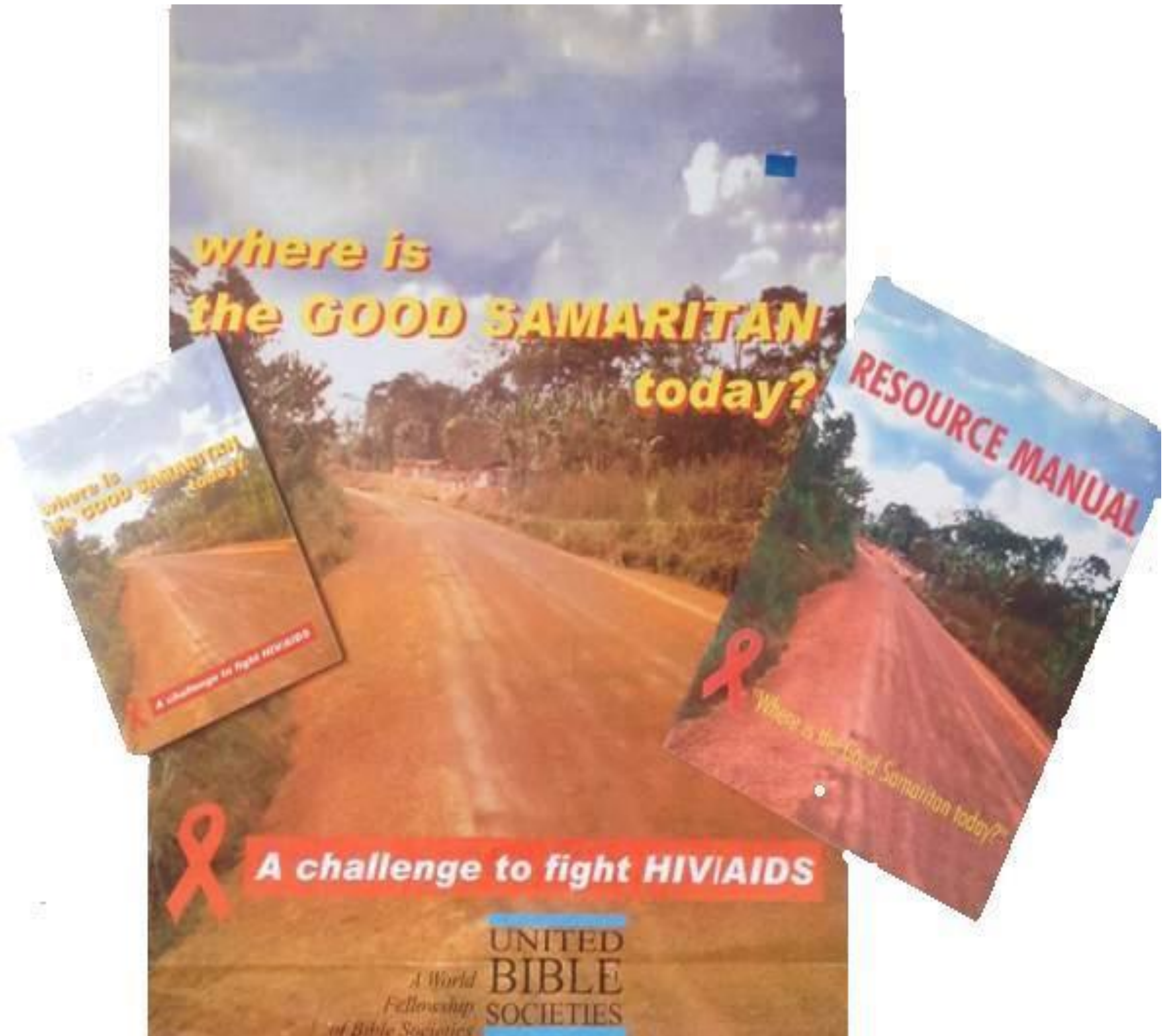
THE BIBLE SOCIETY OF KENYA

THE GOOD SAMARITAN PROGRAMME EVALUATION REPORT



PROF. ELISHIBA KIMANI

DR. PAULINE KAMAU

JULY 2015

ACKNOWLEDGEMENTS

The completion of this evaluation process was a result of contribution of many stakeholders and beneficiaries of the Bible Society of Kenya (BSK). The evaluation team particularly recognizes and applaud the invaluable support from the Bible Society Kenya Programme team, led by Mr. Thomas Tharao, Head of Operations, Pastor Anthony Gatonye and Joseph Irungu, the Programme Assitants. The team was particularly professional and forthright in the provision of guidance and feedback during the entire evaluation process. Pastor Anthony Gatonye is specially acknowledged for his diligence in coordinating the logistics as well as arranging for all stakeholders interviews, Focus Group Discussions and Decentralized Workshops for observations.

