03 What role do you play in the project activities?

04 Does the community support these activities YES NO

05 If YES; Please state how:

07 How do you feel members of this community have responded to this intervention? Positively Negatively

08 What have been the strengths of this intervention from your perspectives?

09 In your own opinion what have been the weaknesses of this project?

10 What lessons have you learned from the project that FPFK can use in future projects?

11 What changes would you propose to FPFK on the project?

12 According to your own opinion have the needs of the community been addressed? YES NO

13 If YES; How?

If No what else could be done to meet them?

14 Do you/Community/Churches accept to live and share with People Living with HIV YES NO

Do people Living with HIV and AIDS have a right to; YES NO

i. Sex

ii. Share food with non infected people

iii. Mix with other members of the church

iv. Hold position in the group or churches

v. Mix freely and eat with children

THANK YOU!

Appendix IV: Data Collection Template for Pastors

KEY INFORMANT INTERVIEW GUIDE

TARGET PARTICIPANTS: *PASTORS*

	THE END TERM PROJECT EVALUATION OF HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014) **KEY INFORMANT INTERVIEW GUIDE I**	
1.0	**INTRODUCTION**	
1.1	DATE OF INTERVIEW	_____
1.2	VENUE	_____
1.3	FACILITATOR	_____
1.4	DESIGNATION	_____
2.0	**IMPLEMENTING FPFK HIV AND AIDS PROJECT**	
2.1	a) How long have you been in the FPFK HIV&AIDS Awareness and Preventive Project? _____ b) Would please estimate the number of your church members that have benefited from FPFK Project? _____ c) May you state the type of activities carried out by your church under FPFK HIV&AIDS Awareness and Preventive Project? _____	

2.2	Which methods have your church used to deliver project activities to members? PROBE FOR: Seminars, church services, special church meetings, church caucuses etc
2.3	How would you rate the adequacy of the project activities? What would you like done differently to improve project adequacy?

2.4	In your own opinion, what were the positive changes in your church members' lives, and behaviour of the youth and community members observed? PROBE FOR: the IMPACT and the BENEFITS of the project on the lives of church members in general, the youth in particular, and the community at large, etc.
2.5	What is your own opinion about the sustainability of the activities initiated through the church by the FPFK project?
2.6	What changes would you recommend to make the project function better within the church set up?
	THANK YOU!

Appendix V: Data Collection Template for Local Administrators

THE END TERM PROJECT EVALUATION OF HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014)

KEY INFORMANT INTERVIEW GUIDE

TARGET PARTICIPANTS: *LOCAL ADMINISTRATORS*

	THE END TERM PROJECT EVALUATION OF HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014) **KEY INFORMANT INTERVIEW GUIDE I**	
1.0	**INTRODUCTION**	
1.1	DATE OF INTERVIEW	_____
1.2	VENUE	_____
1.3	FACILITATOR	_____
1.4	DESIGNATION	_____
2.0	**IMPLEMENTING FPFK HIV AND AIDS PROJECT**	
2.1	a) How long have you partnered with FPFK in the HIV&AIDS Awareness and Preventive Project? _____ _____ _____ _____ _____ b) Would you please estimate the number of your community members that have benefited from FPFK Project? _____ _____ _____ _____ _____ c) May you state the type of activities your community members participate in under the FPFK HIV&AIDS Awareness and Preventive Project? _____	

2.2	Which methods have been used to deliver project activities to community members? PROBE FOR: Seminars, local community *barazas*, etc.
2.3	How would you rate the adequacy of the project activities? What would you like done differently to improve project adequacy?

2.4	In your opinion, what would you say were the positive changes in your community members in general, and the youth in particular? PROBE FOR: the IMPACT and the BENEFITS of the project on the lives of community members in general and the youth in particular, etc
2.5	What is your own opinion about the sustainability of the activities initiated through the church by the FPFK project?
2.6	What changes would you recommend to make the project function better within the church set up?
	THANK YOU!

