Faith, Health, and Development:
Collaborating for Sustainable HIV Community Care
The Faith, Health Collaboration and Leadership Development Program (FHCLDP) is a multi-sector team-based model that builds partnerships among FBOs, HIV treatment programs, and civil society organizations to support sustainable, community-based HIV prevention and treatment services and to help people living with HIV remain in clinical treatment programs by offering coordinated community support services. The program was piloted in Nakuru County in 2014 with funding from the U.S. government’s President’s Emergency Plan for AIDS Relief (PEPFAR) in a collaboration between St. Paul’s University (Limuru, Kenya) and the Interfaith Health Program (IHP) of Emory University (Atlanta, USA).

Since fall 2011, IHP has worked with colleagues at St. Paul’s University in Limuru, Kenya to adapt The Institute for Public Health and Faith Collaborations, a successful CDC-funded program of IHP that trained faith and health leaders to address the most serious health disparities in their communities. In October 2013, this adaptation was completed, and a program for a new generation of community collaborations was launched in March 2014 entitled the Faith, Health Collaboration and Leadership Development Program (FHCLDP). In this new program, 19 individuals from Nakuru County, Kenya, representing a spectrum of faith-based organizations, health facilities, and civil society organizations from Nakuru County, came together in four interdisciplinary teams.

Efforts such as the FHCLDP can help lower barriers for treatment and provide support services for people who are HIV infected and encourage wider scale HIV testing in local communities. This in turn helps strengthen mechanisms for referral into treatment for those who test HIV positive and retention in care for those who enroll into HIV primary care. Referral and retention are key elements in helping people living with HIV to maintain their HIV medication regimens and thus lower the likelihood of transmitting the virus to someone who is uninfected.

Religion has been used to justify HIV stigma and discrimination but it can also be an important source to challenge such stigma and discrimination. The FHCLDP equips local leaders from faith-based, psychosocial, and clinical programs with knowledge and tangible, measurable activities to fight stigma and increase support services for those living with HIV. With the success of the FHCLDP, IHP is already working to collaborate with other colleagues in Kenya to expand the program to two other Kenyan counties next year and lay the groundwork to replicate the program in other countries as well.
The Faith, Health Collaboration Leadership and Development Program

This document provides a summary description of the Faith, Health Collaboration and Leadership Development Program (FHCLDP), a project being carried out by the St. Paul’s Institute for Lifelong Learning and Leadership Development Center (SPILL) at St. Paul’s University (Limuru, Kenya) and the Interfaith Health Program (IHP) at Emory University (Atlanta USA).

BACKGROUND

The FHCLDP offered by SPILL and IHP was born from the Institute for Public Health and Faith Collaborations, a national program of IHP. IHP, in partnership with US Centers for Disease Control and Prevention and other notable leaders in the fields of public health, healthcare, religion, and education, developed and implemented “the Institute” in the United States from 2001 to 2007, with 78 teams of 400 leaders from a broad range of local organizations and sponsors from rural and urban areas in 24 states participating in the program. The vision of the Institute was to train teams of faith and health leaders to address the most serious health disparities in their communities, including HIV/AIDS, obesity, suicide and violence prevention, and improved access to care.

A key premise of the IHP Institute was to help these teams achieve their goals for their communities. This was accomplished by 1) addressing the underlying social determinants of disease and health disparities, and 2) creating enduring leadership relationships among multi-sector partners.