Also acknowledged in a special way is the United Bible Society office in Nairobi and Madam Viola Kirongo, HIV Service Coordinator for allowing Mr. Costa Juma, HIV Service M&E Officer to join the evaluation team in the field. Mr. Costa Juma provided very essential services as a translator of the local language to the evaluation team. The team also feels highly indebted to the programme beneficiaries, (volunteers, religious leaders, Decentralized Workshop participants, collaborating partners, PLWHAs and other programme beneficiaries) for their time, perseverance and openness in sharing the required information.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS 4
1.0 INTRODUCTION 5
2.0 FINDINGS 6
2.1 Programme Management: 6
2.2 Efficiency, Effectiveness and Impact of the Programme 6
2.3 Appropriateness of Programme Design and Strategies 6
2.4 Capacity Building and Training materials 6
2.5 Programme Sustainability 6
2.6 The challenges being experienced in programme implementation 7
2.7 Best Practices and Lessons learnt 7
3.0 RECOMMENDATIONS FOR PROJECT IMPROVEMENT 7
4.0 INTRODUCTION AND CONTEXT ANALYSIS 9
4.1 OBJECTIVES OF THE EVALUATION 9
4.2 SCOPE OF THE EVALUATION 10
4.3 EVALUATION METHODOLOGY 10
5.0 EVALUATION FINDINGS 10
5.1 The programme management, coordination and staffing 10
5.2 Efficiency, Effectiveness and Impact of the Programme 11
5.3 Appropriateness of Programme Design and Strategies 12
5.4 Capacity Building and Training materials Capacity Building: 12
5.6 Programme Sustainability 12
5.7 The challenges being experienced in programme implementation 13
5.8 Best Practices and Lessons learnt 14
6.0 RECOMMENDATIONS FOR PROJECT IMPROVEMENT 15
6.1 Coordination and Follow-up 15
6.2 Capacity building 16
6.3 Training materials 16
REFERENCES 17
ANNEX 1 18
EVALUATION TOOLS 18
Tool 1: Effectiveness and efficiency of the project 18
Tool 2: Interview guide for implementing partners (church leaders, NGO/Institutional Coordinators. 19
Tool 3: Interview guide for Volunteers. 21
Tool 4: Checklist for the observation of the DWs 24
Tool 5: Checklist for the observation of the Support Group IGAs 24

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BSK	Bible Society of Kenya
COVAW	Coalition on Violence against Women
DWs	Decentralized Workshops
FGD	Focus Group Discussion
GOK	Government of Kenya
GS	General Secretary
GSP	Good Samaritan Programme
IRC	International Rescue Committee
JICA	Japan International Cooperation Agency
NASCOP	Kenya NationalAIDs and STI Control Programme
NACC	National Aids Control Council
NoBS	Norwegian Bible Society
PLWHA	People Living with HIV
PMTC	Preventing Mother to Child Transmission of HIV
TOR	Terms of Reference
UBS	United Bible Society
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

1.0 INTRODUCTION

HIV remains a global concern, although HIV infections in Kenya have dropped from 3.1 million to 2 million, with AIDS related deaths coming down to 41%. Sub-Saharan Africa still carries the blunt of the pandemic. According to the UNAIDS report released during an International Conference on '*Financing for Development'* held in Addis Ababa, Ethiopia (July 2015), Inspite of Kenya being the fourth highest with new infections, it has reversed the spread due to among others, access to anti-retroviral therapy among adults with HIV aged 15 years and above. Access to ARVs in the country stands at 50 per cent in global context of nearly 15 million people on HIV treatment. The Good Samaritan Programme (GSP) is one of the interventions that the Bible Society of Kenya is using to reduce HIV infections, stigma and encouragement to HIV testing. BSK implements the programme with support from Norwegian Bible Society (NoBS) and United Bible Society (UBS). Part of the financial support for the project is channeled through Digni and originates from NORAD (the Norwegian Agency for Development Cooperation).

The programme objectives are to provide knowledge about HIV and avoidance of risky behavior, enhance uptake of VCT and openness on HIV status, eradicate stigma, advocate for the rights of PLWHA to restore their dignity and equality, as well to renew the churches social responsibility with a special focus to promoting unity and love among community and neighbourhood to care and support people infected and affected by HIV and AIDS. The evaluation focused on the GSP adult programme. The following areas in Nyanza region were selected for the evaluation, Homa Bay, Kisumu, Nyando and Katitu areas.

The evaluation process was guided by the following objectives:

- Assess programme management, coordination and staffing.
- Establish the efficiency, effectiveness and impact of the programme.
- Assess the appropriateness of programme design and strategies.
- Assess the effectiveness of trainings processes and use of materials.
- Identify the challenges being experienced in programme implementation.
- Assess the programme sustainability.
- Identify some lessons learnt and recommendations for future improvement.
- Identify the recommendations for
  - (a) Future implementation.
  - (b) Viability of the programme beyond the NoBS support.

The evaluation process involved a review of selected documents, among which were the project plan, internal reporting tools and field reports, project reports to the donor, training materials as well as GSP evaluation reports for other countries. Interviews involved selected programme staff and partners. Focus Group Discussions were also done PLWHAs and participants in Decentralized workshops. An Observation checklist was also utilized during the Decentralized workshops and income generating activities of support groups, mainly to corroborate some of the information generated during the interviews and FGDs.

2.0 FINDINGS

2.1 Programme Management:

The programme organization and implementation incorporates the identification and sensitization of church leaders, Training of Trainers for volunteers, organization of Decentralized workshops, homes follow-up visits. The project officer and assistant in Nairobi office are responsible for the management of the programme in Kenya, while the volunteers coordinate field activities in addition to receiving field reports for onward forwarding to Nairobi BSK office. Also incorporated within the programme implementation strategy are the County government officials, local NGOs and CBOs dealing with issues related to HIV and AIDs.

2.2 Efficiency, Effectiveness and Impact of the Programme

a) **Reduction of Stigma:**
   Many of the infected are able to openly reveal their status and are passionate about talking to others on how to prevent and reduce stigma of the infected and affected.

b) **Increased Knowledge of Disease Transmission and Treatment of HIV:**
   Discussions during the interviews, FGDs and observations in DWs revealed that there is increased knowledge of HIV and AIDS.

c) **Willingness to Undertake VCT:**
   In addition to an increased number of people going for VCT in local health centres, GSP, beneficiaries are tested at home, where such services are offered

d) **Behaviour Change:**
   PLHIV in support groups freely reported consistent use of condoms, while the public health officer reported an increased demand for condoms.

