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EXTERNAL EVALUATION OF AED CAP KENYA PROJECTABLE PARTNERS PROGRAM—KENYA SMALL GRANTS AND INSTITUTIONAL STRENGTHENING PROGRAM II (KSGISP II)

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ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired immunodeficiency syndrome
BCC	Behavior change communication
BOH	Beacon of Hope
CABDA	Community Asset Building and Development Action
CAP	Capable Partners Program
CBO	Community-based organization
COLIDEF	Community Livelihood Development Forum
CREADIS	Community Research in Environment and Development Initiatives
CSI	Child Status Index
CSO	Civil society organization
CWS	Church World Services
CWSK	Child Welfare Society of Kenya
EOP	End of project
FBO	Faith-based organization
GOK	Government of Kenya
HCI	Homeless Children International
HEART	Health Education Africa Resource Team
HI	Handicap International
HIV	Human immunodeficiency virus
HMIS	Health Management Information Systems
HVFI	Hope Valley Family Institute
HWWK	Hope Worldwide Kenya
IDF	Institutional Development Framework
IFBO	International faith-based organization
IGA	Income-generating activities
INGO	International nongovernmental organization
IS	Institutional strengthening
ISO	Intermediary support organization
IST	In Service Training
KAIS	Kenya AIDS Indicator Survey
KENWA	Kenya Network of Women with AIDS
KHBC	Kenya HIV/AIDS Private Sector Business Council
KSGISP	Kenya Grants and Institutional Strengthening Program
Kshs	Kenyan shillings

KUAP	Kisumu Urban Apostolate Program
LWA	Leader with Associates
M&E	Monitoring and evaluation
MCC	Makindu Children's Center
MoGCASD	Ministry of Gender and Children Affairs and Social Development
MSC	Most significant change
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Program
NGO	Nongovernmental organization
NIA	Neighbors in Action
OPH	Office of Population and Health, USAID
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	Persons living with HIV and AIDS
PMP	Project monitoring plan
PMTCT	Prevention of mother-to-child transmission
PSS	Psychosocial support
QA	Quality assurance
RAPADO	Rural AIDS Prevention and Development Organization
RFA	Request for applications
SAPTA	Support for Addiction Prevention and Treatment in Africa
SCAD	Students' Campaign Against Drugs
SFIC	Franciscan Sisters of the Immaculate Conception
TA	Technical assistance
TICH	Tropical Institute of Health and Development
USAID	United States Agency for International Development
US$	United States dollar
USG	United States government
VCT	Voluntary counseling and testing
WASDA	Wajir South Development Association
WAYAAP	Women and Youth Against AIDS and Poverty
WEMIHS	WEM Integrated Health Services
YARD	Youth Action for Rural Development

EXECUTIVE SUMMARY

This end-of-project evaluation of the Academy for Educational Development (AED) Capable Partners Program (CAP) Kenya Project was conducted March 1–April 8, 2010. AED CAP Kenya is managed under a leader with associate (LWA) contract, and each LWA has broad programmatic objectives to which activities must relate. AED CAP Kenya has four such objectives:

- Strengthening the operational and technical capacity of local nongovernmental organizations (NGOs), networks, and intermediate support organizations (ISOs);
- Strengthening linkages between local organizations (NGOs, co-ops, networks, governments, and businesses);
- Increasing the capacity of NGOs, networks, and ISOs to advocate for policies or programs; and
- Disseminating tested innovations, best practices, and lessons learned.

The concept of using grants as a vehicle for institutional strengthening (IS) and of building both the technical and the organizational capacities of NGOs is central to the AED CAP approach. Specific tools have been developed to facilitate this. This evaluation therefore looked at:

- Grants management,
- Institutional Strengthening,
- Overall project performance, and
- Sustainability.

It produced:

- Recommendations for addressing issues identified during the evaluation that can further improve AED CAP Kenya Project activities through the rest of the current project period; and
- Recommendations for designing future programs to build the capacity of grassroots organizations in Kenya.

Although the AED CAP Kenya Project has not been able to meet all the targets the President's Emergency Plan for AIDS Relief (PEPFAR) set for the period, it was well-planned and executed, to the benefit of the subgrantees and by extension the Kenyans they serve. There is ample evidence that AED CAP Kenya has met its mandate and that the subgrantees it has supported are better able to contribute to the improved health and well-being of Kenyans. The tools developed and lessons learned from this project should be of immense benefit to any project designed to strengthen the capacity of civil society organizations, within and outside Kenya.

The evaluation team used a combination of random and purposive sampling: It sampled 20 subgrantees, of which 17 were active (50% of the current group) and 3 were closed out. The group included NGOs, faith-based organizations (FBOs), civil society organizations (CSOs), networks, and umbrella organizations as well as community beneficiaries of the services of subgrantees. From the findings it appeared that all categories benefitted equally. Data were gathered, using standardized guidelines, from AED CAP Kenya, stakeholders, subgrantees, and beneficiaries. Analysis was primarily comparative and descriptive.

GRANTS MANAGEMENT

The AED CAP Kenya Project has established an effective infrastructure for soliciting and managing grants effectively using 10 logical and replicable steps or tasks. The project has so far awarded 49 subgrants, ranging from Kshs 3,340,400 (US$43,952) to Kshs 210,024,890 (US$ 2,763,485). The grants total Kshs 1,168,614,378 (US$15,376,505), and were awarded using a closed universe solicitation method. By closing the universe using standard eligibility criteria, AED CAP Kenya limited the competition to organizations with proven dedication, experience, and qualifications. This proved effective and efficient.

Since the associate award was signed on December 30, 2005, AED CAP Kenya has awarded five cycles of grants. All but the first cycle were issued by soliciting applications from a closed universe. Because subgrants had to be approved by AED Washington before any funds could be disbursed, there was delay in the release of the first disbursement and a cash flow gap when the subgrant was renewed. The project's requirement that subgrantees make financial reports monthly, although viewed positively by most for keeping them on their toes, was considered by some to be too demanding. They suggested reports be quarterly. Some subgrantees felt that by sticking to monthly reports, AED CAP Kenya was not demonstrating confidence in them even after thorough capacity-building in financial management.

Additionally, although its grant agreement so specified, AED CAP Kenya has not involved government technical experts in either design of the request for applications or the technical review. This should be done to inspire government confidence in the program and foster sustainability.

INSTITUTIONAL STRENGTHENING

The AED CAP Kenya Project has from its inception sought to provide appropriate and timely technical assistance (TA) to subgrantees. Its strategies, including the10-step grant- making process, the pre-bidding workshop/conference, and pre-award visits, produced a win-win situation for both subgrantees and the project by clarifying issues and expectations and providing a road map for applicants.

As an AED associate, AED CAP Kenya has at its disposal a plethora of tools for organizational assessment and IS that have been tested in as many as 54 countries, which it has modified for use in Kenya. These tools include

- the 10-step grant-making process;
- the Institutional Development Framework (IDF) and the organizational development assessment and measurement tool;
- the most significant change (MSC) monitoring and evaluation (M&E) methodology used to gather qualitative information about changes that have occurred in NGOs as a result of AED CAP's institutional development; and
- the Financial Systems Assessment Tool.

AED CAP Kenya has also formulated its own tools, which are shared internationally, e.g., the electronic (E) updates and other unique mechanisms, such as the Founders Forum and the Partners Forum, interwoven with exchange visits, which facilitated networking, sharing, and learning. These innovations have been used effectively to build subgrantee capacity. According to the organizations visited, these challenged, encouraged, and motivated them to want to do better. The subgrantees credited the project for many positive changes and growth in their organizations.

AED CAP Kenya has particularly demonstrated leadership on the HIV/AIDS scene in Kenya. Its staff are well represented in national technical working groups (TWGs); for example, its OVC program officer and senior program officer are both members of the National Steering Committee for Orphans and Vulnerable Children (OVC). The project is also actively represented on the Kenya National HIV/AIDS Strategic Plan (KNASP) Review TWG, the National AIDS and STI Control Program MARPS (most-at-risk populations) TWG, and the National AIDS Control Council (NACC) M&E Working Group.

Subgrantees are also encouraged to become involved at the district decision-making level so that they can influence decision making and prevent duplication of interventions. As a result some AED CAP Kenya subgrantees have endeared themselves favorably to the district technical leadership. For example according to the Rarieda district children's officer, Rafiki wa Maendeleo, which functions as the Secretariat for the Area Advisory Council, is highly regarded in the community because it is "very cooperative, especially in responding to emergencies." AED CAP Kenya works effectively with the private sector and outsources training on such topics as tax management, policy development, and strategic planning. It has also strengthened the capacity of the Kenya HIV/AIDS Private Sector Business Council, which ensures that policies for the workplace are implemented in the private sector.

AED CAP Kenya emphasizes seven major areas in the management system of each subgrantee:

- Leadership and governance;
- Strategic planning and decision-making;
- Financial management: budgeting, financial control, transparency, etc.;
- Human resources management: policies and compliance with labor laws;
- Coordination and collaboration, including building working relationships with government and other organizations doing similar tasks;
- Procurement management; and
- M&E.

The project used a four-fold approach:

- Capacity building through workshops and other training;
- Provision of templates specific to each area;
- Follow-up and mentoring; and
- TA provided by a consultant where longer-term assistance was needed, e.g., for drafting strategic plans and manuals.

To heighten each organization's management capability, boards, chief executive officers, managers, and teams were trained in effective leadership. Gaps, strengths, and weaknesses were identified; needs unique to each organization prioritized; and strategies tailored to the needs of each subgrantee. The seven prime areas of focus included: Leadership and Governance; Strategic planning and decision making; Financial management: Budgeting, financial control, transparency; Human resources management: policies and concurrence with existing labor laws; Coordination and collaboration, including working relationships with government and other organizations doing similar tasks; Procurement management; and Monitoring and Evaluation.

Of the 17 active CSOs visited, 14 (80%) stated that with AED CAP Kenya support they had built up their boards, and their leadership had become more participatory. All 17 (100%) indicated that staff were working together better as a team, and all had drafted strategic plans; had better financial management systems in place; had a human resources manual consistent with the labor laws of Kenya; had extended collaboration and coordination among themselves and with government institutions; were following procurement procedures spelled out in a manual; and had an M&E manual. For some of these activities the project provided consultants, but most training and intensive coaching and mentoring was done by project staff.

There were, however, indications that although M&E training had been given to all subgrantees visited, this area needed more attention. Some subgrantees were not using the information collected to make informed decisions. It should be remembered, however, that the project still has another eight months to complete its mandate.

AED CAP Kenya has been monitoring progress and making periodic spot checks to verify data. The umbrella organizations visited indicated that they follow the same procedure in checking on reports from sub-subgrantees and field workers.

Although the project had no specific charges or indicators for sustainability, it has nevertheless emphasized sustainability throughout and has given subgrantees training in sustainability, resource mobilization, proposal development, etc. Over 50% of the subgrantees visited had diversified their funding sources to three or more other donors; the AED CAP Kenya Project was the sole source of financial support for only one. Several subgrantees had extended the concept of sustainability to their beneficiaries, helping them to become self-sustaining by emphasizing income-generating activities (IGA), skills development, education, etc.

Although most subgrantees had written strategic plans, only a few of those visited had and were following a clearly articulated sustainability plan. Many hoped that the AED CAP Kenya Project would continue to support them indefinitely.

BUILDING TECHNICAL CAPACITY

Based on evidence from field visits with subgrantees and findings from assessment tools created by the project, the technical capacity-building carried out through forums, workshops and trainings, one-on-one technical assistance, and HIV/AIDS E-Updates was innovative, well-received, and effective, resulting in better services to the Kenyan people.

All subgrantees interviewed provided numerous examples of how their stronger technical capacity, as a result of project-provided TA, had improved the quality and effectiveness of their work. For example, staff of Health Education Africa Resource Team (HEART) said that they were now able to incorporate age-specific prevention messages; address issues of sexuality, personal development, and self-esteem; and integrate OVC 6+1 activities into their programs, ensuring a more holistic approach to serving OVC.