With this model and these objectives in mind, SPU and IHP conducted redesign, feasibility, and planning activities to implement the Institute in Kenya as the FHCLDP. The overarching objectives of the FHCLDP are:

**to address social challenges, including . . .**

- HIV-related stigma and discrimination still felt from families, providers, congregations, and communities
- Limited resources for livelihood that make it hard to eat well and to get to health facilities
- Poor integration of spiritual beliefs into HIV treatment, leading some to opt for herbal or spiritual healing instead of clinical care and lifesaving ARVs

**and create opportunities to . . .**

- Build enduring partnership relationships and a commitment to joint action
- Understand in new ways all the resources available in the community that can be mobilized around a shared hope and vision
- Develop a context-specific community action plan to respond to the social-structural forces that impact people living with HIV

The program targets grassroots, community-level leaders with a commitment to improve the holistic health of their community through established networks and partners; an approach essential to cost effectiveness and sustainability. Leaders from civil society organizations, faith-based organizations, and religious communities work together in teams to analyze the contextual social-structural forces that impact the teams’ communities, identify local community assets, and develop change strategies that inform the action plans they implement back in their communities.
THE ROLE OF TRUST

Religion does not inevitably contribute to stigma; it can also serve as a sociocultural framework in which trust can be distinctively created and deepened. The FHCLDP focuses on mobilizing this trust in support of people living with or affected by HIV to address HIV-related stigma. Whether religion generates trust or justifies stigma depends on a number of factors:

1. **Religious beliefs:** What are the beliefs of a religious tradition and how do those beliefs influence health behaviors of individuals and communities? Does a religious tradition (and its affiliated FBOs/FBHSs) prioritize compassion and seek to offer care for anyone in need or does it believe that some individuals should be rejected for failing to maintain certain moral standards?

2. **Structure:** How are religious communities and FBOs/FBHSs structured? Do they relate to broader religious authorities with some autonomy or with strict oversight? What allows some FBOs/FBHSs to adopt HIV prevention practices not supported by religious authorities?

3. **Relationship to the broader civil society:** How does a religious community relate to governmental/political structures and with those in civil society who are not part of that community? Are the HIV programs offered by civil society, governmental, or international donors welcomed as valued partners or viewed with suspicion?

4. **Level of agency in individuals and communities:** Can an individual, FBO, or religious community adopt or advocate for controversial policies (e.g., condom use or inclusion of MSM)? If a person living with HIV (PLHIV) experiences stigma from one religious community, do they remain, leave religious communities altogether, or create new religious networks?

Trust, both at the interpersonal and systems levels, may play a significant role in quality of care, adherence to treatment, and health outcomes. Respectful care, fairness, and prioritization of patients’ needs are all components of trust that the FHCLDP supports.

“T
here is also the earning of trust . . . reaching a point where you earn the trust of these people. By earning their trust, now we have also been encouraged because whatever we are saying, they are believing us. So, we are in a better position to help them and also the good relationship that has developed over time is one of the factors that has helped us to succeed. – Team focus group respondent

THE CURRICULUM

Several distinctive design features were incorporated in the development of the FHCLDP curriculum, including:

1. A leadership development scaffolding that progresses from the individual, to team, to organization, and then to community-scale knowledge integration and application

2. A focus on the team’s local context employing experiential learning principles to analyze their communities and develop change strategies

3. Two workshops with two-month segments of time for guided community action learning. Together, the workshops and the community action learning serve as the cornerstone of all the learning activities for the program.

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THE PARTICIPANTS

The target audience for the program consisted of formal and informal leaders at the local level who share a commitment to the holistic health of their communities. Recruitment of participants for the FHCLDP occurred primarily through established networks and partners, such as the NGO Training Institute (NGOTI) at SPILL, the Masters in Community Care and HIV/AIDS (MACC) program at St. Paul’s, the Christian Health Association of Kenya (CHAK), the National AIDS Control Council (NACC), and Kenya AIDS NGO Consortium (KANCO). Drawing participants from these networks helped ensure fit with the program goals and lay a foundation for sustainability and success of the community action plans.

