



**ACE AFRICA**

**ORPHAN AND VULNERABLE CHILDREN PROGRAMME:**

**MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN AND  
PEOPLE LIVING WITH HIV/AIDS IN RURAL KENYA**

**EXTERNAL EVALUATION REPORT  
MARCH 2006**

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## ACRONYMS

|          |                                                         |
|----------|---------------------------------------------------------|
| ACE      | Action in the Community Environment                     |
| BOEW     | Bungoma Organization for the Empowerment of Women       |
| CBO      | Community Based Organization                            |
| CiC      | Children in Crisis                                      |
| CR       | Comic Relief                                            |
| CRC      | Child Rights Committees                                 |
| CSO      | Civil Society Organization                              |
| CtC      | Child to Child                                          |
| FBO      | Faith Based Organization                                |
| FGD      | Focus Group Discussion                                  |
| FHI      | Family Health International                             |
| HIV/AIDS | Human Immuno Virus /Acquired Immune Deficiency Syndrome |
| IGA      | Income Generating Activity                              |
| KANCO    | Kenya Aids NGO Consortium                               |
| KII      | Key Informant Interviews                                |
| M&E      | Monitoring and Evaluation                               |
| MoA      | Ministry of Agriculture                                 |
| MoE      | Ministry of Education                                   |
| MoH      | Ministry of Health                                      |
| NGO      | Non-Governmental Organization                           |
| OVC      | Orphans and Vulnerable Children                         |
| PLWA     | People Living With HIV/AID                              |
| RC       | Resource Centre                                         |
| SMART    | Specific Measurable Achievable Realistic and Time Bound |
| WHO      | World Health Organisation                               |

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## EXECUTIVE SUMMARY

### 1.1 Introducing ACE AFRICA

Action in the Community Environment (ACE AFRICA), a registered Non-Governmental Organization (NGO) in Kenya has been implementing a programme on mitigating the impact of HIV/AIDS on children and people affected and infected in rural areas of Bungoma District since September 2003. In July 2004, ACE AFRICA through the support of Children in Crisis (CiC) received a grant from Comic Relief (CR) to expand the mitigation programme of HIV/AIDS through the promotion of health education, food security, nutritional assistance, capacity building and support among the infected and affected in rural communities of Bungoma District, Western Province Kenya. Bungoma District was selected for this programme because it has a high prevalence of HIV/AIDS and over 50% of the population lives below the poverty line.

The programme targets Orphans and Vulnerable Children (OVC) as primary beneficiaries in its implementation. It has adopted a holistic approach towards community capacity building and support. The project activities have included establishment of community resource centres (RC) for HIV/AIDS information dissemination and community outreach, access and mobilization, training and capacity building in agriculture and nutrition, herbal remedies, Income Generating Activities (IGAs) and micro finance as well as child to child HIV/AIDS awareness and guidance in schools, child rights, counseling and Voluntary Counseling and Testing (VCT), and the provision of nutritional supplements and small scale provision of secondary school fees.

In its operations, ACE AFRICA works closely with the Ministries of Health, Agriculture and Education, local administration, NGOs, CBOs, project partners and community support groups to implement the programme in six project areas in the district namely Bukembe, Kabuchai, Mechimeru, Bulondo, Milo and Kabula.

**ACE MISSION:** "To reduce the impact of HIV/AIDS on rural communities in Africa through health promotion, food security and nutritional assistance, education opportunity, community capacity building and support among the infected and affected so that orphans and vulnerable children can develop to their full potential."

**ACE AIM:** 'To increase the capacity of rural communities in Western Kenya where there is a high prevalence of HIV/AIDS to improve the food security, nutrition, health and social and economic status of People Living With Aids (PLWA), OVC, Youth, Guardians & Community Carers.'

**BENEFICIARIES:** Orphans and Vulnerable Children (OVC), People Living with HIV/AIDS (PLWA), Guardians, Community Support Group members and youth

## 1.2 Introducing Bungoma, Project Components and Desired Outcomes

Bungoma District, Western Province currently has official HIV/AIDS prevalence rates of 7% (Bungoma 2004) and at the end of 2005 it was estimated that it has one of the highest incidences of Orphans and Vulnerable Children (OVC) in Kenya with official numbers standing at 23,476. The population of the rural areas of Bungoma district is approximately 1,184,523 (2006 population projections according to the Bungoma District's Development Plan 2002 to 2008) with an average household size of eight. 52% of this population lives below the poverty line and based on the official HIV prevalence rate approximately 61,320 is infected. UNICEF however, estimated that the numbers of orphans and vulnerable children in Bungoma District at the end of 2005 had risen to 45,435 and this is in line with their prediction that 11% of children living in Sub Saharan Africa are orphans due to HIV/AIDS.

ACE AFRICA has been implementing the project of mitigating the impacts of HIV/AIDS in the six project target areas. At the end of 2005, it was estimated that the official total population of these areas was 281,652 of which 58% are children under the age of 18 years. Operational research by ACE AFRICA (2005) and a separate study by the Constituency AIDS Control Council (CACC 2005) suggest that HIV/AIDS prevalence rates and incidences of orphans and vulnerable children in these areas are far worse than official national statistics portray. Findings indicate that the actual adult HIV prevalence rate (based on the number of adults showing the signs and symptoms of HIV/AIDS) is as high as 36% and the numbers of OVC is estimated to be over 8,600 in ACE AFRICA's six areas of operation alone. In keeping with UNICEF's national study, it was found that 11% of primary school going children were OVC and that this is likely to dramatically increase given the estimated number of people showing the signs and symptoms of full blown AIDS and the number of polygamous families in the areas. It is also worth noting that the predicted 11% in the ACE study does not include children in nursery or secondary schools, the 5% of children who are not in school at all and those children who are vulnerable but not yet orphaned. It is estimated that the numbers of OVC in the six areas of operation will increase to approximately 19,000 by the end of 2006.

ACE AFRICA adopted a componential approach in dealing with issues impacting negatively on those affected and infected by the HIV/AIDS virus, particularly OVC. The five project components include:

- Establishment of rural community support centres, providing information, education and referral for those infected and affected by HIV/AIDS
- Improvement of the skills and capacity of the community in nutrition, agriculture and the cultivation and use of herbal remedies in the context of the practical realities of HIV/AIDS
- Enhancement of the sustainability of community activities through training in income generation
- Establishment of child to child HIV/AIDS education/life skills/counseling facilities for OVC with a focus on HIV HIV/AIDS prevention and positive living
- Facilitation of the reduction of stigma and discrimination associated with HIV/AIDS by raising levels of awareness in the community

From the above project components, the expected project outcomes were:

- 6 Community Support Centres and demonstration kitchen gardens established
- 3000 community members using Community Support Centres per year
- 240 community members trained in nutrition/income generation/Micro finance/CtC per year
- 90 households with established kitchen gardens per year
- 60 new community members using herbal remedies per year
- 300 new children using Child to Child methods per year
- 6 Community Health Workers assigned to ACE activities
- 12 sub location committee meetings and quarterly meetings of the referral network per year
- Evaluating involvement of local NGOs, CBOs, and government departments
- 150 people per year referred via Community Support Centres to district and local services.
- Development and use of community databases
- 20 PLWA/ OVC at each site receiving nutritional support and counseling per month
- 600 community members and 1200 OVC attending community events and educational 'fun' days per year

### **1.3 The Need for External Evaluation and Terms of Reference**

Through the partnership between ACE AFRICA and CiC, ACE AFRICA received project funding from CR in July 2004 for a period of two years. This grant ends in June 2006 and ACE AFRICA intends to submit an application for continued funding in July 2006. ACE AFRICA through its already established but constantly evolving M&E system conducted an internal evaluation exercise in June 2005 to review year one of the project implementation in order to carry lessons learnt into the second year of programming.

According to the grant agreement between ACE AFRICA, CiC and CR and in keeping with ACE AFRICA's strategic plan, an external evaluation was planned, to among other things, assess the achievements realized, challenges encountered and the impacts the programme has created among the target groups. Concord Consultancy and Training Services was selected to carry out the assignment with the following agreed terms of reference:

1. To assess to what extent the grant has achieved the objectives set out to :
  - Test and further develop a methodology and approach to work with people affected by HIV/AIDS
  - Place ACE in a stronger position to attract future funding
2. To measure the impacts of the programme in terms of the following:
  - Improved overall health of OVC and PLWA
  - Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS
  - Improved community access to support services and networks
  - Reduction in stigma and discrimination associated with HIV/AIDS

3. To determine if the quantitative targets have been met
4. To consider the validity of the original project objectives and whether they meet the needs and priorities of the target groups
5. To consider if and how the project has adapted the original objectives to best meet the needs and priorities of the target groups
6. To analyze the achievements in relation to project primary data and assess whether there have been any unexpected outcomes as a result of the project
7. To assess systems of monitoring and evaluation including records of project activities and measurement of outcomes against project inputs. To assess how the project has worked with other relevant organizations and key stakeholders
8. To assess how the project has worked with other relevant organisations and key stakeholders
9. To assess the working relationship between ACE AFRICA and CiC
10. To review staff performance, work priorities and time commitments
11. To assess ACE AFRICA's development of best practice system of support
12. To assess the sustainability of project interventions
13. To assess the cost effectiveness of the programme based on its achievements and outcomes

In order to capture learning from the grant, the evaluation should answer:

- i) How food security and livelihoods opportunities of the beneficiaries were enhanced through this grant
- ii) How effective the approach has been in tackling opportunistic infections through the use of herbal remedies
- iii) How child to child activities promoted positive living among beneficiaries of this grant resulting in prevention of HIV/AIDS?
- iv) What are the key critical factors that contributed towards the success, or lack of it, in achieving the expected impact of this grant?

This report touches on specific findings about strengths, weaknesses, opportunities and threats in the implementation of the programme for the last two years since the start of Comic Relief funding. The report has along these issues captured detailed analysis of the implementation and impact of the program. We have analyzed both qualitative and quantitative data emerging from interviews with the community and project partners sampled for the exercise, ACE AFRICA staff and available literature materials sourced at ACE AFRICA secretariat.

The report is presented in an executive summary, purpose, methodology and tools employed for the survey, detailed analysis of evaluation findings, conclusions and recommendations.

## **1.4 Summary findings of the evaluation**

Some of the salient findings of the evaluation are as follows:

### **1.4.1 Programming Work**

Awareness level of the project among the community is very high especially among beneficiaries, and the communities in the six project areas ACE AFRICA is working. According to quantitative data derived from household information, majority of respondents interviewed (73.8%) expressed knowledge of the work being implemented by ACE AFRICA. A good number of partners such as GoK ministry officials, partner organizations like Luke's Fund, FHI and BOEW expressed awareness of project components under ACE AFRICA's HIV programme. This came out as ACE AFRICA engages these partners in facilitating activities like trainings along their lines of expertise and work engagements and programmes. For example, personnel from the Ministry of Agriculture, who in partnership with ACE staff, are mainly involved in activities relating to training beneficiaries in the agriculture and nutrition component.

Programmatic approach is appropriate for the desired outcomes. Establishment of RC, capacity building in agriculture and nutrition, herbal remedies, IGA, CtC and the reduction of stigma and discrimination which runs throughout all components have been well received in the target communities. In terms of effectiveness, capacity building the target groups through various approaches has worked well to ensure project sustainability. For the two years, the programme has been running, a total of six community resource centres have been established as had been planned in the grant agreement. The resource centres are managed by Community Activators and Gardeners. Under IGA a total of Kshs 322,335 has been loaned out to different project beneficiaries in the six project areas. Out of this a total of Kshs 87,298 has been recovered against the expected amount of Kshs 144,588, while outstanding loan is at Kshs. 267,122. This represents a repayment rate of 60.4%. The income generating activities are welcome to the community, however many key informants (KI) are not aware about its scope and reach. After internal evaluation findings at the end of year one, ACE AFRICA found it necessary to change strategy in the giving of loans due to the fact that repayments from individuals were low. In year two, ACE changed to provide groups with loans who had specific IGAs relating to nutrition. This strategy has ensured group responsibility in loan repayments and so far group loan repayments were 100% on schedule.

Adoption of skills and empowerment strategies imparted through capacity building trainings is above average as witnessed by the numbers of established kitchen gardens, support groups and the making of nutritional supplements by the beneficiaries. However, use of the resource centres is not at full capacity due to the fact that resource materials such as brochures, pamphlets and other IEC materials on HIV/AIDS are scarce and lacking.

A sample of the resource centres and demonstration kitchen gardens were visited. The locations of the kitchen demonstration gardens and their proximity to the resource centres depend on community donation of land. The evaluator did not visit all the gardens or centres. Some of the land where gardens are established are donated by the Ministry of Health (MOH) facilities, some by schools and some by individuals. This means that gardens are sometimes far from the centres.

The demonstration gardens came out strongly as having benefited the community in terms of skills adoption and transfer. They help the project beneficiaries who have been trained in agriculture to observe good agricultural practices at a small-scale level. They also provide OVC and PLWA with food.

While the use of resource centres and community activators is a good and effective strategy for community beneficiary outreach, it has both merits and demerits. The use of project community activators is welcome among the community and project beneficiaries however there is need to further their skills through capacity building organized by ACE AFRICA. Other interviewees feel though that the activators' objectivity in beneficiary selection, mobilization and targeting might be compromised as they are community members and have their biases towards certain individuals. The activators and gardeners are motivated to work although they feel that their allowances need to be revised.

Medical supplies are inadequate, unreliable and inconsistent due to shortages at the district level. The health centres, which are being used as delivery points, are facing a problem with patients who were benefiting from the supplies. One case reported has been out of supplies for the last six months. ACE AFRICA sources funds for basic medication independently from the CR grant.

The secondary school bursary programme for a few selected OVC is having a positive effect on the lives of those benefiting. ACE AFRICA currently supports 34 children on full four year bursaries. Some of the suggestions raised by the community includes streamlining cut off points for an OVC to get support when transiting to secondary after sitting for Kenya Certificate for Primary Education (KCPE) (350 marks). This is one of the project components that we feel the community recognizes as very beneficial. However, note should be taken that the medical supplies and school fees programmes are funded through donations from well wishers and sponsors and consequently are restricted. These activities have evolved during Comic Relief (CR) funding through project implementation and needs identification.

The agriculture and nutrition component is an area where the community has felt impact. It has enabled PLWA and OVC to achieve food security and nutritional knowledge as well as acting as a supplementary income source. Follow-ups in the field need to be fostered with a more focused strategy of ensuring adoption and sustainability. Expansion within the target groups also needs to be addressed.

CtC clubs in schools came out strongly as an avenue in the reduction of stigma among OVC and discrimination from other fellow pupils. Its peer education approach ensures integration of OVC in schools and the community. In school guidance and counseling sessions have helped children take control and ownership of their behaviour process. An issue that requires addressing is the sustainability of training teachers who are sometimes transferred to other schools, hence leaving a gap in knowledge. However, there have only been two incidences of this out of 105 trained teachers.

The issue of herbal remedies received different opinions from the community and KI who are health experts. ACE AFRICA uses local registered traditional herbalists through local and

district channels to train beneficiaries on herbal medicines that are locally available for the management of HIV/AIDS infections. The strategy has enabled a good number of beneficiaries adopt the practice by establishing herbal gardens and referrals to the herbalists. Also as part of the National Health Policy on use of Herbal Medicine, ACE AFRICA advocates in its trainings that patients choose to use herbal remedies either as an alternative or as a compliment to conventional medicine. However medics interviewed as key informants expressed concern that this might pose a challenge in determining the effectiveness of either mode of treatment. They feel that promoting herbal remedies is a good idea but it needs to be given to the PLWA as an alternative not as a compliment to artificial drugs. Other challenges attributed to herbal remedies include religion and fear expressed by some beneficiaries to associate with witchcraft.

Although not a micro finance institution, ACE AFRICA also implements activities under the IGA and micro finance components. Micro finance training is offered to individuals and groups who already have small businesses to help them run their businesses more efficiently to increase household income in order to support OVC. Through implementation, ACE has developed strong links with micro finance organizations that are better placed to give loans to micro finance trainees. These are Jamii Bora Trust, KWFT and K-Rep Bank among others. IGA trainees with business potential are given the same training as micro finance but in addition they are trained on business proposal writing, budgeting and record keeping. Businesses are identified according to local demand and trainees are assessed with an established assessment form prior to loans being given. Likewise their commitment to supporting OVC is measured.

Networking and collaboration have been fostered through partnerships with other organizations and institutions implementing HIV/AIDS programmes in Bungoma and national networks. ACE AFRICA has been engaging with these partners through participation and staff representation in periodic meetings and forums. Reports filed indicate that ACE AFRICA has been participating in monthly partner meetings with all FHI 'Impact' partners and some NGOs and CBOs involved in HIV/AIDS and OVC work in Bungoma district. In addition quarterly meetings have been held with; the Bungoma Area Advisory Council for OVC, the Divisional Stakeholders relating to Agriculture and Nutrition and the district planning meetings. ACE AFRICA has also been involved in quarterly networking meetings with government line ministries. Finally ACE AFRICA has attended quarterly meetings at the national level with the Kenya Aids NGOs Consortium (KANCO) and KECOFATUMA and other national NGOs.

Stigma and discrimination among the PLWA and OVC has gone down tremendously. This is mainly attributed to ACE activities as well as other partners in the district. Results indicate that this is manifested by the increased number of infected people disclosing their status in the community and the retention and acceptance of OVC in school. According to information generated from the household data, the majority of respondents felt that people infected with HIV/AIDS nowadays are more willing to declare their status publicly due to reduced stigma and discrimination. The health status of the majority of PLWA and OVC accessing ACE services and others has improved, marked by weight and appetite gain among other indicators including those formerly bed ridden getting back to productive activities.

The majority of household respondents who were interviewed further listed some of the reasons for these marked improvements as; affordability, availability and accessibility of ART/ARV (26.9%); increased HIV/AIDS awareness (15.6%); the availability of VCT and guidance and counseling services (14.4%); support services being provided by organizations like ACE AFRICA (4.7%); and increased numbers of support groups formed by PLWA and the community to fight HIV/AIDS (4.1%)

#### **1.4.2 Governance and Staff Performance**

There is a work planning process (monthly) in the organization. Findings indicate that 80% - 90% of work planned is completed within the timeframe.

Reporting systems are very well in place and this in our view enhances results captured through M&E. However M&E indicators with justifiable targets over a long period of time are missing. Targets in the grant document are not easily monitored as qualitative output; outcome and impact indicators are not developed against them in a formal matrix format.

Communication between staff members is favorable as well as with the project beneficiaries. Communication between ACE and local and national partners is favorable for structured networking through partnership and monthly and quarterly meetings and forums.

The working relationship between ACE AFRICA and CiC for the two years CR project is according to information gathered from ACE staff and especially the Executive Director friendly, cordial and non-antagonistic. There is a common understanding especially at ACE on contractual agreements between the two organizations and what is expected of each of them. ACE AFRICA has clear guidelines to staff on who is responsible for communicating with CiC on official issues that is, the Executive Director, the Programmes Director and/or the Finance and Administration manager. Financial applications are made by ACE to CiC in advance for every month's expenditure. The communication system between ACE and CiC is favorable considering distance, logistical issues and technicalities. However, a more interactive communication system needs to be put in place in future, especially for feedbacks on reports and other official correspondences.

Financial management systems are in place (manual and computerized accounting procedures i.e. quickbooks, petty cash accounting and voucher processing). CiC, ACE auditors, management board and the MANGO training coordinators who trained the staff members on financial management have approved these systems. Financial budgets are pre approved by CiC on a monthly basis for routine project activities and counter approved at the monthly management meetings. The board also approves any expenditure outside the pre-approved budget before cheques are signed. The board made the decision on signatories to CR project account after due consultation and review of the practicalities of the system. Geographical and financial restraints resulted in this process where the Executive Director and Programme Director sign the cheques. The Finance Director of CiC also and ACE external auditors provided advice on the issue of signatories. Finally and most importantly the ACE AFRICA financial accounts are audited externally every quarter.

However in future for purposes of engaging with other donors with different financial disbursement procedures aimed at creating autonomy and independence of the implementing organization, ACE needs to ensure that only one member of the management who has executive roles in running the organization becomes a signatory top such a project account. This is the common practice and will ensure trust by stakeholders as well as conventional cheque signing processes. None of the management board members apart from the Executive Director and Programmes Director are signatories to ACE bank accounts. This is a bit concerning based on the fact that these two have executive responsibilities in the running of the organization.

ACE needs to invest in transport means that will enable staff in charge of fieldwork to more effectively conduct community outreach during follow-ups.