2.3 Appropriateness of Programme Design and Strategies

The use of the churches' leaders in mobilizing community support has worked well in gaining community support for the GSP. Other commendable strategies use of local home visits as well as networking with local leaders and health officers.

2.4 Capacity Building and Training materials

The duration of the TOTs was three (3) days, while that of DWs varied from time to time depending on the availability of the trainees and the volunteers. Volunteers relied more on the flipchart as it is user friendly and effective in an area where majority of the trainee are illiterate, while the videos were rarely used due to lack of equipment and electricity in most churches where the training are done.

2.5 Programme Sustainability

The use of the volunteers and churches leaders who enjoy trust from the local communities in itself guarantees programme sustainability in the long run. Equally commendable to this effect is the engagement of the PLHIV, existence of support groups, involvement of the affected and infected male and female and the introduction of income generating activities. Additionally the use of the churches as training venues is an added advantage.

2.6 The challenges being experienced in programme implementation

1) **High turnover of the Volunteers:**

The number of those active in the field was few due to high turnover. This was as a result of having to engage in daily means of livelihood and frequent movement from the rural areas to in search of employment.

2) **Training:**

The duration for the TOTs and DWs was inadequate to cover principles of GSP, training materials and training methodologies.

a) The training materials are not user friendly since most of the participants only speak the local language (Dholuo).
b) The volunteers did not seem to understand how to mainstream gender in the training process.

3) **Finances:**

a) Volunteers reported financial; constraint in photocopying, scanning and forwarding the reports to Nairobi.
b) The beneficiaries of the DWs during home visits experience financial constraints in terms transport, resulting with the majority of them being inactive.
c) There are delays in sending the payment for the resource people after DWs.

4) **Slow follow up visits and feed back:**

a) There was a slow and sometimes lack of follow up of the home visits by the volunteers.
b) It takes long for the volunteers to receive feedback of the reports that they send to the BSK coordinators in Nairobi.

5) **Training Materials:**

a) There was lack of enough material *(booklets and flip chats)* for those visiting the homes.
b) Non-use of the video (DVD due to lack of electricity and
c) The content in the resource manual was too complex for use by volunteers during the DWs.
d) Lack of appropriate materials to be left in the homes for reference and further dissemination of information on HIV and AIDS, after the visits.

2.7 Best Practices and Lessons learnt

- The inclusion of women and men in support groups and in DWs.
- Inclusion for the elderly people as both infected and affected.
- Inclusion of both HIV positive and negative male and female in support groups.

3.0 RECOMMENDATIONS FOR PROJECT IMPROVEMENT

Based on the evaluation findings, the following are recommended for the improvement of the GSP output:

a) There is need to strengthen the capacity and engagement of the volunteers to take full charge of local programme coordination at the regional level, while the follow-up from BSK office in Nairobi should be intensified.
b) The duration of the TOTs training should be lengthen to 4 or 5 days, while the DWS should cover several sessions, spread over three or four days so as to provide the adequate knowledge and skills for effective passing of HIV and AIDS messages.

c) The training should include a session on gender and human rights.
d) BSK country office should ensure volunteers have enough materials to supply to the trainees during home visits.
e) BSK country office should ensure that materials translated into the local language are adequate for use by the trainers.
f) Small sized and simplified leaflets replicated from the flip charts should be developed to be distributed during the home visits as well as other such as the meeting by local leaders and *Chiefs' Baraza*)
g) The resource manual and booklet should be revised and simplified for use in training.

4.0 INTRODUCTION AND CONTEXT ANALYSIS

HIV and AIDs remains a global concern. WHO report, (2013) observes that the epidemic continues to grow, as 5,700 people contract HIV everyday, nearly 240 every hour. According to the same report, AIDs related illnesses account for an estimated 2.1 million individuals worldwide. An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV, while about 9% of adults' deaths in the developing world are related to opportunistic infections as a result of AIDS. Within the developing world, Sub-Saharan Africa is more heavily affected by HIV and AIDs than any other region in the world, with prevalence rate of 5% among the adults.

According to a report released in Addis Ababa, Ethiopia, during an International Conference on Financing for Development (July 2015), in Kenya, the number of those living with HIV stand at 1.6 million people. Some 58,465 people died of HIV related illnesses in 2013.The national prevalence rate is at an average of 6%, among adults. While an estimated 191,840 of people living with the HIV virus are children in Kenya, 815,630 out of 1.6 million people living with HIV are women aged 15 years and above, accounting for 58 percent (GOK, 2014). The same report observes that Kenya is among 35 African Countries that have stopped or reversed their HIV epidemics by more than 20 per cent in the past 14 years. This is in spite of Kenya being fourth highest with new infections. The reverse has been due to, among others, access to anti-retroviral therapy among adults with HIV aged 15 years. ARV access in the country stands at 50 per cent in a global context of nearly 15 million people on HIV treatment.

Observing the same trend, Kenya AIDS Strategic Framework (2014/15-2018/19) reports that the HIV prevalence has dropped by 2 percentage in the last 5 years, while the new infections among children has dropped by almost half, within the same period. According to the Kenya Government Report (2014), five counties, namely Nairobi, Homa Bay, Siaya, Migori and Kisumu contribute over 50% of the new infection rates in the country. Out of these, approximately 44% of all adults living with HIV in the country are in the following 5 Counties: Nairobi (164,660); Homa Bay (140,600), Kisumu (118,500), Siaya (113,000) and Migori (77,700).