Recruitment of teams with four to five participants in each team began in November of 2013. The four teams selected from Nakuru County (overall HIV prevalence 5.6%, 2011) provided a broad array of HIV prevention and treatment services in the urban and peri-urban communities of Nakuru town. The 19 participants were evenly distributed between the health, faith, and civil society sectors; with different roles that included community outreach workers, NGO community educators, hospital pastoral care community outreach staff, religious leaders, and community developers.
THE WORKSHOPS

The leadership development workshops offered participants an opportunity to analyze the social vulnerabilities that perpetuate health disparities and foster their leadership potential by collaboratively developing the shared commitment, solutions, and plans that are most likely to work in their communities. Participants prepared for the first workshop by developing a case analysis of the HIV disparities in their community, identifying those most vulnerable to infection or disease progression, and describing the social-structural forces that are barriers to testing, treatment, and long-term support. Teams worked with the case analysis throughout the workshops as they were given new tools and an opportunity to think critically about the social factors that perpetuate disparities and the assets in their community that can be mobilized to address them. The end “products” of the program are contextually relevant community action plans. Because the community leaders who comprised the teams developed these plans, a sense of ownership and investment in their successful implementation was strengthened.

The implementation of a pilot set of workshops of the FHCLDP began in October of 2013 with IHP and SPILL engaging key partners, recruiting teams, and preparing SPU staff as faculty instructors and facilitators. Following team recruitment and preparation, there were four key phases of learning and action: Workshop I (March 9-13), a two-month Community Action Learning (CAL) period; Workshop II (May 25 – 28); and a second two-month CAL period followed by a final evaluation (Figure 1).

WORKSHOP I

Beginning Sunday evening and concluding mid-day Thursday, the first workshop was held for the four teams from Nakuru County at the Bontana Hotel in Nakuru town. The workshop was led collaboratively by SPILL and IHP staff. SPU staff gave lectures and representatives of NACC, CHAK, and KANCO participated as observers to support the teams and provide feedback to SPILL. The workshop core content areas included:

**Workshop I Curriculum Content Sessions**

<table>
<thead>
<tr>
<th>Social disparities and HIV vulnerabilities framework</th>
<th>Conflict transformation and adaptive leadership</th>
<th>Mapping community health assets</th>
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<tr>
<td>Personality tendencies and collaborative leadership</td>
<td>Reframing organizational strengths</td>
<td>Vision and action plan development</td>
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CAL I | MARCH-MAY 2014

By employing active learning principles during the two months between Workshops I and II, the teams worked to implement the action plans they developed at the end of Workshop I. SPILL staff visited each team in April to assess and facilitate action learning and implementation. Activities and assignments to facilitate action learning included:

- Assessment and integrative learning questions
- Guidance on a progress report that included identifying challenges and learning needed to address them
- Instructions on a team presentation to be made at the beginning of Workshop II

WORKSHOP II | MAY 25-28, 2014

The second workshop, also held at the Bontana Hotel in Nakuru town, focused on further integration of collaborative leadership skills and refinement of the teams’ vision and action plans. In this workshop, teams thought more critically about the role of religion in addressing HIV social disparities and vulnerabilities and explored ways to use systems thinking to address the more challenging social structural factors that perpetuate discrimination and treatment disparities among particular populations. A representative from National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK) was invited to provide a presentation based on the perspective of a person living with HIV, which was well-received by the participants.

**Workshop II Curriculum Content Sessions**

<table>
<thead>
<tr>
<th>HIV social health disparities and the role of religion</th>
<th>Vision and action plan development</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV stigma and discrimination</td>
<td>Systems thinking</td>
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**WORKSHOP II BEGAN WITH AN EXERCISE TO REVIEW THE CORE CONCEPTS LEARNED IN THE FIRST WORKSHOP USING THE FOLLOWING CASE STUDY:**

Jane is a 12 year old girl who lives with her aged and ailing grandmother and uncle in Lare village. She lost both her parents to AIDS when she was two years old. Unfortunately she also tested positive for HIV. Jane works in the neighbour’s shamba for casual work. Occasionally she comes down with ailments associated with HIV and is unable to earn a living. And she is not on treatment. A married man in the village has begun making advances on her and has been luring her with small pocket money and buying sodas and mandazis. It is rumoured that she was seen leaving a lodging with him.