OVERALL PROGRAM PERFORMANCE AND IMPACT

Through FY 2009 the AED CAP Kenya Project had met or exceeded 16 of its 23 quantitative PEPFAR indicators. However, while the indicators measure the number of individuals reached and services provided, they do not adequately measure progress toward the objective of the project: institutional strengthening—though it is clear that the project has significantly improved the technical and management capacity of the 49 organizations it has worked with.

AED CAP Kenya has created and uses a number of unique methods to assess strengths and weaknesses of subgrantees, among them management questionnaires, the IDF, rapid organizational reviews, and the MSC technique. These tools have also been used to determine

increases in institutional strength over time. Of the 27 organizations for which two IDFs have been completed, 18 (67%) showed a positive score (improvement), ranging from 5% to 63%.

AED CAP Kenya Project's 2006–2008 Project M&E Plan (PMP) and the draft PMP for 2009–2010 both added four qualitative indicators for measuring and reporting on improved HIV/AIDS service delivery and increased quality of services delivered. The results have never been reported. Though substantial information exists, it is not necessarily complete or consistent for all organizations.

All organizations responded positively when asked if the community or individual beneficiaries were better off as a result of AED CAP Kenya activities. For example, more than one subgrantee said that as a result of project TA, more OVC, particularly older girls, are attending school and are staying in school longer, and that their performance in school has improved. Similarly, all subgrantees provided positive examples of how the services they provide with project assistance have changed as a result of the capacity development they have undergone. For example, several said that as their monitoring systems and program approaches improved, so did the quality of the services they provide. All these tools result in a wealth of information for each organization, and often their stories are told in the project's very comprehensive and articulate quarterly reports—but quarterly reports, no matter how good, seldom live on beyond the project itself.

SUSTAINABILITY, REPLICABILITY, AND SCALE-UP

In its efforts to promote sustainability, the AED CAP Kenya Project has helped subgrantees prepare strategic plans and tools and conducted workshops on resource mobilization and fund-raising strategy. However, to date not all subgrantees have benefitted from these. The project has also promoted networking and sharing among CSOs, which enables them not only to learn from each other but to make referrals and use each other's facilities and services to avoid duplication, waste, and overstretching of resources. By extension this makes them more sustainable. For CSOs headed by their founders the project established the Founders' Forum, which besides building their confidence enabled members to plan ahead and begin to build structures for sustaining their organization after they were no longer there. Delegation, succession planning, and mentoring of potential successors is now common among organizations headed by their founders.

Although some subgrantees, such as the counselors for substance abuse programs, felt that some components of the project would continue even without AED CAP Kenya funding, most felt that they still required project funding to sustain their activities and help them grow. Some felt that if funding is to cease they would need at least a year's notice so they could make alternative plans. They had written their strategic plans with the expectation that this funding would continue.

Despite its positive rating of the efforts of AED CAP Kenya in the IS of CSOs in Kenya, the evaluation team still saw room for improvement and made 17 recommendations about what AED CAP Kenya can do to strengthen its performance before the grant ends in December 2010. It also made 6 recommendations for any follow-on project.

I. RECOMMENDATIONS FOR THE CURRENT PROGRAM

Recommendation 1. Moving forward, especially if the project scales up, the request for applications (RFA) invitation committee should also consider factors like the number of children and OVC in each district and the percentage of OVC served, to ensure a more equitable distribution of subgrantees in the eight provinces and to target the districts most in need.

The project also should support the districts in mapping civil society organizations (CSOs) and identify organizations actively engaged with the community that are not yet on the current AED CAP Kenya invitation list.

Districts should also be given help to review their HIV/AIDS annual operating plans so that districts targeted by specific RFAs are able to prioritize the technical interventions to be funded. CSO mapping reports at the National AIDS Control Council (NACC) and MOGCASD should be updated before RFAs are released to eliminate the problem of NGOs with no beneficiaries springing up in response to an RFA. According to staff of the National AIDS and STI Control Program (NASCOP), the review of annual strategic plans and mapping reports would be more objective if the exercise is conducted without being pegged to a specific RFA.

Recommendation 2. For a closer partnership with the government and a heightened sense of the government's ownership of the program, AED CAP Kenya should identify champion officers, e.g., from district Children's Affairs departments, and appoint them to the technical review committees responsible for screening concept papers. This will allow district departments to contribute not only to the quality of projects to be funded but also to the design of an effective and sustainable supervision mechanism. Similarly, AED CAP Kenya should solicit input from the National OVC Steering Committee in drafting future RFAs to improve engagement with national government entities and ensure that RFAs are aligned with national priorities.

Recommendation 3. In addition to their current engagement as advisors on policy development and tax management, it would be useful to also involve private audit firms in pre-award assessment of prospective subgrantees. This will not only speed up the pre-award assessment visits, thus reducing the RFA gestation period, it will also give the project an objective assessment of financial risk for all prospective subgrantees and possibly avert the inevitably lengthy process when subgrantees are suspended for financial mismanagement.

Recommendation 4. AED CAP Kenya should obtain a waiver from AED Washington so that it can start issuing multiyear subgrants of at least two years. AED Washington should also decentralize the subgrant approval process. (There is a clause in the subgrant agreement specifying that funding is subject to availability of funds, satisfactory progress, and the continued relevance of AED CAP Kenya and USAID programs. This clearly implies that if USAID does not continue funding the cooperative agreement, the liability of AED CAP Kenya on the subgrant is limited to funds already obligated.)

Recommendation 5. The subgrant portfolio should be ranked and the better-performing organizations graduated to quarterly rather than monthly reporting. The latter could be allowed to access second-quarter release as accountability for the first quarter is being reviewed. An extra control measure can be instituted specifying that funds for the third quarter would not be released until 100% of the advance for the first quarter has been used up.

Recommendation 6. For the remainder of the project AED CAP Kenya should emphasize M&E so that each subgrantee understands how to use M&E data gathered in decision making.

Recommendation 7. TA in technical capacity building should be accelerated through 2010.

Recommendation 8. In its final year, AED CAP Kenya should look for ways to empower organizations to build their own technical capacity and ensure that this important building block in institutional development will continue either internally within each organization, through contracting in groups for TA from a local expert organization, or through other mechanisms to ensure sustainability. For example, a future HIV E-Update could identify websites for continual updating on HIV topics of interest.

Recommendation 9. By the end of 2010, AED CAP Kenya should document each organization's improvement in technical capacity over the project period.

Recommendation 10. The quality of target-setting could be greatly improved if USAID/ PEPFAR were to include the grantee (AED CAP Kenya) in initial target-setting.

Recommendation 11. To ensure that the rich qualitative and narrative data accumulated for each organization is not lost, the story of each institution's strengthening process and accomplishments in technical capacity development should be written up and preserved through a combined effort by AED CAP Kenya and the organization itself.

Recommendation 12. AED CAP Kenya should determine how it can best report on the four qualitative indicators in its PMP to track institutional strengthening (IS) and capacity building for 2010. Alternatively, it should propose other indicators that will actually be reported on consistently along with PEPFAR data on a quarterly or annual basis as a measure of IS and technical capacity development.

Recommendation 13. By the end of 2010, AED CAP Kenya should determine how best to document improved quality of services and program interventions that have worked particularly well, using technical briefing papers, annotated assessment and monitoring tools, best practices, success stories, and reports of successful innovations. Narrative and intermittent reporting on individual organizations in quarterly reports would then complement, not substitute for, more formal and consistent tracking.

Recommendation 14. For the remainder of the grant period, AED CAP Kenya should give particular attention to helping current subgrantees to diversify their funding sources, especially those that seem to be having difficulty in doing so.

Recommendation 15. AED CAP Kenya should pay particular attention to resource mobilization and target subgrantees that have not yet diversified their resource base. AED CAP Kenya Project should help subgrantees to prepare sustainability plans.

Recommendation 16. Each subgrantee should be guided and assisted to draft a sustainability plan before the end of the current AED CAP Kenya project.

II. RECOMMENDATIONS FOR A FOLLOW-ON PROJECT

Recommendation F1. The project should put in place separate strategies and procedures for close-out, termination for cause, and graduation. Graduation should be a goal for a certain percentage of subgrantees, stated as an indicator: "X organizations graduated and fully self-sustaining by end of project [EOP]."

Recommendation F2. Subgrants of at least two years should be provided for organizations that are sound and performing well.

Recommendation F3. The new project grantee should identify three or four Kenyan NGOs that can be built up to help the grantee to do advocacy, provide management and technical capacity building, and manage grants. While the grantee would not be expected to replace itself during the 4- to 5-year project period, the process for ensuring sustainability should be started.

Recommendation F4. Several Kenyan organizations should be trained to provide TA for IS and technical capacity building as part of a longer-range sustainability goal.

Recommendation F5. In addition to the PEPFAR II indicators, additional indicators that measure IS and technical capacity development should be incorporated into quarterly and annual tracking. For annual reporting, several impact indicators should also be determined.

Recommendation F6. A future IS program should emphasize the number of institutions strengthened; the nature and quality of that strengthening; and the ability of graduates to function effectively on their own, rather than being directed solely to service targets. While service targets are necessary to ensure impact, there is also a need to report against indicators for IS.

III. BACKGROUND AND CONTEXT

NGOs are part of a larger group of nonprofit organizations endeavoring to meet Kenya's social, economic, development, health and welfare needs. Most nonprofit organizations are self-supporting, relying on fees and dues. NGOs, however, rely more on donors. In comparison to the numbers in other categories, such as women's and youth groups, NGOs are few in number. A 2005 study by Karuti Karanga and Winnie Mutullah at the University of Nairobi found that in the eight years from 1997 to 2005, the number of NGOs had quintupled, from 836 in 1997 to 4,099 in 2005, a 490% increase. Even then there were indications that the exact number of NGOs was unknown, but it is safe to assume that the number has continued to increase.

Several factors were cited to account for this growth:

1. Kenya has a rich tradition of philanthropy and volunteerism rooted in the communal relationships of African society. *Harambee* (pooling of resources to provide basic services) is an expression of this tradition and the spirit of volunteerism. This tradition is the foundation of nonprofit initiatives in the country.

2. The capacity of the state to provide basic services has been declining because economic growth has been sluggish. Structural adjustment programs have reduced the government's ability to provide services. Throughout the 1990s, nonprofit organizations filled the gaps in service.

3. Donors shifted their attention and funding to NGOs, which led the number to mushroom. The NGOs in turn used community organizations as their entry point for development work. The advent of HIV as a threat to national security was a major factor in galvanizing donor support to NGOs.

Of all the nonprofits, NGOs tend to rely almost exclusively on external sources of funding, generating only a small percentage of revenue from their own sources. According to the 2005 study, about 1,339 NGOs (33% of the 4,099 NGOs registered) reported on sources of funding: of total revenue of about $285 million, close to 90% came from donors, about 6% from own sources, and the rest from private sources (including foundations) and individuals. Most NGOs have inadequate management and limited technical skill to deal effectively with the huge and varied demands brought about by the HIV pandemic.

The 2007 Kenya AIDS Indicator Survey (KAIS) found HIV prevalence among Kenyan adults aged 15–64 to be 7.1%—an estimated 1.4 million adults were living with HIV. Prevalence varies widely by province, being highest (14.9%) in Nyanza Province and lowest (0.8%) in North Eastern Province. It is slightly lower in rural (6.7%) than in urban (8.4%) areas, but the greatest HIV burden is borne by rural areas because that is where the vast majority of the population lives. An estimated 1 million adults living in rural areas are HIV-positive. Although knowledge of HIV status has increased, especially among women, in 2007 only 16% of those infected knew their status to be positive, which meant that 84% of adults infected did not realize it. Women were much more likely (41%) to have been tested and know their status than men (25%). The KAIS found that nearly 350,000 married or cohabiting couples were discordant, putting the uninfected partner at heightened risk for HIV. This health crisis threatens Kenya's stability, economic growth, and prospects for making a positive contribution to the region.