### **1.4.3 Expected and achieved outputs**

In the two year CR grant, it was agreed that ACE AFRICA would achieve the following targets:

- 6 Community Support Centres and demonstration kitchen gardens established
- 3000 community members using Community Support Centres per year
- 240 community members trained in agriculture and nutrition/income generation/Micro finance/ child to child per year
- 90 households with established kitchen gardens per year
- 60 new community members using herbal remedies per year
- 300 new children using Child to Child methods per year
- 6 Community Health Workers assigned to ACE activities
- 12 sub location committee meetings and quarterly meetings of the referral network per year
- Evaluating involvement of local NGOs, CBOs, and government departments
- 150 people per year referred via Community Support Centres to district and local services.
- Development and use of community databases

The table below summarizes the above targets against the project outcomes after 20 months.

| <b>Indicator</b>                                                                                                            | <b>Comic Relief Target</b> | <b>Comic Relief Year 1 Actual<br/>July 04 – June 05</b>                                  | <b>Comic Relief Year 2 Actual<br/>July 05 – Feb 06</b>                                   | <b>Comic Relief Current Cumulative</b>                                                   | <b>All funds Cumulative<br/>Sept 03 – Feb 06</b>                                         |
|-----------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Community support centres established                                                                                       | 6                          | 6                                                                                        | 6                                                                                        | 6                                                                                        | 6                                                                                        |
| Community members using support centres                                                                                     | 3,000 per year             | 3,183                                                                                    | 5,750                                                                                    | 8,933                                                                                    | 10,881                                                                                   |
| Community members trained<br>- Agriculture & Nutrition<br>- IGA<br>- Micro Finance<br>- Child to Child<br>- Herbal Remedies | <b>240 per year</b>        | 130<br>62<br>65<br>106<br>60<br><b>Total 423</b>                                         | 118<br>65<br>54<br>54<br>61<br><b>Total 350</b>                                          | 248<br>127<br>119<br>160<br>121<br><b>Total 775</b>                                      | 578<br>131<br>119<br>169<br>241<br><b>Total 1,238</b>                                    |
| Households with established Kitchen Gardens                                                                                 | 90 per year                | 96                                                                                       | 82                                                                                       | 178                                                                                      | 400                                                                                      |
| New community members using Herbal Remedies                                                                                 | 60 per year                | 147                                                                                      | 245                                                                                      | 392                                                                                      | 578                                                                                      |
| New children using Child to Child methods                                                                                   | 300 per year               | 2,373                                                                                    | 2,848                                                                                    | 2,848                                                                                    | 2848(as of Feb 06 members recorded)                                                      |
| Community Health Workers assigned to ACE activities                                                                         | 3                          | 3(total of 6)                                                                            | 6                                                                                        | 6                                                                                        | 6                                                                                        |
| Sub location committee meetings & quarterly meetings of referral network                                                    | 12 per year                | 12                                                                                       | 42                                                                                       | 54                                                                                       | 95                                                                                       |
| People receiving support from local organisations each month                                                                | 1080 per year              | 349 OVC receiving monthly support from SG<br>543 members referred to local organisations | 590 OVC receiving monthly support from SG<br>387 members referred to local organisations | 590 OVC receiving monthly support from SG<br>930 members referred to local organisations | 590 OVC receiving monthly support from SG<br>974 members referred to local organisations |

| Indicator                                                                                                                                           | Comic Relief Target | Comic Relief Year 1 Actual July 04 – June 05 | Comic Relief Year 2 Actual July 05 – Feb 06 | Comic Relief Current Cumulative                                                           | All funds Cumulative Sept 03 – Feb 06 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------|
| OVC at each site receiving monthly support e.g. food from demo, group & individual gardens and supplements                                          | n/a                 |                                              | 978                                         | 978                                                                                       | as of now 978                         |
| PLWA/OVC who have received counselling each month                                                                                                   | 1440 per year       | 815 (619 PLWA,196 OVC)                       | 518 sessions held <sup>1</sup>              | 1,333 sessions<br>On average<br>27 PLWA<br>17 OVC<br>25 Guardians<br>counselled per month | 1,674 sessions held                   |
| Sensitised per year<br>Community members -Fun Day<br>OVC /other children -Fun Day<br>Community sensitised through<br>other sensitisation activities | 600<br>1200         | 1,211<br>2,173<br><b>Total 3,290</b>         | 675<br>1,499<br><b>Total 1,765</b>          | 1,886<br>3,672<br><b>Total 5,055</b>                                                      | 2,013<br>3989<br><b>Total 5,055</b>   |
| No community group gardens                                                                                                                          | n/a                 | 11                                           | 12                                          | 12                                                                                        | 12                                    |
| No. clients receiving VCT services                                                                                                                  | n/a                 | 194                                          | 315                                         | 509                                                                                       | 509                                   |
| No community members trained Child Rights                                                                                                           | n/a                 | 135                                          | 81                                          | 216 (six committees set up)                                                               | 216                                   |
| No children trained child rights                                                                                                                    | n/a                 | 968                                          | 2,297                                       | 3,265                                                                                     | 3,265                                 |
| No active support groups                                                                                                                            | n/a                 | 39                                           | 41                                          | 41                                                                                        | 41                                    |
| No individuals involved in community support groups                                                                                                 |                     |                                              | 800                                         | 800                                                                                       | 800                                   |

<sup>1</sup> Professional counseling sessions last one hour – ACE has employed an additional counselor ( not funded by CR) totaling two professional counselors, however daily time restraints means that it is not possible to conduct more professional counseling per week without employing another counselor.

## 1.5 Recommendations

The following is a summary of the recommendations proposed by the evaluators for consideration in future programming and implementation by ACE AFRICA in trying to further or scale up the project on mitigating the impacts of HIV/AIDS on the rural communities in Kenya.

1. Organizational structure – ACE AFRICA should focus on streamlining its organogram to create the right inter-linkage between organization's governance levels and programme components. The organization needs to critically look at its organogram to enhance effective communication, networking, work delegation, supervision and feedback mechanisms.
2. Staff capacity – ACE AFRICA needs to invest in staff capacity enhancement through refresher and advanced courses for staff members. ACE AFRICA should also explore more practical, effective means of enabling field officers to access and conduct fieldwork through improved transport mechanisms.
3. Programming –
  - The development of a long term programme logical framework whether it is a donor requirement or not to be shared with relevant partners especially staff, donors and programme reviewers.
  - The component of small scale provision of secondary schools seems to compliment the CR funded component of CtC and OVC guidance and counseling in schools and other support services provided to the OVC. In future ACE needs to seek donors to support this in addition to the current individual sponsors.
  - The component of Micro Finance and training in IGA and provision of IGA loans. The assessment of individuals with potential to run IGA and repay loans has not been successful and not yielded a 100% success as some individual loans are still being written off. This was rightfully identified after the first year of operation and the IGA loans are now and should only go to organized groups.
  - There is need is to intensify and expand training of community beneficiaries to establish and maintain kitchen gardens. This component is very sustainable however more on-farm training and follow up should be adopted to ensure maximum impact.
  - ACE AFRICA needs to explore possibilities of diversifying its programme components. ACE AFRICA needs to focus on creation of awareness, and management of STDs for sex workers in Bukembe and Kanduyi areas among others.
  - ACE AFRICA needs to intensify programming to reach more beneficiaries. We propose that ACE AFRICA and partners implementing HIV/AIDS programmes in Bungoma should utilize the existing collaborative and networking efforts like stakeholder forums to conduct a proper geographical area mapping of the locations (project areas) to cover the whole district rather concentrate in a few areas while ignoring others. This will solve the problem of duplicity and ensure streamlined stakeholder targeting that encompasses all areas. For instance, World Vision began its activities in Bungoma in the same project areas where ACE AFRICA had established operations. In response ACE AFRICA shifted its areas of operation in Milo project area so as to avoid duplication. Some project areas like Kabula are still being shared by the two organizations but providing different services.

4. Strategic planning – In our assessment we also learned that ACE implements more than one programme with overlapping interventions aimed at mitigating the impacts of HIV/AIDS in Bungoma. Earlier in our recommendations we had alluded to the fact that the CR funded programme need to be reviewed in future in terms of putting in place a logical framework to help in monitoring and evaluating progress and results. ACE AFRICA has expressed the intention to continue sourcing for additional funds for scale-up and intensification in activities, we propose that all these should be harmonized in a strategic plan. ACE AFRICA should explore as a matter of priority the development of a strategic plan that will highlight SWOT issues and future programming directions.

## PART ONE: BACKGROUND INFORMATION

### 1.0 Introduction

HIV/AIDS is the most serious of Africa's many public health problems, as it differs from other traditional public health challenges. The epidemic continues to expand affecting both adults and children, resulting in unique social and economic consequences. World wide, it is estimated that about 22 million people have died of AIDS; 3.8 million of them being children. 36 million are currently infected with HIV and out of these approximately 70% live in sub-Saharan Africa. UNAIDS/WHO estimates show that in 1999 alone, 5.3 million were newly infected with HIV. Earlier estimates had projected that the number of children under the age of 15, who will have lost one or both parents from all causes, including AIDS, in a sample of 34 severely affected countries, would be 40.3 million by the year 2005 and 44.2 million by 2010.

As the HIV epidemic continues to ravage sub-Saharan Africa, more challenges start emerging, which have significant effects on child survival, growth and development. The number of orphans and children infected with HIV increases as a parallel epidemic to that of HIV infection on the adult population.

Kenya is one of the African countries with the highest prevalence of AIDS and incidence of HIV infection. According to the National AIDS Control Council and the Ministry of Health (AIDS in Kenya, 2001) there are about 2.2 million Kenyans living with HIV infection. To date the estimated number of those who have died of AIDS is over 1.5 million. An estimated 180,000 died in the year 2000 and another 300,000 became infected with HIV in the year 2000.

One of the worst consequences of AIDS deaths is an increase in the number of orphans. An orphan, as defined by UNICEF and UNAIDS, is a child under the age of 15 years who has lost the mother due to AIDS. However this definition of orphan does not include those children who have lost their fathers due to HIV/AIDS. Monk notes that, "by excluding children who have only lost their father, young people between the ages of 15-18 and non-orphaned children living in households that foster orphans, the UNAIDS definition fails to recognize many of the children rendered vulnerable by the pandemic and that in reality the figures of HIV orphans should be multiplied by four". It is also worth considering that given the nature of the disease and the number of children caring for sick orphans that the children are in effect orphans before losing a parent. With this definition, the number of AIDS orphans has probably reached over 1.1m.

HIV/AIDS has had a profound impact on Kenya and other African countries. The African extended family system that could have absorbed children orphaned by AIDS is unable to do so due to the rising levels of poverty. Poverty has eroded the capacity of Kenyan families to take up additional children and responsibilities. Prior to the AIDS epidemic, approximately 6% of the children under the age of 15 years in East Africa were orphans. The extended family members cared for these orphans, and when the need arose, community members came together to assist. However, the explosive spread of AIDS over the past 2 decades has contributed to a doubling in number of orphans.

## 1.1 The Kenyan context

The current Kenyan Population size is estimated to be over 32 million people. Of these, the children's population is about 44% of the entire population. Over 50% of the population is less than 16 years old. The numbers of 15-49 years that are HIV positive is about 2.2 Million. 150,000 children between 0-14 years are HIV positive.

Of an estimated 15 million Kenyan children, approximately 1,800,000 are orphans, a third of who are under five years old. 650,000 have lost both their parents to AIDS (UNAIDS, UNICEF and USAID: *Children on the Brink*, 2004). The number of orphans and other children made vulnerable by HIV/AIDS (OVC) is projected to grow to 2.5 million by 2010. 500,000 of these children will have lost both parents, mostly due to HIV/AIDS (UNAIDS, UNICEF and USAID: *Children on the Brink*, 2004). To date, OVC have been primarily absorbed into the extended family system, but this social safety mechanism is now under threat due to the twin menaces of economic stagnation and the HIV/AIDS epidemic.

Given that 56% of the Kenyan population lives below the poverty line, most families who are prepared to take in OVC are themselves barely able to afford food, shelter and basic services including education and healthcare. Their willingness to accept additional children into their family is typically determined by their ability to feed and clothe them, and to provide them with care and shelter, even while they struggle to care for their own offspring. Preliminary evidence from elsewhere in the region suggests that providing small cash grants to families prepared to take in children might dramatically reduce the number of children living in 'child-headed households', through encouraging relatives or other community members to take responsibility in providing care. Such care is crucial to avoiding OVC falling into a vicious cycle, whereby they have no choice but to live and work on the streets or engage in risky behavior in order to survive.

The following are just a few of the problems children affected by AIDS and their families may experience:

**Psychological distress:** The stress of losing a parent and sometimes being separated from brothers and sister can reduce the ability to cope. The orphaned child may lose hope in his/her future.

**Anxiety about safety:** Children living in families affected by HIV/AIDS worry about the future. This elevated degree of anxiety may trigger behavior problems such as aggression or emotional withdrawal.

**Lack of parental nurturing:** Denial, fear and stigma compound the stress within families dealing with AIDS. Parents may not be able to deal with their children's physical and emotional needs. Children may be unable to express their mixed feelings of grief, anger and fear.

**Problems with basic needs:** Children affected by HIV/AIDS may experience food insecurity, shortage of clothing and inability to pay for medical care. Their caregivers will need additional income.

**Problems with inheritance:** Orphans may lose their parent's property to "grabbing" by extended relatives or other people.

**Problems with safety and child protection:** Households affected by HIV/AIDS are depleted of economic resources, and the child may need to generate cash. Working for a wage exposes a child to economic and sexual risks. Girls orphaned by AIDS may be married at an early age to relieve their families of financial burden.

**Less education:** The chance of children affected by HIV/AIDS going to school is reduced, and those who go spend less time in school. This is attributed to the lack of money to pay school fees, and time spent taking care of sick parents and younger siblings.

**Stigma and Discrimination:** Fear of people living with HIV and AIDS is widespread, and communities react by isolating and discriminating against PLWA and their children. Fear is a powerful deterrent to people seeking voluntary counseling and testing (VCT) and disclosing HIV+ status to family members and friends. Parents often fear informing their children of being HIV+ which tends to increase children's anxiety and fear of not knowing what is happening to their parents and how to cope.

## 1.2 Government and Other Stakeholder Initiatives

In recognition of the above issues, the Government of Kenya has developed a policy for OVC, a key aspect of which is the provision of a direct cash subsidy to families caring for OVC. To this end the government allocated Ksh.48Million for financial year 05/06 towards assisting orphans and vulnerable children (OVC) in the country. The amount was to scale up the Conditional Cash Transfer (CCT) programme, through which the government financially supports the OVC. The CCT approach is a rights-based social safety net, that is designed to help the OVC and their households cope with chronic poverty.

Currently, OVC receive Kshs 1,000 per child every month, through the programme that is undertaken by the government in conjunction with NGOs and other development partners. However, it is conditional that the beneficiary must be immunized, attends school and acquires a birth registration certificate. Other stakeholders to inform this policy include UNICEF, DFID among others. The rationale for this undertaking is to provide evidence on whether a 'safety' net system is feasible and sustainable. This pilot project is modeled on similar existing systems in South Africa, Zambia and Tanzania.

## 1.3 Emerging Trends

Research in developing countries on the socio-economic impacts of HIV/AIDS on households has shown the main impacts to be social, psychological and economic (UNAIDS 1999). Whilst there has been increased attention given to the social economic dimensions of AIDS on children there has been little research into the psychological impact of the epidemic. However research shows that psychological impact can manifest itself in a number of ways and children orphaned by HIV show an increase in stress and trauma, feel hopeless or angry and are more prone to depression (Foster/William 2000).

Whilst it is important to address the specific psychological needs of AIDS OVC it is important that they are assessed in relation to all aspects of a child's life. This too must be considered within the normalcy range of childhood in a particular socio-economic and geographical context.

HIV affected children have the same needs, as other children – nutrition, exercise, education, love, and affection. Beyond these, affected and infected children whether orphaned or not may have special needs such as counseling, medical treatment, vocational training and encouragement of self-reliance. A child's development is dependent on all of these needs and each must be adequately addressed (Kumar/Pani 2002).

Psychological needs differ according to social and cultural beliefs and contexts. It is therefore necessary to assess specific community perceptions, as the needs of children orphaned are made vulnerable by the disease. In order to understand the circumstances of communities existing coping mechanisms must be assessed so as to extend programmes and utilize existing support mechanisms through increased communication. The circumstances of AIDS OVC need to be addressed in a culturally sympathetic and realistic manner in order to make programmes sustainable. Thus the importance for the strengthening of Home Based Care programmes and improved collaboration amongst health care providers' communities and families through better training mobilization and sensitization to guarantee that the human rights of all Kenyans are respected is paramount.

A workshop in Zimbabwe involving partners from East and Southern African countries aimed to assess the proliferation and effectiveness of OVC community based initiatives concluded that whilst the community responses to the needs of the OVC were proliferating there were no networks to assist in their development. The organic and informal activities of community members were considered vital in strengthening their capacity to cope. It was however recommended that stakeholders must be aware of their respective niche roles, act appropriately and work together to support community mechanisms. Policy/resource organizations should make greater commitments to the development of supportive OVC policy and commit more funding through intermediaries.

#### **1.4 HIV AIDS Trends in Bungoma District**

Bungoma District, Western Province currently has official HIV/AIDS prevalence rates of 7% (Bungoma 2004<sup>2</sup>) and at the end of 2005 it was estimated that it has one of the highest incidences of Orphans and Vulnerable Children (OVC) in Kenya with official numbers standing at 23,476<sup>3</sup>. The adult population of the rural areas of Bungoma district is approximately 876,000 with an average household size of eight. 52% of this population lives below the poverty line and based on the official HIV prevalence rate approximately 61,320 is infected. UNICEF<sup>4</sup> however, estimated that the numbers of orphans and vulnerable children in Bungoma District at the end of 2005 had risen to 45,435 and this is more in line with their prediction that 11% of children living in Sub Saharan Africa are orphans due to HIV/AIDS.

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<sup>2</sup> Government of Kenya official prevalence for Bungoma District based on Annual report for Health Education Department 2004

<sup>3</sup> Government of Kenya National AIDS Control Council (2005) Provincial estimates of OVC

<sup>4</sup> UNICEF projections based on National consensus of 1999, Children on the Brink and Spectrum (2005)

ACE AFRICA has been implementing a project of mitigating the impacts of HIV/AIDS on PLWA and OVC in the six (out of a total of forty two areas in the district) project areas<sup>5</sup> within the district namely: Bukembe, Bulondo, Kabuchai, Kabula, Mechimeru and Milo. At the end of 2005, it was estimated through a mapping survey conducted by ACE AFRICA that the official total population of these areas was 264,000<sup>6</sup>, of which 58% are children under the age of 18 years. This operational research by ACE AFRICA 2005<sup>7</sup> and a separate study by the Constituency AIDS Control Council suggest that HIV/AIDS prevalence rates and incidences of orphans and vulnerable children in these areas are far worse than official national statistics portray. Findings indicate that the actual adult HIV prevalence rate (based on the number of adults showing the signs and symptoms of HIV/AIDS) is as high as 36%<sup>8</sup> and the numbers of OVC is estimated to be over 8,600 in these six areas of operation alone. In keeping with UNICEF's national study, it was found that 11% of primary school going children were OVC and that this is likely to dramatically increase ( if not double by the end of 2006) given the estimated number of people showing the signs and symptoms of full blown AIDS and the number of polygamous families in the areas. It is also worth noting that the predicted 11% in the ACE study, does not include children in nursery or secondary schools, the 5% of children who are not in school at all and those children who are vulnerable but not yet orphaned. The chief's projections of 15% include these variables and they predict that it is likely that there could be as many as 19,000 OVC in these six areas of operation by the end of 2006.

It is against this backdrop that ACE AFRICA has been implementing an Orphan and Vulnerable Children programme in Bungoma, Western Kenya since September 2003. The choice of Bungoma was informed by the fact that it has one of the highest HIV/AIDS prevalence rates in the country and consequently a high incidence of OVC. ACE AFRICA's programme is a holistic approach to mitigating the impact of HIV/AIDS on rural communities where poverty is rife. ACE's main focus is to improve the lives of children infected/affected by HIV/AIDS and works through community structures, guardians, resource persons, local NGOs and government agencies to implement this programme.

ACE AFRICA working in partnership with Children in Crisis has received funds from trusts, schools and individuals in the UK as well as donor organizations in Kenya. In July 2004 ACE in partnership with CiC received a grant from Comic Relief, which led to doubling in the annual budget and an enormous increase in activities and reach. An internal evaluation of the programme took place in May/June 2005, which informed the design and delivery of Year 2 project activities. Findings were to inform programme planning and feed into future donor applications. The overall objective of this external evaluation is to establish what has been achieved during the Comic Relief Grant July 2004 – February 2006.

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<sup>5</sup> One project area may cover one or more locations

<sup>6</sup> Bungoma District Development Plan 2002 - 2008

<sup>7</sup> ACE AFRICA Mapping survey Bungoma Western Kenya (2005)

<sup>8</sup> Based on study records and responses from chiefs, assistant chiefs, nurses, elders and teachers

## PART TWO: EVALUATION PURPOSE, METHODOLOGY AND TOOLS

### 2.1 Purpose of the Evaluation

The specific objectives of the external evaluation were:

1. To assess to what extent the grant has achieved the objectives set out by CiC and ACE AFRICA and test and further develop a methodology and approach to work with people affected by HIV/AIDS
2. To assess ACE's position to attract future funding
3. To measure the impacts of the programme in terms of the following:
  - Improved overall health of OVC and PLWA
  - Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS
  - Improved community access to support services and networks
  - Reduction in stigma and discrimination associated with HIV/AIDS
4. To determine if the quantitative targets (as set out in the grant agreement) have been met
5. To consider the validity of the original project objectives and whether they meet the needs and priorities of the target groups
6. To consider if and how the project has adapted the original objectives to best meet the needs and priorities of the target groups
7. To analyze the achievements in relation to project primary data and assess whether there have been any unexpected outcomes as a result of the project
8. To assess systems of monitoring and evaluation including records of project activities and measurement of outcomes against project inputs.
9. To assess how the project has worked with other relevant organizations and key stakeholders
10. To assess the working relationship between ACE AFRICA and CiC
11. To review staff performance, work priorities and time commitments
12. To assess ACE AFRICA's development of best practice system of support
13. To assess the sustainability of project interventions
14. To assess the cost effectiveness of the programme based on its achievements and outcomes

In order to capture learning from the grant, the evaluation should answer:

- How food security and livelihoods opportunities of beneficiaries have been enhanced through this grant
- How effective the approach has been in tackling opportunistic infections through the use of herbal remedies
- How Child to Child activities promoted positive living among young beneficiaries of this grant resulting in prevention of HIV/AIDS
- What are the key critical factors that contributed towards the success, or lack of it, in achieving the expected impact of this grant

## **2.2 Evaluation Methodology**

The evaluation used three approaches to obtain both primary and secondary data for the purpose of analysis and derivation of impact results, conclusions and recommendations. The evaluation team performed a literature review, interviews using questionnaires and focus group discussions to collect both qualitative and quantitative data for informed appraisal of the program.