At the home front, Jane avoids playing with other children because they keep reminding her that she has the “bad” disease and should not get close to them. She also does not have a birth certificate and when her grandmother tried to register her, she did not succeed as she did not have all the required documents hence she gave up. Hence Jane has not been in school. Her parents did not leave a will. Her uncle is an alcoholic who sells anything at any price to buy alcohol. Whenever he is drunk, he becomes violent to both Jane and her grandmother threatening to kill them and sell the shamba. He has been reported to the village elders but this has not stopped him from being violent.
Employing action learning principles during the two months after Workshop II, the teams worked to implement their revised action plan, submit a progress report, and participate in follow-up evaluation focus groups. Activities and assignments to facilitate action learning included:

- Assessment and integrative learning questions
- Guidance on a progress report and follow-up evaluation activities

PROGRAM EVALUATION

The purpose of the program evaluation was to assess the impact of the program on participating teams and their community efforts to achieve sustainable community-based HIV prevention, treatment, and support. The program FHCLDP logic model (Figure 2) represents the linkages between program resources, activities, and short- and long-term outcomes. Short-term outcomes were assessed through self-administered surveys at the conclusion of each workshop. Long-term outcomes were assessed in two ways: 1) within Workshop II through a presentation summary of CAL I activities and revision of the action plan, and 2) in focus groups, which were held with the four teams and two groups of beneficiaries' two months following Workshop II. Finally, two program reviews were conducted, one with SPU internal experts and faculty participants and another with external partner stakeholders to determine appropriate modifications and to develop recommendations and plans for replication.

Figure 2.

### PROGRAM EVALUATION

**Input:** Community teams, Emory IHP, SPU/SPILL, NGOI, MACC, CDC/PEPFAR, NACC, KANCO CHAK

**Learning Space:**

- Team Preparation
- Workshop I
- Workshop II
- Community Action Learning

**Outputs:**

- **Short-term Outcomes:**
  - Broadened understanding of holistic health (STO-1)
  - Strengthened awareness and development of collaborative leadership (STO-2)
  - Increased knowledge & recognition of community assets (STO-3)
  - Strengthened understanding of action for community change (STO-4)

- **Long-term Outcomes:**
  - Implementation of Action Plan (LTO-1)
  - Practices that ensure equal access to community resources (LTO-2)
  - Sustained community-based HIV prevention, treatment & support (LTO-3)
  - Transformed Communities (LTO-4)

**Activities:**

**Pre-Workshop Assignments:** Knowledge/Skill Gain Surveys; Progress Reports; Site Visit Records; Action Plans (I and II); Final Report; Focus Groups; Possible Interviews; Internal and External Reviews

**Meeting Plan:**

- **Workshop I:**
  - Evaluation of learning objectives and participation revealed the following:
    - 1. Complete attendance and active participation in all stages of the program
    - 2. Positive feedback from participant workshop surveys on 14 elements of workshop structure, content, knowledge gain, and participation for Workshop I had a mean of 4.6 (strongly agree) (standard deviation=.26).
    - 3. At the conclusion of each workshop, in response to an open-ended question, teams reported the following benefits of their participation:
      - Workshop I:
        - Recognizing untapped resources in the community
        - Understanding the value of team work and the benefits of what can be accomplished together
        - Gaining knowledge of the ways HIV social disparities can be handled
      - Workshop II:
        - Improving upon an action plan to be implemented within the community
        - Understanding the role of religious institutions in addressing HIV social disparities
        - Increasing their knowledge of systems thinking in regards to stigma and discrimination and their relationship to HIV

**LONG-TERM OUTCOMES**

**Team Community Action Planning:**

On the first day of Workshop II, each team made a presentation to showcase their collaborative leadership skills and to provide accountability on following through with their proposed action plans from Workshop I. During the workshop, teams further refined and enhanced their action plans as they integrated new thinking and learning. At the conclusion of Workshop II, the teams made a second presentation of their revised action plans and team agreements. The action plans are summarized below and on the following pages.