Kenya is one of 15 focus countries for PEPFAR, which has helped countries around the world to make significant progress in combating HIV/AIDS. Since its inception in 2003, PEPFAR has contributed $18.8 billion worldwide for rapid implementation of an approach that integrates prevention, treatment, and care, including life-saving antiretroviral treatment. In 2008, the U.S.

government (USG) increased PEPFAR funding to $48 billion to further expand global efforts against HIV/AIDS, tuberculosis, and malaria. USAID/ Kenya has been a major PEPFAR donor since the beginning, increasing comprehensive HIV/AIDS funding from $92.5 million in 2004 to $334 million in 2009.

Kenyan NGOs, CBOs, and FBOs have a vital role in the delivery of health services, especially to those infected and affected by HIV/AIDS. Because of their close links with communities, they are particularly appropriate for reaching those who are marginalized, poor, and underserved. While NGOs, CBOs and FBOs must be registered, the registration process is not rigorous. It requires little more than a small number of members, by-laws, a constitution, and payment of a small fee. As a result the smaller organizations particularly often lack even rudimentary management systems, and financial accounting is generally inadequate.

Under the PEPFAR initiative, USAID/ Kenya supports local organizations providing nonclinical care and support services especially targeted to OVC) through its Kenya Small Grants and Institutional Strengthening Program (KSGISP). This program is implemented by the Academy of Educational Development's Capable Partners Program (the AED CAP Kenya Project).

The first phase of AED CAP Kenya began in November 2004 and was completed in 2006; it set up structures, systems, and procedures to select and manage grants and to begin the process of identifying grantees. The second phase, begun in 2006, was designed to manage grant funding to the many NGOs, CBOs, and FBOs working within communities across Kenya to provide services to those infected and affected by HIV/AIDS, particularly OVC, their caregivers, and people abusing substances. Besides managing the grants, the program provides organizational and technical assistance to improve the capacity of organizations to expand and improve the quality of service. These activities, which contribute directly to the PEPFAR goals for Kenya, are consistent with the USAID/Kenya Strategic Objective, "to reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services," as well as with the NACC strategic framework. Total funding for AED CAP Kenya Project under KSGISP II is $25.3 million; the project completion date is December 30, 2010.

IV. PURPOSE OF THE EVALUATION

This evaluation was commissioned to conduct an EOP assessment of the technical and management capacity-strengthening aspects of the AED CAP Kenya Project and to inform follow-on program design. The evaluation looked at:

- **Grants management,** and the extent to which AED CAP Kenya has established the infrastructure necessary to monitor grants effectively;
- **Institutional strengthening,** including technical capacity development and unique strategies, approaches, and technical assistance (TA) the project employed to enhance HIV/AIDS service delivery and expand HIV/AIDS care and support services within communities;
- **Overall project performance,** determining whether or not AED CAP Kenya activities contributed to meeting targets, the extent to which intended results were achieved, and overall project impact; and
- **Sustainability,** the extent to which AED CAP Kenya had contributed to the sustainability of service delivery in communities and to scale-up and replication of successful models.

The evaluation team also made:

- Recommendations for addressing issues identified during the evaluation that can further improve and strengthen AED CAP Kenya Project activities through the end of the current project; and
- Recommendations for strengthening future programs for building the capacity of grassroots organizations in Kenya.

V. EVALUATION DESIGN AND METHODOLOGY

INTRODUCTION AND OVERVIEW

The evaluation was designed to look at both how effectively AED CAP Kenya managed Associate Cooperative Agreement 623-A- 00-06-00012-00 and the impact of the interventions the project used to build the ability of subgrantees to manage financial resources and enhance their managerial and technical skills for delivering quality care to beneficiaries, especially OVC and people living with HIV and AIDS (PLWHA).

In accordance with the Scope of Work (Appendix A), the three consultants worked together to draft the final work plan, evaluation matrix, questionnaires, and guidelines; select the sample; set out their itinerary; and gather data from USAID, AED CAP Kenya, Government of Kenya stakeholders, and four subgrantees located in Nairobi. This enabled each consultant to become conversant with the data that had to be collected at the provincial level; estimate the time each questionnaire would take; and determine whether any modifications to the questionnaire were required. (Appendix B lists persons interviewed.)

Records and reports prepared by AED CAP Kenya Project at various stages and other background and relevant data provided by USAID Kenya helped shape the approach to the evaluation. (Appendix C lists references consulted.)

Within the team, the grants management specialist concentrated on grants management issues at both the grantee and subgrantee levels; assessing capacity development and the impact of IS was the responsibility of the team leader, who looked at the managerial aspects, and the evaluation specialist, who looked at the technical aspects. Where possible, each consultant collected information on lessons learned; implications for sustainability, replicability, and scale-up; and areas for possible project reinforcement for both subgrantees and their beneficiaries in order to support recommendations.

Subsequently, members of the team fanned out to collect data from the provinces. Two consultants visited two provinces (see Appendix D, the team work plan) and the third met with three subgrantees in Nairobi, one in the Central Province, and one in the Eastern Province. Thus the team reached 6 of the 8 provinces (Appendix E maps sites visited) and 20 subgrantees so that all aspects of AED CAP Kenya interventions were assessed. The team then reconvened in Nairobi to share information and discuss findings and insights, and all contributed to the final report.

METHODOLOGY

Steps Taken

- Review of documents provided by USAID/ Kenya and identified during interviews (Appendix C)
- Development of an evaluation matrix to ensure that data were collected for all aspects of the AED CAP Kenya Project (Appendix F)
- Sample selection (Appendix G)
- Survey of selected subgrantees using team-prepared standardized guidelines for consistent data collection (Appendix H)

- Interviews with both technical and managerial informants, including grants managers, program managers, M&E staff, financial officers, and AED CAP Kenya staff involved with IS. Beneficiaries of subgrantees were interviewed to confirm services received, and satisfaction with them, and to elicit suggestions for possible improvements (Appendix B)
- Sharing, discussion, and analysis of findings.

The Evaluation Process

Figure 1 depicts the evaluation process; Figure 2 shows the areas of focus.

Figure 1. Evaluation Process

Figure 2. Areas of Focus

Sampling

Sample selection was a combination of random and purposive. Purposive sampling was done first to ensure that the evaluation covered all categories of subgrantees specified in the grant program aims set out in the Associate Cooperative Agreement. To facilitate this, all subgrantees were categorized by type, whether NGO, CBO, FBO, IFBO, or INGO, and by prime area of focus, whether OVC, PLWHA and OVC, or other (Appendix G).

Criteria for purposive sampling were:

- Types of interventions—e.g., for OVC, HIV, substance abuse, disabled
- Types of implementing partners: e.g., NGOs, FBOs, CBOs, umbrella organization
- Provinces with the most subgrantees and higher population density. (Most subgrantees in Nairobi were assessed. Many of these had branches or sub-subgrantees in other provinces.)
- Subgrantee programs that had been closed out or terminated, to ascertain procedures used, issues, and sustainability.

The provinces selected were accessible from key points like Nairobi, Kisumu, and Eldoret to would enable the consultants to visit the maximum number of programs in the time available, and programs within these were randomly sampled. Ultimately six of the eight provinces where subgrantees operated were included in the sample.

AED CAP Kenya was asked to check the list of subgrantees to see if it contained any that they would classify as success stories so that the team could identify lessons learned that could inform future programs. As a result, one subgrantee was added to the list.

As a result of this procedure the survey reached 20 subgrantees, of which 17 were active (50% of the 34) and 3 were closed out. The subgrantees consisted of NGOs, FBOs, CBOs, and IFBO and INGOs that were umbrella organizations for local CBOs. The sample included:

- Organizations currently working with HIV/ AIDS-affected populations, specifically those delivering services to children in the areas of nutrition, shelter, health, education, economic empowerment, and psychosocial care.
- Organizations focused on families, communities, and OVC themselves that were being strengthened to scale up and improve the quality of their prevention, support, and care services.
- Organizations working on policy initiatives to support care and support for OVC, including advocacy for basic legal protections; transformation of public perception of HIV/AIDS; and school-based prevention, care, and support programs. This covered the broad spectrum of organizations supported by in the AED CAP Kenya Project.
- Beneficiaries of subgrantees, to confirm services received and satisfaction with them, and get suggestions for future programs.

The Analysis

The analysis, which was primarily comparative and descriptive, included assessment of:

- How grants were managed, from solicitation through grants infrastructure, disbursement, financial management, financial and program reporting, procurement, audits, and graduation or termination.
- The impact of inputs on the management of subgrantee organizations in terms of governance and leadership, strategic planning, financial management, human resources management, coordination and collaboration, procurement management, M&E, and quality assurance (QA).
- The benefits and impact of TA for capacity building on services for OVC, HIV/AIDS prevention, or care and support. This component also included aspects related to tools applied, such as self-assessment tools, workshops, and templates, E-Updates, the partners forum, and exchange visits.
- Impacts on the community in terms, e.g., of programs for caregivers, guardians, "duty bearers," life skills development, and income-generating activities (IGA).
- Beneficiary satisfaction with services received.

The analysis also collated and compared lessons learned by the grantee and subgrantees, and elicited recommendations from both for improving the project.

VI. FINDINGS

GRANTS MANAGEMENT

The Subgrants System and Funding Cycles

AED CAP has an effective infrastructure for soliciting and managing grants effectively that is executed through 10 logical and replicable steps:

- Subgrant program design
- Preparation of call for proposals
- Creation of a subgrants application package
- Release of the RFA and pre-bidders workshop
- Receipt and assessment of applications
- Award of subgrants and obligation of funds
- Subgrant implementation, programmatic administration, M&E
- Promotion of the subgrant program and subgrantee networking
- Disbursement of funds and financial monitoring
- Subgrant close-out.

According to the subgrants flow chart (Appendix I), the award process is expected to take 15 weeks, and AED CAP Kenya provided capacity-building to prospective applicants at every stage. For instance, before releasing the RFA for the Partners Program, AED CAP Kenya held a pre-bidders conference to clarify the scope of work and respond to prospect queries related to each grant cycle. Applicants whose concept papers were successful were invited to a proposal development workshop and trained on how to prepare work plan and budgets. Before the proposal development workshop AED CAP Kenya made a site visit to each prospective subgrantee to verify information in the concept papers. All prospective subgrantees were also invited to a grants management workshop where AED CAP Kenya clarified its expectations and standard operating procedures before an award was signed.

All unsuccessful applicants in each stage received very detailed written feedback. As of December 31, 2009, AED CAP Kenya had awarded 49 subgrants ranging from Kshs 3,340,400 (US$43,952) to Kshs 210,024,890 (US$2,763,485), for a total obligation of Kshs 1,168, 614,378 (US$15,376,505). The average subgrant for IS was Kshs 500,000 a year. Nine of the subgrants had already been closed by December 31, 2009.

Since December 30, 2005, when the Associate Award was signed, AED CAP Kenya has awarded five cycles of grants. All but the first cycle were issued using the closed universe solicitation method. Instead of issuing an RFA for the first cycle, subgrantees were selected from a list of 15 supplied to the project by USAID and taken from an earlier RFA issued by PEPFAR/USAID. AED CAP Kenya took these 15 organizations through the other steps of the selection process and awarded three-month subgrant agreements under CAP I to nine of them for January 1, 2006–March 31, 2006. All nine organizations then received a nine-month CAP II award for April 1 through December 31.

The objective of the second cycle RFA was to grant awards to 10–12 organizations working in the OVC PEPFAR program area and obligate up to US$730,000. Based on the modified budget the project and USAID targeted 73 prospects for a by-invitation-only solicitation and ultimately released the solicitation to 60. Of the 60, 10 had been on the first-cycle list of 15; 30 were in an AED CAP Kenya database of groups referred by other organizations or USAID; and 20 were referred by the Kenya Children's Department. In this round 11 organizations were awarded one-year grants, effective February 1, 2006, for a total obligation of US$841,570.

The Cycle III RFA was released to 10 invited applicants that were implementing activities to reduce substance abuse, and two one-year subgrants, effective February 2007, were awarded.

Two RFAs, again closed universe solicitations, were released concurrently for Cycle IV, one to organizations working with OVC and the other to organizations working with substance-using populations. After screening, 23 organizations were granted Cycle IV awards, effective February 2008—17 for OVC projects and 6 for substance use programs. Some of the OVC organizations had previously received grants.