4.1 OBJECTIVES OF THE EVALUATION

The overall objective of the evaluation was to assess the Kenya programme performance and provide benchmarks for future improvement through evidence based information. Specific objectives were to:

i. Assess programme management, coordination and staffing.
ii. Establish the efficiency, effectiveness and impact of the programme.
iii. Assess the appropriateness of programme design and strategies.
iv. Assess the effectiveness of trainings processes and use of materials.
v. Identify the challenges being experienced in programme implementation.
vi. Assess the programme sustainability.
vii. Identify the recommendations for
    (a) Future implementation.
    (b) Viability of the programme beyond the NoBS support.

4.2 SCOPE OF THE EVALUATION

The evaluation concentrated on the GSP (adult program). The geographical area of the evaluation was Nyanza, which carries the biggest burden of HIV and AIDS in the country, with specific areas of focus being Homa Bay, Nyando and Katitu (Luo Nyanza).

4.3 EVALUATION METHODOLOGY

The methodology for the evaluation process combined the following approaches:

a) **Documentary Review:** The documents that were reviewed during the preliminary evaluation period were the project plan, internal reporting tools, field reports, project reports to the donor, training materials and GSP evaluation reports for other countries.
b) **Interviews:** These involved the programme staff at BSK offices, volunteers. Key informants interviewed were officers in the Ministry of Health personnel, involved in HIV programmes.
c) **Focus Group Discussions:** These were done with participants in Decentralized workshops. Care was taken to include infected and affected men and women, adults and the elderly.
d) **Observations:** These were done during the Decentralized workshops and income generating activities of support groups. The aim was to corroborate some of the information generated during the interviews and FGDs

5.0 EVALUATION FINDINGS

The presentation of the findings is based on the seven thematic areas which were informed by the evaluation objectives as provided for in the Terms of Reference (TOR) as follows:

5.1 The programme management, coordination and staffing

a) Management:

The overall contact person for the programme is the General Secretary (GS) of BSK, who works closely with the head of operations, project officer and the assistants. The programme organization and implementation is in the following levels:

i. identification of church leaders through their networks,
ii. sensitization of the leaders,
iii. Training of Trainers for volunteers who are identified by church leaders through the church,
iv. Decentralized workshops,
v. Home visits and follow-up visits by volunteers.

The project officer coordinator in Nairobi office is responsible for the management of the programme in Kenya.

c) Programme Coordination:

The volunteers coordinate field activities of other trainers, in addition to receiving the activities' reports, which they send to Nairobi office. On the other hand, the programme officer in Nairobi office is in charge of all programme activities and facilitates the project annual planning by the BSK staff.

d) Staffing:

The programme officer together with the two assistants plan the field activities, key among which is the training of trainers and follow-up visits, home visits are coordinated by the volunteers. The role of the volunteers play a critical role in

ensuring effective mobilization of the community to participate in DWs and subsequently disseminate the information to the community members through home visits, health centres as well as in the chiefs' meetings, commonly known in Kenya as the C*hief's barazas.* Also incorporated as partners within the programme implementation strategy are the local health officers operating in the health centres, local NGOs and CBOs dealing with issues related to HIV and AIDs.

5.2 Efficiency, Effectiveness and Impact of the Programme

On the whole it was noted that various categories of programme beneficiaries have successfully been reached including the affected and infected adults and the elderly. Both mainstream as well as evangelical churches have successfully been targeted as entry points in community mobilization. Evidently, the project has achieved its objectives. In particular the DWs and the home visits were effective in in reaching the community with HIV and AIDS messages. Other effective ways of passing HIV and AIDS messages being adopted by the volunteers were visit to health centres, local hospitals, and chiefs' meetings (Barazas).

In particular, the efficiency and effectiveness of the programme specific to the set objectives were as follows:

a) Reduction of Stigma

The programme has been effective in reducing stigma, especially in Nyando village, where the volunteers have managed to work together with the Luo Council of elders in reaching the community with HIV and AIDS messages. As a result, many of the infected are able to openly reveal their status and are passionate about talking to others on how to prevent and reduce stigma of the infected and affected. The success was affirmed by one participant in the FGD who stated that "I *was in denial…. but after meeting with the support group, I am now able talk about HIV and AIDS and people know my status. I am no longer afraid or feel stigmatized*". It is then not a wonder that the support groups comprise male and female affected and infected who work together as they freely share information and participate in group activities.

b) Increased Knowledge of Disease Transmission and Treatment of HIV

i. Observations in DWs revealed that there is increased knowledge of HIV and AIDs in terms of modes of transmission, prevention and management. This was also confirmed during the FGDs with programme beneficiaries in support groups.
ii. Further, the booklet ("*Where is the Good Samaritan today")* was found in some homes that were visited during evaluation.
iii. The community health officer interviewed reported an increased demand of condoms in the area.
iv. The PLHIVs in the support groups also reported having adequate knowledge of not only how to live positively, but also self care and protection from re-infection.

c) Willingness to Undertake VCT

i. The evaluation noted an increased number of people visiting VCT in local health centers, as reported by the health officers interviewed during DWs.
ii. Another remarkable outcome as a result of the GSP programme in the area is that people have accepted to be tested at home, where such services are being offered. This was found to be happening in the areas of Nyando and Katitu, where three volunteers informed the evaluation during the interviews that they have been participating in home testing.

d) Behaviour Change

The programme was found to have impacted on behavior change in that the PLHIV in support groups freely reported consistent use of condoms. Confirming the same, the Public health officer reported a consistent increase in the demand for condoms.

5.3 Appropriateness of Programme Design and Strategies

The use of the churches as an entry point to community mobilization has worked very well in the area where the population which is predominantly Christian in Evangelical and mainstream churches. To this effect the evaluation n noted the following:

i. The use of the Bible principle, "*Where is the Good Samaritan"* has a cultivated community trust and support for the programme.
ii. The recruitment of volunteers from among the churches leaders makes it easy for the community to accept the HIV and AIDS messages. For example, a couple in Nyando has been able to reach many people through DWs because they are volunteers and leaders in a local Church known as *"Christ Commission Missionaries).*
iii. Networking with local leaders and health officers has not only made it easy to win the trust and interest of the local communities, but has also added a lot of value in the programme achievements.
iv. The encouragement of home visits by the beneficiaries of DWS training has effectively mobilized the community to benefit from the programme outcomes.