1. **Kingdom Culture**
   - Kingdom Culture represented a variety of community strengths, including community-based organization leaders, faith leaders, and health workers. The team aimed to support women living with HIV and empower them to live healthy, fulfilling lives by addressing the pressing psychosocial issues that impact the capacity of the women to stay in care.

   To this end, the team’s specific objectives were to:
   - Improve the nutrition status of women living with HIV
   - Empower women to initiate income-generating activities (IGAs)
   - Increase awareness of HIV and the importance of preventive and treatment adherence measures
   - Reduce community stigma of HIV

Collectively, the group led nutrition and gardening training sessions among HIV positive female support groups. They also trained these groups on how to seek loans through microfinance institutions to start small businesses and provide sexual education to community members. They continued to support women in their community through ongoing support groups.
2. LaFlamingo. La Flamingo was comprised solely of leaders from civil society organizations. The team drafted a vision of “promoting collaborative leadership for a healthy community free of HIV social disparities.” To support this goal, the team committed to:

- Building the capacity of the community and collaborative leadership to address HIV social disparities
- Identifying and utilizing local community assets such as religious health assets, referral systems, and human resources
- Providing mentorship on behavior change for alcohol and drug addicts in collaboration with a local community NGO partner in Nakuru County, the Family AIDS Initiative Response (FAIR)

The team met with other NGOs and attended quarterly stakeholder forums to enhance community collaboration. They spearheaded a mentorship program to promote behavior change among alcohol and drug addicts through Alcoholics Anonymous. They are expanding their referral work to now the Catholic Diocese in Nakuru to provide services to key populations including sex workers, men who have sex with men, and drug users.

3. Love and Care. As a mixed group of health workers and a minister, Love and Care hoped to provide an easier, healthier environment for people living with HIV. Specifically, they aimed to:

- Create HIV awareness and reduce stigma
- Reduce poverty associated with HIV
- Use their networks to coordinate support through government and NGOs
- Provide support to people with HIV through home-based care and defaulter tracing for HIV and TB

The group conducted health talks to initiate dialogue around HIV in the community in order to reduce stigma and discrimination. They collaborated with NGOs and FBOs and provided trainings in detergent making and home gardening techniques to support income generation and improved nutrition. The Love and Care group continues to conduct HIV and TB treatment defaulter tracing and provide home-based care to infected community members.

4. Unitary Action. Unitary Action represents clergy leaders and a community health worker and focuses on individuals taking control of their own lives to be healthy members of the community. They aim to:

- Build capacity through IGAs
- Educate and provide nutrition for healthy living
- Train youth on HIV prevention
- Conduct TB and HIV treatment defaulter tracing

The group trained community members on income generating projects and creating sustainable gardens. Simultaneously, they conducted nutrition education and encouraged TB and HIV treatment defaulters to adhere to medication, pointing them toward support groups and home follow-ups. Lastly, Unitary Action continues to support community members in disclosing their HIV status to those they trust and encourage sustained dialogue around HIV in the community.

Focus Groups:

Focus groups were held with both the teams and beneficiaries. The aim of the four team focus groups was to better understand the impact of participation in the program, especially the teams’ efforts to enlist and support HIV positive persons in treatment. Additionally, questions probed the teams’ perception of the usefulness of the overall program content and identified the particular community challenges that could be addressed by this program. Likewise, the two focus groups with beneficiaries were designed to capture their unique perspective on what communities could do that would be most helpful to those who are HIV positive, i.e. getting tested, entering into treatment, and staying in treatment.

The questions aimed to understand the support mechanisms (as well as obstacles and barriers) that facilitate testing and retention in care. Two of the questions focused on the support that organizations offer to help those in treatment stay in care; those insights were used to validate and improve curriculum design.

Team Focus Group Themes:

Responses to the focus group questions revealed five predominant themes across all four teams. Within each theme, there were key elements, and we used quotes taken from the focus group transcripts to provide more in-depth meaning to these elements.