Cycle V grants were client-directed— requested by USAID—and awarded to two members of the Health NGOs Network (HENNET), effective May 2009.

The Closed Universe Solicitation Method

Four of the five cycles of grants were based on closed universe solicitations. That approach is used when USAID and AED agree that there are few eligible NGOs in a given country; AED CAP Kenya indicated in its initial application to USAID that it wished to close the universe for the grants program. This approach can be useful wherever NGOs tend to be organized only because an RFA is issued. By closing the universe, AED CAP Kenya limited the competition to organizations with proven dedication, experience, and qualifications. The invitees were selected according to the following strategic criteria:

- The organizations chosen could significantly increase the number of OVCs reached by the AED CAP Kenya program.
- They had high potential for meeting the eligibility criteria set out in each RFA and had appropriate HIV/AIDS program experience.
- New projects filled the gaps in OVC interventions in the existing grant portfolio, specifically the area of protection, including advocacy and legal awareness.

Invited applicants were required to attend a pre-bidders' workshop where AED CAP Kenya clarified the scope of work, amount of funding, eligibility requirements, and terms of the RFA. The workshop also included an overview on restricted goods and certifications. The project asked invited applicants to submit a concept paper, which was reviewed before qualified applicants were asked to submit workplans and budgets for funding. Table 1 summarizes the RFAs issued, applications received and reviewed, and grants awarded. As the table suggests, the closed universe approach coupled with the pre-bidders' workshop proved effective in weeding out ineligible applicants; several CSOs did not submit applications after they attended the workshop and became clear on the expectations.

TABLE 1. RFAS RELEASED AND FUNDED							
Funding Cycle	Number of Applications Issued (A)	Applications Received (B)	B/A* 100	Pre-Award Assessment	Awarded (C)	Pass Rate C/A*100 (Percent)	Pass Rate C/B* 100 (Percent)
I	13	13	100	9	9	69	69
II	73	42	58	12	7	10	17
III	10	6	60	4	3	30	50
IV	280	75	27	29	17	6	23
V	28	12	43	8	6	21	50
Total	404	148	37	62	42	10	28

Source: AED CAP KENYA Quarterly Performance Reports, March 15, 2010.

On average only about 37% of invited applicants submitted a concept paper after attending the workshop. This saved them from incurring the costs of preparing a submission that would be unsuccessful. Furthermore, in an environment where NGOs with no constituency are known to get registered simply to respond to RFAs, the closed universe and workshop was an innovative way to ensure that concept paper review was manageable. For example, in Cycle IV a list of 280 prospective applicants was obtained from the NACC and the MOGCASD databases, but most of them could not meet the basic eligibility criteria. Thus, the project approach improved the RFA pass rate from 10% to 28% and AED CAP Kenya was able to provide prompt and detailed feedback to unsuccessful applicants because they were fewer of them. The role of the MOGCASD and NACC was limited to sharing the list of credible organizations. They were not involved in the selection process.

Recommendation 1: Moving forward, especially if the project scales up, the RFA invitation committee should also consider factors like the number of children and OVC in each district and the percentage of OVC served there, to ensure a more equitable distribution of subgrantees in the eight provinces and to target the districts most in need.

The project also should support the districts in mapping civil society organizations and identify organizations actively engaged with the community that are not yet on the current AED CAP Kenya invitation list.

Districts should also be given help to review their HIV/AIDS Annual Operating Plans so that districts targeted by specific RFAs are able to prioritize the technical interventions to be funded. CSO mapping reports at the National AIDS Control Council (NACC) and MOGCASD should be updated before RFAs are released to eliminate the problem of NGOs with no beneficiaries springing up in response to the RFA. According to staff of the National AIDS and STI Control Program (NASCOP) who were interviewed, the review of annual strategic plans and mapping reports would be more objective if the exercise is conducted without being pegged to a specific RFA.

Partnership with the Government

Although its solicitation review procedures allow AED CAP Kenya field offices to nominate prominent citizens of the host country on the basis of sectoral expertise, regional balance, impartiality, and ability to respect the confidentiality of the decision making process, AED CAP Kenya has not exploited this opportunity of partnership with central and district technical staff.

Recommendation 2: For a closer partnership with the government and a heightened sense of government ownership of the program, AED CAP Kenya should identify champion officers, e.g., from district Children's Affairs departments, and appoint them to the technical review committees responsible for screening concept papers. This will allow the district departments to contribute not only to the quality of projects to be funded but also to the design of an effective and sustainable supervision mechanism. Similarly, AED CAP Kenya should solicit input from the National OVC Steering Committee in future RFAs to improve the engagement with national government entities and ensure that RFAs are aligned with national priorities.

The subgrantees interviewed indicated that AED CAP Kenya provided detailed and prompt feedback on the monthly financial reports, and subsequent disbursements were released on time. Cash flow gaps were experienced only at the time of subgrant renewal; this problem is highlighted in Recommendation 4.

Partnership with the Private Sector

All the subgrantees interviewed pointed out that the professional firms AED CAP Kenya contracted with to conduct the tax management and policy development workshops did an excellent job of meeting subgrantee expectations. They recommended that the project continue to hire private companies to handle such specialized topics. The private audit firms have also helped to improve subgrantee financial management through on-the-job training to address issues identified during the audits, which have been a major cause of subgrantee suspensions.

In June 2008, AED commissioned a consultant to audit a sample of CAP Kenya grantees to assess current risks to the program. After the audits, it was recommended that all the other Kenya grantees be audited, and 26 active grants were. The grantees are located in Nyanza, Western, Rift Valley, Eastern, Central, Nairobi, and Coast provinces. The objective of the audits was to form an opinion about whether AED CAP Kenya grants were being used in accordance with the grant agreements and to identify expenditures that might have been paid in contravention of the agreements or inappropriately in any other aspects.

Recommendation 3: In addition to their current engagement as advisors on policy development and tax management, it would be useful to also involve private audit firms in pre-award assessment of prospective subgrantees. This will not only speed up the pre-award assessment visits, thus reducing the RFA gestation period, it will also give the project an objective assessment of financial risk for all prospective subgrantees and possibly avert the inevitably lengthy process when subgrantees are suspended for financial mismanagement.

9–12 Month Subgrant Periods

The grant periods presented some difficulties for subgrantees. All subgrants had to be approved by AED Washington before any funds could be disbursed. Most of the subgrantees interviewed pointed out that the cumbersome process and the delays associated with approval of subgrants had negative effects on service delivery. For example, between September and December 2009, there was significant delay in the release of the disbursements (see Appendix J). A number of subgrantee staff did not receive their salaries while AED CAP Kenya was processing the cost extensions. Some subgrantees reported inter-project borrowing to accommodate the delay in disbursements. They pointed out that a multiyear subgrant agreement would not only offer opportunities to deepen the impact of the projects but also enable them to retain the staff they need. Many mentioned that it was counter-productive to spend a whole year building the capacity of staff only to lose them at year-end because their employment could not be guaranteed.

Recommendation 4: AED CAP Kenya should obtain a waiver from AED Washington so that it can start issuing multiyear subgrants of at least two years. AED Washington should also decentralize the subgrant approval process. (There is a clause in the subgrant specifying that funding is subject to availability of funds, satisfactory progress, and the continued relevance of AED CAP Kenya and USAID programs. This clearly implies that if USAID does not continue funding the cooperative agreement, the liability of AED CAP Kenya on the subgrant is limited to funds already obligated.)

Monthly Reporting Requirements

The first subgrant disbursement covers operations for two months; at the end of the first month the subgrantee reports expenses in the first month and requests funds for the third month, etc. No cash flow gap is expected because the next disbursement is released before the end of the second month. Although some subgrantees indicated that monthly financial reporting requirements "kept them on their toes" and helped them to adapt quickly to strict financial discipline, it was evident that the monthly requirement affected project activities and in some cases may have undermined expected impact. The closed-out subgrantees interviewed indicated that project staff were forced to spend too much time responding to queries instead of concentrating on project implementation. However, nearly all the subgrantees interviewed did acknowledge the exemplary work of AED CAP Kenya staff in providing timely and detailed review notes on each monthly report.

Recommendation 5: The subgrant portfolio should be ranked and the better-performing organizations graduated to quarterly rather than monthly reporting. The latter could be allowed to access second-quarter release as accountability for the first quarter is being reviewed. An extra control measure can be instituted specifying that funds for the third quarter should not be released until 100% of the advance for the first quarter has been used up.

INSTITUTIONAL STRENGTHENING

Improving Effectiveness and Efficiency

From its inception, the AED CAP Kenya Project has sought to provide appropriate and timely TA to subgrantees. Its strategies produced a win-win situation for both the subgrantee and the project. For example:

- From the pre-award assessment and site visits the project learned about each prospect's program capacity, financial management, and the adequacy of its general governance and accountability. This enabled AED CAP Kenya to plan appropriate interventions. At the same time, it gave potential subgrantees the opportunity to look at their strengths and weaknesses and to appreciate where interventions might be of help.
- The proposal development and budgeting workshop enabled each subgrantee to build proposal writing and budgeting skills with expert support. As a result, most were able to use these skills not only in putting their proposals to the project together but also to write proposals to source other grants, as many have done (see Table 2). The proposals also formed the basis for the project grant agreement and provided a roadmap for AED CAP Kenya to follow in monitoring their progress.

TABLE 2. DIVERSIFICATION OF SUBGRANTEE FUNDING

	2006		2007		2008		2009	
	No. of Donors	Total Funding (Kshs. millions.)	No. of Donors	Total Funding (Kshs. millions)	No. of Donors	Total Funding (Kshs. millions)	No. of Donors	Total Funding (Kshs. millions)
Reachout			2	9.3	2	9.1	3	9.3
HVFI			2	3.7	4	6.8	5	9.3
CWS	3	103.3	3	246.8	2	246.1		
SAPTA	2	4.9	3	16.7	4	20.7	5	21
HI	4	43.5	12	119.8	19	233.8	18	287.6
SFIC	1	5.6	1	7.2	1	6.3	1	9.5
Nazareth	2	40.5	3	42.6	2	42	2	45
WEMA	1	4.6	3	15.8	5	33.2	7	27
YARD			5	8	7	11	6	10
HWWK	7	89.2	11	110.9	12	182.9	17	226.3
CREADIS	7	11.1	7	16.7	9	15.8	11	16.3
HEART		0.0	7	24.5	7	33	8	27
KHBC					7	26.7	7	21.9
Rafiki			4	7.9	5	10	5	9.6
Twana	1	9.5	1	6.4	1	7.4	1	8
RAPADO	4	7.2	7	32.9	8	29.5	5	26.1
Ripples	4	18.1	9	46	10	40.4	12	53.7
Helpage	8	265.5	7	48.2	10	995.9	9	236.5
WAYAAP			2	4.2	2	8.1	3	14.8

TABLE 2. DIVERSIFICATION OF SUBGRANTEE FUNDING								
	2006		2007		2008		2009	
KENWA	11	48.3	12	53.7	19	58.3	22	55.9
St. Camillus	4	26.1	5	28.3	5	45.1	3	37.1
CABDA			6	11.4	6	17.7	5	14.8
KUAP	5	33.7	6	22	5	49.2	4	35.5
MCC	6	7.4	6	9.6	5	10.9	4	11.8
NIA	1	5.9	2	8.8	5	14.7	4	15.1

Source: AED Cap Kenya.

- The grants management workshop, the *Grants Management Manual*, and reporting and management templates that were given and explained to each subgrantee, made grants management easier for both sides. Since subgrantees were each made aware of the terms and expectations of the grant and their and the project's responsibilities, the potential for conflict was considerably reduced.

These first steps were both effective and timely and led to efficient management of subgrants. All subgrantees interviewed considered them very appropriate and successful in helping them to manage their grants. They also gave positive ratings to subsequent TA.

Due to time constraints, the team was able to visit only three of the 19 subgrantees that were closed out. One was closed for financial mismanagement, one failed to stick to the agreement, and one chose to opt out on the grounds that the monthly reporting was taking too much time away from patients and had found another source of funding with less onerous requirements.