5.4 Capacity Building and Training materials Capacity Building:

Two levels of training, namely the TOTs for volunteers and DWs have effectively been utilized in the areas visited during evaluation. However the duration of the training sessions for the TOTs was three (3) days, while that of DWs took a few hours of a morning or an afternoon and varied from time to time depending on the availability of the trainees and the volunteers. The reasons given were lack of resources to provide refreshments and lunch for the participants.

5.5 Training Materials:

While the booklet and the chart are supposed to be used simultaneously to complement each other, volunteers were relying more on the flip chart because it is user friendly and effective in an area where majority of the trainee are illiterate. The Videos were rated as useful with easy messages though not often used due to lack of equipment and electricity in most churches where the trainings are done. The volunteers used skits and dramas used during DWs, a strategy that effectively complemented the use GSP materials, since majority of the programme targets were illiterate.

5.6 Programme Sustainability

The evaluation process revealed that the programme sustainability is guaranteed for the following reasons:

i. The support that the "*Where is the Good Samaritan Programme*" is receiving from churches and local communities.
ii. The engagement of the PLHIV and the existence of support groups, which have identified income generating activities for their economic empowerment.
iii. The inclusion of the affected and infected male and female in the support groups and the fact that they freely work together and supporting each other.

iv. The venues used for the training are local structures, namely the churches and homes.
v. The network with government through the Ministry of Health, VCTs, and local organizations whose activities focus on issues of HIV, AIDS and human rights such as COVAW, JICA and IRC and Ministry of Health, especially VCT Centres, where testing is done.
vi. The volunteers as the core facilitators of the programme are knowledgeable and passionate about the programme and being from the local churches, they enjoy a lot trust from the local communities.

5.7 The challenges being experienced in programme implementation

Although the GSP was highly embraced by the members of the communities visited and that the volunteers and participants of DWs positively identified with its values and principles, the following were some of the challenges identified:

a) High turnover of the Volunteers:

Although the Assistant programme officer reported having trained many volunteers since the start of the programme in 2006, the number of those active in the field was few due to high turnover. Two reasons were given for the turnover, namely:

- Poverty which causes many trained volunteers to be less active as they engage in daily means of livelihood
- Frequent movement from the rural areas to towns (mainly Nairobi, Kisumu and Homa Bay) in search of employment.

b) Training:

Generally, the duration of the training for both TOTs and DWs was found to be inadequate to cover the intended programme course for the "*Where is the Good Samaritan Programme*" as stipulated in the Resource Manual, booklet and the flipchart. More specifically:

i. The evaluation established that the three (3) days for volunteers is not effective to cover the expected training methodology and the practice on how to effectively use training materials *(the Resource manual, flip charts, booklet and video).*
ii. The DWs which are usually carried out in an average of two hours either in the mornings or afternoons requires several training sessions so as to enable the participants to appreciate the values and principles of "*Where is the Good Samaritan Programme*", understand the messages in the training materials and also acquire basic skills on how to effectively use them during the home visits.
iii. The use of English language was a challenge since most of the participants only speak the local language (Dholuo).
iv. Delay by the head office in terms of the payments for the resource persons in the DWs (***PLHIV, Heath official and the volunteer trainer)*** at the BSK. The delay, sometimes by several months, does not only result in delaying the planned training activities but also negatively affect the relationship between the volunteers and resource persons.
v. Although men and women were well represented in the participation of DWs, the volunteers did not seem to understand how to mainstream gender in the training process and especially in the discussions on spread of infection, prevention and behavior change.

c) Finances:

i. Cost of sending reports to BSK poses a financial challenge to unemployed volunteers, as they are expected to photocopy, scan and forward them to Nairobi through email.
ii. The beneficiaries of the DWs during home visits experience financial constraints in terms transport, resulting with the majority of them being inactive.

d) Slow follow up visits and feed back

i. Although the follow up visits are important since they give morale to the support groups to continue with their work, there was a slow follow up of the home visits by the volunteers.
ii. It also takes long for the volunteers to receive feed back of the reports that they send to the BSK staff in Nairobi, a situation that slows the organization of DWs.

e) Training Materials

While there was a concern from all the volunteers on lack of enough material *(booklets and flip chats)* for those visiting the homes, the utilization of the videos was affected by lack of electricity and equipment in most of the venues used for trainings. Other challenges related to training materials were that:

i. The materials being in English pose a time constraint during the training since the information has to be translated into Dholuo as majority of the participants are illiterate.
ii. The content in the resource manual was too complex for use by volunteers during the DWs, with some of information being found to be no longer relevant to the current issues in HIV and AIDs.
iii. During the home visits, the trainers mainly use flip chart which and have no materials that can be left behind for reference and further dissemination of information on HIV and AIDS.

5.8 Best Practices and Lessons learnt

The evaluation team noted some best practices that can be replicated, elsewhere where BSK is implementing the GSP.

- The inclusion of almost equal number of women and men in support groups as well as in DWs.
- Inclusion for the elderly people as both infected and affected.
- Inclusion of both HIV positive and negative male and female in support groups. This was especially commendable as evidenced in the following *verbatim* of two cases, documented during FGD with support group members in Nyando, South Nyanza.