TEAM FOCUS GROUP THEMES

- Appreciating the importance of collaboration
- Recognizing the role of religion
- Identifying, engaging, and strengthening existing assets
- Building new confidence, commitment, and sense of responsibility
- Addressing economic needs as a priority

The picture above shows one of the Unitary Action team members training a group in Kiratina to make lotion for home use and also for sale.
Appreciating the importance of collaboration. The most frequently mentioned theme, collaboration, related to the value of working together, both within the team and more broadly with other organizations and networks.

The training has helped us to have a strong relationship within ourselves. And I think this is fundamental in implementing our duties because without cohesion we cannot be able to move forward as a team. And this has helped us to actually respect one’s opinion or ideas. And this has helped us to know that within our members or within us, there are those that have great ideas that can move us forward. So in one way or another it has helped us to have that strong relationship.

I think we have become closer. Previously we, it was this program which brought us together. But now there is that closeness that if you want something and need to know, you can tap on the skills and the ability of the team members. You know maybe Lillian and Prudence are doing HTC, which I’m doing so you can tap on somebody else’s skills and experience.

Networking and Partnership Relationships

I have come to realize that each one of us is unique; everybody has got something that we will need to work as a team and also I came to learn the agreement that we had it also bounds us together and brings us together guides us to work and bring that accountability.

Through coordination with other partners, we are able to reach any people in the community and thus making our work easier.

Okay, looking at the objective, to build the capacity of the community to address HIV social disparity. We find that we are more into microfinance than provisional life skill. So when we are introduced to Sheila about the Hand-in-Hand, that’s when we went to there. So that we can look at how can we achieve this particular objective through partnership. Because their main role is to build the capacity and also to provide the seed money.

Recognizing the Role of Religion. Team members expressed two themes related to the role of religion: 1) the ways in which the FHCLDP led religious leaders to see HIV as an important issue in their communities and congregations, and 2) the importance of collaboration between FBOs and CBOs – a collaboration that CBOs may not fully consider. The first theme came from team members speaking as people who were part of a Christian church and the second came from staff members of secular CBOs.

Two team members, a local pastor and a lay church member, stated:

We identified as one of the community assets, the mosque and the church... But we have never looked at the congregation as an asset... So when you look at the church critically it is not only the building, but also the programs which they are running, or even we find that the health facility, like the PCEA has got a clinic, and they charge fairly than the other private facility. So if you just know what is your responsibility towards the community, you will be surprised.

Seeing clergy can be involved to support their program and advocate for the rights of those infected.

Team members from the staff of local CBOs in Nakuru stated:

W e identified as one of the community assets, the mosque and the church... but we have never looked at the congregation as an asset... so when you look at the church critically it is not only the building, but also the programs which they are running, or even we find that the health facility, like the PCEA has got a clinic, and they charge fairly than the other private facility. So if you just know what is your responsibility towards the community, you will be surprised.

I think when it comes to like the sex workers, I can now say there is collaboration between faith, health, and the church. For example the issues of the Catholic Diocese... through championing the program of income generating activities, he [the Catholic diocese coordinator] believes that along the way some may decide to settle with their family, take care of their family, and even if some don’t stop the sex work completely, but in a way it will reduce their chances of contracting the virus because they will be using more of their time to go generate some income from the activities they will be doing. So I tend to believe that there is some collaboration between health and faith.
Identifying, engaging, and strengthening existing assets. The emphasis on strengths and assets is an underlying philosophy of the program and is given particular attention in the community health asset mapping session in Workshop I. This change in perspective, from needs and challenges to strengths and assets, led team members to see themselves and elements of their community in new ways.

"By drawing this map we discovered that there is this land we could use for gardens. So much we hadn't seen was there in our community!"

Through coordination with other partners, we are able to reach any people in the community and thus making our work easier."