AED CAP Kenya staff considered financial mismanagement and failure to meet commitments or grow to be the major reasons for termination of grants. In the former cases, grant funds were not necessarily stolen but rather were used to fund activities other than those agreed on. Future subgrantees need to clearly understand that this choice can cause them to lose their grants. The need to meet increasing targets seemed to have spelled doom for the organizations that did not grow. There seems to have been a major source of tension between the need to help institutions to grow and the requirement to meet PEPFAR targets.

It also appears that once funds are known to be available, some organizations write their proposals accordingly. It is not clear how these can be spotted in advance.

Health facilities seem to start with the best intentions, but as their workload increases so do demands on their time, and patients take precedence over monthly reports. Implementation of Recommendation 5 should help solve this problem.

Once subgrantees were selected, AED CAP Kenya focused on seven areas in which to build up their management and technical ability. Gaps, strengths, and weaknesses were identified, needs prioritized by the organization and the project together, and strategies tailored to each subgrantee.

The seven areas that received special attention were:

- Leadership and governance
- Strategic planning and decision making: planning ahead
- Finances: budgeting, financial control, transparency, etc.

- Human resources: policies and compliance with labor laws
- Coordination and collaboration: working relationships with government and other organizations doing similar tasks
- Procurement
- M&E: how the organization monitored progress and outcomes.

AED CAP Kenya used four approaches to helping organizations addressing identified needs:

- Capacity building through workshops and other training
- Provision of templates specific to each area
- Follow-up and mentoring
- TA from a dedicated consultant where longer-term assistance was needed, e.g., for drafting strategies, manuals, etc.

As of September 2009, 97% of active organizations had received formal training in report writing, 89% in M&E, and 61% in the use of Quick Books, but only 50% had received training in resource mobilization, and even fewer (39%) were given policy and procedure training (see Appendix K). However, organizations that had not been trained in policies and procedures were given on-the-job TA by consultants to help them draft strategic plans and manuals.

The fact that half were not trained in resource mobilization may help explain the low numbers of organizations that have diversified to five or more donor sources or substantially increased their funding beyond the AED CAP Kenya grant (see Table 2). AED CAP Kenya did, however, conduct a sustainability workshop while the evaluation team was still in Kenya in order to help subgrantees draft sustainability plans.

AED CAP Kenya also introduced unique mechanisms—the Founders Forum, the Partners Forum, and exchange visits—that facilitated sharing and learning. These, according to the organizations, challenged, encouraged, and motivated them to want to do better. Subgrantees credited the project for the many positive changes and growth in their organizations. Table 3 lists management systems put in place through the project through March 2010.

TABLE 3. MANAGEMENT SYSTEMS INSTALLED IN SUBGRANTEE ORGANIZATIONS THROUGH AED CAP KENYA							
Organization	**Strategic Plan Development and Review**	**Financial Policy Manual**	**HR Policy Manual**	**Coordination & Collaboration; Teambuilding**	**M & E Training and Manual**	**Leadership/ and Board Skills Development**	**Administrative /Procurement Policy Manual**
Beacon of Hope	√	√	√	√	√	√	√
CABDA	√	√	√	√	√	√	√
COLIDEF	√	√	√	√	√	√	√
CREADIS	√	√	√	√	√	√	√
CWSK	√	√	√	√	√	√	√
HI	√	√	√		√		√
HEART	√	√	√	√	√	√	√
HVFI	√	√	√	√	√	√	√
KENWA	√	√	√	√	√	√	√
KUAP		√	√	√	√	√	√
Nazareth	√	√	√		√		√
Neighbors in Action	√	√	√	√	√	√	√
Rafiki	√	√	√	√	√	√	√
Raphaelites	√	√	√	√	√		√
SAPTA	√	√	√	√	√	√	√
Twana Twitu	√	√	√	√	√	√	√
YARD		√	√	√	√	√	√
Total Active N=17	16	17	17	16	17	14	17
Percentage Active with Closed out N=3	94	100	100	94	100	80	94
St. Mary's		√	√	√	√		
TICH						√	
WEMHIS					√		
Total Closed out with	0	1	1	1	2	1	0
% closed out with	0	33	33	33	66	33	0

As of September 2009, project records show that of all the subgrantees,

- 62% had strategic plans;
- 89% had financial management manuals;
- 89% had a human resources policy; and
- 96% had received M&E training.

Additionally, 84% of staff at these organizations had been trained in team-building skills and 44% of their boards of directors had received training.

Moreover (see Table 3), of the 17 active subgrantee organizations the evaluation team visited,

- 15 (80 %) had strengthened their boards by adding more vibrant and professional persons who they felt were moving the organization forward. They also thought that leadership had become more participatory and managers were working together better as a team.
- 16 (94%) had strategic plans.
- All 17 (100%) were using financial management guidelines and financial templates. Some also said that their financial management was so much better that they had attracted other donors.
- All 17 also had a procurement manual and tried to follow it. Some expressed concern, however, that even though budgets were approved for items and they had got three quotations, AED Washington approval was still required for the actual purchase. AED CAP Kenya, however, mentioned the need to check for conflicts of interest; in one case supplies were sourced from a board member.
- All 17 had a human resources manual that was consistent with national labor laws. One stated, however, that cited financial constraints had prevented it from implementing the policy on severance pay. High staff turnover was also mentioned as contributing to such failure.
- All 17 had drafted and were using an M&E manual, but there were indications that, although all had received M&E training, this area needs more attention because some were not using the information gathered to make informed decisions.

Recommendation 6: For the remainder of the project AED CAP Kenya should emphasize M&E so that each subgrantee understands how to use data gathered in M&E for decision making.

- The 17 active and 3 closed-out organizations had all coordinated their activities with district and local government agencies and with organizations they met at the Partners Forum. There was some indication, however, that collaboration with senior levels of government needs further reinforcement so that it will trickle down.

In monitoring progress AED CAP Kenya has been making periodic spot checks to verify data. The umbrella organizations visited follow the same procedure in checking reports from sub-subgrantees or field workers, but this tends to make them late in meeting the deadline for reporting on the 5th of the following month. They asked that the deadline for umbrella organizations be the 10th rather than the 5th.

- Although the AED CAP Kenya Project has emphasized organizational sustainability throughout its program, the subgrantees seemed to have concentrated on making their *beneficiaries* self-sustaining by emphasizing IGA and education, etc., rather than ensuring their own sustainability. None of the organizations visited had a clearly articulated sustainability plan. This is discussed further below.

Coordination with Government

AED CAP Kenya is well represented in national technical working groups (TWGs); for example, both its OVC program officer and its senior program officer are members of the National Steering Committee for OVC. The project is also actively represented in such groups as the Kenya National HIV/AIDS Strategic Plan (KNASP) Review group; the National AIDS and STI Control Program MARPS TWG, and the National AIDS Control Council (NACC) Monitoring and Evaluation Working Group.

Subgrantees are encouraged to become involved at the district and community decision making levels so that they can prevent duplication of interventions. As a result, some are involved with district health teams, and some have earned the respect of district technical leadership. For example, in Rarieda District, Rafiki wa Maendeleo functions as the Secretariat of the Area Advisory Council, and the District Children's Officer said it is highly regarded in the community because it is "very cooperative especially in responding to emergencies."

The testimony of one IGA beneficiary in Lucy Village in Rarieda also provides evidence of strong community support for the project, and it was clear from beneficiary feedback generally that communities appreciated AED CAP Kenya's interventions. In Kakamega, Community Asset Building and Development Action (CABDA) has actively reached out to the community, and government leaders, especially the chiefs and staff of the district Department of Children Affairs, recently participated in the review of the CABDA Strategic Plan. However, the government has not yet been involved in selection of subgrantees (see Recommendation 2).

Improving the Quality of Community HIV/AIDs Services

In the early years, project TA for IS focused primarily on grants management and organizational systems, such as financial and human resources management and M&E. This was largely dictated by and consistent with the need to lay a solid foundation for managing USAID funding in compliance with USG standards and for timely, consistent, and accurate reporting on PEPFAR indicators. Between 2006 and 2009, TA for capacity building was provided in five major ways: regular partners meetings, exchange visits, workshops and trainings, one-on-one assistance, and electronic newsletters.

Partners Forums. Assistance with community-level HIV/AIDS programming and program design was provided early on through Partners Quarterly Meetings, which began in April 2006 and morphed a year later into the Partners Forum, which generally meets twice a year. (As the number of subgrantees grew, quarterly meetings were deemed too time-consuming both for AED CAP Kenya to prepare and subgrantees to attend. See the 2007 AED CAP Kenya Quarterly Reports.) All current subgrantees are members of the Partners Forums, which gives their staff opportunities to:

- Share success stories and seek advice on how to deal with problems;
- Form issues-oriented collaboration networks; and
- Learn how to deliver services more effectively from expert speakers and exchange visits with other partners.

The forums also give AED CAP Kenya the opportunity to share new information about PEPFAR programming, mission priorities and emphasis areas, and changes in Government of Kenya (GOK) policies. Experts were invited to give presentations on such issues as the importance of birth certificates and how to procure them for OVC; pediatric management of HIV/AIDS; meeting the needs of elderly caregivers; the Kenya National AIDS Strategic Plan; and adoption regulations and guidelines.

The evidence is overwhelmingly positive that these meetings helped subgrantees to improve the quality of the services they deliver. Every subgrantee visited was able to give examples of how they benefitted. For example:

- Neighbors in Action had sought the advice of the adoptions expert who spoke on how to legalize OVC "adoptions" in their area, as is required by law.
- Based on several sessions on quality improvement, Hope Valley Family Institute (HVFI) began coordinating with other organizations in their area in order to provide better and more complete services to OVC. Previously HVFI had not realized the potential of networking for improving program results. Now HVFI networks regularly with local government and community officials, the APHIA II project, and other local service organizations.

Exchange Visits were an outgrowth of Partners Forums where grantees heard from peer organizations about successful interventions and activities and how similar challenges were met, barriers mitigated, and results improved. With AED CAP Kenya assistance, exchange visits were organized to observe successful program activities:

- Raphaelites—Redhill Place learned from an exchange visit arranged during a Partners Forum how to improve case management for substance abusers and how to improve records and filing.
- Neighbors in Action (NIA) learned about school gardening through an exchange visit to Youth Action for Rural Development (YARD) and was able to adopt such activities to improve food security among OVC.
- After hearing about Hope World Wide's Community Kids Clubs during a Partner's Meeting, HVFI arranged a visit to see the clubs in operation, and set up its own successful Kids Club. This proved to be more effective in providing psychosocial support (PSS) than operating through the schools.

Workshops and Trainings. Since July 2008 the project has put on eight workshops and trainings, which reached 220 participants, to enhance the knowledge and skills needed to implement program interventions in nutrition care for PLWHA, mitigating HIV and AIDS among OVC; integrating HIV prevention into both OVC and substance abusers programs, mitigating stigma and barriers to HIV service access, using the CSI to focus program decision at the individual child level, and strengthening HIV testing (see Appendix L).

Again, the evidence confirms that the trainings and workshops led to significant programmatic improvements. For example, HEART staff incorporated age-specific prevention messages; addressed issues of sexuality, personal development, and self-esteem; and integrated PEPFAR's 6+1 core essential services for OVC into their programs, ensuring a more holistic approach to serving OVC. Numerous organizations (e.g., HVFI, Beacon of Hope [BH], St. Mary's Medical Centre, YARD, NIA) cited the Child Status Index (CSI) Workshop as helpful in allowing them to track each child as an individual and ensure that each gets the best possible mix of services needed to thrive. The nutrition training helped HVFI to target specific food and nutrition needs of various client groups, particularly those who are HIV-positive. Organizations visited stated

that they felt more confident as a result of their increased technical capacity and were better able to work within communities and offer more appropriate services.

One-on-one Technical Assistance was provided as needed, starting in 2006, to individual subgrantees and their staff by AED CAP Kenya Project team members during quarterly field visits. This strengthened programmatic work in technical areas related to the types of interventions the subgrantees were implementing. These visits began on a regular quarterly basis in late 2007 for the 5-7 Substance Abuse Program (SAP) grantees; visits for non-SAP grantees picked up in mid-2008 with the recruitment of the second technical staff person. Feedback on CAP Kenya staff's willingness to provide this one-on-one assistance was again positive. For SAP grantees, the assistance usually focused on redesigning the way addiction treatment services were offered and providing more user-friendly, community-based services; OVC programs were given recommendations for expanding the package of services or better integrating with the community to improve program outcomes.