### **2.2.1 Sample Population Size and Segmentation**

For the purpose of this study, the population was considered to be the community members, PLWA, OVC, support groups and partners of ACE AFRICA in the six project areas where ACE AFRICA operates in Bungoma District. The subjects for the purpose of the evaluation were grouped in three categories;

#### **i) Implementing Partners**

- Ministry of Health – District and Local
- Ministry Agriculture – District and local
- Ministry of Education – District and local
- District Nutritionist
- Children’s Department
- Community and Religious leaders
- District and local NGOs and CBOs

#### **ii) Community Members**

- People Living With AIDs (PLWA)
- Orphan and Vulnerable Children (OVC)
- Widows and Widowers
- Guardians
- Youth
- Community Support Groups
- Children in partner schools
- ACE AFRICA community activators and gardeners

### iii) ACE AFRICA staff

- Management
- Agriculture and Nutrition, Herbal Officer and Assistant
- Children’s Officer
- Monitoring and Evaluation Officer
- Income Generating and Micro Finance Officer
- Counsellors
- Office Assistant

## 2.2.2 Instruments and Evaluation Methods/ Procedure

Various techniques were utilized while carrying out the evaluation assignment with an objective to eliminate biases in the data received and see through the spirit of the main study objectives.

### 2.2.2.1 Qualitative

The following techniques and corresponding instruments (where applicable) were employed:

**Desk study** – Various literature materials were availed by ACE AFRICA to the consultants for review to inform scoping, sample targeting, monitoring and evaluation systems in place, quantities of direct services components and items delivered and received by various beneficiaries, micro finance loans disbursement and returns, and follow-ups for skills transfer adoption indications by target beneficiaries.

Other literature materials enabled the evaluation to find out organizational management systems and structures, personnel policies, management and accounting procedures. Finally project background information and proposal logical framework provided a good avenue to put the picture straight on what ACE AFRICA intended to achieve at the inception of the project, what were the goals, objectives, activities and objectively verifiable indicators to guide in benchmarking results achievement and impacts created.

**Focus Group Discussions (FGD)** - FGD guides and tools were developed and administered to the following group of target beneficiaries:

- i. Caretakers and Guardians
- ii. Community Activators and Gardeners
- iii. Youth
- iv. OVC

With the help of specially trained research moderators and enumerators, the evaluation team in collaboration with ACE AFRICA staff mobilized the above groups each from the six project areas for focused discussions held at the project site Community Resource Centers. Each FGD session consisted of between 8 and 12 members of each of the above groups.

**Key Informant Interviews (KII)** – Key informant interviews were conducted using KII guides, by the evaluation team targeting the following key people:

- Religious leaders
- Nurses
- School heads
- Community leaders
- Partners – BOEW, World Vision, FHI, Lukes Fund
- Government departments – MoE, MoA, MoH

The first group of Key Informant Interviews (KII); religious leaders, nurses at community dispensaries and health centres, school heads and community leaders were each sourced from the six project areas. The second group mainly falling under the category of ACE AFRICA partners was targeted at the district level. Logistical arrangements taking care of appointments for meetings with the KII were done by ACE AFRICA staff.

**Staff interviews** on work performance and programming were conducted targeting each and every staff of ACE AFRICA. A specially designed tool was administered by the consultants on one-to-one basis to foster privacy and confidentiality of information provided.

**Field visits** - The consultants also conducted sporadic field visits to the project sites, community resource centres, and kitchen gardens and to one of the support groups making nutritional flour.

### 2.2.2.2 Quantitative Sampling

Purposive sampling method was used in the survey to target PLWA and households<sup>9</sup> who were administered with questionnaires. Specifically PLWA within the target areas were administered with questionnaires. Enumerators were trained on questionnaire administration before the fieldwork exercise. This was also aided by a translation of the questionnaires during the training to assist the enumerators communicate and relay information effectively to the respondents. A total of 320 questionnaires were administered to households and PLWA.

### 2.2.3 Training of Research Assistants

The interviewers were trained thoroughly on instrument administration, interview techniques, procedures and skills and the importance of the survey and research process. The training exercise took two days with the major output being a translated version of the household tool and a pre-test done to assess the applicability of the designed tools and ascertain the effectiveness of the training.

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<sup>9</sup> Household members are those treated by this evaluation as general community members not necessarily having directly benefited from the ACE AFRICA project activities. Their opinions were sought as third party views on issues to do with awareness of the programme on the ground and the impact felt by the community at large.

## **2.2.4 Data Collection**

Data collection started immediately after training of enumerators. Experienced interviewers administered questionnaires, and conducted FGD sessions using one to one interviews in households and organized meetings for focused groups respectively. Each FGD session was handled by two research assistants, a moderator whose duty was to facilitate the discussions using the guides and probe while the enumerator was responsible for note-taking and assisting the moderator on time and group observational dynamics.

The primary data collection exercise took a total of five working days. While in the field the consultants and ACE AFRICA staff were constantly in touch with research assistants to supervise their work, offer necessary technical advice in cases of difficulties and collect already administered tools.

A work plan was developed to guide the evaluation exercise taking care of dates, activities planned, venues, target groups and responsibility assignments.

## **2.2.5 Data Processing and analysis**

Both qualitative and quantitative methods of data analysis were utilized. For qualitative analysis, the consultants collected and collated data from qualitative sources as described above. The data was analysed in relation to the evaluation objectives.

Quantitative data was analysed using SPSS for aggregation, development of frequency distribution, pie charts and graphical representations. Quantitative data was analysed in relation to the targets set out in the grant agreement.

## **PART THREE: DETAILED ANALYSIS OF EVALUATION OBJECTIVES**

### **3.0 Introduction**

For the purposes of clarity, objectivity and comprehensive reporting and analysis of information coming from the field, this section provides information on the successes the programme has created, and challenges experienced within the four thematic areas of:

- Improved overall health of OVC and PLWA
- Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS
- Improved community access to support services and networks
- Reduction in stigma and discrimination associated with HIV/AIDS

These themes were interpreted using information collected from different groups of target respondents.

### **3.1 PLWA Questionnaire**

#### **a) Improved overall health of OVC and PLWA**

Two of the direct beneficiary groups targeted by ACE AFRICA in its programming are PLWA and OVC. ACE AFRICA has targeted these groups through the following activities with a view of mitigating the health impact of HIV/AIDS: training in agriculture and nutrition, herbal remedies and IGA and micro finance and the provision of counseling, VCT and nutritional supplements.

#### **Findings**

Improvement in health conditions of OVC and PLWA were associated with the provision of nutritional supplements, improved nutrition through the agriculture and nutrition programme and knowledge of and use of herbal remedies. In addition the referral of beneficiaries by ACE AFRICA to district services who provide Anti Retroviral/Anti Retroviral Therapy (ARV/ART) in collaboration with other implementing partners in the district like Luke's Fund, FHI and the line ministries at the district level has had a positive impact on the health of PLWA. ACE AFRICA also works alongside these groups in the area of nutrition.

A total of fourteen (n = 14) PLWA were administered with questionnaires. Out of this, all of them admitted to being bed ridden prior to the project intervention by ACE AFRICA. In addition, they suffered from diarrhoea, loss of weight and appetite and general weakness. They stated that since receiving training in agriculture and nutrition, the use of herbal remedies, the provision of nutritious food from kitchen gardens, nutritional supplements and medical supplies amongst other services their health had improved in the following ways:

- Increase in appetite
- Substantial weight gain
- Soft and smooth skin
- Reduced pains and aches
- Reduced diarrhoea
- Reduce stress and conditions that lead to stress build up
- Good response to ARV treatment due to boosted immunity from nutritional supplements

These achievements, according to the respondents had been made possible by the high quality of services provided by ACE AFRICA including their referral and information dissemination strategies.

ACE introduced Child to Child (CtC) clubs in primary schools. Activities in these clubs include HIV/AIDS awareness, health education, nutrition and the establishment of kitchen gardens and direct support such as school uniforms, soaps and blankets. ACE AFRICA has also implemented 'In school Guidance and Counselling' in partner schools. Some schools as direct consequence of community training have established kitchen gardens and are purchasing nutritional supplements from the IGA groups trained by ACE.

So far ACE AFRICA has trained 105 teachers and 55 head teachers from 55 primary schools in Child to Child health education in the areas where they operate, these schools have established clubs with a total of 2,848 child members. The process involves children identifying health issues in the community, possible causes and providing solutions both in the school and community. The children are active agents of change and are also responsible for identifying vulnerable children in their community and reporting to the club. Activities include establishing leaky tins and dish racks in schools, planting trees and school kitchen gardens from which they feed OVC.

Children from 11 school clubs are also visiting the sick in the community and providing food, clothing and helping PLWA and OVC with farming, cooking and cleaning. The club members also raise awareness of HIV/AIDS issues by singing songs, performing plays and poems at schools and at community functions. The evaluation revealed that stigma and discrimination associated with HIV/AIDS has reduced as well as child awareness of the risks of HIV/AIDS increased as a result of these clubs.

## **b) Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS**

Some of the problems affecting people infected and affected with HIV/AIDS particularly in Bungoma as revealed in the baseline survey include:

- Lack of knowledge and capacity to improve the nutritional, health, agricultural, economic and psychosocial status of OVC, PLWA and the community at large
- Lack of economic security to sustain care for PLWA and OVC in the rural communities
- Low levels of awareness of the agricultural potential of the area and improved farming techniques to improve supply and nutritional content of food intake

ACE AFRICA aimed to address these issues through community training and capacity building on different programme components to ensure knowledge and skills transfer and adoption by the community. One advantage of this approach is that it enables the target beneficiaries to take control of activities aimed at delivering support to them. Capacity building in the support for PLWA and OVC was designed along the following programmatic components:

- Knowledge and skills improvement in agriculture and nutrition and the use of herbal remedies in the treatment of opportunistic infections
- Training in income generation activities and micro finance
- Reduction in stigma and discrimination

Through the well established channels of community outreach enhanced by community activators, gardeners and project field officers, community-training needs have been identified and addressed accordingly. ACE AFRICA has been collaborating with government departmental professionals and other personnel from partnering organizations in the district to facilitate training and capacity building based on identified needs.

### **Findings**

In each of the six project areas, an average of 100 per area (according to community activators and gardeners) community members affected and infected with HIV/AIDS have undergone trainings on different components. Findings indicate that the training on agriculture, nutrition and herbal remedies has had a remarkable impact on; food security, improved nutritional intake and access to increased household income. Those trained have adopted the farming methods passed on to them by developing their own kitchen gardens for household consumption as well as other OVC in the community.

Identifiable improvements in the lives of PLWA introduced by the programme are:

- Knowledge of and practice of healthy eating habits in relation to HIV status
- Improved farming methods and affordable organic techniques leading to increased food production

In addition two PLWA support groups have been trained by ACE (in partnership with the MoA and District nutritionist) in the production and marketing of nutritional flour. The flour is made up of soya, millet, cassava, maize, green grams and sorghum as a means of an immune booster and appetizer for PLWA and malnourished OVC. These groups are now producing 240 bags of 2 kg flour each month and sell them to ACE AFRICA who, in turn distribute them to PLWA and OVC within their areas of operation. In addition, the groups are independently selling 100 bags of 2kg flour to their community members. The streamlining of the IGA component with the nutritional component has led to; improved health of OVC and PLWA, increased household and group income and an increase in the numbers of OVC outside the households supported.

### **c) Improved community access to support services and networks**

#### **Findings**

Other challenges faced in the community include:

- Lack of knowledge of and accessibility to existing support for OVC and PLWA
- Ineffective and insufficient support mechanisms for OVC and PLWA

ACE AFRICA aimed to address these issues through improving the capacity of existing support groups and the establishment of new ones. These support groups are used as both emotional and resource based (food, basic household items) support for PLWA and OVC. In addition groups identify vulnerable children within their community who need support. Within these groups PLWA are able to share experiences and gain strength from each other in the challenges they face within the community hopefully resulting in more individuals acting as positive role models in the community, thereby reducing stigma and discrimination.

ACE AFRICA has encouraged the formation of PLWA and OVC support groups and sustained the already existing ones by recruiting more membership and using them as avenues for reaching out to other vulnerable people and community members affected by the disease. This has resulted in ACE AFRICA working with a total of 41 community support groups, approximately 800 individuals.

### **d) Reduction in stigma and discrimination associated with HIV/AIDS**

#### **Findings**

ACE AFRICA in its programming has addressed the challenge of stigma and discrimination in order to foster positive living, increased support to the community and greater understanding of HIV/AIDS. Awareness raising activities which include OVC Fun day, support group meetings and community sensitisation have taken place involving 10,613 community members. VCT services have reached 509 individuals resulting in an increased number of people knowing their status. The above has resulted in:

- More people declaring their status openly after being tested positive.
- PLWA being increasingly involved in community activities
- Community members now discuss and talk about HIV/AIDS more commonly and openly
- Community members are more willing to interact and support PLWA and OVC
- An increase in the amount of community support and care for those infected and affected.

### 3.2. Focus Group Discussion with the Youth

#### a) Improved Overall Health of OVC and PLWA

##### Findings

Discussion with the youth focused on trying to establish how in their opinion the ACE programmes has helped in improving the health of people infected. Two FGD sessions were carried out. Each FGD had an average of six (6) youth with an average number of 4 females and 2 males per group.

According to the youth, they feel that ACE AFRICA's impact has been felt through; counseling services in encouraging PLWA to be open about their status and start living positively, nutritional supplements alongside the training in agriculture and nutrition have enabled beneficiaries to establish kitchen gardens and maintain a healthy diet which has actually made progress in improving the health of PLWA.

*“Right now it is almost impossible to tell if someone is suffering from HIV/AIDS. Frequency of deaths has gone down, weight loss is no longer there and with nutritional supplements life with HIV/AIDS is just a normal one,”*

Youth

This illustrates that in terms of health, PLWA health status has changed for the better and they are now engaging in productive activities. Opportunistic infections which are associated with HIV/AIDS are now being more effectively managed through better nutrition. Youth reported that as a result of the training in agriculture and nutrition, OVC and PLWA are now healthier, have a prolonged life span and conduct their businesses as usual.

#### b) Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS

##### Findings

ACE AFRICA has organized seminars for the youth on IGA, agriculture and nutrition and given bursaries to OVC for secondary school education. Children in CtC schools have been targeted through fun days and sports that have helped them learn about HIV/AIDS.

The agriculture and nutritional skills acquired by the youth have been put into practice by starting vegetable gardens at home to provide nutritional support for PLWA and OVC under their care. Demonstration gardens established at each of the community resource centres have been used to teach the community how to plant a variety of indigenous and exotic vegetables using organic methods of farming.

### c) Improved community access to support services and networks

#### Findings

ACE AFRICA established six community support centres which act as central community points for the sharing of ideas and support amongst the infected and affected, referral points and networking base for support groups as well as the provision of counselling, VCT, IEC materials and training. These centres are situated close to rural medical centres and dispensaries which has enabled more community members to access support services.

ACE AFRICA works with 6 rural youth groups with an average of 120 youth. Activities are carried out at the resource centres where the youth are sensitized about HIV/AIDS, they mobilize the community to come for VCT, discussions and trainings are held on how to increase their capacity to care for OVC (i.e. as youth headed households) through group and individual income generating activities. During the sessions, youth perform plays to inform community members about HIV/AIDS issues that affect them. Distance from the centres was stated as a problem for some youth and they reported that in some instances the centres were poorly maintained and often invitations for meetings from ACE are received late. In terms of networking and group formation, more youth have become aware of HIV/AIDS and are now joining groups for accessing support services.

*“Formation of support groups especially for us youth is important; forming this group has enabled more youth to know about HIV/AIDS and more are joining”* Youth Group Member

### d) Reduction in stigma and discrimination associated with HIV/AIDS

#### Findings

The youth associate stigma and discrimination with low levels of awareness of the community about HIV/AIDS. Youth reported that previously HIV/AIDS was considered a taboo, meaning that it was very hard for those infected to come out in public due to stigma and discrimination. They stated efforts to reduce stigma have led to more PLWA declaring their status openly in the community and an increase in the numbers of people going for testing. This was also attributed to the fact that once tested, PLWA were able to receive support.

*“Stigma and discrimination associated with PLWA and OVC has gone down over the past two years. The PLWA and OVC are more accepted now than in the past,”* Youth Group Member

The youth reported that OVC are often talked about negatively and thought of as being cursed by other children and at the family level many do not want to share food, utensils etc with PLWA. ACE AFRICA’s activities such as; counselling, VCT and community sensitization have according to the youth group interviewed, played a significant role in the reduction of stigma and discrimination associated with HIV/AIDS. The youth stated that through CtC and In school guidance and counselling, OVC are attending school more regularly and socialize better with fellow pupils.

### **3.3 FGD with Community Activators and Gardeners**

#### **a) Improved Overall Health of OVC and PLWA**

The approach used by ACE AFRICA in programming ensures that community outreach and mobilization are priority issues. In its design the programme has employed the services of community activators and gardeners to help in community outreach. Community activators are in charge of managing community resource centres in each of the six project areas, dissemination of information to the community, and ensuring office field-liaison for activities implementation and follow-ups for skills transfer and adoption. They are also in charge of assisting the community in developing support groups, assessment of OVC needs, client referrals and mobilization.

Gardeners are specifically in charge of the agriculture and nutrition component. Their role is to assist the beneficiaries and the community in sustaining individual and group kitchen gardens through proper agricultural practices.

#### **Findings**

The focus group discussion session targeted and met with nine community activators and gardeners. The group consisted of six males and three females. They represented the 6 project areas. Information gathered from community activators reveal that the health condition of PLWA and OVC in their areas<sup>10</sup> has improved verified by weight and appetite gain and body strength.

#### **b) Increased community capacity and will to provide and sustain support for OVC and those infected and affected by HIV/AIDS**

#### **Findings**

ACE AFRICA has organized seminars to train the community. Resource people from the ministry at the district and local level are called upon to help facilitate the trainings. Trainees are followed up by activators, gardeners and field officers as well as mentors.

Trainings are demand driven. The activators help to identify community needs and trainees in partnership with the field officer in charge. ACE AFRICA provides technical support for the capacity building of activators, developing work plans and the monitoring of data collection.

Successes in community capacity building include:

- Increased awareness of HIV/AIDS and willingness to be tested, accomplished through mobile VCT services
- Training in agriculture and nutrition and consistent follow-ups ensure transfer of knowledge and support during implementation

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<sup>10</sup> Each of the activators was asked to give the total number of beneficiary OVC and PLWA within their. On average there are 4,386 beneficiaries per area.

- Improved health of OVC and PLWA through improved eating habits as a result of the above
- Increased number and efficacy of OVC support groups
- Availability of IEC material at the centres has increased information dissemination
- Child to Child clubs have encouraged the adoption of healthier habits such as the use of leaky tins. Furthermore, clubs have reduced discrimination against OVC.
- Child Rights Committees have ensured enhanced schooling of OVC through maintenance of rights of the child
- Small scale provision of secondary school fees has helped some students join secondary schools

Through training in herbal remedies, the community can now make their own herbs from herbal gardens, nutrition training has enhanced PLWA resistance to opportunistic infections and training in IGA and savings has helped the community engage in small-scale businesses and diversify their entrepreneurial management orientation.

### **c) Improved community access to support services and networks**

#### **Findings**

Resource centres have been established in order to provide information to the community, and are being managed by community activators. Seed banks are being maintained at the centre through seed donations by individuals and community groups. At the resource centres, the community is provided with information on how to form groups and proposal writing skills.

The activators are trained and their capacity built on the carrying out of community mobilization, client referrals, HIV/AIDS community sensitization, and follow-up activities in order to monitor and record progress in their areas.

ACE AFRICA has facilitated the formation of six area community Child Rights Committees (CRC) whose mandate is to identify, solve and refer child rights abuse cases. In addition, these committees inform community members and especially children on the rights of the child and the role of the committee. The committees are made up of local leaders, retired professionals, teachers and representatives from various target groups. These committees act as a referral point at both local and district level.

The CtC teachers are trained to use child centred approaches in the identification and mitigation of health issues in the community. The CtC teachers do not perform the role of guiding and counseling but every primary school has a teacher who is designated by the MoE to counsel in schools. ACE works with these teachers to strengthen their in school guidance programmes.