"Okay, looking at the objective, to build the capacity of the community to address HIV social disparity. We find that we are more into microfinance than provisional life skill. So when we are introduced to Alice about the Hand-in-Hand, that's when we went to there. So that we can look at how can we achieve this particular objective through partnership. Because their main role is to build the capacity and also to provide the seed money."

Building new confidence, commitment, and sense of responsibility. This theme was not tied specifically to any of the focus group questions but emerged from a number of individuals across the teams. Participants described a sense that they could do more than they had previously thought.

The last time we were not going there. I was not going there to talk to them. Because I was feeling like how could I go and talk to that lady, how do I start? But now I have the power. I can go there and talk everything to them and show them my people have the rights to access treatment.

We have been able to be positive . . . more faith that these could conquer it . . .

Addressing economic needs as a priority. While poverty was an important part of the social vulnerabilities framework, it emerged as a critical priority for reducing HIV social disparities. All the teams described numerous types of IGAs as a key component of their work.

"To me I think if we empower them economically this is going to help them not reverse and go back to their former habits, so if we empower them they will have something to help them."

Beneficiary Groups:

The two beneficiary focus groups named the essential needs and challenges and the ways communities would help address them.

<table>
<thead>
<tr>
<th>BENEFICIARY FOCUS GROUP NEEDS AND CHALLENGES</th>
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<tbody>
<tr>
<td>1. Stigma and discrimination</td>
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<tr>
<td>2. Family</td>
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<tr>
<td>3. Fear and denial</td>
</tr>
<tr>
<td>4. Support groups</td>
</tr>
<tr>
<td>5. Supportive health care providers</td>
</tr>
<tr>
<td>6. Financial resources</td>
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<tr>
<td>7. Beliefs about herbs and/or prayer and healing</td>
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1. **Stigma and discrimination.** Both groups discussed how stigma and discrimination contributed to reluctance to get tested and to seek treatment.
   - Some were afraid of being seen going to VCT and would also travel far away if possible to get their medicine
   - They anticipated being treated differently and being judged by the community, friends, and family
   - They were concerned that HIV infection would impact their livelihood and took care not to have physical signs of illness that would deter customers
   - For some, stigma was such a deterrent that they would rather die than have people know they have AIDS
   - Some of the AA group participants spoke about being “branded” at the CCC [the Comprehensive Care Centre run by CHAK] and for them, a barrier was not being treated as a “normal person"
   - Some reported discrimination in the workplace

   "I was thinking of fear of being discriminated ‘cause maybe when people see me . . . maybe this day’s many people know how the drugs look like, so imagine when I go for the medicine and maybe my friends like Cindy and John are coming around and then they will see me taking those drugs I’m afraid I’ll lose my friends."

2. **Family.** For many, family was at times both a support and a barrier. Family could be a motivator, particularly if the person was able to stay with them and live to bring up children. For the HIV-positive women, some family members strongly encouraged herbal remedies and discouraged testing and taking medication; husbands in particular prevented and strongly discouraged getting tested, and when tested, one claimed the doctors were wrong. The HIV positive women felt that those family members who were able to keep confidentiality were a source of support.

   "I feared what people would say if I had HIV. What would they think about me? What will my parents think of me? They would think that I am immoral, but when I checked around I realized that there were very many people living with disease, when I went to PGH I found very many people and this encouraged me, I felt stronger to face life."

   "Whenever I mentioned about HIV test my husband would become wild and violent he would say that he was not sick. I knew that I had to keep quiet about it."
Fear and denial. Some of the participants perceived HIV infection as synonymous with death – they spoke of it as “fast death” – and reported “deciding to ignore” or “choosing to ignore” the symptoms and the test results. A few in the HIV positive group only faced the reality of their condition when they very sick and didn’t want to suffer any more, which was four to five years after their test. Fear and denial for most were consistently reinforced by family members, while caring and friendly counselors and health care providers helped participants overcome their fears.