HIV E-Updates, initiated in August 2008, have proven to be extremely popular. In recognition that HIV activities and programs are dynamic, these electronic newsletters, intended to support technical development and continuous learning, provide thematic information about HIV/AIDS topics. The newsletters summarize general concepts and information and also offer toolkits, guidelines, strategies, and links to curricula that can be adapted (see Appendix M for a list of the 19 issues so far). In October 2009, AED CAP Kenya surveyed readers to gauge satisfaction with and the usability of the newsletter content and the usefulness of the range of topics that had been covered. Of the 23 readers who responded, 92% found the content to be just right or easy to understand; 96% found it to be useful or very useful; and 100% found it to be relevant to their programs' needs. One reader recommended more information on "children's issues in relation to care and treatment and …counseling and testing of children"; the project responded by focusing the next issue (February 2010) on HIV testing for infants and children.

The evidence confirms that this overwhelmingly positive reader response was not exaggerated and that information in the newsletter has been used to improve the quality of program activities and services delivered. CABDA was motivated to set up an information corner in the staff room where materials on HIV/AIDS are available for staff use; hard copies of the HIV E-updates form the core of the collection. HVFI also shares the information with community and local government counterparts and has used web links to training manuals to improve PSS, behavior change communications (BCC), life skills training, and program activities. From an E-update, Rafiki staff learned that only 40% of males in their area were circumcised, and they have since increased their efforts in this area. Many particularly appreciated the issue that updated them on changes in government HIV/AIDS policies.

It is therefore safe to conclude, based on subgrantee feedback, that the project's technical capacity building through forums, workshops and trainings, one-on-one TA, and HIV/AIDS E-Updates was well received and helped improve the quality of services delivered. Technical sessions provided through Partners Forums and one-on-one TA began in mid-2006, but the bulk of capacity-building was not offered until midway through 2008.

Recommendation 7: TA in technical capacity building should be accelerated through 2010.

Subgrantees were not only overwhelmingly positive about the capacity-building mechanisms offered but also identified areas where more trainings, workshops, and information are needed:

- Communications, BCC message and material development, and methods for evaluating BCC message impact
- How to integrate anti-gender-based-violence activities into programs
- Prevention with PLWHA
- Prevention among adolescents
- HIV prevention materials for those whose literacy is low.

Because much of the capacity development has been carried out directly by AED CAP Kenya staff, when the project ends, so does much of the capacity development.

The AED CAP Kenya Project has done a great deal to build the technical capacity of its 49 subgrantees. Most of the relevant information is scattered through files and quarterly project reports and subgrantee narrative reviews; it has not yet been consolidated into a single comprehensive document.

Recommendation 8: In its final year, AED CAP Kenya should look for ways to empower organizations to build their own technical capacity and ensure that this important building block in institutional development will continue either internally within each organization, through contracting in groups for TA from a local expert organization, or through other mechanisms to ensure sustainability. For example, a future HIV E-update could identify websites for continual updating on HIV topics of interest.

Recommendation 9: By the end of 2010, AED CAP Kenya Project should document each organization's improvement in technical capacity during the project.

PROJECT PERFORMANCE AND IMPACT

As of September 30, 2009, since 2006, AED CAP Kenya Project had obligated $15,069,156 million to 49 NGOs, CBOs, and FBOs through small grants to improve their organizational and technical capacity to implement and monitor HIV/AIDS programs that serve an increasing number of Kenyans. This EOP evaluation was tasked with assessing:

- Progress toward achievement of project targets;
- The extent to which AED CAP Kenya has established an infrastructure that makes it possible to monitor grants effectively;
- Achievements and impact of the project's IS approaches to building both management and technical capacity; and
- The extent to which the project's IS activities in Kenya have improved HIV/AIDS service delivery and expanded community HIV/AIDS care and support services.

Progress against PEPFAR Indicators

PEPFAR originated as a multicountry emergency program to save lives and improve the quality of life for millions of PLWHA around the globe. Results have been captured against standard indicators that are of necessity quantitative. AED CAP Kenya Project's Performance Monitoring

and Evaluation Plan (PMP) for January 2006 through September 2008 and the draft PMP for the period through 2010 includes 23 standard PEPFAR indicators**.** Of these, the project has met or exceeded 16 (see Appendix N). Through its subgrantees:

- **37,912** individuals were reached through community messages promoting HIV prevention with abstinence or be faithful (AB) messages.
- **64,751** individuals were reached through community outreach promoting HIV prevention through behavior change other than AB.
- **19, 350** individuals were provided HIV-related palliative care (including treatment for tuberculosis).
- **34, 743** OVC were reached with essential services.
- **31,441** individuals received counseling and testing for HIV and received their test results.
- **391** individuals were trained in HIV-related institutional capacity-building.

The project has thus affected substantial numbers of lives. While the numbers do not speak directly to impact, they do speak to the magnitude of the services and interventions carried out.

Target-setting on such a massive scale is an inexact science, but it appears the AED CAP Kenya targets were not always raised by reasonable percentages. For example, in FY 08, the project's target for the first indicator, number of individuals reached with prevention AB messages," was 7,000. In fact, that year the project managed to reach over 26,000 individuals. Without confirming with the project how many more could be reached in FY 09, PEPFAR then assigned it a target of 170,000 individuals. While AED CAP Kenya negotiated this number down to 60,000 in its 2009 workplan, it was still not able to double the 2008 achievement, so this target was not met; yet it did reach 11,000 more people than in the previous year. Target-setting in which the grantee participates would surely result in more realistic targets.

Recommendation 10: Target-setting could be greatly improved if USAID/ PEPFAR were to include the grantee (AED CAP Kenya Project) in initial target-setting.

More Effective Grants Management

As has already been documented, AED CAP Kenya established early on an infrastructure that has proved effective for soliciting applications and managing and monitoring grants. In 2007, AED Headquarters chose AED CAP Kenya from among all its projects worldwide to receive its Leadership in Grants Management Award.

As the number of grants has increased, the project has recruited additional staff to support grants accounting, management, and monitoring. In October 2006, the AED CAP Kenya M&E system was assessed by a Department of State Presidential Management Fellow, who determined that it "meets PEPFAR and USAID contractual obligations."

Impact of Project IS Approaches

While the PEPFAR indicators measure the numbers of individuals reached and services provided, they do not adequately measure progress toward meeting the objective of the project: assessing the extent to which AED CAP Kenya, through its IS approaches and TA, has been able to build the technical and institutional capacity of the 49 organizations it has worked with. Six PEPFAR indicators track the number of organizations provided with TA for HIV-related policy development and institutional capacity building and the number of individuals trained in HIV-

related policy development, institutional capacity building, reduction of HIV-related stigma and discrimination and community mobilization for HIV prevention, care, or treatment. In its first four years, AED CAP Kenya has achieved only about half the targets for these indicators. But the indicators do not begin to measure the true extent to which organizational capacity has been built.

Recommendation 11: To ensure that the rich qualitative and narrative data accumulated for each organization is not lost, the story of each institution's strengthening process and accomplishments in technical capacity development should be written up and preserved through a combined effort by AED CAP Kenya and the organization itself.

Measuring Institutional Strengthening

AED CAP Kenya Project uses unique tools and approaches to assess subgrantee strengths and weaknesses and identify gaps, particularly management questionnaires, the Institutional Development Framework (IDF), rapid organizational reviews, and the most-significant-change (MSC) technique. Since the IDF produces an overall numerical score for an organization, it is possible to compare later scores with the baseline score to get a rough indication of improvement over time. Of the 27 organizations for which two IDFs have been completed, 18 (67%) showed improvement in IS, ranging from 5% to 63%, between the two IDFs. Instead of a third IDF, AED CAP Kenya Project carries out an MSC exercise that produces a narrative story of change.

Together all these tools produce a wealth of information for each organization. Often these stories are told in the project's very comprehensive and articulate quarterly reports; but quarterly reports, no matter how good, seldom live beyond the project itself.

Measuring Improvement in Technical Capacity

AED CAP Kenya's IDF tool provides a rough measure of change in IS and has a section on technical capacity. The section, however, is heavily focused on gender and human rights concerns. In an effort to provide a more comprehensive review of gaps and strengths in HIV/AIDS technical skills so as to better focus capacity development support, AED CAP Kenya developed the HIV/AIDS Technical Assessment Tool. Its scoring system determines:

- A program's technical level of development based on the presence of components essential for comprehensive, sustainable, and effective programs;
- Whether the program is meeting the minimum standards of practice for the specific activity (e.g., prevention, OVC support) as specified in PEPFAR guidance; and
- The level of specific HIV/AIDS training and expertise represented within the program.

The score is analyzed to identify each program's HIV/AIDS technical capacity. While this tool is intended to identify program and knowledge gaps for better-targeted TA, it also offers a rough measure of overall capacity improvement because of AED CAP Kenya efforts. The 15 grantees assessed in both 2008 and 2009 demonstrated substantial improvement in technical capacity:

- In 2008, only 7 subgrantees (47%) had "on-going, planned, and age-specific HIV/AIDS prevention activities"; the next year there were 12 (80%).
- In 2008, 8 organizations (53%) had mechanisms in place to check the quality of program activities; in 2009, 12 (80%) had QA mechanisms in place.

- In 2008, no organizations could claim that at least 75% of their program staff were trained in HIV/AIDS topics; by 2009, in 8 of the 15 organizations 75% of the staff were trained and knowledgeable.

(See Appendix O for more complete findings.)

Interestingly, the AED CAP Kenya 2006–2008 PMP set out four additional indicators for tracking results under the project's Objective 2: Improved HIV/AIDS service delivery and quality through institutional capacity building. These are:

- Number of grantees providing HIV/AIDS and STI-related services that conform to recommended minimum essential packages;
- Number of grantees provided with TA (by type) for capacity building;
- Number of grantees demonstrating improvement in targeted aspects of institutional capacity, as measured by the IDF; and
- Number of organizations demonstrating adherence to agreed quality service standards.

These more qualitative indicators, while discussed occasionally in the report of individual organizations or subgroups of organizations, were not reported on quarterly or at the end of the fiscal year with the PEPFAR indicators. Yet much effort went into the IS and capacity-building activities these indicators were meant to track—and, clearly, considerable IS has taken place. There is substantial information available about this, although it is not necessarily complete or consistent for all organizations. AED CAP Kenya has included the same four indicators in its draft 2009–2010 PMP, which was recently submitted to USAID for approval.

Recommendation 12: AED CAP Kenya should determine how it can best report on the four qualitative indicators in its PMP to track institutional strengthening and capacity building for 2010. Alternatively, it should propose other indicators that will actually be reported on consistently along with PEPFAR data on a quarterly or annual basis as a measure of institutional strengthening and technical capacity development.

Effect of Project Work on Services in the Community

Measuring the real impact in terms of improved health or quality of life outcomes within the communities served by a project is never easy. All too often is not even attempted. Yet every evaluation wants to document this information. In response to the 2006 assessment of the project's M&E systems by a Department of State Presidential Management Fellow, AED CAP Kenya planned "to develop impact indicators." In response to a recommendation that "randomized surveys should be carried out to measure impact," AED CAP Kenya stated that it would "ensure that organizations have relevant baseline data and collect relevant data on impact level indicators." Regrettably, neither not done, and there is no documentation of project impact.

In an effort to assess impact, this team collected from each organization visited information on two questions:

- How is the community better off as a result of your activities with the AED CAP Kenya Project?

- How have the services you provide with AED CAP Kenya Project assistance changed as a result of the institutional strengthening and capacity development your organization has undergone?