Appendix VI: Data Collection Template for Local Facilitators

	QUESTIONS	RESPONSES				INSTRUCTIONS
1.0	**Introduction**					
1 1	Region	_____				
1 2	Name	_____				
1 3	Sex	◊ *Male* ◊ *Female*				
1 4	Start Date as LF (Year)					
1 5	Education level	◊ *Primary* ◊ *Secondary* ◊ *College* ◊ *University* ◊ *Others* *Specify*_____				
1 6	Contacts	Telephone_____ Fax_____ E-mail _____				
2.0	**Project Implementation and Overall Impact**					
2 1	How many years have you worked with FPFK as Local facilitator	>1 yrs	2-3 yrs	3-6 yrs	<7yrs	
2 2	As community facilitator how many beneficiaries have you reached	Planned outreach		Actual Reached		
2 3	Kindly list activities you do during the FPFK project outreach					*List in order of priority*
2 4	List the tools used in training communities and rate their effectiveness in achieving the desired results.	*Training tools*	*V effective*	*Effective*	*Ineffective*	*V ineffective*
2 5	State methods commonly used during outreach to the community members and rate their effectiveness in achieving the desired results.	*Training methods*	*V effective*	*Effective*	*Ineffective*	*V ineffective*

2 6	In line to 2.4 & 2.5 what would you like changed;					
	a) Tools used in the project					
	b) Methods of training applied in the project					
2 7	In your opinion, how did the HCD, HRBA and Advocacy approaches contribute to achievement of the project goal?					
2 8	State the observed changes in the behaviour and attitude of community members reached by the project.					
2 9	What other impact do you think this project contributed to (Whether in short or long run).					
2 10	What challenges did you experienced during the project implementation at the community level?					*Prioritise and select the most important*
2 11	How could the challenges identified in 2.10 above be addressed?					
2 12	List any five most important forms of support from the FPFK that helped you to carry out your work effectively.					
2 13	What kind of support would you recommend for FPFK to make Local Facilitators more effective?					
2 14	Identify any three critical capacity needs of community members that FPFK should consider.					
2 15	How would you rate effectiveness of feedback mechanisms between FPFK and the local facilitators?	*Feedback mechanisms*	*V. effective*	*Effective*	*Ineffective*	*V. ineffective*
2 16	a) In your own opinion do you think this activities initiated by FPFK are	Yes		No		

	sustainable			
	b) Why do you think so?			
	THANK YOU!			

Appendix VII: Data Collection Template: Referral Facilities

	QUESTIONS	RESPONSES				INSTRUCTIONS
1.0	**Introduction**					
1 1	Region					
1 2	Type of facility					
1 3	Address					
1 4	Mobile phone					
1 5	Contact person					
2.0	**Implementing FPFK HIV and AIDS Project**					
2 1	How long have you worked with FPFK HIV and AIDS Awareness and Preventive Project?	>1 Year	1-3 years	4-10 years	<10 years	
2 2	How many people have been referred to your facility by FPFK project team					
2 3	State the type of services offered to FPFK beneficiaries in your facility.					*List in order of importance*
2 4	Please state the number of;	Technical Staff	Administrative staff	Non technical staff	others	
2 5	a). How would you rate the adequacy of your facility?	*V. Adequate*	*Adequate*	*Inadequate*	*V. Inadequate*	
	c) If your answer to 2.5a) above is inadequate to Very inadequate what would you like done differently					
2 6	How has your facility contributed to;	a) Changes in the behaviour of Youth members of the church b) Changes among community members				
2 8	a) In your own opinion do you think activities initiated through your facility by FPFK project are sustainable	Yes		No		
	b) Why do you think so?					

29	What changes would you recommend to make the project function better within the church set up?		
	THANK YOU!		

Appendix VIII: Data Collection Template for *Project Staff*

	QUESTIONS	RESPONSES	INSTRUCTIONS
1.0	**Introduction**		
1 1	Field Office		
1 2	Name		
1 3	Sex	◊ *Male* ◊ *Female*	
1 4	Department		
1 5	Position		
1 6	Education level	◊ *Diploma* ◊ *Degree* ◊ *Masters* ◊ *Other professional training* Specify_____	
1 7	Contacts	Telephone_____ Fax_____ E-mail_____	
2.0	**Project Implementation and Overall Effectiveness and Efficiency**		
2 1	How many years have you worked in the FPFK project as a staff		
2 2	In your opinion, what is the goal of the project?		
2 3	a) List the project strategies or approaches that have been used in this project?		
	b) In your opinion how effective are	Approaches / V.E / E / IE / VIE	

	they?					
2 4	Please, provide the following data by gender in terms of programme outreach	*Supported groups*			*Males*	*Females*

2.5	Rate the capacity of the following in delivering the project goal.	*Position/title*	*V. good*	*Good*	*Poor*	*V. poor*
		Project staff				
		Finance Staff				
		PSC				
		Board				
2.6	Rate quality of the reports received	Quality of the report				
		Timeliness of the report				
		Depth of the report				
2.7	How are these reports kept at the Field office and National office?	◊ *Manual system* ◊ *Electronic system* ◊ *None*				
2.8	State any four forms of feedback mechanisms between the Field office and National office					*List in order of priority*
2.9	a) How regular is the reporting to the Headquarters on progress of the project?	◊ *Quarterly* ◊ *Biannually* ◊ *Once a year*				*Tick the most appropriate*
	b) To the donor?	◊ *Quarterly* ◊ *Biannually* ◊ *Once a year*				
2.10	In the past one year, how many times was you visited or been visited on project follow up?	◊ *1-2* ◊ *3-4* ◊ *5+*				