### **d) Reduction in stigma and discrimination associated with HIV/AIDS**

#### **Findings**

The activators strongly associated stigma and discrimination to lack of awareness. As the level of awareness increases, people become more receptive. Stigma manifests itself in people, making them even fear going for VCT. They reported that in terms of gender, women come out to

declare their status more than men. Most of the women are widows and are in serious need of help.

Respondents stated that cases of stigma are now reducing due to the following (although not exclusively indicated by):

- More people going for VCT
- Increased number of HIV+ people are disclosing their status in the community
- An increase number of HIV+ people confiding their status to caregivers such as nurses, community activators, HBC providers and counselors.

### 3.4 Focus Group Discussions with Care Givers/Guardians

Care givers and guardians range from PLWA, widows, widowers, grandparents, community activators, HBC providers, support group members, youth, and other community members – all of whom are caring for OVC within their households and within the community.

1. Milo where a group of 10 caregivers/guardians (5 men and 5 women) between the ages of 25 years to 70 years were met.
2. Mechimeru, where a group of 23 caregivers/ guardians (3 men and 18 women) between the ages of 31 – 64 years were met
3. Bukembe, where a group of 6 female caregivers/guardians between the ages of 30 – 55 years were met

### Findings

The majority of guardians and caregivers of OVC are widows whose spouses have died due to HIV/AIDS. Guardians stated that assistance from ACE AFRICA included; training in agriculture and nutrition and herbal remedies, counselling, provision of seeds and nutritional flour and basic needs such as clothes, medication, school uniforms and secondary school fees.

*“Of direct benefit to the improved health of OVC and PLWA are drugs for PLWA, nutritional flour, herbal remedies, training in agriculture and nutrition, healthy eating and pre and post testing guidance and counseling.”*  
Guardian in FGD

These support services have enabled them to start vegetable gardens to improve nutritional status of the PLWA and OVC under their care thereby increasing their resistance to opportunistic infections. Respondents reported that before ACE started offering this support to PLWA and OVC, the situation was terrible, many were bedridden and depressed. Having tested positive they developed a negative attitude towards life. However, they stated that with the provision of counseling services, training in agriculture and nutrition and provision of medical supplies, many PLWA are now strong and able to do casual work, have gained weight and have a more positive outlook towards life.

*“Before ACE AFRICA initiated their programme on HIV/AIDS, our work as caregivers, especially to PLWA was so difficult. We used to handle patients wasting to die with no training in nursing. Right now our work has been made easier because the PLWA are contributing to making their lives better. They have become more productive and living positively.”*  
Female caregiver

### 3.5 Key Informant Interviews<sup>11</sup>

A total of twenty eight (25) Key Informant Interviews (KII) were conducted by the evaluation team targeting ACE collaborators and partners (CSOs) and government departments and ministries at the district level, community leaders, church leaders nurses at the medical dispensaries at centres situated at the project areas, schools heads and teachers in CtC partner schools.

#### Findings

According to information collected from this group, significant progress has been witnessed ranging from improvement of health status of OVC and PLWA to reduction in stigma and discrimination. This they note has mainly been made possible by those infected with the disease coming out and declaring their status to access support services available. For those who have not declared their status despite secretly testing positive they note, have not seen any change at all. They are still thin and experience symptoms associated with HIV/AIDS. Most of them appreciated that once a client goes public and undergoes counseling, they are referred to support groups where most of their emotional, medical and basic needs are taken care of.

ACE AFRICA has assisted in providing PLWA and OVC with nutritional supplements to improve their immunity to resist opportunistic infections. Other activities have involved training them in the benefits of good nutrition and capacity building in the production of food through organic methods of agriculture to foster healthy eating.

Key informants positively identified some of the indicators associated with improvement in health as weight gain, regaining of ones appetite, and those who were formerly bed ridden are now walking and engaging in income generation for families. Other issues stated by the key informants included the life span of PLWA. They reported that due to ART/ARV and medical supplies, the health and immune system of PLWA have been boosted hence they now live longer than before.

Majority of PLWA through guidance and counseling have also refrained from engaging in unhealthy practices that might complicate their situation. Some of the nurses mentioned that the PLWA are now aware that engaging in unprotected sex is a health hazard. Before, the trend was that there was a strong urge by those infected to also engage in multiple sexual relationships with an aim of infecting others. This in essence contributed to high deterioration in their health conditions

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<sup>11</sup> See the full list of Key informants interviewed in annexure

### 3.6 Questionnaire for households

#### Introduction

Household individuals, as had earlier been explained for the purpose of this evaluation are local residents within the six project areas ACE AFRICA works in. Their opinion in terms of awareness of project interventions, activities and service delivery is very important to gauge the extent at which even those people who are not necessarily in direct contact with ACE AFRICA as beneficiaries are feeling impacts. Their opinions, especially for those who do not benefit at all from project interventions, are emanating from daily interactions with people affected and infected with HIV/AIDS. This group was administered with questionnaires specially developed and translated into the local language for easy understanding of concepts. A total of (n=320) respondents were interviewed.

Out of the 320 respondents 40% were men and 60% were women. In terms of age distribution; those in the 15-20 were 2.5%; 20-25 years were 13.8%; 25-30 years were 9.1%; 30-35 years were 16.9%; 35-40 years were 12.8%; 40-45 years were 14.1%; 45-50 years were 5.6% and who are 50 years or above were 25.3%. This outcome shows that majority of community members targeted for information, were the aged. This generated more reliable information based on the fact that this group interacts a lot with ACE AFRICA beneficiaries who are PLWA and OVC. In terms of marital status, majority of respondents interviewed were married (75.3%) of the total, followed by widowed (13.4%) and single (10%). In terms of education level majority of the respondents 47.5% had primary education, 36.9% had secondary education, 8.1% had no formal education, and 6.3% had tertiary education while 1.3% had university education. Occupation wise majority 41.6% reported to be engaged in small scale farming, 23.1% were doing small scale businesses, 15.6% were involved in the jua kali (informal sector) while 9.7% and 9.4% were in formal employment and unemployed respectively.

#### Findings

##### a) Improved Overall Health of OVC and PLWA

To establish public opinion about the impacts the programme has created in trying to improve the health condition of OVC and PLWA, an open ended question was posed to the household individuals wanting how activities being implemented by ACE AFRICA have helped in improving the health of PLWA and OVC.

Results indicate that:

PLWA now have enhanced body strength

PLWA who were formerly ailing are now up and walking

PLWA are now showing weight gain.

Incidence of skin problems and diarrhoea amongst PLWA has reduced

Activities need to be scaled up to reach more beneficiaries in the target areas

## b) Improved community access to support services and networks

Respondents noted that impact of ACE AFRICA activities in relation to increased access to support services in the community were due to the following:

Provision of VCT

Provision of Counselling

Training in IGA and Micro Finance

Training in Agriculture and Nutrition

Improved food production in the community

Improved community awareness on HIV/AIDS through CtC clubs

Establishment of community resource centres

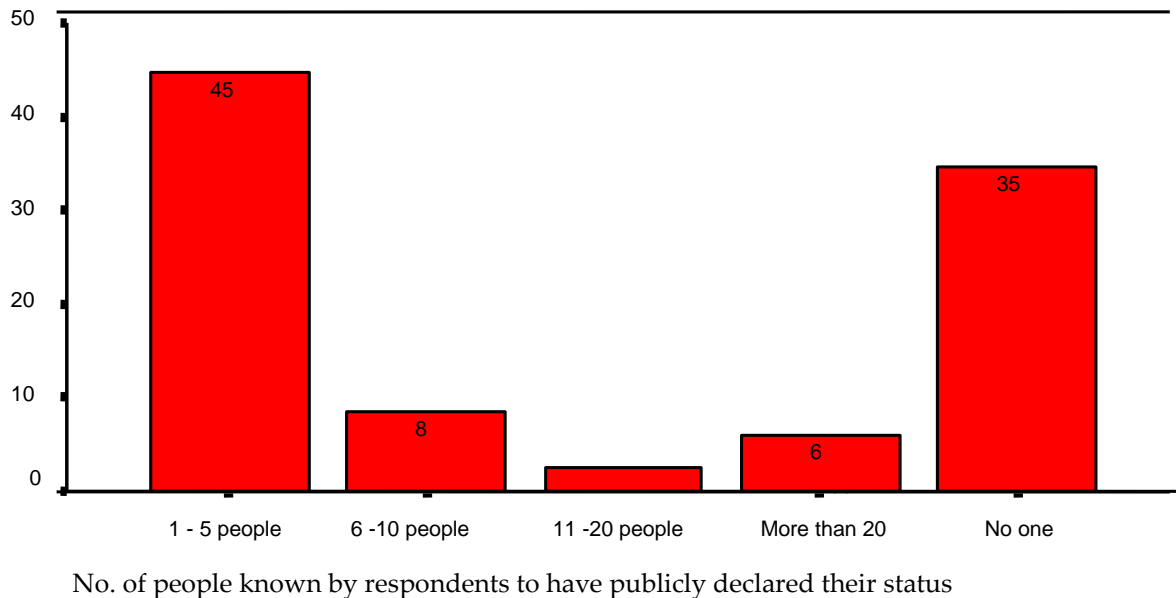
Establishment and strengthening of support groups

7.2% of respondents stated that they did not know if access to support services had improved.

## c) Reduction in stigma and discrimination associated with HIV/AIDS

Fig. 1: Percentage distribution of respondents according to number of PLWA known to have declared their status publicly

Percentage of respondents



Some positive responses from informants regarding reduction of stigma and discrimination include:

“Community members now treat HIV/AIDS cases as normal.”

“PLWA are not discriminated against by the community.”

“OVC are attending schools more regularly.”

“PLWA are now free to share out their problems with the community.”

“OVC & PLWA through counseling and other support services are now living more positively.”

### **3.7 Programme methods and approach in working with people affected by HIV/AIDS**

ACE AFRICA’s multi-faceted approach and integrated methodology has worked successfully to attain the pre-designed project objectives and programme components in the last two years of implementation. The two year programme under evaluation began in July 2004 and will be complete in June 2006.

So far ACE AFRICA has managed to establish a strong partnership and working relation with many organizations and stakeholders in the district and the six project areas. These include; Community Health Workers (CHWs), PLWA, OVC, Youth, relevant line ministries like Agriculture, Health, Education, District Nutritionist, Culture and Social Services, NGOs and CBOs, Council for Human Ecology Kenya (CHEK). Through these collaborations, ACE AFRICA has been able to train the community PLWA, OVC, carers and staff and to monitor and evaluate their needs. ACE AFRICA collaborates closely with the Ministry of Education (MOE) through teachers and schools, which has enhanced the effectiveness of the Child-to-Child (CtC) training in life skills, children rights and safe sexual behaviour. The existing linkages and partnership between ACE AFRICA and the various stakeholders in the district, is a positive indicator of networking that is likely to enhance community ownership both at the grassroots and district. It is hoped that this will create long-term impact and a sustainable community led project.

The evaluation revealed that the community support centres and demonstration gardens established by ACE were an appropriate mechanism for team building, solidarity and bonding between the OVC, PLWA and the affected individuals and support groups in the community. It was confirmed by the Key Informant Interviewees (KII) that ACE AFRICA is a place for support, advice, referrals, training and capacity building. This positive perception is encouraging for a continued partnership between the community, ACE AFRICA and other stakeholders in Bungoma.

In terms of relevance with the National Aids programme for Kenya, the ACE AFRICA project addresses all three priority areas of the National Aids Control Council (NACC) five-year strategic plan 2005/06 - 2009/10. These include: i) prevention of new infections ii) improvement treatment and care, protection of rights and access to effective services for infected and affected people iii) mitigation of socio-economic impact of HIV/AIDS on the OVC and PLWA. It is recommended that when the new nation-wide TOWA programme (i.e. Total War Against Aids) is launched, that through this ACE AFRICA strengthens its integration and capacity with new stakeholders.

The ACE AFRICA project is significant in relation to the Millennium Development Goals (MDG.) It addresses most of the critical goals including i) abject poverty and hunger ii) reduction of child mortality rates and iii) combating HIV/AIDS, Malaria and other diseases. In this regard, if adequately supported financially and technically, ACE AFRICA will be able to localize the implementation and fulfillment of the Millennium Development Goals in Bungoma District. This may go a long way to impact on the fulfillment of the same goals in other districts and the country as a whole by the year 2015.

The ACE AFRICA project has positively impacted on the farming systems, within the project sites. It has helped to diversify the production of both food and cash crops as a strategy of promoting food security and alternative sources of income in the six target areas. Prior to the ACE AFRICA intervention, the agricultural potential of the project sites were not fully realized.

The project has also led to improved nutritional and health status of the OVC and PLWA and the affected individuals and households participating in the ACE programme components. The use of indigenous food crops, vegetables and food supplements have impacted positively on the lives of the infected and affected individuals in the six project sites of Bungoma district. This project should not only be expanded but also replicated to other parts of the Western province and the country.

It is in the opinion of the external evaluators that ACE AFRICA has the requisite institutional and human resource capacity to implement similar and bigger projects for longer periods. The institutional memory and operating system in place should be strengthened and expanded to benefit communities beyond the six project areas. This calls for more financial and technical support to enable ACE AFRICA to fulfill the ever increasing expectations from the target communities to expand this holistic approach in the mitigation of the impact of HIV/AIDS.

### **3.8 Achievement of Quantitative targets in Grant Agreement**

As per the grant provided to us by ACE AFRICA, these were the agreed upon outputs:

- 6 Community Support Centres and demonstration kitchen gardens established
- 3000 community members using Community Support Centres per year
- 240 community members trained in nutrition/income generation/Micro finance/CtC per year
- 90 households with established kitchen gardens per year
- 60 new community members using herbal remedies per year
- 300 new children using Child to Child methods per year
- 6 Community Health Workers assigned to ACE activities
- 12 sub location committee meetings and quarterly meetings of the referral network per year
- 150 people per year referred via Community Support Centres to district and local services.
- 20 PLWA/ OVC at each site who have received nutritional support & counseling per month
- 600 community members and 1200 OVC attending community events and educational 'fun' days per year

Against the above ACE AFRICA has been able to achieve these outcomes:

### **3.8.1 Agriculture and Nutrition**

ACE AFRICA has established 6 demonstration kitchen gardens and trained 578 (with 400 established kitchen gardens) beneficiaries in organic methods of farming and nutrition resulting in an average of 248 (out of which 38 are mentors) individual community members with 178 established kitchen gardens, 12 community groups and 25 schools with kitchen gardens. Numbers of active gardens vary according to unavoidable variables such as; drought, death, sickness and people moving away. ACE AFRICA has also trained 38 community members as Trainers of Trainers who monitor and follow up trainees in the field providing advice on the ground under the guidance of the Agricultural officer and Ministry of Agriculture farmer field staff. This mentoring system has proved to be very effective in monitoring trainees' progress. Internal evaluations, research and operational findings indicate that community members have increased knowledge about nutrition and its impact on the health of PLWA and OVC and are changing their farming habits from cash crops to food crops, thereby improving household diet, health and income through small scale sales. Findings also indicate that each trainee has increased the number of OVC supported on average by 100%. Through individuals, groups and demonstration gardens, an average of 927 OVC and PLWA receive food on a monthly basis as a direct result of the training.

### **3.8.2 Child to Child Health and HIV/AIDS**

ACE AFRICA has trained 105 teachers and 55 head teachers from 55 primary schools in the areas where they operate in Child to Child health education. These schools have established clubs with a total of 2,848 child members. The process involves children identifying health issues in the community, possible causes and providing solutions both in the school and community. The children are active agents of change and are also responsible for identifying vulnerable children in their community and reporting to the club. Activities include establishing leaky tins and dish racks in schools, planting trees and school kitchen gardens from which they feed OVC. Children from 11 school clubs are also visiting the sick in the community and providing food, clothing and helping PLWA and OVC with farming, cooking and cleaning. The club members also raise awareness of HIV/AIDS issues by singing songs, performing plays and poems at schools and at community functions. The internal evaluation revealed that stigma and discrimination associated with HIV/AIDS has reduced as well as child awareness of the risks of HIV/AIDS increased as a result of these clubs.

### **3.8.3 Child Rights and in school Guidance**

ACE AFRICA has trained 216 community members made up of teachers, religious and community leaders, councilors, chiefs and assistant chiefs, People Living with HIV/AIDS, guardians and youth in the Rights of the Child. 120 of these make up six community Child Rights committees which ACE has established. These committees identify and are informed by community members of cases of abuse such as child rape, early marriage, neglect, denial of basic rights such as food, shelter and education, they then in turn either solve the problem at the community level or refer the case onto the Human Rights Watch or the Children's Department. Child Rights committees have given 3,265 children and community members information about

the Rights of the Child and research indicates that community members are now more aware of the rights of the child and know that if they do not protect them, they will be answerable to the committees. 85% of cases reported to the committees in this phase of operation have been solved at the community level and the remaining 15% reported to others at the district level. In school guidance has been given to 2,509 children and has proven to be a valuable inroad into identifying vulnerable children and providing for their needs and counseling.

### **3.8.4 Income Generating Activities**

ACE AFRICA has trained 127 community members in Income Generating Activities and 119 in Micro Finance. These businesses have enabled individual guardians and PLWA as well as support groups to increase their household income and together they are now supporting a total of 360 OVC every month with food, clothes, school equipment, fees, medication and nutritional supplements. Specific IGA projects including the manufacturing and marketing of nutritional flour locally by two groups of People Living with HIV/AIDS and their supply to the community has had a dramatic effect on the health of PLWA and OVC resulting in fewer bedridden cases, greater and quicker recovery from sickness, better child attendance at school and weight gain in both adults and children. It has also had a positive impact on the reduction of stigma associated with HIV/AIDS resulting in more people going for VCT testing and openly revealing their sero status to the community. In addition the groups have increased their individual and group income enabling them to care for more OVC and PLWA. In addition, the commercial production of the SPK004 sweet potatoes has also been successful with two youth groups helping them to increase their household income and ability to care for OVC. The potatoes are popular, affordable and have a high content of Vitamin A which helps to boost the immune system. ACE AFRICA has identified a source to market the potatoes both locally and nationally. ACE works with 41 PLWA and OVC support groups.

### **3.8.5 Voluntary Counseling and Testing (VCT) and counseling**

ACE has been conducting VCT in conjunction with the Ministry of Health as an outreach service in the six rural areas of operation. ACE has two trained counselors who visit each centre once a week and conduct VCT clinics twice a month. The evaluation revealed that the provision of VCT in the rural areas has played a huge role in the reduction of stigma and discrimination associated with HIV/AIDS. ACE has provided 509 community members with VCT and provides an average of 70 PLWA, guardians and OVC with regular counseling each month.

### 3.9 Validity of Project Objectives in Meeting Needs and Priorities of Target Groups

In programming, project objectives are derived from situational analysis of a certain problem/issue/aspect through baseline information. Defined by the nature of factors affecting the target group, objectives are designed as short-term SMART response strategies to counteract challenges experienced.

Before ACE started implementing the programme on mitigating the impacts of HIV/AIDS on the rural community in Bungoma, a baseline survey had been conducted that among other issues revealed that:

- Despite various support mechanisms, there was little collaboration between organizations and they are virtually unknown in rural areas. Accessibility is largely limited to those in urban areas and communication about the needs of OVC requires structure in order for effective support.
- There is a need to improve the nutritional, health, agricultural, economic and psychosocial status of OVC, PLWA and the community at large. This was derived from the fact that the nutritional intake of a substantial percentage of households in Bungoma was significantly below the recommended balanced diet
- Basic medicine was in short supply. The use of traditional herbal remedies in conjunction with conventional medicine would be beneficial. However, the beneficiaries, in using herbal remedies due to cultural factors and stigma among those infected, were experiencing a lot of challenges.
- The agricultural potential of the area is good. Farming techniques needed to be changed in order to encourage the planting of food crops as well as cash crops.
- Community Health Workers could not cope with the burden that was being placed on them.
- Existing Child-to-Child activities were minimal, as communities had become fragmented due to the impact of HIV/AIDS. There was a need for these to be developed.
- The remuneration for cash crops is often delayed or non-existent thus income generation activities need to be introduced to improve household financial security and to sustain community activities

Following the above concerns ACE AFRICA designed a programme along these objectives:

- To establish rural community support centres, providing information, education and referral for those infected/affected by HIV/AIDS particularly.
- To improve the skills and capacity of the community in nutrition, agriculture and the cultivation and use of herbal remedies in the context of the practical realities of HIV/AIDS.
- To enhance the sustainability of community activities through training in income generation.
- To establish Child-to-Child activities/ Life Skills/ counseling facilities for OVC with a focus on HIV/AIDS prevention and positive living.
- To facilitate the reduction of the stigma and discrimination associated with HIV/AIDS by raising levels of awareness and understanding in the community.

The establishment of rural community support centres was perfectly thought of to intervene in providing information to the community on issues of HIV/AIDS. The centres have been used to

assist as channels of activity implementation, reporting to the community on project implementation in the area and creation of awareness to the community about ACE AFRICA activities and on HIV/AIDS.