“Denial . . . ‘cause sometimes, yes you know like you messed somewhere and psychologically you don’t want to accept something might be wrong. So you find yourself denying while you are being eaten inside but you don’t want to tell anyone; you don’t want to be judged. And people say . . . there is a myth . . . if you get to know your status and you are positive and you start thinking . . . the disease will get worse”

Support groups. Both groups often cited the positive role of support groups. The women’s support group was more specific about its role in encouraging adherence and staying in treatment. They spoke of the encouragement they get from one another that helps overcome stigma and discrimination.

“We learn from each other, encourage one another, speak about treatment and remind each other of the importance...we share knowledge and skills, enlighten each other . . . seeing others on treatment doing well was a benefit, too.”

Supportive health care providers. Some identified counseling as a factor in overriding family beliefs and barriers. Quite a few participants in both groups spoke of friendly providers and those that were encouraging of testing and treatment. Assurance of confidentiality from the providers was mentioned as important, as well as “showing love.”

“One in treatment said, “I felt at home at the CCC.”

Financial resources. Different kinds of financial resources were important for getting into and staying in treatment, such as money for food and transportation and land for growing food and generating income. Financial support helped when taking time off from work for appointments and to getting medicine. Participants encouraged organizations to help with training on conducting IGAs partnering with banks, offering merry-go-rounds and table banking, and referring to microfinance institutions.

“IGAs helps you buy food and decreases stress.”

Beliefs about herbs and/or prayer and healing. Taking herbal remedies and participating in prayer and religious healing practices were mentioned often, particularly in the HIV-positive group. These treatment choices were often strongly reinforced by family members and seen as better than taking medication for the rest of one’s life.

“He referred me to my brother who is a herbalist. They used to force me to take the herbs . . . I went down and became very sick because I had no appetite. So I decided not to take the herbs and not to go to hospital . . . just stay at home and wait to die. I was approached by neighbor who advised me to seek treatment in hospital. I secretly went to a nearby health centre and was given drugs and immune boosting flour. I regained my health . . . my brothers were not happy because I was taking drugs. They neglected me and stopped supporting me. I became very strong and healthy.”

Internal and External Review
Two program reviews were conducted, the first with internal FHCLDP faculty and staff from SPU’s SPILL and the second with invited partner stakeholders external to the program (i.e., NACC, CHAK, KANCO, and NEPHAK). Internal and external perspectives each yielded particular insights that will be used to adapt the program when it is offered in the future. Both reviews included full reports on evaluation data, and participants ensured that the needs of their respective constituents were represented. Internal and external reviewers made recommendations in the following areas:

1. Partner and stakeholder engagement
2. Team criteria, promotion, and recruitment
3. Curriculum structure and format
4. Curriculum content and pedagogy
5. Staff roles and capacity
6. Ongoing team community action learning and implementation support
7. End-of-workshop evaluation survey methodology

SUMMARY
The FHCLDP was successfully implemented as a pilot in Nakuru County, Kenya. A number of characteristics of the pilot contributed to this success, including:

- The highly collaborative joint effort made by SPU and Emory
- The institutional capacity of SPILL
- The team recruitment and level of individual and team participation in the workshops and in action plan implementation
- The in-country partner engagement and support
- The emphasis on evaluation, particularly group data and input from the internal and external reviewers

Given this first stage of success and the strong need for mobilization of community resources and support to augment HIV clinical services, planning is underway to replicate the program in Nairobi County and expand it to other countries to be identified by PEPFAR in 2015.

This replication and expansion will begin with a Training of Trainers in the first quarter of 2015. This approach to expansion and replication will support PEPFAR’s priorities in capacity building and sustainability by creating local networks of multi-sector teams to support referral into treatment and retention in care for those who test HIV-positive.

To the extent that is feasible all of the recommendations are being acted upon and incorporated into the next implementation phase. One important and distinctive challenge will be to identify how SPU and their key partners can assure the structure and environment needed for the ongoing learning, peer support, and accountability of the