Story One

When I learnt about the "Good Samaritan Programme support group, I decided to join. My husband was uncomfortable when and he insisted that I leave the group since the community members would assume that I am HIV+. I had always tested negative, although my husband was HIV+. Because of being with the group, I have learnt a lot on HIV and AIDs, which helped me in supporting my husband, although he eventually died. Further, when my sister started exhibiting some symptoms of HIV infection, I knew what to do and what to tell her. I started to support her with the information I had received from the support group, advising her on the diet, taking her medication and she started eating well and gained weight. Am happy that many other people both HIV positive and negative have joined our support group. Together, we continue to help reducing stigma and supporting both the infected and affected in our community.

Story two

When I started getting sickly, I refused to visit the hospital to be tested for HIV, although I suspected that I could be HIV+. I was lying to my church members that I had been tested and that I did not have the virus. One day, I listened to a member of this support group and decided to go for VCT, where it was confirmed that I am HIV positive. With the counseling from the centre and the members of the support group, I eventually accepted my status and started living positively. I have benefited a lot from the activities of the support group. In particular, we all have an income generating activity of poultry keeping. We sell eggs, and make rice cakes from the left-overs of the crashed rice here in Nyando. In living positively. I take my medication as required and support others who are in the same situation of denial.

6.0 RECOMMENDATIONS FOR PROJECT IMPROVEMENT

Due to its entry point through the churches and use of local volunteers in community mobilization, the programme is widely accepted. However, considering the following recommendations, the programme could achieve more:

6.1 Coordination and Follow-up

a) There is need to strengthen the capacity of the volunteers to take full charge of local programme coordination. This needs to be formalized with specific Terms of Reference (ToR) soon after engagements of volunteers, after TOT. Further the commitment would further be guaranteed with an allocation of a small remuneration for transport and upkeep.

b) The importance of the follow-ups for home visits by volunteers should be emphasized during the TOTs. As part of participants' individual planning, they should indicate individual schedules for home visits, in the next 4 months.

c) The programme assistants should be facilitated to make regular coordination and follow-up visits in the field to ensure the adherence to the planned schedules. The coordination and follow-up could be improved with the engagement of a local coordinator specific to the region. This would improve the receiving of the required support for DWs training and feedback from BSK.
d) Disbursement of the required financial support for the DWs should be intensified so that volunteers are able to receive their requests for finance to pay the resource persons before the planned training.

6.2 Capacity building

The effective achievement of the "*Where is the Good Samaritan Programme*" can best be achieved with effective training of volunteers. As such:

a) The duration of the TOTs training should be lengthen to 4 or 5 days, so as to cover the entire package in the booklet, flip chart and videos and to allow the demonstration of the most appropriate training approaches.
b) There is need to consider ways of motivating the volunteers so that they are able to give more of their time to the GSP activities. One of the ways could be to give some financial allowances, partly to cater for their transport costs during homes visits, and costs of sending reports to BSK head office.
c) Given the importance of understanding of gender in the spread HIV, prevention and behavior change, the training programme for TOT should have a session on gender as well as human rights in relation to HIV and AIDS.

6.3 Training materials

The GSP training package was found to be adequate with the booklet, resource manual and a flipchart. However for effective utilization of the same materials, the following are recommended:

a) BSK country office should ensure that volunteers have enough materials for the trainees who are doing home visits, especially the flip chart which is commonly used.
b) BSK country office should ensure that materials translated into the local language are adequate to reach all volunteers other trainers and programme beneficiaries.
c) Small sized leaflets replicated from the flip charts should be developed to be distributed during the home visits as well as other forums being utilized to pass HIV messages, such as the *Chiefs' Barazas*).
d) The booklet and the resource manual should be revised and simplified for use by volunteers during the DWs. The two should also be repackaged so that it is more relevant to the current issues in HIV and AIDs and in the context of Christian values.

REFERENCES

Berbert Akampwera and Thomas Alveteg (February *2012). Evaluation of the Bible Society of Uganda Good Samaritan HIV/AIDS Program 2009-2011,* final report.

Bible Society of Malawi (November 2011*). Mid-term evaluation: Where is the Good Samaritan"*

Else Margrethe S. And Mauril Koudoha (October 2008). *Final report: End-of-project evaluation HIV/AIDS.* Bible Society Togo.

GOK (2014 a), *Kenya New HIV Estimates*, Ministry of Health Publication, Nairobi

GOK (2014 b), *Kenya Aids Strategic Framework 2014/2015 - 2018/19,* Ministry of Health, Nairobi.

GOK (2005),*AIDS in Kenya, Trends, Interventions and Impact.* Ministry of Health Publication, Nairobi.

Elishiba Kimani and Oleh Kam (February 2013). *The Good Samaritan (GSP) and Take Charge Youth Mid Term Evaluation in Côte d'Ivoire*. Bible Society of Côte d'Ivoire.

Norad (2008). *Organizational Performance Review 2008.* Norwegian Bible Society

Tilder Kumichii Ndichia and Herve KOkora Kouandé (January 2010). *Mid-term evaluation of the "Good Samaritan" Project.* Bible Society of Côte d'Ivoire.

Tilder kumichii Ndichia and Andrew Aliane Salaka (November 2011). *Mid-term evaluation report: Where is the Good Samaritan now?". Bible Society of Malawi.*

UBSCI (2009). *The UBS HIV and AIDS program position paper for Africa 2009,*

UNAIDS *World AIDS Day Report | 2013.* Geneva: Switzerland

UNAIDS Global Report 2012/ Geneva: Switzerland

ANNEX 1

EVALUATION TOOLS

I. Tool 1: Interview guide for programme staff in BSK office. Achievements of the project in terms of project management, efficiency and effectiveness and impact of the programme

1. Did you contribute to the identification of approaches used in the project? If yes, how and at what level?
2. What are the major changes on different activities of the project since the 1st mid-term evaluation?
3. What is the main objective of the project in the area of behavior change?
4. Is the project on track to achieving its objectives and results, especially willingness to undertake VCT and reduction of stigma?
5. Do you think that the project has given correct understanding of HIV and AIDs, of the risks and preventative measures and caring of PLWHA and OVCs?
6. From the activities, do you think the project helps beneficiaries to make good decisions and avoid risks? Explain.
7. From the activities, do you think PLWHA are treated equally with others under all circumstances at all levels of the society?
8. What are the short-term effects of the project, whether intended or unintended, and in relation to the overall goal of the project?