Improvement of skills and capacity of the community in nutrition, agriculture and cultivation and use of herbal remedies has been the most effective strategic objective. Looking at the needs of PLWA and OVC, food security is not only an issue of quantity but also quality. Good nutritional practice is known even in normal circumstances to improve body immunity and metabolic processes for healthy living. HIV/AIDS affects the immune system by weakening body immunity to diseases.

From sustainability perspective, service providers are concerned about continuity of programme interventions when they as primary facilitators scale down support or totally wind up programming from a certain area. As such ACE AFRICA strategy to transfer knowledge and skills to the community on good agricultural practices with small scale support in seeds and follow-ups to ensure knowledge adoption was imperatively the best strategy. It ensures long-term reliable support through production of nutritious food by the beneficiaries themselves. Food security is hence achieved.

The strategic objective of IGA and loans has its merits and demerits. As it is ACE AFRICA has not developed to a full-fledged micro finance organization. Greater part of its project activities is direct free support to PLWA and OVC. The community is integrated into this support system due to their supportive role of home-based caregivers. When a project is set, the perception of the beneficiaries is very vital in future progress. Training in IGA was supposed to enable beneficiaries acquire business entrepreneurial skills so that they could start small-scale business to support their livelihood and especially in supporting OVC and PLWA.

By issuing IGA loans, ACE had intended to help the community get small capital for investment in business to utilize the skills acquired. However, loan repayment has proved to be a big problem. One of the reasons fronted by the officer in charge of IGA and micro finance is that, since ACE offers direct support to its beneficiaries in the other project components, individual repayments under IGA loans are ongoing but have been delayed or in some instances written off due to unexpected death, relocation or calculated moves by loanees.

Although ACE AFRICA does an assessment of the potential of the would-be loanees through an established assessment form, in addition to measuring their commitment in supporting OVC, the assessment shows that a good number of individual loans have been declared bad debts. After the first year of CR funding, ACE recognized that recovering loans from individuals was problematic and thus changed in Year 2 to only providing loans to groups. Of these groups, repayment is 100% on schedule. More than 60% of the money loaned out has been loaned to groups. With half of these group loans, grace period for repayment had not yet been reached at the time of the evaluation but they are currently repaying on schedule.

Another strategic objective, which has seen serious achievements, is the CtC activities and life skills and counseling. OVC had a major problem of stigma and discrimination, and this hindered

their positive living. By using CtC, outreach to children is high, retention in schools is improved and stigma and discrimination reduced through counseling. The strategy has been identified by teachers in partner schools to undergo training to become CtC teachers. Through CtC ACE AFRICA organised OVC fun days in partner schools to help children intermingle and compete through informally organized game fairs as well as providing a forum to disseminate information about HIV/AIDS. ACE through this strategic objective, has also been offering direct support to particularly vulnerable OVC e.g. uniforms, soaps, blankets and other basic needs.

The CtC clubs have enabled OVC to learn good healthy and agricultural practices in school through demonstration gardens and school activities. In some schools, children have been instrumental in transferring the knowledge from school to home.

One problem, which ACE needs to address, is the issue of CtC teachers. Once a school has been approached and become a CtC school partnering with ACE, two members of staff and the head are trained by ACE on OVC HIV/AIDS issues and health education. However, whenever a teacher is transferred, a gap is created. However, so far the transfer rate is too small to cause any serious hitches. Only 2 out of the 105 teachers ACE works with in CtC schools have been transferred.

It has been reported that what kills AIDS victims is not the disease itself but the stigma and discrimination associated with it. Logical thinking imperatively identifies stigma and discrimination reduction as key ways of controlling and managing the impacts of HIV/AIDS on the affected and infected. Various activities have been carried out by ACE AFRICA to create more awareness in the rural community of Bungoma about HIV/AIDS. The incumbent situation before ACE intervention showed that people were not willing to visit VCT and those who had tested positive were not willing to come out in public about their status.

### **3.10 Monitoring and Evaluation systems**

ACE AFRICA has a well-established M&E system. The organization has recently employed an M&E officer who guides, develops M&E tools and consolidates monthly data sheets generated in the field showing quantitative aspects of programme progress. The M&E system also entails spontaneous field spot checks by the M&E officer and overall management of the work being conducted by field officers, counselors, community activators, community mentors and other partners involved in the evaluation process.

At the field level project field officers are in place for each project component. They work in liaison with community activators, gardeners and local government representatives. Their responsibilities include, conducting field follow-ups to monitor how project beneficiaries adopt skills transferred to them through trainings and capacity building, regulating the mentoring system and compiling field reports.

Feedback from the field in terms of trainings, beneficiaries seen, support services supplied, counseling sessions conducted, PLWA health trends among others, are compiled in field data

sheets. These are then used by the field officers to compile monthly reports, which are then consolidated as ACE AFRICA project monthly reports submitted to CiC for perusal.

In terms of measurement of outcomes, it was apparent that apart from quantitative targets and case study reports, there is no programme logical framework showing programme goal, purpose, activities, outputs/outcomes, Objectively Verifiable Indicators (OVI), Means of Verification (MoV) and assumptions for the long term. Results based management requires that a logical framework of a programme must be developed to link inputs and outputs and processes of implementation (activities and strategies) with outcomes. Without this one may not be a position in programming to judge input requirement levels sufficient to realize qualitative targets.

While programme monitoring is a continuous process during project activities implementation, project evaluation comes either mid term or at the end of the project to assess the project impacts and results achievement. ACE AFRICA has an internal monitoring and evaluation system in place. A programme internal evaluation exercise was conducted in June 2005 as per the grant agreement in order to take record of what the project had been able to achieve, challenges experienced and lessons learnt to inform Year Two of programming.

### **3.11 Collaboration and Networking**

Unlike other districts in Kenya where one can hardly find operations and programme implementation presence by national NGOs, FBO, TUs (basically the CSO sector), Bungoma is relatively fortunate to have major NGOs intervening in the districts by implementing various programmes. If stakeholders strategize properly to further the already existing networking forums and ventures and plan how to effectively conduct stakeholder and project areas mapping, these organizations can have greater impact.

This evaluation exercise established that there are more than five (5) major NGOs operating in Bungoma in the HIV/AIDS sub-sector. They include ACE AFRICA, World Vision, FHI, Luke Fund, and the MoH Home Based Care among others. Other strategic stakeholders in the sub-sector include government line departments and ministries at the district level, CBOs and devolved government funds on HIV/AIDS. Devolved government funds include community based organizations supported by CACC, CDF, CBF, LATF, KCDTF, Njaa Marufuku among others.

ACE AFRICA has consistently consulted with government line departments and ministries for collaborative efforts such as the facilitation of training and capacity building activities organized for its project area beneficiaries e.g. in running trainings in agriculture, nutrition and herbal remedies, ACE AFRICA alongside its field officers, has engaged the services of district agricultural specialists working with the Ministry of Agriculture for training facilitation as well as IGA and MF specialists from local organizations.

Records provided by ACE AFRICA (minutes and reports of meetings) show that the organization in partnership with other organizations and institutions implementing HIV/AIDS programmes in Bungoma and national networks like KANCO. ACE AFRICA has been engaging

these partners through participation by its staff members in periodic meetings and forums. An inventory of such kind of collaborative engagement towards enhancing networking reflected in minutes and activity reports filed by ACE AFRICA indicate that ACE AFRICA has been participating in monthly partners meetings between FHI and all NGO's and CBO's in Bungoma district involved in HIV/AIDS and OVC work in Bungoma district; in the Bungoma Area Advisory Council for OVC's quarterly, in the Divisional Stakeholders meetings relating to Agric and Nutrition quarterly, in the District planning meetings quarterly. ACE AFRICA has also been involved in quarterly networking meetings with government line ministries and partner NGO's and CBO's. Finally ACE has been involved in KANCO and KECOFATUMA quarterly meetings for network members.

Another element of collaboration the organization is fostering is in service delivery. It came out clearly, that there is a good working relationship between FHI and its partners, Luke Fund and ACE AFRICA. The three organizations' secretariats, for that matter, are housed in the same building. ACE AFRICA has been working closely with these organizations to harmonize service delivery in their common target areas. FHI has steered partner review meetings between ACE, FHI and World Vision. One thing that came out clearly in our discussions with some key informants representing these organizations is that there exists some form of competition between some organizations. This, we were made to understand is one being fueled by the district government through either implied or explicit preference of some organizations because of their scope and magnitude of presence being felt in terms of volume of support services offered. The other situation is where some organizations demean the work of others especially when there is a shared project area and or target groups, by trying to show their services are more superior.

In many instances partners have similar target groups. Collaboration between World Vision, FHI and ACE AFRICA are shown through the implementation of activities which compliment each other (like VCT and support group meetings) and the use of community resource centres established by ACE at the local health centres. There is also collaboration between ACE and Ministry of Education through the use MoE facilitators for CtC training and teachers and head teachers trained in the CtC approach. The special programmes officer and the Early Child Development officer at the MoE conduct trainings in conjunction with ACE staff through a symbiotic working partnership. ACE AFRICA has also been working closely with the Ministry of Agriculture where it gets professional advice on the establishment of demonstration gardens and farming methods. There has been an on going technical input from front line and District Agricultural Extension Officers in the field, training, curriculum development and follow up

### **3.12 Working Relationship between ACE AFRICA and CiC**

The working relationship between ACE AFRICA and CiC for the two year grant period, according to information gathered from ACE staff and especially the Executive Director is friendly, cordial and non-antagonistic. There is a common understanding especially at ACE on contractual agreements between the two organizations and what is expected of each one of them. ACE AFRICA has clear guidelines to staff on who is responsible for communicating with CiC on official issues that is, the executive director, the programmes director and/or the finance and

administration manager. Financial applications are made by ACE to CiC in advance for every month's expenditure. The communication system in between ACE and CiC is favorable considering distance, logistical issues and technicalities. The CiC technical support and cordial relationship has enabled ACE AFRICA to gain experience and confidence and now has successfully registered as a UK Charity. Indeed this is a step forward that the organizations can now solicit for funds directly from big organizations from UK. However, further collaboration as partners in development needs to be encouraged.

### **3.13 Staff performance, work priorities and time commitments**

ACE AFRICA has 11 members of staff handling programme management, field operations, finance and administration. Each member of staff has employment contracts spelling out terms of service and job descriptions. In the evaluation exercise 10 members of staff were interviewed on issues of work performance and programming. Each member of staff is in charge of providing technical and field assistance to a particular programme component and /or finance and administration. Period of service of members of staff differ with some having worked with ACE since its inception while others are barely one year old in the organization. In terms of academic qualifications, the least qualified is a tertiary certificate holder in respective field.

All staff members are really motivated to work due to the fact that working with PLWA and OVC is a challenging task, which interests them as they can see positive changes in the lives of their beneficiaries through their services. Others are motivated to work due to the freedom they have been given to work under minimal supervision enhancing personal responsibility and integrity, and as a source of income to earn a living. The working environment is reported to be conducive and favorable to staff interactions with management fellow staff and beneficiaries.

Management of workload in terms of logistics arrangements is fairly good. ACE AFRICA has in place two functional vehicles which members of staff use for fieldwork. Transport allowance is also available to staff members. The mechanism put in place by having community activators and gardeners to assist field officers through the community resource centres is very effective in terms of community outreach, follow ups and mobilization. Workload management in terms of technical competencies is above average. The officers in charge of different project components are people well qualified some with university degrees along those fields and necessary work experience to manage project planning, implementation, monitoring and evaluation and reporting.

Workload management in terms of time allocation is very flexible. The organization stipulates official working time between 8AM and 5PM. After this no one is forced to work overtime. However, in many instances staff members realize that fieldwork really consumes their time and that the only time left to do feedback reports and sort out administrative issues is outside official working hours. This coupled with the flexibility mechanism that ACE management has been fostering, enables staff members to find their own free time to finish up their work as expected.

There is a weekly and monthly work planning process in the organization. It came out that about 80% - 90% of work planned is completed within the expected timeframe. Reporting systems are

very well in place, through field data sheets filled weekly by field officers and this in our view enhances results achievement through M&E. The organization has also hired the services of an M&E officer in charge of; field work monitoring of all project staff record keeping in the field (including community volunteers), regular verification of activities and data in the field and ensuring timely and efficient collection of monthly and quarterly reports and data

Communication between staff members is conducted through staff meetings, informal one-to-one dialogue and through memos and circulars although rarely. Communication between ACE and local organizations is conducive for structured networking. There appears to be a very cordial working relationship between ACE AFRICA and government line ministries e.g; MoE (through the CtC clubs in schools, guidance and counseling in schools and the small scale provision of secondary school fees), MoA through collaboration in training and community follow ups and MoH through local and district administration. Official communication channels like letters, information sharing through meetings, and engagement of experts from these institutions in ACE AFRICA's activities like beneficiary capacity building trainings and M&E follow-ups are used. All quarterly reports are sent to local partners and specific activity reports from all partners are written and disseminated at monthly and quarterly partner meetings.

The communication system in between ACE and CiC is favorable considering distance and logistical issues and processes involved. Financial management systems are in place (manual, and accounting procedures i.e. petty cash accounting and voucher processing)

In terms of financial management there is a proper expenditure vetting processes where by the Finance Manager checks and the Executive Director or Director of Programs approves depending on nature of activity. If the activity requires sums more KShs 100,000 the Executive Director approves. Asset purchase is approved by the board. CiC and ACE AFRICA also have in place funds disbursement procedures. In the current system, there are periodic (monthly) not lump sum funds disbursement procedures. ACE AFRICA is expected by CiC to make monthly returns including details of activity implementation and financial reporting before funds are disbursed for the following month's activities. This in a way has ensured that ACE accounts are only liquid to the extent of monthly roll out plans.

### **3.14 Development of Best Practice in Programming and sustainability**

Best practice is defined in social terms as what works well in a given situation comparing all other alternative ways and means of doing the same thing. In applying the concept of best practice, an analysis of ACE AFRICA strategic objectives<sup>12</sup> indicates that a lot of visible success has been achieved under the agriculture, nutrition and herbal remedies project component. This component has depicted outstanding achievements in supporting and capacity building the project target beneficiaries in achieving nutritional food security to feed those PLWA and OVC<sup>13</sup>.

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<sup>12</sup> As had earlier been carried out in the section of validity of project objectives

<sup>13</sup> For quantitative outcomes refer to section on achievement of quantitative targets in the grant above

41 community support groups are now working with ACE to provide sustainable care to OVC in their communities. Out of this, two support groups have established themselves in the business of making of nutritional flour and are now, through ACE AFRICA, supporting 240 PLWA and OVC per month in the project areas. Majority of the community members are small scale farmers and thus association with agricultural advancement aimed at providing the much needed nutrition is highly adaptable. These support groups support on average 410 OVC per month with basic needs such as clothing, medication, soap etc and 12 community groups have established community gardens which provide 180 OVC with food per month.

To ensure proper transfer of skills ACE AFRICA has established a system of community follow up which involves field officers, community activators and gardeners, mentors and MoA extension officers. Given the large numbers of trainees and importance of community resource person's involvement, community activators conduct follow ups with the aim of gathering basic data. These are monitored on a monthly basis by the M&E officer for quality control. The field officers conduct more focused and analytical follow ups to offer advice and guidance and to ensure that project objectives are met. Technical follow ups are conducted with the assistance of the qualified personnel from ACE and its partners. ACE AFRICA has increased the number of community volunteers (through the retraining of 38 mentors) to assist in following up the increasing number of trainees under the agriculture and nutrition component.

This component (agriculture and nutrition) has shown evidence of and the potential for community members to sustain nutritional support and food security for people infected and affected by HIV/AIDS. It is evident that trained community members are putting into practice the methods they have been taught. The two support groups who have been trained in the processing and manufacturing of nutritious flour are providing community members with regular flour. At this point the community is in a much better position to handle the projects alone but would benefit from investment in the purchase of posho mills to make the business more profitable. They have even acquired the skills in proposal writing to enable source for alternative funding.

Training in micro finance and IGA and provision of loans to groups which started in the second year is also sustainable, but ACE AFRICA needs to ensure that the assessment system which is in place to vet those who can access the business loans is fool proof. It should ensure that those targeted with the loans have business potential, are committed to supporting OVC and can repay the loans duly.

The establishment of CtC clubs in schools to create awareness to the children about HIV/AIDS, health education and life skills counseling is also an example of good practice. This component has enabled children to have a better awareness of HIV/AIDS resulting in a reduction in stigma and discrimination. Children have acquired good farming skills through the establishment of school kitchen gardens which are used to feed OVC, these skills, in some instances have been transferred to their homes. Material support such as school uniforms, blankets and other basic requirements has ensured that OVC are able to attend school more regularly. In terms of sustainability the CtC strategy is on the way to being sustainable.

The implementation of small-scale provision of secondary school fees to deserving OVC has been well received (this component is not under the CR grant.) The component has a vetting system, which has been designed in conjunction with the MoE, of the selection of OVC. Only OVC who gain over 350 marks (out of the possible 500), are destitute and have no other means of furthering their education are supported. The numbers are dependent on individual donors and gender balance is considered in selection. The system has been established and is monitored by a committee headed by the MoE. However, awareness about the system among the community is still low. ACE needs to create awareness about the vetting system to all relevant and concerned individuals and authorities to avoid controversy arising from ignorance. When people are heard complaining that the pass mark has been deliberately put so high to lock out deserving cases, it is concerning especially if some of these are teachers from the CtC schools. In the next funding phase ACE needs to discuss with CR and CiC possibilities of CR supporting this component.

### 3.15 Assessment of programme cost effectiveness based on its achievements and outcomes

#### Introduction

Cost-effectiveness analysis measures program effectiveness by adding a measure of program cost per unit of effect (for example, per number of HIV infections averted). By comparing the costs and consequences of various interventions, cost analyses and cost effectiveness estimates can assist in priority setting, resource allocation decisions, and program design. In conducting the assessment of the cost effectiveness of ACE AFRICA's project intervention, the evaluation looked at various approaches of measuring cost effectiveness decided to use *effectiveness analysis* due to the data (risk behavior, demographic information, intensity, and time of service use) which was sourced from the field and secondary data provided by ACE on programme financing.

Effectiveness analysis entails examining the impact of an intervention on the behavioral, biological, social, or policy outcomes that the intervention was designed to affect. This type of analysis is often considered "outcome evaluations." However, it includes both effectiveness analysis (impact on these measures in the context of true to life service provision, such as an actual intervention in the field), and efficacy analysis (impact on these measures in an intervention being implemented under ideal or "gold standard" conditions). Efficacy analysis typically includes a direct comparison of intervention approaches made, such as would be seen in a multi-arm research study. Health economists frequently discuss the need to understand the "counterfactual" argument for this sort of analysis. "Counterfactual" is a term used by health economists to describe what the finding is being compared to.

The evaluation studied the project grant document, results in terms of outcomes (qualitatively and quantitatively) and triangulated this information with the cost of providing ARV/ART as alternative. project resources in terms of financial, human and other in kind contributions were costed at a total of the whole project grant (funds requested from CR between June 2004 and May 2006) which is £199,385.72 or Kshs 14,355,771.84. This sum was divided in equal proportion to direct the number of direct beneficiaries of ACE AFRICA's project interventions, that is, PLWA and OVC. Outcome effectiveness on PLWA was assessed on the basis of Life Years Saved (LYS) through access to ACE AFRICA's support services. In addition the risk on potential victims was

evaluated on the basis of official statistics on HIV/AIDS infection rates (incidences and prevalence).

The improvements on awareness levels of HIV/AIDS (limiting new infection), health status of PLWA due to proper diet and reduction of stigma and discrimination were some of the most important factors affecting death rates. Outcome effectiveness on OVC was assessed through school enrollment, retention, performance and transition rates resulting from reduced stigma and discrimination, provision of minimum basic needs and child rights watch through CRC. The other parameters considered were provision of support services to OVC caregivers and issuance of IGA loans to beneficiaries committed to supporting OVC.

For the two years ACE has worked in Bungoma, it has reached and supported 240 PLWA and 1,879 OVC. This totals to 2,119 direct beneficiaries of ACE AFRICA's programme intervention of mitigating the impacts of HIV/AIDS. With a budget of Kshs 14,355,771.84 each beneficiary has approximately accessed a total of Kshs 6,774.79 for the two years. In order to estimate the cost effectiveness of ACE AFRICA's mitigation of HIV/AIDS interventions, we estimated the cost of HIV/AIDS impacts and effects mitigated through support services. The cost per direct beneficiary as derived from the grant budget was discounted at a rate of 5% (average annual inflation rate). All costs estimates were adjusted to year 2004. From these costs we calculated the cost per LYS for each mitigation approach based on the following assumptions: 1) Mean survival time from infection to death for HIV+ infants is 3.5 years; 2) Mean survival time from infection to death for HIV+ adults is 10 years; 3) Mean age of HIV diagnosis is 27 years old; 4) life expectancy at birth is 60 years (statistics from Bungoma District Development Plan 2002 – 2008).

Based on statistics from National Aids Control Council (NACC), the programme costs for provision of ARV treatment in developing country settings like Kenya, ranges from \$ 350 per patient to \$ 1,123 per patient. Other analysts have suggested that using programme cost estimates of tuberculosis (TB) directly observed therapy (DOT) is a proxy indicator for ARV therapy programme costs. The cost of TB therapy in Sub-Saharan Africa range from \$ 672 for DOT to \$ 1,897 for conventionally delivered treatment. We used \$ 672 per month as a middle range estimate of the flat cost to administer and monitor the ARV treatment therapy. Because there is no data on the effect of HIV/AIDS ART (HAART) treatment on life expectancy, we assumed with continued treatment, recipients would live out to Kenya's national life expectancy of 66 years without AIDs mortality instead the districts life expectancy of 60 years.