All the organizations interviewed responded positively with one or more examples of how the community or beneficiaries (OVC, caregivers, substance abusers, etc) were better off (see Appendix P for complete responses). The following responses, heard more than once, were typical:

- More OVC, particularly older girls, are attending school and are staying in school longer, and performance in school is improved.
- Communities are better engaged with and more responsive in supporting OVC.
- OVC feel more hopeful and show improved self-esteem, particularly older OVC who have successfully completed training in income-generating skills.
- After PSS training teachers are responding to OVC with more compassion.
- More people are accessing voluntary counseling and testing (VCT) services and learning their status because they hear that treatment is available.
- There is better recognition of the rights of the child within the community.
- Improved quality of life for PLWHA has resulted from PSS, more holistic care and referrals, and improved nutrition and income-generating skills.

There was a similar plethora of positive examples when the organizations were asked (Appendix Q) how the services they provide with AED CAP Kenya Project assistance have changed as a result of the IS and capacity development they have undergone:

- With better understanding of how all the components of the OVC 6+1 essential services work synergistically, they have been able to provide more comprehensive and effective services to OVC and their families.
- OVC services are better focused on the individual child since they have learned to use the CSI monitoring and decision-making tool.
- Service quality has improved with better monitoring systems and program approaches.
- Delegation of authority to program managers or a leadership team has streamlined project implementation, and there are fewer hold-ups if the director or founder is away.
- Increased networking with local government and peer organizations has helped them solve challenges, try new activities, and achieve better results.

Most of the organizations had several success stories to recount or already filed away. AED CAP Kenya quarterly reports have often highlighted a particularly successful program activity or individual success stories, either provided by the organizations or documented from the MSC exercises. But this rich repository of qualitative information and that elicited by all the assessment tools and the MSC exercises have never been collected and analyzed for results by type of program or TA input. AED CAP Kenya intended at one point to put together technical briefing papers that would record the results of specific project interventions, but this has not yet been done.

Recommendation 13: By the end of 2010, AED CAP Kenya should determine how best to document improved quality of services and program interventions that have worked particularly well, using technical briefing papers, annotated assessment and monitoring tools, best practices, success stories, and reports of successful innovations. Narrative and intermittent reporting on individual organizations in quarterly reports would then complement, not substitute for, more formal and consistent tracking.

SUSTAINABILITY, REPLICABILITY, AND SCALE-UP

The AED CAP Kenya Project gives subgrantees the tools and skills they need to be sustainable. These tools, especially those used for financial management, are replicable, and many subgrantees mentioned that the systems built by the project have helped them to diversify their funding base and raise funding locally. For example, the Kenya Network of Women with AIDS (KENWA) was able to raise funds from the NACC, Safaricom, and other local firms with corporate responsibility programs. Some were trying to invest in real estate and other IGA.

The additional funds, however, seem to be small. Table 2 shows that of 25 organizations whose funding and diversification between 2006 and 2009 AED CAP Kenya studied, for two the AED CAP Kenya grant was their only source of funding, one had two donors, three had three donors, three had four donors, and four had five donors. Funding for each of these organizations was less than Kshs 20,000,000. However, the other 12 (48%) were able to diversify to more than six donors. Donors to KENWA increased from 11 to 22 donors, but its net revenues increased only 14.3%, from Kshs 48,900,000 to 55,900,000.

Recommendation 14: For the remainder of the grant period, AED CAP Kenya project should give particular attention to helping current subgrantees to diversify their funding sources, especially those that seem to be having difficulty in doing so.

International NGOs (INGOs) such as Handicap International (HI) generally showed remarkable increases in income; but donations to Help Age declined from Kshs 265,500,000 to Kshs 236,500,000. No local CSO was able to raise as much as KENWA. These findings highlight the need for subgrantees to step up their ability and efforts to raise their own sources of funding if they are to become self-sustaining.

Recommendation 15: AED CAP Kenya should pay particular attention to resource mobilization and specifically target subgrantees that have not yet diversified their resource base. AED CAP Kenya Project should help subgrantees to prepare sustainability plans.

AED CAP Kenya helped subgrantees to prepare strategic plans; it also put together networks, such as the Founders Forum, which in addition to building the confidence of founders enabled them to look ahead and begin to build structures for sustaining their organizations after their departure. Delegation, succession planning, and mentoring of potential successors is now a common feature of organizations headed by their founders.

Although AED CAP Kenya has emphasized sustainability from the beginning, subgrantees seem to have been more concerned with making their beneficiaries self-sustaining than themselves. None of the organizations visited had a clearly articulated sustainability plan. In March 2010, however, AED CAP Kenya Project presented a sustainability workshop for current subgrantees that should be of great benefit to all of them.

Recommendation 16: Each subgrantee should be guided and assisted to draft a sustainability plan before the end of the current AED CAP Kenya project.

Although about half of the subgrantees visited had diversified their funding sources to more than six donors, they all seemed to have the impression that the AED CAP Kenya Project would support them indefinitely.

Recommendation 17: During its final year, AED CAP Kenya should look for ways to empower organizations to ensure that this important building block in institutional development will continue, either through internal mechanisms within each organization or through contracting in groups for technical capacity building TA from a local expert organization or other mechanisms to ensure sustainability of the process. Additionally a future HIV E-Update could identify websites for continual updating on HIV topics of interest.

Most subgrantees were confident that, although they still required AED CAP Kenya Project funding to sustain their activities, some components of the project would continue with or without that funding; for example, counselors for substance abusers would continue discharging their duties because they were part of the community.

APPENDIX A. SCOPE OF WORK

GLOBAL HEALTH TECHNICAL ASSISTANCE PROJECT
GH TECH
CONTRACT NO. GHS-I-00-05-00005-00
SCOPE OF WORK

I. TITLE

Activity: **External Evaluation of AED CAPABLE PARTNERS PROGRAM—Kenya Small Grants and Institutional Strengthening Program II (KSGISP)**

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

Early March to mid-April, covering a 5-week period.

III. FUNDING SOURCE

USAID/Kenya

IV. PURPOSE

The purpose of the evaluation is to conduct an end-of project evaluation (March 2010), including the review of technical and management aspects of the CAP-Kenya project, as well as to inform follow-on program design.

V. OBJECTIVES

USAID/Kenya's Office of Population (OPH)'s strategic objective is to *reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*. It directly supports the Government of Kenya's efforts toward reducing unintended and mistimed pregnancies, improving infant and child health, reducing HIV/AIDS transmission, and reducing the threat of infectious diseases.

VI. BACKGROUND

Since its inception in 2003, the President's Emergency Plan for AIDS Relief (PEPFAR) has made significant progress in combating HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) throughout the world. Combining $18.8 billion in funding and an integrated approach that includes prevention, treatment, and care, PEPFAR has supported life-saving antiretroviral treatment for 2.1 million people and care for over 10.1 million through September 2008. To build upon these achievements, President George W. Bush signed legislation in July 2008 authorizing up to $48 billion over the next five years to continue the U.S. Government's global efforts against HIV/AIDS, tuberculosis, and malaria. Kenya is one of the 15 focus countries under the PEPFAR initiative. According to the 2007 Kenya AIDS Indicator Survey, more than 1.4 million Kenyans live with HIV/AIDS—7.4 percent of adults aged 15–64. This health crisis threatens Kenya's stability and its positive contributions to regional affairs.

Strengthening the capacity of indigenous institutions involved in HIV/AIDS program implementation and evaluation is a key component to achieving scale-up and results, and to ensuring long-term sustainability of Emergency Plan-assisted programs. A programmatic approach to this initiative is working with these grassroots organizations and building the

capacity of these organizations so that they are well-positioned to effectively respond to the HIV/AIDS epidemic.

The Kenya Grants and Institutional Strengthening Program II (KSGISP II) was designed with a goal to increase capacity of NGOs, FBOs, and CBOs to deliver quality HIV/AIDS care and support services among local communities.

The Capable Partners Program (CAP) is a 5-year Leader with Associates (LWA) Cooperative Agreement between USAID/DCHA/PVC-ASHA and the Academy for Educational Development (AED), with its main sub partner, Management Systems International (MSI). CAP is dedicated to enhancing the organizational development and sustainability of local non-governmental organizations (NGOs) and NGO networks.

The objective of the USAID/Kenya Small Grants and Institutional Strengthening Program (II) is to manage grant funding to, and improve the quality of services provided to, Kenyan NGOs working with HIV/AIDS-affected orphans and vulnerable children, NGOs working more broadly to address HIV/AIDS in Kenya, and NGOs in other sectors. The program provides organizational and technical strengthening assistance to improve the overall capacity of local NGOs, faith- and community-based organizations, to implement and monitor HIV/AIDS programs. Small Kenyan NGOs, FBOs, and CBOs will be strengthened to work more effectively with orphans and vulnerable children and/or to address HIV/AIDS and related issues in Kenya. *(List of NGOs, FBOs, and CBOs being supported is attached as Appendix I).*

Specifically, AED/CAP Kenya has engaged in the following under the Associate Award:

1. Development of infrastructure to support a small grant and institutional strengthening program;
2. Development of overall parameters of the grant program;
3. Facilitating participatory organizational assessments with grantees;
4. Provision of technical assistance specifically for those grantees that need to improve their financial capacity; and
5. Managing all obligated USAID/Kenya funds and reporting results to the Mission.

The expected results to achieve objectives in Kenya include:

1. NGOs currently working with HIV/AIDS-affected populations and specifically orphans are able to deliver quality care, support, and HIV prevention services to their clients more effectively and efficiently.
2. NGOs increase their ability to create community- and family-based activities to support orphans and vulnerable children.
3. NGOs increase their capacity and improve their skills to identify and quantify problems faced by targeted vulnerable populations, including OVC.
4. NGOs not currently working specifically on HIV/AIDS increase their capacity to work in their respective communities to deliver quality services.
5. NGOs working on HIV/AIDS increase their organizational capacity and sustainability of service delivery in their communities through awareness-raising and advocacy programs on HIV/AIDS prevention, care, and support.

VII. SCOPE OF WORK

The evaluation will focus on evaluating the impact of the CAP-Kenya's small grants project and will focus on evaluating both technical and management aspects of this activity. The evaluation component should assess program effectiveness and outcomes, as well as the potential for replicability, scale-up, and sustainability. The evaluation approach should include both evaluation design as well as development of an evaluation model, which assesses implementation and evaluation processes, outputs, and outcomes. The evaluation team will also develop a program description for an improved Small Grants and Institutional Strengthening Activity for Kenya.

Overall scope for the evaluation component will include:

1. Determination of whether the USAID/Kenya-funded CAP-Kenya program for activities for the Small Grants and Institutional Strengthening contributed to meeting mandated targets and the extent that the intended results were achieved;
2. An assessment of the program's impact;
3. Identification of unique strategies and approaches employed by the USAID/K-funded CAP-Kenya project that have been instrumental in achieving outcomes;
4. Recommendations for addressing issues that will have been identified in the course of the evaluation; and
5. Recommendations for strengthening future programs dealing with capacity building of grassroots organizations in Kenya.

The evaluation should address, but not limit itself to addressing, the following specific questions:

- Overall Project Performance: Progress of the CAP-Kenya program toward achievement of the specific project objectives and OPH's objectives. Did CAP-Kenya activities focused on institutional strengthening and small grants to local organizations contribute to meeting mandated targets, and what has been the impact? How appropriate have the strategies employed by CAP-Kenya been for the profile of local organizations that the project targets?
- Technical Assistance: What have been the specific challenges, obstacles, and lessons learned and to what extent have sub grantees integrated comprehensive HIV and AIDS programming principles in their programming?
- Grant Management: To what extent has CAP-Kenya established an effective infrastructure necessary to monitor grants effectively? What have been the achievements of grant program development and implementation in integrating quality control structures in subgrantee programs to ensure continued quality improvement?
- Institutional Strengthening: What have been the achievements and impact of the institutional strengthening approaches and strategies used by CAP-Kenya? To what extent has institutional strengthening of activities of CAP-Kenya resulted in enhanced HIV/AIDS service delivery and expanded community level HIV/AIDS care and support services?
- Sustainability: To what extent has CAP-Kenya supported sustainable development of NGO networks in Kenya and realized sustainability of service delivery in communities that CAP-Kenya subgrantees are working in?

The evaluation should provide empirical evidence to answer these questions; conclusions should be based on findings, and recommendations for future mission action will be based on an assessment of the results of the evaluation exercise.