2.11	How would you rate the adequacy of the training provided to Regional staff and Head office staff in relation to challenges involved in their functions		*V. adequate*	*Adequate*	*Inadequate*	*V. inadequate*
		Staff				
		Head office Staff				

2.12	a) List any training materials if you have and rate their effectiveness	Training Materials	VE	E	IE	VIE
	a) Comment on the adequacy of the training materials?					

2.13	How effective are the staffs in performing their functions, in view of the project goal?		*V. effective*	*Effective*	*Ineffective*	*V. ineffective*

	Indicate number of beneficiaries per local facilitator?						
2.14	State the methods used to impart knowledge during training sessions. Rate how	*Training Methods used by Local Facilitator*	*VE*	*E*	*IE*	*VIE*	

	effective they are						

2.15	State the observed positive behaviour change among the beneficiaries.	
2.16	List some of the challenges encountered during project implementation.	*Prioritise and select the most important*

2.17	a) In your own opinion do you think this project is sustainable	Yes	No
	b) Why do you think so?		

c) What other measures do you think should be initiated to ensure sustainability of the project interventions at the local level?

THANK YOU!

Appendix IX: Data Collection Template for Board/PSC/GS

THE END TERM PROJECT EVALUATION OF HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014)

KEY INFORMANT INTERVIEW GUIDE

TARGET PARTICIPANTS: *NATIONAL BOARD AND PROJECT STEERING COMMITTEE*

Moderator's name_____
Signature_____

Name and title of the Informant (Optional)
_____

County_____
Town_____

Date of Interview_____ Starting time _____Stopping time_____

1) What is the role of the Board/ PSC/GS in the project?
2) How would you rate the effectiveness of the current administrative structure?
3) In your own opinion, how relevant is the project to the Vision and Mission of the organization?
4) May you state the type of activities carried out by your church under FPFKHIV&AIDS Awareness and Preventive Project?
5) May list all the policies that guide the implementation of the project
6) What is your assessment of the approaches used in reaching project desired goals?

   PROBE FOR: HCD, HRBA, Local Facilitators, Support Groups

7) How would you rate the effectiveness of the project goals?

   PROBE FOR: How the project has reduced Denial, Stigma, and Discrimination, as well as helped OVCs

8) How would you rate the project implementation processes?

   PROBE FOR: EFFECTIVENESS OF HIV and AIDS Policy Implementation, Reporting system to Board/PSC, Decision making process by Board/PSC, Sessions of the Board and or PSC

9) How would you rate the effectiveness of PR system of FPFK during the project implementation
10) What other PR activities would you like to effect both at the community and National

Level

11) What is your own opinion about the sustainability of the activities initiated through the church by the FPFK project?
12) May you state any four strengths of FPFK in implementing the programme

PROBE FOR: areas of weaknesses of FPFK in implementing the programme, opportunities that FPFK can seize to improve programme implementation, and threats to the successful implementation of the programme

13) What measures have or should FPFK put in place to ensure sustainability of the project interventions?
14) What changes would you recommend to make the project function better within the church set up?

THANK YOU!

Appendix X: Data Collection Template for Government Officials

THE END TERM PROJECT EVALUATION OF HIV&AIDS AWARENESS AND PREVENTIVE PROJECT (2010-2014)

KEY INFORMANT INTERVIEW GUIDE

TARGET PARTICIPANTS: *GOVERNMENT OFFICIALS*

Moderator's name_____
Signature_____

Name and title of the Informant (Optional)
_____

County_____
Town_____

Date of Interview_____ Starting time _____Stopping time_____

Guiding questions for interviews with Government line ministries officials.

These questions are used as guidelines for aiding KII interviews with government officials. Guiding questions will first be internalized by the interviewer and then applied in a flexible way depending on flow of the conversation.

Guiding questions for Discussions with Key Informants

[1] When did you start working with FPFK in the project?
[2] What activities are you involved in within FPFK HIV & ADIS Project?
[3] What methods have you used in undertaking these activities?
[4] How has FPFK program affected your work as government in terms of: Project Design, Planning, Implementation and Results) How can this be improved/what should be done to improve it?
[5] What would you say about FPFK program in relation to: efficiency, effectiveness, relevance, sustainability and impact?
[6] Have these activities influenced in any way the government policies and or procedures?
[7] What lessons have you learnt? Any emerging best practices that have occurred since you started engaging with FPFK on this programme?
[8] What are some of the challenges you do meet in working with FPFK?
[9] What recommendation(s) would you suggest for FPFK to improve in their program delivery for your ministry and community as a whole?