### **ACE AFRICA outcomes on mitigating the of impacts HIV/AIDS**

When ACE began working in Bungoma in September 2003, the HIV/AIDS prevalence rate was over 10%. Currently the rate has reduced to 7%. We assume that through support services offered by ACE AFRICA, and with continuous support, the PLWA life span has increased by 10 years (ART increases life of HIV+ patients by 29 years). According to data obtained from the evaluation, currently it is estimated that one (1) out of ten (10) people in the district is HIV+. Thus the rate has reduced from the then 3 out of 10 two years ago. This shows the trickle down effect mitigation approaches on HIV impacts can have in not only helping victims cope and live positively, but also act as a preventive measure on new infections or incidences. At a cost of Kshs

6774.79 ACE AFRICA has played a complimentary role to that of government and other non-state actors for two years to achieve more or less the same results of mitigation the impacts of HIV/AIDS instead of ARV/ART budget of Kshs 1,161,216 ( $\$672 \times 72$  Exchange Rate (ER)  $\times 24$  months) for the same period.

This means that Kshs 3,387.395 ( $6774.79/2$  years) has been used for each LYS instead of Kshs 580,608 ( $672 \times 72$  (ER)  $\times 12$  months) for each LYS under ART treatment. From this analysis, the programme being implemented by ACE AFRICA on mitigating the impacts of HIV/AIDS among rural communities has proved to be very cost effective in managing HIV+ patients and acting as a preventive measure against new infections. The cost used in terms of financial allocations is just 0.58% of what would have been used under ART.

## PART FOUR: CONCLUSIONS AND RECOMMENDATIONS

### 4.1 Conclusions

The evaluation concludes that after twenty months of implementation under the CR grant ACE AFRICA has made remarkable progress in achieving the expected outcomes as laid down in the grant agreement.

The organization has established 6 demonstration kitchen gardens and trained 248 beneficiaries in organic methods of farming and nutrition resulting in an average of 178 individual community members, 12 community groups and 25 schools with kitchen gardens. Numbers of active gardens vary according to unavoidable variables such as; drought, death, sickness and people moving away.

ACE AFRICA has also trained 38 community members as Trainers of Trainers (mentors) who monitor and follow up trainees in the field providing advice on the ground under the guidance of the Agricultural officer and Ministry of Agriculture farmer field staff. This mentoring system has proved to be very effective in monitoring trainees' progress. Internal evaluations, research and operational findings indicate that community members have increased knowledge about nutrition and its impact on the health of PLWA and OVC and are changing their farming habits from cash crops to food crops, thereby improving household diet, health and income through small scale sales. Findings also indicate that each trainee has increased the number of OVC supported on average by 100%. Through individuals, groups and demonstration gardens, an average of 927 OVC and PLWA receive food on a monthly basis as a direct result of the training.

Remarkable achievements are manifested in the faces of the PLWA and OVC and the community at large. This was evidenced quantitatively through data showing that;

- Average of 1,879 OVC receiving support on a monthly basis through ACE activities and ACE supported community groups. Support includes: provision of basic medication, blankets, mosquito nets, school uniforms, primary and secondary boarding school fees, clothes, shoes, nutritional supplements, counseling and food from kitchen gardens.
- Over 34,000 community members have accessed ACE services. Services include: training in: Agriculture & Nutrition, Herbal remedies, Income Generating Activities, Child Rights, Child to Child HIV/AIDS Education, Provision of: Counseling, Voluntary Counseling & Testing, medication, nutritional supplements, food from ACE gardens & community gardens.
- 41 community support groups are now working with ACE to provide sustainable care to OVC in their communities

The programme has succeeded in mitigating the impacts of HIV/AIDS on those affected and infected by the disease. High achievements have been realized in the areas of ensuring food security through the agriculture and nutrition component that has enabled the beneficiaries to have at least three meals in a day which was not the case before. The food support from the kitchen gardens is in addition to nutritional supplements. The component on Child to Child,

counseling and VCT services for the community have reduced the spread of HIV/AIDS from a previous prevalence rate of 14% to less than 10%. Behaviour change among the youth has been fostered through counseling services that have focused on the demystification of HIV/AIDS in relation to cultural issues.

The livelihoods of PLWA and OVC have been greatly impacted in relation to the four parameters of improvement.

1. The health status of PLWA has improved tremendously. At the time ACE AFRICA did its baseline survey in 2002, the health status of PLWA was marked with loss of weight, people being bed ridden, and symptoms of HIV/AIDS were easily determinable through opportunistic infections. Right now the project has addressed the health issues through nutritional supplies, support groups, referrals of PLWA to partner organizations offering ARVs, herbal remedies and capacity building in agriculture and nutrition. This has ultimately impacted on the health of PLWA and OVC.

2. The reduction of stigma and discrimination. When ACE AFRICA intervened in Bungoma in 2003, stigma and discrimination was marked by non-disclosure of status, fear to visit VCT centres, and disassociation from public life by those infected. The current situation after only two years can be described as remarkable. OVC who had dropped out of school due to discrimination are now back in school. The child to child clubs approach for HIV awareness and counseling has highly promoted positive living among children and the young beneficiaries. The clubs formed in schools integrate both OVC and non-OVC children in counseling sessions to address issues related to HIV/AIDS. This has helped in changing the attitude of children and to make them more aware of the risks of HIV infection within their communities. Topics on how the disease is spread, symptoms, abstinence and care for the infected have helped the young beneficiaries be more accommodative and responsible for their behavior. ACE AFRICA has enabled 2,879 children to take part in club activities and to mobilize children from CtC clubs from 11 schools to visit and provide food and care for community members affected and infected with HIV/AIDS.

3. Improvement of community access to support services and networks have attributed to; i) formation of more support groups in the targeted project areas ii) more referrals of community members infected to other organizations iii) referrals to networks and government medical healthcare systems for drugs and further support services. Working with i) district line ministries in training and capacity building and collaboration in service delivery ii) other local partner organisations in creating and strengthening partnerships iii) the engagement of community members such as activators, gardeners and those in support groups targeted by micro finance training and IGA have all generated the necessary social capital that has enhanced community ownership of the project and cost reduction in project interventions. Through this close collaboration, ACE has secured land (for demonstration gardens) and other office space at local health centres in each of the six project areas to set up Community Resource Centres.

4. In terms of coordination and management, ACE AFRICA has managed to implement the project in two years with a lean secretariat and systems have been well put in place to streamline human resource and financial management. Entrenchment of good communication systems through conventional and dynamic horizontal and vertical information flow in the organisation has by and large furthered participatory inclusion and engagement of project beneficiaries in problem identification and strategic intervention.

5. Input factors like consultancies have been minimized. Field outreach costs have been well managed based on local situations with the least costs possible. M&E systems have been strengthened with the implementation of an effective internal M&E system in the organisation facilitated by an M&E officer. However, we propose that ACE now needs to access funds to strengthen the M&E system through the recruitment of an additional M&E staff and/or appropriate data analyst to assist the staff already in place in order to effectively collect and analyse data in the field.

Finally the programme according to our SWOT analysis has a 75% success rate and 25% failure rate

*The following factors have contributed to the 75% success of the programme:*

**Programmatic approach and design:** The project was designed in non prioritized componential entities that have had a holistic approach towards capacity building within communities affected by HIV/AIDS. This approach has proved to be effective in mitigating the affects of HIV/AIDS on those infected and affected, particularly children and ways in which their community can support them.

**Working at the grassroots/community level:** ACE AFRICA has to be commended for its decision to set base in Bungoma. Many organisations which are mainly funded from abroad have the tendency of claiming to address grassroots issues while their offices are based at the capital cities. It is unrealistic to address HIV/AIDS through theory and one must have first have experience of what is happening on the ground to have the compassion and commitment to solve it. The strategy of establishing their offices in Bungoma has enabled ACE to cut field costs, foster a strong relationship with the local community and encourage community ownership of the project. Issues of monitoring progress and impact are more tangible at the grassroots.

**Proper project activity scaling:** ACE AFRICA gauged the resources available and decided to cover only six project areas instead of the whole district. This has made the objectives achievable with emphasis laid on proportion and scale of intervention for realistic impacts.

**Networking and collaboration** with the government line ministries, local and national partner NGOs has been very positive.

**Community social empowerment**, through training and capacity building working strongly to ensure skills transfer and adoption and sustainability assurance.

**Proper personnel and financial management systems** have created trust among the community on how ACE AFRICA is transparent and accountable in its operations. This also goes in line with communication and information sharing mechanisms that ACE AFRICA has put in place to ensure community beneficiaries' needs are addressed, community participation and ownership of the project and good relationship between ACE AFRICA, CiC and CR fostered for continued funding support.

**Proper systems of project management and M&E** - project management covers activity planning, preparation/logistic arrangements, implementation/facilitation, reporting, monitoring and evaluation. The right mechanism has been put in place by ACE to intervene at every stage. Good reporting and filing systems have furthered confidence in information processing and dissemination of findings of all records of project activities.

*The following factors have contributed to the 25% failure of the programme:*

**Lack of a substantively developed project logical framework (log frame matrix):** In drafting the project grant proposal that CR funded, ACE AFRICA did not elaborately design a project log frame showing programme goal, purpose, activities, outputs/outcomes, Objectively Verifiable Indicators (OVI), Means of Verification (MoV) and assumptions. This made it difficult to assess results based on agreed upon outputs and outcome indicators. Results based management requires that a logical framework of a programme must be developed to link inputs and outputs and processes of implementation (activities and strategies) with outcomes.

**IGAs and Micro Finance project component implemented through a trial-and-error method (learn-from-doing approach).** In the first year of operation (2004/05) ACE AFRICA the project beneficiaries (individuals and groups) with IGAs training and MF loans. However, loan recovery from most of the individual beneficiaries became cumbersome as their credit worthiness and commitment to repay the loans had not been guaranteed. This was however reviewed after the internal evaluation after the first year and the IGAs and MF component was reformed to only target groups and potential business people (beneficiaries) with already started businesses. Their ability to repay the loans is now being vetted through as assessment process with written documentation.

## 4.2 Recommendations

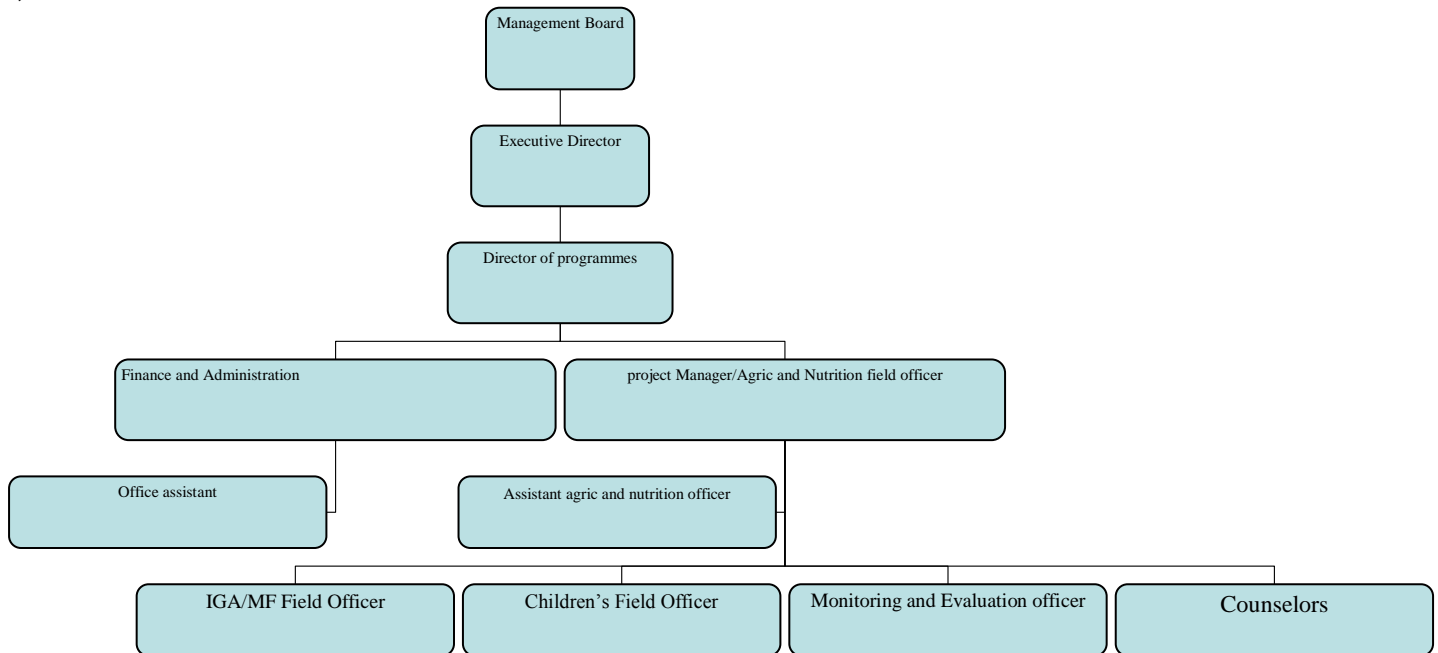
From the issues arising above in our discussion, we propose the following recommendations for future programming by ACE AFRICA under the HIV/AIDS programme.

### 1. Organization governance and management systems

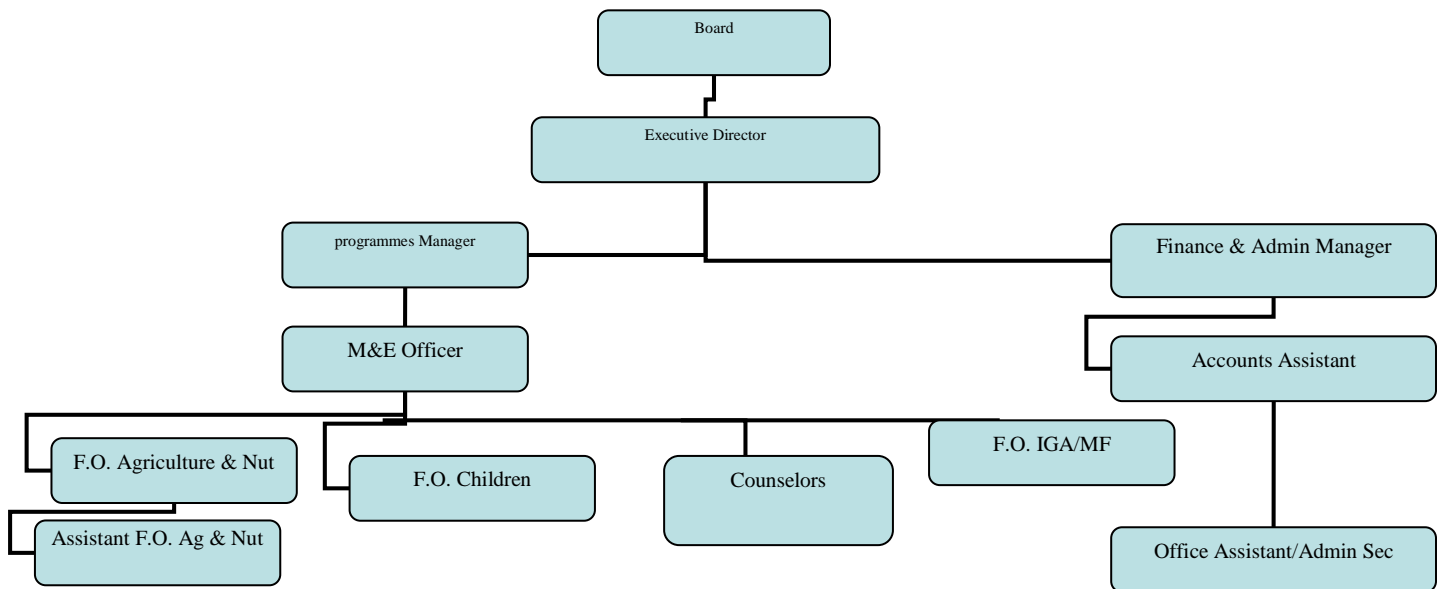
From our analysis of how ACE AFRICA is structured as an organization, we feel there are certain gaps that need to be addressed. The first one is in terms of inter-staff support, delegation of duties, assistance and subordination. The organization has the necessary human resources adequate to take charge of programme planning and management and organizational administration. However the structure needs to be streamlined to create the right inter-linkage

between organization’s governance levels and programme components. The organization needs to critically look at its organogram to enhance effective communication, networking, work delegation, supervision and feedback mechanisms. Based on what is currently the organization structure we propose structural realignment as illustrated.

**i) Current structure<sup>14</sup>**



**ii) Proposed Structure**



<sup>14</sup> ACE Management Board works in conjunction with the ACE UK board. The office assistant and assistant agric and nutrition officer are subordinate to field officer level.

## **2. Staff Capacity Building and Logistical support**

ACE AFRICA needs to invest in staff capacity enhancement through refresher and advanced courses in the line of profession and empowerment through organized sessions for staff knowledge and experience sharing and information exchange.

On the issue of logistical arrangements for workload management, we recommend that ACE AFRICA should explore more practical, effective means of enabling field officers access and conduct fieldwork. The current situation involves inadequate vehicles which are expensive to maintain which is not cost effective. ACE should invest in the procurement of either motorbikes or new vehicles.

## **3. Programming**

The scope of programming work used by ACE AFRICA is largely voluntary direct service delivery to the PLWA, OVC and other affected members of the community. ACE AFRICA in retrospect has done well to ensure skills transfer to the community to manage support for PLWA and OVC. Training and capacity building activities have been conducted to this effect. There are a few issues that ACE needs to address in future:

1. Development of programme logical framework whether it is a donor requirement or not. This log frame must be shared with relevant partners especially staff, donors and programme reviewers.
2. Enhance small scale provision of secondary schools which seems to compliment the CR funded component of CtC and OVC guidance and counseling in schools and other support services provided to the OVC. In future ACE needs to attract donors to support this in addition to the current individual sponsors.
3. As was rightfully identified by ACE after the first year of operation, the IGA loans should only go to organized groups.
4. Increase training of community beneficiaries to establish and maintain kitchen gardens. This component is very sustainable. However more on farm training should be adopted to ensure maximum impacts
5. Diversification of activities to include the commercial sex workers in the district. Bungoma as a district is situated along the Northern Corridor, a road with many transit truck drivers. Commercial sex work in the area is thriving in small centres in the district like Bukembe and Kanduyi. This phenomenon increases the risk of infection among the population. As such ACE AFRICA needs to focus on creation of awareness, and management of STDs for sex workers in Bukembe and Kanduyi project areas among others.

Future phases should ensure community members are; i) targeted with capacity building to adopt skills and maintain them in practice ii) support groups formed acquire the needed skills to seek for and obtain alternative local government support and funding for their activities iii) more potentially high achieving OVC in the last year of primary school are able to transit to secondary school iv) IGA groups like those producing the nutritional flour have further

investment like the provision of posho mills as well as continued follow-ups from ACE to support and develop into fully sustainable businesses.

#### **4. Collaboration and networking and intensification of beneficiary targeting**

In terms of programme area geographical mapping and taking into consideration the resource constraints, we propose that ACE AFRICA and partners implementing HIV/AIDS programmes in Bungoma utilize the existing collaborative and networking efforts like stakeholder forums to conduct a proper geographical area mapping of the locations (project areas) to cover the whole district rather concentrate in a few areas.

#### **5. Need for a Strategic Plan.**

In our assessment we also learned that ACE implements more than one programme with overlapping interventions aimed at mitigating the impacts of HIV/AIDS in Bungoma. Earlier in our recommendations we had alluded to the fact that the CR funded programme needs to be reviewed in future in terms of putting in place a logical framework to help in monitoring and evaluating progress and results.

Considering all these adding to the fact that ACE AFRICA has also expressed intention to continue sourcing for additional funds for scale-up and intensification in activities, we propose that all these should be harmonized in a strategic plan. ACE AFRICA should explore as a matter of priority focus embarking on the development of a strategic plan that will highlight SWOT issues and future programming directions.

This in our view will help the organization in fundraising and streamlining of structure, governance, operations and programming. ACE should use the already existing good rapport and strong relationships with donors to request for technical and financial assistance towards the facilitation and development of a strategic plan.