Tool 1: Effectiveness and efficiency of the project

1. How do PLWHIV perceive the programme and how have they been integrated into the programme?
2. Were the activities of the project undertaken in the context of the needs of the HIV and AIDs sector? Explain.
3. Was the project approach appropriate to address the identified problems and needs of the community and target beneficiaries?
4. Has the project been on track to achieving its overall objectives and results in identified areas of eradication of stigma, knowledge about AIDs and risky behaviour, (behaviour change)? Explain.
5. Were there capacity building measures taken in project implementation and support from GSP?
6. To what extent are the materials suitable for the intervention with regards to the target groups: information about HIV and AIDs, level of language, utilization of local language?
7. Can the cost of the intervention be justified by results? Explain.
8. To what extent is the budget suitable for the intervention with regards to the scope of activities planned?
9. Is there a networking strategy in place?
10. What are the main key networks that have been developed?
11. What role does each of these networks play?
12. What has been the impact of these networks in the project? Explain.

Impact and results of the project

1. Who keeps tracks of the project achievement?
2. How is monitoring done?
3. Have you developed monitoring tools?
4. Are the beneficiaries of the project involved in monitoring of the project?
5. To what extent does BSK project staff utilized tools developed to measure results and impact of the project?

Appropriateness of programme design and strategies, management, coordination and staffing.

1. What approaches are used in project implemention?
2. Did you contribute to the identification of approaches used in the project? If yes, how and what level?
3. How are the approaches used, fit in each strategy for the acquisition of knowledge? Change of behavior.
4. Was the project management approach appropriate to address the identified problems and needs of community members and target beneficiaries?
5. Were project staff well equipped to manage the project? If no, why?What was the involvement and capacity of volunteers and trainees in the programme?
6. Is the programme on track to achieve its objectives its overall objectives and results?

Challenges experienced in the project

1. Is there an operational plan and workplan?
2. Have all activities been implemented? If no, why?
3. What do you think of the implementation strategy of the project?
4. What are the challenges faced during implementation of the project?
5. Are the staff well equipped to manage the project? If no, why?
6. Has the project been implemented in a transparent manner? Explain.
7. Have there been major deviations from the original plans? Explain

Future Sustainability beyond by funding

1. To what extent are the issues of sustainability taken into account in planning and implementation of the project?
2. What sustainability measures have been taken into consideration when designing and implementing the project?
3. What are the strengths/weaknesses/threats and opportunities of the project?
4. Are there better alternative ways to implement the project to better meet the objectives? Explain.
5. What is the long-term viability of GSP beyond NoBS funding?

Tool 2: Interview guide for implementing partners (church leaders, NGO/Institutional Coordinators.

Achievements of the project in terms of project management, efficiency and effectiveness and impact of the programme

1. Did you contribute to the identification of approaches used in the project? If yes, how and at what level.
2. How are the approaches used fit in each strategy for the acquisition of knowledge?Change in behavior, reduction of stigma? Explain and give examples.
3. What do you think of the programme implementation strategy of the project?
4. What do you think of the coordination and implementation of the project?
5. What are the major challenges faced in the implementation of the project?
6. Do you think the project staff were well equipped to manage the project? Explain.
7. Are the project staff sufficient to implement the project? If no, why?
8. What do you think of the staff workload?
9. Was the project approach appropriate to address the identified problems and needs of the community and target beneficiaries?
10. What was the gender approach to the project?

Efficiency, effectiveness and impact of the project

1. What are the main objectives of the project?
2. Was the project approach appropriate to address the identified problems and needs of the community and target beneficiaries?
3. Has the project been on track to achieving its overall objectives and results in identified areas of eradication of stigma, knowledge about AIDs and risky behaviour, (behaviour change)? Explain.
4. Were there capacity building measures taken in project implementation and support from GSP?
5. To what extent are the materials suitable for the intervention with regards to the target groups: information about HIV and AIDs, level of language, utilization of local language?
6. Does stigma still exist in the community?
7. How does the project fight stigma?
8. How are the PLWHA integrated in the implementation of the project?
9. From the activities of the project, do you think stigma will be eradicated and human rights restored among the PLWHA?
10. Do you think the intervention has helped the churches, society and other partners to change attitudes of stigma and discrimination of people infected and affected by HIV and AIDs?
11. Were the appropriate actions in the context of needs of the HIV and AIDs sector? Explain.
12. Was the project appropriate to address the identified problems and needs of the community members and target beneficiaries?
13. Did the project design and structure adequately support and facilitate achievement of desired results?

14. To what extent are the materials suitable for the intervention with regards to the target groups: information about HIV and AIDs, level of language, utilization of local language?
15. Can the cost of the intervention be justified by results? Explain.
16. To what extent is the budget suitable for the intervention with regards to the scope of activities planned?
17. What are the short-term effects of the project, whether intended or unintended (negative or positive) and the relation to the overall goal of the project?

Impact and results of the project

1. Who keeps tracks of the project?
2. How is monitoring done?
3. Are the tools able to measure impact/results effectively? Explain.
4. Are the beneficiaries of the project involved in monitoring of the project?
5. To what extent have the local churches and other formal partners participated in the programme been strengthened as agents of change?
6. To what extent does BSK project staff utilized tools developed to measure results and impact of the project?