THANK YOU!

Appendix XI: List of Participants

MIKINDURI F.G.D.

NO.	NAME	GROUP
1	Benadicta Kirito	Mwiganda
2	Lydia Nkongai	King'oo
3	Julia Ncece	Kiriene
4	Delfina Kadogo	Kittiiri Mwiciuri
5	Stephen Kangukia	Kiriene Tuinuane Men
6	George Iguna	Kagaene Upendo
7	Joshua Kobia	Kiriene Murithi
8	Salome Kalaju	Ruuju
9	Isaiah Mpuria	Mkwambaja
10	Cecilia Kanini	Mukatia Marega

OL'KALAU F.G.D.

NO.	NAME	GROUP
1	Jane Irungu	Tumaini La Kuishi
2	Esther Wanjiku	Ebenezer Kirima
3	Hannah Wairimu	Rironi
4	Philis Njoki	Family Hope
5	Mercy Wachira	Ebenezer Kirima
6	Jane Muthoni	Ebenezer Kirima
7	Ruth Nyambura	Rurii
8	Gladys Muthoni	PORFAR
9	Bridget Wambui	PORFAR
10	Stephen Kagwe	Tumaini La Kuishi
11	Bernard Mwangi	Rurii

MOILO F.G.D.

NO.	NAME	GROUP
1	Elizabeth Isaiah	
2	Joyce Ole Maina	
3	Agnes Marko	
4	Leah Petro	
5	Rebecca Kadiko	
6	Matthews Supeet-Interpreter	
7	Agnes Tomai	

ILTILAL F.G.D.

NO.	NAME	GROUP
1	Neema Leina Kaunda	
2	Leah Mpatai	
3	Monica Kisioki	
4	Mary Samuel	
5	Pauline Musa	
6	Neema Moinani	
7	Lucy Petro	
8	Anne Musa	

ISIOLO COMBINED F.G.D.

NO.	NAME	GROUP
1	James Lomaniko	Lakira
2	Gabriel Lesoipa	Lakira
3	Patrick Ekai	Ong'an
4	Morris Lerantilei	Ong'an
5	Rose Ekai	Ong'an
6	josephine Mawaku	Ong'an
7	Josephine Lenaiber	Labarchereki
8	Indila Lesingiran	Labarchereki
9	Robbert Lekiondo	Labarchereki

KABATI/NKATHA COMBINED F.G.D.

NO.	NAME	GROUP
1	Rahab Wanjiku	Kabati HCD
2	Esther Kamau	Kabati HCD
3	Caroline Njeri	Kabati HCD
4	Lucy Wangari	Nkatha Support Group
5	Esther Wambui	Kabati HCD
6	Rahab Macharia	Nkatha Support Group
7	Mary Wayu	Nkatha Support Group
8	Hellen Muthegi	Nkatha Support Group

BOARD

NO.	NAME	POSITION
1	David Musumba	Member/Deputy General Secretary
2	Jonah Kitur	Member

PSC

NO.	NAME	POSITION
1	Pilipili Solanka	Chairperson, PSC
2	Moses Kosgey	Member
3	Rose Mutava Mwalili	Member/Treasurer

STAFF

NO.	NAME	POSITION
1	Walter Andhoga	General Secretary
2	Peter Thuku	Staff In Charge of OD Process
3	Nelly Koonyo	Team Leader-HIV & AIDS Awareness and Preventive Project (Mt. Kenya & Maasailand)
4	Margaret Githaiga	Field Staff, Mt. Kenya
5	Lavy Kefa	Field Staff, Mt Kenya
6	Alice Maiyani	Field Staff, Maasailand
7	John Saitoti	Field Staff, Maasailand
8	Paul Mwaniki	Accountant
9	Adam Theuri	Field Staff, /Driver
10	Karachi Matongo	Team Leader, Youth HIV & AIDS Project
11	Magdalene Kelel	Team Leader, Maasai HIV & AIDS Project

TEAM HIV AND AIDS PROJECT 2000-2004 and 2006-2009

NO.	NAME	POSITION
1	Guna Ostren	Project Initiator
2	Hanne Ostren	Project Initiator
3	Clement Otieno	Former Project Staff (Currently Centre Manager, Thesalonia, Muhoroni)