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## ANNEX ONE:

### OVC SUPPORT DISAGGREGATED DATA

The average number of OVC's supported on a monthly basis as a direct result of ACE AFRICA's intervention is as follows:

|                                                               |              |
|---------------------------------------------------------------|--------------|
| • OVC receiving basic medication                              | 41           |
| • OVC receiving nutritional supplements                       | 51           |
| • OVC receiving counseling                                    | 17           |
| • OVC receiving food from support group gardens               | 180          |
| • OVC receiving food from demo gardens                        | 54           |
| • OVC receiving food from individual trainees                 | 693          |
| • OVC receiving school uniform                                | 10           |
| • OVC receiving blankets                                      | 5            |
| • OVC receiving mosquito nets                                 | 5            |
| • OVC receiving support from PLWA/OVC support groups          | 410          |
| • OVC receiving support from IGA/MF trainees                  | 360          |
| • OVC supported in Primary boarding school                    | 13           |
| • OVC supported in Secondary boarding school                  | 13           |
| • OVC receiving clothes and shoes                             | 27           |
| <b>TOTAL No of OVC regularly supported on a monthly basis</b> | <b>1,879</b> |

## ANNEX TWO: LIST OF KEY INFORMANTS

| No. | Name               | Designation              | Location/project area/Organisation | Contacts                           | Date of Interview |
|-----|--------------------|--------------------------|------------------------------------|------------------------------------|-------------------|
| 1   | Agnes Nambuye      | KECHN                    | Bukembe                            | Box 183<br>Bungoma                 | 14.03.06          |
| 2   | Innocent Sifuna    | DDPHO                    | Bungoma Dist. Hospital             |                                    |                   |
| 3   | Wycliffe Kokonya   | programmes Officer       | FHI, Bungoma                       | Box 869<br>Bungoma<br>Tel.05530940 | 17/03.06          |
| 4   | Kennedy Bunyasi    | Chief                    | Bukembe                            | Box 34 Bukembe<br>Tel. 0733421837  | 14.03.06          |
| 5.  | Eliud Muyekho      | Ag. Chief                | Kabuchai                           | Box 1475 BGM<br>Tel. 0735562242    | 15.03.06          |
| 6   | Maristella Wechabe | Immediate DAO            | Bungoma                            | Tel. 0735259126                    | 16.03.06          |
| 7.  | Barasa Wanyonyi    | H/M                      | Kabuchai Primary School            | Box 163 BGM<br>Tel. 0733704437     | 16.03.06          |
| 8   | Jane Mukhwana      | Field Officer - BOEW     | Bungoma                            | Box 1162 BGM<br>Tel. 05530281      | 16.03.06          |
| 9   | Dismas Famba       | Church Leader            | Mechimeru                          | Box 27 BGM                         | 15.03.06          |
| 10  | Geoffrey Ruchu     | Drug Keeper – Lukes Fund | Bungoma                            | Box. 662 BGM<br>Tel. 0735180539    | 16.03.06          |
| 11  | Florence Wekesa    | Sister in Charge         | Kabuchai Health Centre             | Box14 BGM<br>Tel. 0734404815       | 15.03.06          |
| 12  | Genetrix Amatha    | Education Officer        | Bungoma                            | Box 40BGM<br>Tel. 05530148         | 16.03.06          |
| 13  | Ignatius Chemuiku  | Reverend                 | Kabula                             | Box 248 BGM<br>Tel. 0720265041     | 14.03.06          |
| 14  | Joseph Mwanja      | Assiatant Chief          | Kabula                             | Box 1044 BGM<br>Te. 0735712783     | 14.03.06          |
| 15  | Elijah Mogaka      | Nurse                    | Bulondo                            | Tel. 0733403410                    | 14.03.06          |
| 16  | Masai Wilfred      | Chairman -               | Bulondo                            | Box 349 BGM                        | 14.03.06          |

|    |                      |                                                      |                          |                                        |          |
|----|----------------------|------------------------------------------------------|--------------------------|----------------------------------------|----------|
| 17 | Julius Masibo        | Chief                                                | Sitilikho -Milo          | Box 1559<br>Webuye<br>Tel. 0733543290  | 16.03.06 |
| 18 | Beatrice<br>Mulamwia | Sister in<br>Charge                                  | Milo                     | Box. 1559<br>Webuye<br>Tel. 0733233479 | 16.03.06 |
| 19 | Gladys Webuke        | H/M – Sango<br>FYM Pr.<br>School                     | Mechimeru                | Box 607 BGM<br>Tel. 0734532167         | 15.03.06 |
| 20 | Cosmas<br>Wanjala    | Member of<br>Child Rights<br>Com. & LATF<br>Chairmen | Mechimeru                | Box 1339 BGM<br>Tel. 0735719174        | 15.03.06 |
| 21 | Helen S. Wabile      | Sister in<br>Charge                                  | Kabula Health<br>Centre  | Box 25 Kabula<br>Tel. 0733571529       | 14.03.06 |
| 22 | Jasica Maelo         | KECHN                                                | Mechimeru                | Box 14 BGM                             | 14.03.06 |
| 23 | Joseph Lugende       | Clan Elder                                           | Bukembe                  | Box 183 BGM                            | 14.03.06 |
| 24 | Jairus Munuya        | Planing<br>Chairman –<br>Friends<br>Church           | Bukembe                  | Box 183 BGM                            | 14.03.06 |
| 25 | Chebii Stephen       | Coordinator                                          | World Vision,<br>Bungoma | Tel. 0735873527                        | 16.03.06 |

**ANNEX THREE: LIST COMMUNITY ACTIVATORS AND GARDENERS INTERVIEWED  
ON 14<sup>TH</sup> MARCH 2006 AT FHI'S BOARDROOM**

| <b>No</b> | <b>Name</b>       | <b>Location/project Area</b> | <b>Sex</b> |
|-----------|-------------------|------------------------------|------------|
| 1.        | Janepher Ngoicho  | Marakaru Sub Location        | Female     |
| 2.        | Elizabeth Wasike  | Kabula                       | Female     |
| 3.        | Esther Wamalwa    | Bukembe                      | Female     |
| 4.        | Joel Muhuyi       | Milo                         | Male       |
| 5.        | Julius Oqera      | Mechimeru                    | Male       |
| 6.        | Ferdinand Wanyama | Mechimeru                    | Male       |
| 7.        | Francis Wesonga   | Kabula                       | Male       |
| 8.        | Martin Martin     | Kabuchai                     | Male       |
| 9.        | Bramuel Chaki     | Mechimeru                    | Male       |

## ANNEX FOUR: EVALUATION TOOLS

## ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.

## TOOL 1: QUESTIONNAIRE FOR BENEFICIARY PLWA

## a) Respondents Details

In the table below indicate where you fall by column

| 1. Sex                                                                  | 2. Age                                                                                                                                                                                                                                                                                                       | 3. Marital and Family Status                                                                                                                                 | 4. Education Level                                                                                                                                                                                                                                            | 5. Occupation                                                                                                                                                                                                  |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| i) Male <input type="checkbox"/><br>ii) Female <input type="checkbox"/> | i) 15-20 <input type="checkbox"/><br>ii) 20-25 <input type="checkbox"/><br>iii) 25-30 <input type="checkbox"/><br>iv) 30-35 <input type="checkbox"/><br>v) 35-40 <input type="checkbox"/><br>vi) 40-45 <input type="checkbox"/><br>vii) 45-50 <input type="checkbox"/><br>viii) 50+ <input type="checkbox"/> | i) Single <input type="checkbox"/><br>ii) Married <input type="checkbox"/><br>iii) Widowed <input type="checkbox"/><br>iv) Divorced <input type="checkbox"/> | i) No formal education <input type="checkbox"/><br>ii) Primary Education <input type="checkbox"/><br>iii) Secondary Education <input type="checkbox"/><br>iv) Tertiary Education <input type="checkbox"/><br>v) University Education <input type="checkbox"/> | i) Formal <input type="checkbox"/><br>ii) Informal/jua kali <input type="checkbox"/><br>iii) Unemployed <input type="checkbox"/><br>iv) Business <input type="checkbox"/><br>v) Other <input type="checkbox"/> |

## b) General Introductory Questions

1. When were you diagnosed with HIV/AIDS (probe for year and age?)

2. Where (place of diagnosis)

- i) Hospital
- ii) VCT
- iii) Prenatal Clinics

3. When did you declare your status publicly?

4. Who is aware of your status?

- i) Family members
- ii) Community
- iii) Employer
- iv) Friends
- v) Others

5. Are you in any welfare group for HIV/AIDS?

6. What kind of assistance have you received (probe for assistance provided by ACE AFRICA)
7. Apart from the above support what other support do you require?
8. What challenges do you encounter as a PLWA?
9. What do you think can be done to address them?

**c) Establishment of Rural Community Support Centers, providing information, education and referral for those infected and affected by HIV/AIDS**

1. How does ACE provide its services to the community?
  - i) Through staff
  - ii) From a central point (at their offices)
  - iii) Visits to those in need like PLWA
  - iv) Through community groups formed around issues/needs
  - v) Through chiefs/provincial administration
  - vi) Through centres like schools, churches, health centres e.t.c.
  - vii) Others
2. Are you aware of any community support centre providing services to those infected and affected by HIV/AIDS in the location?
  - i) Yes
  - ii) No
3. If yes how many are you aware of
4. What services or help do you get from these centres?
  - i) Information on HIV/AIDS
  - ii) Referral for those infected and affected
  - iii) Others
5. What is your view on the quality of service provided by these centres on referral and information provision?
  - i) High
  - ii) Good
  - iii) Fair
  - iv) Poor
6. How accessible are the centres to the PLWA in terms of distance, service providers' perception and affordability of services (if user fees are charged)?
  - i) Nearer and reachable easily
  - ii) Service providers are in tolerant
  - iii) Service providers are tolerant and hospitable
  - iv) Far away from reach (transportation means needed)

- v) All is well in terms of distance and service
- vi) Indifferent
- vii) Others

7. How have the centres helped you improve your life as PLWA (probe for health, nutrition, information e.t.c.)

**d) Improvement of the Skills and capacity of the community in Nutrition, agriculture and the cultivation and the use of herbal remedies in the context of practical realities of HIV/AIDS**

1. What nutritional challenges do you experience as PLWA?

- i) Loss of appetite
- ii) Weight loss
- iii) Stress
- iv) Diarrhea
- v) Boils and rashes
- vi) Body weakness
- vii) Others

2. Do you have knowledge on herbal remedies towards the management of HIV/AIDS?

- i) Yes
- ii) No

3. What help have you gotten from ACE AFRICA to improve your skills on good nutritional habits?

- i) Training on health eating
- ii) Training in food production
- iii) Introduction of new farming methods
- iv) Others

4. What training have you gotten from ACE AFRICA to improve your agricultural skill?

- i) Kitchen gardening
- ii) Farm management
- iii) Organic farming
- iv) Others

5. How has this knowledge helped you agriculturally?

6. What barriers do have against the use of herbal remedies in controlling HIV/AIDS?

- i) Cultural
- ii) Access/availability
- iii) Perception
- iv) Ignorance
- v) Lack of knowledge on usage
- vi) Others

7. How has ACE programme helped you improve and encourage utility of herbal remedies?

8. What changes do see in your health as a result of this support?

- i) Increased Appetite
- ii) Weight gain
- iii) Body Strength
- iv) Brighter Skin
- v) Reduced boils and rashes
- vi) Reduced pains and aches
- vii) Reduced diarrhea
- viii) Lack of Stress

9. What material assistance have you gotten towards improving your health?

- i) Nutritional supplements
- ii) ARVs/ART
- iii) Counseling to manage stress
- Others

**e) Enhancement of the sustainability of community activities through training in income generation**

1. What are your sources of income?

- i) Business
- ii) Farming
- iii) Formal employment
- iv) Casual jobs
- v) Support from groups and family
- vi) Others

2. Have you received any training or support from ACE AFRICA on income generation?

- i) Yes
- ii) No

3. If yes, how has it helped you improve your household income?

4. Have you accessed micro finance from ACE to assist you start or improve your IGA venture?

- i) Yes
- ii) No

5. a) If yes, what was the eligibility criteria?

- i) Collateral
- ii) HIV/AIDS status
- iii) Responsibilities towards caring for the PLWA and OVC
- iv) Already established IGA

- v) Business plan
- vi) Group application
- vii) Others

b) Which IGAs do loanees venture into?

6. Are there specific areas or activities you are expected to venture into when accessing the loan

- i) Yes
- ii) No

7. If yes, which ones

8. What is the loan repayment system (if there is?)

9. Have you repaid/ or are you in the process of repaying the loan given

- i) Yes
- ii) No

10. If no, why

**f) Establishment of child to child services/life skills/counseling facilities for OVC with a focus on HIV/AIDS prevention and positive living**

1. What is your opinion on the child to child services introduced by ACE AFRICA programme on?

- Creating awareness on HIV/AIDS to children in school
- Life skills provision
- Counseling for OVC

**g) Facilitation of the Reduction of Stigma and Discrimination associated with HIV/AIDS by raising levels of awareness in the community**

1. What kind of support do you get from ACE AFRICA to help you cope with stigma and discrimination from the community and public at large?

- i) Counseling and emotional support
- ii) HIV/AIDS Awareness creation
- iii) Other

2. How is the community targeted to help them accommodate PLWA?

3. How can prove that stigmatization and discrimination of PLWA among the community has reduced

- i) Many people are now declaring their status
- ii) PLWA are increasingly being involved in community affairs
- iii) People now discuss the HIV/AIDS commonly and publicly

- iv) Those uninfected do not fear mixing with PLWA
- v) Others

**h) Achievements of the programmes**

1. How do you feel now as compared to when the program had not started?
2. How has it helped to improve the livelihood of the community, PLWA and OVC in general?
3. Since the introduction what tangible changes are there (probe for children taken to school, awareness created, HIV/AIDS prevention and care services including facilities offered and established e.t.c.)

**g) Best Practice and Recommendations**

- 1 Which activities by the ACE AFRICA bring you as an individual or your group with others in the location, division or district?
3. What is your opinion about the networking? How many networks of PLWA have been formed (probe for location, division of district?)
4. What are the requirements for one to be a member in these groups a part for sharing a common problem of HIV/AIDS?
5. How have the networks improved your access to support?
6. In implementing the programme has ACE AFRICA involved the community and other organized groups like SHG, NGOs, Churches, Schools e.t.c.?
7. What are your comments on how ACE AFRICA has implemented this programme in this area in terms of consultations, engagement, service delivery, care, information dissemination and exchange and sustainability?
8. What would you like them to do differently and why?

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL SIX: FOCUS GROUP DISCUSSION GUIDE FOR COMMUNITY SUPPORT GROUPS AND ACE AFRICA COMMUNITY ACTIVATORS AND GARDENERS**

Date and Time of Interview.....

**Participants Details**

- Number of participants.....
- Group.....
- Age Groups.....
- Sex Distribution .....Men.....Women
- Location.....

**Establishment of Rural Community Support Centers, providing information, education and Referral for those infected and affected by HIV/AIDS**

1. How does ACE AFRICA generally provide support to mitigate the impacts of HIV/AIDS among infected and affected people in the community (probe for channels of service delivery such as HBC, VCT, home visits,)
2. How are community members involved in provision of this support for sustainability and ownership purposes
3. What activities are you involved in (probe for location and target groups – widows, PLWA, OVC e.t.c.?)
4. How many beneficiaries are under your care and/or support?
5. How do you deliver your support to the community (probe for community support centres VCT, training, awareness, networking)
6. What is your opinion on the effectiveness of Community Support Centers

**Improvement of the Skills and capacity of the community in Nutrition, agriculture and the cultivation and the use of herbal remedies in the context of practical realities of HIV/AIDS**

1. How does ACE deliver capacity building on nutrition, agriculture and cultivation and use of herbal remedies to the community?
2. How are you involved in the activities?

3. What support do you receive from ACE to enable you deliver on the above and how effective is it?
4. What are some of the successes you see among the communities due to this component of the project?
5. If it were to be done all over again, what would you recommend (approach, activities, and sustainability?)

### **Enhancement Of The Sustainability Of Community Activities Through Training In Income Generation**

1. What are the sources of income of majority of the community members?
2. How does ACE AFRICA deliver training in income generation?
3. How are you involved in the activities?
4. What support do you receive from ACE to enable you deliver on the above and how effective is it?
5. What are some of the successes you see among the communities due to this component of the project?
6. If it were to be done all over again, what would you recommend (approach, activities, and sustainability?)

### **Establishment of Child To Child Services/Life Skills/Counseling Facilities For OVC With a Focus on HIV HIV/AIDS Prevention And Positive Living**

1. What is your opinion on the child to child services introduced by ACE AFRICA program on?
  - Creating awareness on HIV/AIDS to children in school
  - Life skills provision
  - Counseling for OVC
2. How have they helped change the lives of children and OVC under your care and others in the community?
3. What role has this program helped in furthering the realization of children rights
4. How sustainable are the programmes?
5. What would you like done differently to achieve higher results

### **Facilitation of the Reduction of Stigma and Discrimination associated with HIV/AIDS by raising levels of awareness in the community**

1. How do you rate the public awareness about HIV/AIDS now as compared to the past (probe for community's perception of PLWA and OVC)
2. In your opinion what is the prevalence rate of HIV/AIDS as compared to two years ago (probe for frequency of deaths, symptoms associated with HIV/AIDS)
3. How many PLWA do you know of?
4. How did you get to know about them?
5. What is the difference between men and women as PLWA in terms of ease with which they declare their status and coping mechanism?
6. What problems do PLWA and OVC experience in the community (probe for stigma and discrimination)?
7. How are you responding to these issues in collaboration with ACE AFRICA?
8. How has life of PLWA and OVC changed in terms :
  - a. Their Health
  - b. Children accessing schooling
  - c. Stigma and discrimination by the public
  - d. Formation of groups to help in access to services
  - e. Strengthened community capacity and skills to handle HIV/AIDS
  - f. Provision of community resources towards HIV/AIDS fight
9. For the time ACE AFRICA has been working what positive impacts have you seen in terms of the fight against HIV/AIDS (probe for indicators)

### **General Improvements, Networking and Best Practice**

1. Which other groups are working in the area towards the fight against HIV?
2. What has ACE AFRICA done to harness the work of these groups
3. What are your recommendations for future programming in this area?
4. For the time ACE AFRICA has been working what positive impacts have you seen in terms of the fight against HIV/AIDS (probe for indicators)
5. What would you recommend in terms of sustainability of the programme (probe for less or no support from ACE)

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL THREE: FOCUS GROUP GUIDE FOR CHILDREN IN PARTNER SCHOOLS AND OVC AND YOUTH**

Date and Time of Interview .....

**Participants Details**

- Number of participants.....
- Group.....
- Age Groups.....
- Sex Distribution .....Men.....Women
- Location.....

**Introductory Questions for Children and OVC**

1. What do you know about ACE AFRICA?
2. What activities does ACE implement in your schools to create HIV/AIDS awareness among the pupils?
3. How does ACE help OVC in school and out of school?
4. What problems do you as children experience in your homes due to HIV/AIDS?
5. What do you think about those PLWA and OVC among you?

**Establishment of Rural Community Support Centers, providing information, education and Referral for those infected and affected by HIV/AIDS**

1. Are you aware of community support centres established by ACE AFRICA to provide information and referral to those infected and affected by HIV/AIDS (probe for location, mode of operation, services offered to various groups e.t.c.)
2. How has the setting up of these centres helped the children and OVC / Youth in the fight against HIV/AIDS
3. Of what benefit are the centres Children and OVC/ Youth in particular (probe for services or support that particular groups gets from the centres
4. What are your opinions on access, relevance, and sustainability of the centres?
5. How do you rate the children / youth awareness about HIV/AIDS now as compared to the past (probe for community's perception of PLWA and OVC)

### **Improvement of the Skills and capacity of the community in Nutrition, agriculture and the cultivation and the use of herbal remedies in the context of practical realities of HIV/AIDS**

1. What types of support and services towards improving the livelihood of children, OVC and Youth are offered by ACE AFRICA?
2. How is the support provided (probe for channels of service delivery such as through schools, HBC, VCT, home visits,)
3. How is the support/services channeled to reach children and OVC / Youth
4. How have your nutritional skills improved in handling care and support to PLWA and OVC under your care?
5. What training, support, assistance is available to improve agricultural practice among the youth (for the youth only)
6. What changes are there due to the above at home, in the school and community at large?
7. Are there herbal remedies for managing HIV/AIDS?
8. How accessible are they to the Children and OVC and Youth
9. What has ACE done to take advantage of this fact to help those PLWA and OVC?
10. What challenges are there on herbal remedies?
11. What are the impacts of these activities on the community including PLWA and OVC
  - ⊙ Nutrition programme
  - ⊙ Agriculture
  - ⊙ Herbal remedies

### **Enhancement of the sustainability of community activities through training in income generation (for the Youth)**

1. What are your sources of income?
2. Have you received any training or support from ACE AFRICA on income generation?
3. If yes, how has it helped you improve your livelihood status as a youth?
4. Have you accessed micro finance from ACE to assist you start or improve your IGA venture (probe for pros and cons for managing the funds)?
5. If yes, what were the eligibility criteria?
6. Which IGAs do majority of young loanees venture into?
7. Are they profitable and if not what drives them into these (probe for peer pressure)
8. Are there specific areas or activities you are expected to venture into when accessing the loan
9. If yes, which ones
10. How has the loan helped you as youth in the fight against HIV/AIDS

### **Establishment of child to child services/life skills/counseling facilities for OVC with a focus on HIV HIV/AIDS prevention and positive living**

1. What is your opinion on the child to child services introduced by ACE AFRICA programme on?
  - Creating awareness on HIV/AIDS to children in school
  - Life skills provision
  - Counseling for OVC

2. How have they helped change the lives of children and OVC and others in the community?
3. What are your opinions on the contribution of the component to children's and Youth awareness on HIV/AIDS
4. (for youth only) How sustainable are the programmes?
5. What would you like done differently to achieve higher results

**Facilitation of the Reduction of Stigma and Discrimination associated with HIV/AIDS by raising levels of awareness in the community**

1. How do you rate the public awareness about HIV/AIDS now as compared to the past (probe for community's perception of PLWA and OVC)
2. In your opinion what is the prevalence rate of HIV/AIDS as compared to two years ago (probe for frequency of deaths, symptoms associated with HIV/AIDS)
3. How many PLWA do you know of?
4. How did you get to know about them?
5. What problems do children and OVC /youth experience in the community (probe for stigma and discrimination)?
6. How does stigma and discrimination manifest itself in the community towards PLWA and OVC
7. How has ACE AFRICA helped reduce this stigma and discrimination?