Future Sustainability beyond by funding

1. To what extent are the issues of sustainability taken into account in planning and implementation of the project?
2. What are the strengths/weaknesses/threats and opportunities of the project?
3. Are there better alternative ways to implement the project to better meet the objectives? Explain.
4. What is the long-term viability of GSP beyond NoBS funding?

Training and Capacity building

1. Have you received training from BSK (GSP)? If yes, what were the training contents and how many sessions have been organized?
2. Do you like the content of the training? What has impressed you most?
3. What methodology was used during the training sessions?
4. Did you like the training methodology?
5. What methodology was used to identify the participants for training?
6. What were the expected outcomes from the different training sessions? Explain.
7. Who were the target audiences?
8. Where were the training venues? How many participants attended the training (men and women)?
9. What materials have been distributed during the training? What is the effectiveness of these materials?
10. Do you use materials to raise awareness within the communities? If yes, how?
11. What challenges do you face in training?
12. What challenges do you face in raising awareness in the community?
13.

Tool 3: Interview guide for Volunteers.

Decentralized training

1. Have you received training from BSK (GSP)?
2. If yes, what were the training contents and how many sessions have been organized?
3. How many times have you been trained?
4. Do you like the content of the training? What has impressed you most?
5. What methodology was used during the training sessions?
6. Did you like the training methodology?
7. What methodology was used to identify the participants for training?
8. What were the expected outcomes from the different training sessions? Explain.
9. Who were the target audiences?
10. Where were the training venues?
11. What materials have been distributed during the training? What is the effectiveness of these materials?
12. Do you use materials to raise awareness within the communities? If yes, how?
13. What challenges do you face in training?
14. How many decentralized training have you done?
15. How many homes have you visited in the last year?
16. What training do you give them?
17. How do you use the GSP materials for home visits?
18. In your view, has behavior change, stigma, openness to VCT changed through home visits?
19. What challenges do you face in raising awareness in the community?
20. What suggestions would you like to make regarding the training and awareness raising in the community?
21. Have you been trained in gender?
22. Do you think gender responsiveness (sensitivity) is important in dealing with PLWHA?

Efficiency, effectiveness and impact of the project

1. In which GSP project activities have you participated?
2. Is the project on track to achieve its overall objectives and results, especially in the project aims? Explain.
3. Has the project promoted awareness and less stigmatisation among beneficiaries?
4. Do you think the project has given correct understanding of HIV and AIDs, of the risks and preventative measures to community?
5. From the activities, do you think that the project will help beneficiaries to make good decisions and avoid risks? Explain.
6. Does stigma exist in the community? Explain.
7. How doe the project fight against stigma?
8. Are the PLWHA integrated into the project?
9. Do you think that the intervention has helped churches and society to change attitudes of stigma and discrimination of the people infected and affected by HIV and AIDs?

10. To what extent are the materials suitable for the intervention with regards to the target groups: information about HIV and AIDs, level of language, utilization of local language?
1. What are the short-term effects of the project, whether intended or unintended (negative or positive) and the relation to the overall goal of the project?

Impact and results of the project

1. Who keeps tracks of the project?
2. How is monitoring done?
3. Are the beneficiaries of the project involved in monitoring of the project?
4. Do you write monitoring reports?
5. Have the local churches that have been involved in the programme strengthened as agents of change in the local community?

Future Sustainability beyond by funding

1. What are the strengths/weaknesses/threats and opportunities of the project? How can the strengths and opportunities be maximized and weaknesses and threats mitigated?
2. Are there better alternative ways to implement the project to better meet the objectives? Explain.
3. What is the long-term viability of GSP beyond NoBS funding?

Focus Group Discussion checklist for PLHIV and Support Group members

1. What do you think of the programme implementation strategy of the project?
2. What do you think of the coordination and implementation of the project?
3. What are the major challenges faced in the implementation of the project?
4. Were the actions undertaken in the context of needs of the HIV and AIDs sector? Explain.
1. Was the project management approach appropriate to address the identified problems and needs of community members and target beneficiaries?
5. Did the project design and structure adequately support and facilitate achievement of the desired results?
6. What is the progress against targets under the objectives in implementing the project according to the work plan?
7. To what extent are the materials suitable for the intervention with regards to the target groups: information about HIV and AIDs, level of language, utilization of local language?
8. What is the relationship between the number of trained people and depth of the training?
9. Can the cost of the intervention be justified by results? Explain.
10. To what extent is the budget suitable for the intervention with regards to the scope of activities planned?

11. What are the short-term effects of the project, whether intended or unintended (negative or positive) and the relation to the overall goal of the project?

Future Sustainability beyond by funding

1. To what extent are the issues of sustainability taken into account in planning and implementation of the project?
2. What are the strengths/weaknesses/threats and opportunities of the project?
3. Are there better alternative ways to implement the project to better meet the objectives? Explain.
4. What is the extent to which the positive (intended) effects of the project will still continue after external assistance has been concluded?
5. To what extent is the project integrated in the overall strategy and work of the BSK?
6. What is the long-term viability of GSP beyond NoBS funding?

Tool 4: Checklist for the observation of the DWs

1. Objectives of the training.
2. Target groups (Male and female).
3. Methods of training (discussions, plenary and group).
4. Use of GSP materials (booklet, films, charts etc.,)
5. Challenges.
6. Best practices.

Tool 5: Checklist for the observation of the Support Group IGAs

1. Nature/type of the activity
2. Objectives of the activity.
3. Target groups (Male and female).
4. Benefits (Observed and inferred)
5. Challenges.
6. Best practices.