**General Improvements, Networking and Best Practice**

1. Impacts
  - Their Health
  - Children accessing schooling
  - Stigma and discrimination by the public
  - Formation of groups to help in access to services
  - Youth awareness about HIV AIDs
2. Other groups they know of working in the area
3. What do they like about the groups
4. Are they aware these groups work with ACE AFRICA, and on what issues
5. If no, do you feel there is need for these groups and why?
6. What would ye recommend in terms of sustainability of the programme (probe for less or no support from ACE)

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL SEVEN: QUESTIONNAIRE FOR STAFF**

**PART ONE: STAFF PERFORMANCE**

Designation..... Date of Interview.....

Period of service.....

Educational Level.....

Sex.....

1. When was the organization founded?
2. What is the status of ACE AFRICA?
3. What are the Vision, Mission and Objectives of the organization?
4. What is the management structure of the organization?
5. For how long have you worked with ACE AFRICA and your roles as a staff member of the Organization?
6. What are you in charge of in the HIV/AIDS programme?
7. What have you been able to achieve in the course of your work with ACE AFRICA (successes made)?
8. What challenges or constraints do encounter in your work internally (secretariat) and externally (with the target groups)
9. Are you motivated to work (yes/no)
10. If yes what motivates you (probe for incentives)
11. If no, why (probe for what is lacking and the desirable state)
12. How would you describe your working environment internally and externally (probe for relationship with partners)
13. What can say about the work load in terms of logistics, technicalities competence and time allowance
14. What capacity needs do have if any and what support do need in terms of capacity enhancement?
15. How do you plan for your work (organizationally at unit/staff level)
16. What is the completion rate of activities scheduled (quarterly, biannually, annually)
17. How would you rate your individual, unit/department and organizational performance in achieving results based on action plans?
18. Finally what interest you most in your work? How has it influenced your work prioritization

**PART TWO: PROGRAMMING WORK**

19. What is the programme focus in terms of Goal, objectives, target groups and geographical coverage and partnership structures?

20. How is the programme implemented;
  - Community targeting, mobilization, and facilitation (outreach)
  - Methodology of activity implementation (e.g. workshops)
  - Timing (probe
  - reporting
  - Financial management
21. How do you gauge the effectiveness of these against results, explain (probe for M&E)
22. What do you think works best based on the experience you have with implementing the programme? Why?
23. Which are the different members of staff engaged in the programme implementation and what are their roles?
24. Would you say the organization has adequate HR capacity to steer the programme
25. In case of shortages, where do they exist
26. What has the programme been able to achieve in the areas it had objected?
27. How can you show that the programme has impacted positively on:
  - a) The health of OVC and PLWA
  - b) Capacity of the community and will to provide and sustain support for OVC and those infected and affected
  - c) Community access to support services and networks
  - d) Stigma and discrimination with HIV/AIDS (probe for output and outcome indicators)
28. What are the challenges/constraints encountered in the course of programme implementation
29. What systems are in place for monitoring and evaluation
30. Is there a programme log frame developed to guide measurement of progress against targets
31. How do you measure outcomes and feedback from beneficiaries
32. What communication system is in place between ACE and
  - e) Amongst staff
  - f) project beneficiaries
  - g) project partners
  - h) CiC and ACE
33. What is the working relationship between CiC and ACE AFRICA?
34. What is your way forward with the program (focusing on the issue of sustainability probe for roles of different stakeholders)

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL TWO: QUESTIONNAIRE FOR HOUSEHOLDS**

Date of Interview.....

*Q'aire Serial Number:.....*

Name of Interviewer.....

Name of Interviewee.....

Area of Interview.....

**a) Respondents Details**

| 1. Sex                                                                 | 2. Age                                                                                                                                                                                                                                                                                                       | 3. Marital and Family Status                                                                                                                                 | 4. Education Level                                                                                                                                                                                                                                            | 5. Occupation                                                                                                                                                                                                |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| i) Male <input type="checkbox"/><br>ii)Female <input type="checkbox"/> | i) 15-20 <input type="checkbox"/><br>ii) 20-25 <input type="checkbox"/><br>iii) 25-30 <input type="checkbox"/><br>iv) 30-35 <input type="checkbox"/><br>v) 35-40 <input type="checkbox"/><br>vi) 40-45 <input type="checkbox"/><br>vii) 45-50 <input type="checkbox"/><br>viii) 50+ <input type="checkbox"/> | i) Single <input type="checkbox"/><br>ii) Married <input type="checkbox"/><br>iii) Widowed <input type="checkbox"/><br>iv) Divorced <input type="checkbox"/> | i) No formal education <input type="checkbox"/><br>ii) Primary Education <input type="checkbox"/><br>iii) Secondary Education <input type="checkbox"/><br>iv) Tertiary Education <input type="checkbox"/><br>v) University Education <input type="checkbox"/> | i) Formal <input type="checkbox"/><br>ii) Informal/juakali <input type="checkbox"/><br>iii)Unemployed <input type="checkbox"/><br>iv) Business <input type="checkbox"/><br>v) Other <input type="checkbox"/> |

**b) Instructions (Tick appropriate pre-coded choices in Roman Numbers and fill in the spaces for open-ended questions)**

1. Do you know ACE AFRICA?

- i) Yes
- ii) No

2. If yes how did you get to know about it?

- i) Through its activities
- ii) Through beneficiary family members and friends
- iii) From chiefs barazas and other provincial administration forums
- iv) Others

3. What are your opinions on the HIV/AIDS programme intervention by ACE AFRICA

4. How have you benefited from the project?

5. Do you have a family member/people you know infected or affected by HIV/AIDS?

- i) Yes
- ii) No

6. How can you describe the person?

- i) PLWA
- ii) OVC
- iii) Deceased victim
- iv) Widow/widower of a spouse who died/suspected to have died of HIV/AIDS

b) Does the community have problems concerning OVC?

- i) Yes
- ii) No

c) Which ones are they?

- i) Many Orphans
- ii) Health related
- iii) School related
- iv) Food related
- v) Others

7. a) What kind of support is this family member getting if any from ACE AFRICA?

b) What kind of support do guardians of OVC get from ACE AFRICA if any you know of?

c) What support do those people taking care of HIV/AIDS victims get from ACE AFRICA

8. How can you rate the prevalence of HIV/AIDS in this community (probe for an estimate of how many out of 10 people?)

- i) High
- ii) Medium
- iii) Low
- iv) Negligible

9. How many people do you know have declared their HIV/AIDS status publicly after being diagnosed with the disease/

- i) Between 1 and 5
- ii) Between 5 and 10 people
- iii) Between 10 and 20
- iv) More than 20
- v) Uncountable
- vi) None

10. Why do you think they have gone public on their status?

- i) Reduced public stigma and discrimination
- ii) Benefits from groups like ACE AFRICA

- iii) Forced by the family or community
- iv) Others

11. What is the awareness level of HIV/AIDS in the community?
12. How has this awareness helped the community reduce incidences of infection and cope with caring for PLWA and OVC?
13. a) Compared to the 1980s when AIDS was discovered, how are the lives of those living with the virus compared to those early days? (Probe for early deaths, stigma, and longer stay)
- b) Why is it different now?
    - i) Support services provided by HIV/AIDS prevention organizations like ACE AFRICA
    - ii) Awareness hence reduced stigma and discrimination
    - iii) Availability of life prolonging drugs (ART/ARV
    - iv) VCTs and counseling services for emotional support
    - v) SHG formed by PLWA and other community groups around fighting AIDS
14. What activities/services does ACE AFRICA offer to OVC and PLWA in this community?
- i) Training in Agriculture and Nutrition, Herbal remedies
  - ii) Childs to Child HIV AIDS awareness
  - iii) Positive Guidance in Schools
  - iv) Child Rights
  - v) Counseling and VCT
  - vi) IGA and micro finance
  - vii) Provision of Nutritional supplements
  - viii) Small scale provision of secondary school fees
15. How has this helped in?
- a) Improving the health of the PLWA and OVC
  - b) Improved community access to support services
  - c) Reduction in stigma and discrimination associated with HIV/AIDS
16. As an individual have you benefited from any service by ACE aimed at creating community access to support services and networks
- i) Yes
  - ii) No
- b) If yes, how has this service changed your attitude towards those PLWA and OVC?
17. What types of other HIV/AIDS support services are available in the community?
- i) PMTCT
  - ii) ART/ARV
  - iii) VCT
  - iv) HBC
  - v) Post exposure counseling
  - vi) Others
18. How does ACE AFRICA work with those other groups offering these services?

19. What are suggestions for improved work around the fight against HIV by ACE AFRICA in this community?

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL TWO: QUESTIONNAIRE FOR HOUSEHOLDS**

Date of Interview.....

*Questionnaire Serial Number:.....*

Name of Interviewer.....

Name of Interviewee.....

Area of Interview.....

**a) Respondents Details**

| 1. Sex                                                                  | 2. Age                                                                                                                                                                                                                                                                                                       | 3. Marital and Family Status                                                                                                                                 | 4. Education Level                                                                                                                                                                                                                                            | 5. Occupation                                                                                                                                                                                                  |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| i) Male <input type="checkbox"/><br>ii) Female <input type="checkbox"/> | i) 15-20 <input type="checkbox"/><br>ii) 20-25 <input type="checkbox"/><br>iii) 25-30 <input type="checkbox"/><br>iv) 30-35 <input type="checkbox"/><br>v) 35-40 <input type="checkbox"/><br>vi) 40-45 <input type="checkbox"/><br>vii) 45-50 <input type="checkbox"/><br>viii) 50+ <input type="checkbox"/> | i) Single <input type="checkbox"/><br>ii) Married <input type="checkbox"/><br>iii) Widowed <input type="checkbox"/><br>iv) Divorced <input type="checkbox"/> | i) No formal education <input type="checkbox"/><br>ii) Primary Education <input type="checkbox"/><br>iii) Secondary Education <input type="checkbox"/><br>iv) Tertiary Education <input type="checkbox"/><br>v) University Education <input type="checkbox"/> | i) Formal <input type="checkbox"/><br>ii) Informal/jua kali <input type="checkbox"/><br>iii) Unemployed <input type="checkbox"/><br>iv) Business <input type="checkbox"/><br>v) Other <input type="checkbox"/> |

**b) Instructions (Tick appropriate pre-coded choices in Roman Numbers and fill in the spaces for open-ended questions)**

1. Do you know ACE AFRICA?

- iii) Yes
- iv) No

2. If yes how did you get to know about it?

- v) Through its activities
- vi) Through beneficiary family members and friends
- vii) From chiefs barazas and other provincial administration forums
- viii) Others

3. What are your opinions on the HIV/AIDS programme intervention by ACE AFRICA

4. How have you benefited from the project?

5. Do you have a family member/people you know infected or affected by HIV/AIDS?

- iii) Yes
- iv) No

6. How can you describe the person?

- v) PLWA
- vi) OVC
- vii) Deceased victim
- viii) Widow/widower of a spouse who died/suspected to have died of HIV/AIDS

b) Does the community have problems concerning OVC?

- iii) Yes
- iv) No

c) Which ones are they?

- vi) Many Orphans
- vii) Health related
- viii) School related
- ix) Food related
- x) Others

7. a) What kind of support is this family member getting if any from ACE AFRICA?

b) What kind of support do guardians of OVC get from ACE AFRICA if any you know of?

c) What support do those people taking care of HIV/AIDS victims get from ACE AFRICA?

8. How can you rate the prevalence of HIV/AIDS in this community (probe for an estimate of how many out of 10 people?)

- v) High
- vi) Medium
- vii) Low
- viii) Negligible

9. How many people do you know have declared their HIV/AIDS status publicly after being diagnosed with the disease/

- vii) Between 1 and 5
- viii) Between 5 and 10 people
- ix) Between 10 and 20
- x) More than 20
- xi) Uncountable
- xii) None

10. Why do you think they have gone public on their status?

- v) Reduced public stigma and discrimination

- vi) Benefits from groups like ACE AFRICA
- vii) Forced by the family or community
- viii) Others

11. What is the awareness level of HIV/AIDS in the community?

12. How has this awareness helped the community reduce incidences of infection and cope with caring for PLWA and OVC?

13. a) Compared to the 1980s when AIDS was discovered, how are the lives of those living with the virus compared to those early days? (Probe for early deaths, stigma, and longer stay)

b) Why is it different now?

- vi) Support services provided by HIV/AIDS prevention organizations like ACE AFRICA
- vii) Awareness hence reduced stigma and discrimination
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- ix) VCTs and counseling services for emotional support
- x) SHG formed by PLWA and other community groups around fighting AIDS

14. What activities/services does ACE AFRICA offer to OVC and PLWA in this community?

- ix) Training in Agriculture and Nutrition, Herbal remedies
- x) Childs to Child HIV AIDS awareness
- xi) Positive Guidance in Schools
- xii) Child Rights
- xiii) Counseling and VCT
- xiv) IGA and micro finance
- xv) Provision of Nutritional supplements
- xvi) Small scale provision of secondary school fees

15. How has this helped in?

- a) Improving the health of the PLWA and OVC
- b) Improved community access to support services
- c) Reduction in stigma and discrimination associated with HIV/AIDS

16. a) As an individual have you benefited from any service by ACE aimed at creating community access to support services and networks

- iii) Yes
- iv) No

b) If yes, how has this service changed your attitude towards those PLWA and OVC?

17. What types of other HIV/AIDS support services are available in the community?

- vii) PMTCT
- viii) ART/ARV
- ix) VCT
- x) HBC

- xi) Post exposure counseling
- xii) Others

18. How does ACE AFRICA work with those other groups offering these services?

19. What are suggestions for improved work around the fight against HIV by ACE AFRICA in this community?

**ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.**

**TOOL TWO: QUESTIONNAIRE FOR HOUSEHOLDS**

Date of Interview.....

*Questionnaire Serial Number:.....*

Name of Interviewer.....

Name of Interviewee.....

Area of Interview.....

**a) Respondents Details**

| 1. Sex                                                                    | 2. Age                                                                                                                                                                                                                                                                                                         | 3. Marital and Family Status                                                                                                                                   | 4. Education Level                                                                                                                                                                                                                                               | 5. Occupation                                                                                                                                                                                                     |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| iii) Male <input type="checkbox"/><br>iv) Female <input type="checkbox"/> | ix) 15-20 <input type="checkbox"/><br>x) 20-25 <input type="checkbox"/><br>xi) 25-30 <input type="checkbox"/><br>xii) 30-35 <input type="checkbox"/><br>xiii) 35-40 <input type="checkbox"/><br>xiv) 40-45 <input type="checkbox"/><br>xv) 45-50 <input type="checkbox"/><br>xvi) 50+ <input type="checkbox"/> | v) Single <input type="checkbox"/><br>vi) Married <input type="checkbox"/><br>vii) Widowed <input type="checkbox"/><br>viii) Divorced <input type="checkbox"/> | vi) No formal education <input type="checkbox"/><br>vii) Primary Education <input type="checkbox"/><br>viii) Secondary Education <input type="checkbox"/><br>ix) Tertiary Education <input type="checkbox"/><br>x) University Education <input type="checkbox"/> | vi) Formal <input type="checkbox"/><br>vii) Informal/jua kali <input type="checkbox"/><br>viii) Unemployed <input type="checkbox"/><br>ix) Business <input type="checkbox"/><br>x) Other <input type="checkbox"/> |

**b) Instructions (Tick appropriate pre-coded choices in Roman Numbers and fill in the spaces for open-ended questions)**

1. Do you know ACE AFRICA?

- v) Yes
- vi) No

2. If yes how did you get to know about it?

- ix) Through its activities
- x) Through beneficiary family members and friends
- xi) From chiefs barazas and other provincial administration forums
- xii) Others

3. What are your opinions on the HIV/AIDS programme intervention by ACE AFRICA

4. How have you benefited from the project?

5. Do you have a family member/people you know infected or affected by HIV/AIDS?

- v) Yes
- vi) No

6. How can you describe the person?

- ix) PLWA
- x) OVC
- xi) Deceased victim
- xii) Widow/widower of a spouse who died/suspected to have died of HIV/AIDS

b) Does the community have problems concerning OVC?

- v) Yes
- vi) No

c) Which ones are they?

- xi) Many Orphans
- xii) Health related
- xiii) School related
- xiv) Food related
- xv) Others

7. a) What kind of support is this family member getting if any from ACE AFRICA?

b) What kind of support do guardians of OVC get from ACE AFRICA if any you know of?

c) What support do those people taking care of HIV/AIDS victims get from ACE AFRICA

8. How can you rate the prevalence of HIV/AIDS in this community (probe for an estimate of how many out of 10 people?)

- ix) High
- x) Medium
- xi) Low
- xii) Negligible

9. How many people do you know have declared their HIV/AIDS status publicly after being diagnosed with the disease/

- xiii) Between 1 and 5
- xiv) Between 5 and 10 people
- xv) Between 10 and 20
- xvi) More than 20
- xvii) Uncountable
- xviii) None

10. Why do you think they have gone public on their status?

- ix) Reduced public stigma and discrimination
- x) Benefits from groups like ACE AFRICA
- xi) Forced by the family or community
- xii) Others

11. What is the awareness level of HIV/AIDS in the community?
12. How has this awareness helped the community reduce incidences of infection and cope with caring for PLWA and OVC?
13. a) Compared to the 1980s when AIDs was discovered, how are the lives of those living with the virus compared to those early days? (Probe for early deaths, stigma, and longer stay)
  - b) Why is it different now?
    - xi) Support services provided by HIV/AIDS prevention organizations like ACE AFRICA
    - xii) Awareness hence reduced stigma and discrimination
    - xiii) Availability of life prolonging drugs (ART/ARV)
    - xiv) VCTs and counseling services for emotional support
    - xv) SHG formed by PLWA and other community groups around fighting AIDS
14. What activities/services does ACE AFRICA offer to OVC and PLWA in this community?
  - xvii) Training in Agriculture and Nutrition, Herbal remedies
  - xviii) Childs to Child HIV AIDs awareness
  - xix) Positive Guidance in Schools
  - xx) Child Rights
  - xxi) Counseling and VCT
  - xxii) IGA and micro finance
  - xxiii) Provision of Nutritional supplements
  - xxiv) Small scale provision of secondary school fees
15. How has this helped in?
  - a) Improving the health of the PLWA and OVC
  - b) Improved community access to support services
  - c) Reduction in stigma and discrimination associated with HIV/AIDS
16. a) As an individual have you benefited from any service by ACE aimed at creating community access to support services and networks
  - v) Yes
  - vi) No
  - b) If yes, how has this service changed your attitude towards those PLWA and OVC?
17. What types of other HIV/AIDS support services are available in the community?
  - xiii) PMTCT
  - xiv) ART/ARV
  - xv) VCT
  - xvi) HBC
  - xvii) Post exposure counseling
  - xviii) Others
18. How does ACE AFRICA work with those other groups offering these services?
19. What are suggestions for improved work around the fight against HIV by ACE AFRICA in this community?

## ACE AFRICA ORPHAN AND VULNERABLE CHILDREN PROGRAMME: MITIGATING THE IMPACT OF HIV/AIDS ON CHILDREN IN RURAL KENYA.

### TOOL EIGHT: TYPES OF QUANTITATIVE DATA

#### General

- project target beneficiaries (estimates)
- Number, titles and names of community opinion leaders involved in the project

#### a) Education (head teachers):

- Enrollment, retention, transition and completion statistics by gender, of children supported by ACE AFRICA and OVC (Probe for improvements realized after programme intervention)
- Number of partners Schools (Primary and Secondary)
- Number of secondary school children being paid for school fees (from ACE confirmed by head teachers)
- Number of schools with CtC clubs
- projects carried out in these schools with CtC clubs
- Membership by pupils in these clubs
- Estimated awareness levels by pupils about HIV/AIDS
- Number of children who have dropped out of schools due to factors associated with discrimination

#### b) Health (Health officials and ACE staff)

- Number of VCT and any other HIV prevention and care facilities supported by ACE
- Health care providers and support groups trained by ACE AFRICA
- Distribution of these facilities and support staff in the area
- Data on number of infected (or those showing symptoms of HIV) visiting the facilities/day
- Types of nutritional supplements provided
- Frequency and quantities provided

#### C) Micro finance and IGAs (ACE and Beneficiaries) :

- Number of beneficiaries of IGA loan (from ACE)
- Amounts accessed by loanees

- Trends of Loan repayment
- Number of loan defaulters
- Number of successful loanees with business/IGAs doing well/thriving

**Organizations (ACE AFRICA and field visits):**

- Number and names of collaborating CBOs and NGOs (specify years of existence, membership, activities and achievements)
- Total number of registered group in the project area dealing with HIV/AIDS
- Groups formed after intervention by ACE AFRICA