In developing a work plan for this evaluation, the evaluation team will incorporate the issues described in the following Sections I–III and further elaborated in the Methodology section of the Scope of Work.

I. Evaluation of the Program Management of CAP-Kenya

To answer the evaluation objectives, the evaluation team will need to gain an understanding of CAP-Kenya activities as well as the key indicators used to measure the contribution of those activities to meeting mandated targets. These will then need to be reviewed against the results and associated targets reported to USAID/Kenya over the life of the project (LOP). CAP-Kenya's monitoring and evaluation staff will need to be interviewed to determine how CAP-Kenya results were obtained from sub-partners. As part of this process, an understanding of CAP-Kenya's systems and sampled partner systems and registers used to record PEPFAR data, including the use of monthly forms to summarize data for reporting to USAID/Kenya, will need to be developed. Additional procedures to test the data's validity and reliability may need to be considered.

Implementing sub-partner officials in each province where CAP-Kenya is working will need to be interviewed to gain an understanding of subgrantee activities that are supported by CAP-Kenya and methods of data collection. Results will need to be traced as noted on selected monthly reports to the underlying source documentation.

The evaluation team will be required to assess management controls over the procurement, storage, and distribution of commodities at the level of the Implementing Partner-AED/CAP and subgrantees under this activity.

II. Evaluation of the Program's Technical Approach in Institutional Strengthening (IS) to Kenya CSOs Engaged in HIV/AIDS Prevention and Service Delivery Activities

To determine to what extent sound technical approaches were being employed by the CAP-Kenya project in working with Kenya CSOs and strengthening their capacity to deliver HIV/AIDS activities, the evaluation team will interview CAP-Kenya program staff, sub-partners, including visiting sampled CSOs/FBOs/NGOs to obtain an understanding of the system for institutional strengthening and small grants as it pertains to CAP-Kenya activities. Evaluation of CSOs' internal control systems should form part of the evaluation in this area.

The evaluation should document to what extent CAP-Kenya's institutional strengthening approaches and activities and key program components have influenced grantee systems, processes, and procedures along the continuum of the organizational developmental domains and overall resulted in a demonstrated increase in institutional capacity in the areas of leadership, advocacy, financial and administrative management, strategic planning, resource mobilization, and monitoring and evaluation.

III. Evaluation of the Program's Effectiveness and Impact

Evaluation of the program's impact will need to be based in part on interviews with the USAID Mission, PEPFAR Office, implementing partner staff, subgrantees, other local NGOs/FBOs not necessarily receiving support from CAP-Kenya, stakeholders, and Kenyan government officials.

The evaluation team will review documents as part of the evaluation procedures. These include excerpts from the CAP-Kenya Cooperative Agreement with USAID/Kenya, agreements with sampled selected sub-partners, and their respective scopes of work.

VIII. METHODOLOGY

The evaluation team will use a combination of techniques, including document reviews, key informant interviews, and survey of selected partners to assess program effectiveness and outcomes as well as potential for replication, scale-up, and sustainability. The evaluation team will review documents prepared by USAID and its implementing partner for this activity, AED/CAPable Partners. The team will collect information from USAID, Government, stakeholders, collaborating partners, and a sample of beneficiaries. The consultant team will:

Document Review

Prior to arriving in country and conducting fieldwork, the team will review various project documents and reports, including but not limited to annual project workplans, progress reports, and results reports; national health strategy and population reports; Government and other monitoring data; project documentation of accomplishments, including process documentation; and USAID strategy documents. A list of key documents is included in Annex I. The USAID/ Kenya team will provide the relevant documents for review.

Team Planning Meetings

A two-day planning meeting will be held, with the team members only, prior to official onset of meetings and work with USAID and others. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the assessment and redesign, and refinement of agenda. In the TPM the team will:

- Share background, experience, and expectations for the assignment
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
- Agree on the objectives and desired outcomes of the assignment
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Develop data collection methods, instruments, tools and guidelines, and methodology and develop an assessment timeline and strategy for achieving deliverables to be presented and approved by USAID and the implementing partner at the end of the TPM.

Debriefings

An oral briefing meeting will be approved by USAID/Kenya and held with USAID/Kenya and other key stakeholders after the site visit work is completed and prior to the departure of the team from the country. The objective of the debriefing would be to share the draft findings and recommendations, solicit comments and inputs, and clarify any remaining questions or issues upon team arrival and before departure.

Field Visits/Key Informant Interviews

The evaluation team will conduct key informant interviews with USAID and key stakeholders, including but not limited to:

1. USAID/Kenya's Program Development and Analysis Offices
2. USAID/Kenya's Office of Population and Health
3. USAID/Kenya's Controller's Office

4. USAID Kenya's Regional Contract's Office
5. PEPFAR Coordinating Office in Kenya
6. Implementing Partner(s) for the CAP Kenya Small Grants and Institutional Strengthening Program (II).
7. Supported NGOs and subgrantees being supported under this activity and conduct field visits as will be agreed upon with the designated AOTR-AED CAPable Partners Project
8. CDC representatives managing similar institutional strengthening and/or grants-making projects
9. Other pertinent USG partners and/pr stakeholders as will be determined during discussions with USAID staff.

In order to assess several DQA issues, the team will conduct a survey of beneficiaries, identifying a representative sample using factors such as:

- Type of assistance
- Women and men
- A mix of older and younger beneficiaries
- Rural vs. urban, etc.

The survey will collect qualitative and quantitative data to be used in answering a variety of questions in the SoW. A variety of methods might be used, including:

- Individual interviews
- Group discussions
- Drawings or other physical models
- Rankings.

Data sources and collection methodologies should also be noted in the final evaluation report. The evaluation team is encouraged to submit qualitative data on program achievements and results.

Proposed work plan and methodology will require approval from USAID.

IX. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

It is anticipated that the evaluation will be carried out by a three-person team consisting of the following persons with specific expertise and experience:

1. Team Leader

The team leader will have overall responsibility for fulfilling the Scope of Work. S/he will coordinate and supervise the assessment. Relevant technical expertise and evaluation experience preferred.

Essential Qualifications

Masters degree or above in institutional capacity building, program management and development, or in any other related field; ten years and above of extensive international experience related to organizational capacity building; designing and/or managing Institutional

Strengthening /Small Grants programs; seven or above years experience in evaluating USAID activities; NGO experience preferred. Previous work in Africa preferred.

The team leader will:

- Finalize and negotiate with client for the team work plan for the assignment.
- Establish assignment roles, responsibilities, and tasks for each team member.
- Ensure that the logistics arrangements in the field are complete.
- Facilitate the Team Planning Meeting or work with a facilitator to set the agenda and other elements of the TPM.
- Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate the workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, payment is made for services, car/driver hire or other travel and transport is arranged, etc.) in coordination with team assistant/logistics coordinator.

2. Grants Management Expert

The grants management expert will provide expertise in institutional strengthening and reviewing and analyzing the grant-making mechanism. Previous financial analysis skills preferred.

Essential Qualifications

Advanced degree with professional experience of not less than seven years in managing and/or evaluating small grants programs and institutional strengthening, preferably with indigenous NGOs. USAID and PEPFAR experience preferred. Previous Africa experience preferred.

3. Evaluation Expert

Essential Qualifications

Master's degree in public health, international development, social science, or a closely related field is required; seven years experience with participatory evaluation methodologies and designs and proven experience in end-of-program evaluations

Three years experience in conducting NGO/CBO/FBO level research in Sub-Sahara Africa, preferably at the grassroots level.

Level of Effort

USAID/Kenya anticipates that the preparation days, in-country work including site visits, as well as drafting and finalizing the evaluation report will be completed according to the following illustrative level of effort (LOE).

The LOE for this assessment is not to exceed:

Task	LOE (Days)
Document review and initial planning and preparation (out of country for international consultants)	3 days
Travel to Kenya	2 days
Team planning meeting in Nairobi	2 days
In-briefing with USAID/Kenya; team presents TPM deliverables to USAID/Kenya	1 day
Interviews and discussions with USAID staff and PEPFAR Coordinating Office	1.5 days
Interviews and discussion with implementing partner for the CAP Kenya Small Grants and Institutional Strengthening Program (II)	1.5 days
Field visits and meetings with NGOs and subgrantees	6 days
Information gap filling, team discussions and analysis & stakeholder meetings	3 days
Draft report writing	4 days
USAID debriefing and consolidation of comments into evaluation report	1 day
Visioning and program description development	7 days
Submission of draft program description	1 day
Travel home	2 days
USAID/Kenya reviews draft report and program description (3 days)	
Program description revisions, based on Mission comments (out of country)	3 days
Team revises final draft report	5 days TL; 3 days TM
GH Tech edits report (3–4 weeks)	
Total LOE per consultant	**TL = 43 days**
	TM = 41 days x 2
Total team LOE for assignment	**125 days**

A 6-day work week is authorized while working in-country.

X. LOGISTICS

GH Tech is responsible for all logistical arrangements, including but not limited to travel and transportation (international and local), country travel clearances with the USAID/Kenya Mission, lodging, communications, document production and reproduction, and all other logistical support deemed necessary. A local logistics assistant may be hired to facilitate site visits and interview scheduling.

USAID/Kenya will provide electronic copies of key documents and background materials and will assist in finalizing key informant lists with contact information. USAID/Kenya will arrange in-briefing and debriefing and assist in making interview appointments when necessary. USAID participation will be determined at the team planning meeting in Nairobi. The team leader, in collaboration with the assigned USAID representative, will be responsible for determining when and where USAID staff may or may not participate.

DELIVERABLES

The evaluation team will report to the designated AOTR-AED/CAPable Partners Project while in-country. Pertinent technical staff will provide technical directions during performance of this assignment.

The deliverables are:

Briefings: The evaluation team will provide regular in-country briefings to USAID/Kenya on progress and discuss problems and issues on a biweekly basis. Additional debriefings will be convened as required by either party.

The evaluators will make an in-country presentation to USAID on the main findings at the end of the in-country reviews and analysis.

Work Plan: The evaluation team will provide a detailed work plan to USAID at the conclusion of the TPM and before commencing the evaluation work. The work plan will outline how the evaluation will be undertaken and the methods to be used. It will be approved by USAID before interviews are conducted.

Methodology: The methodology for collecting and analyzing the data will be prepared during the TPM and reviewed and approved by USAID before commencing the interviews.

Draft Evaluation Report: The first draft of the evaluation report will be submitted before the evaluation team departs Kenya and after the final debriefing so that comments can be incorporated into the draft report.

The report (not including attachments) will be no longer than 30 pages with an Executive Summary, Introduction, Methodology, Findings, Lessons Learned, Strengths, Weaknesses, Opportunities and Conclusions, and Recommendations in English (not including Appendices). USAID/Kenya will circulate the draft within USAID and partners as deemed necessary to review the draft, and provide one set of comments on the draft report within 10 working days of receipt.

Program Description: The evaluation team will provide a new program description for an improved Small Grants and Institutional Strengthening Activity for Kenya

Final Report: The final evaluation report will be due at USAID/Kenya within 3 working days after the team receives comments from USAID/Kenya.

Upon final approval of the content by USAID/Kenya, GH Tech will have the report edited and formatted. This process takes approximately 3–4 weeks. The final report will be submitted electronically. Four hard copies of the report will be provided to USAID/Kenya.

XI. MISSION CONTACT PERSONS

1. Kate Vorley
   AOTR-AED/CAPable Partners Project
   Tel:- + 254 20 862 2282
   Email:- kvorley@usaid.gov

2. Emma Mwamburi
   Alternate AOTR-AED CAPable Partners
   Tel:- + 254 20 862 2000
   Email:- emwamburi@usaid.gov

3. Chris O'Donnell
   Agreement Officer-AED/CAPable partners
   Tel:- + 254 20 862 2000
   Email:- codonnell@usaid.gov

4. Lynn Adrian
   Director-Office of Population & Health
   Tel:- + 254 20 862 2000
   Email:- ladrian@usaid.gov

XII. COST ESTIMATE

TBD

XIII. REFERENCES

1. AED/Capable Partners Agreement
2. Current Program Description
3. Performance Management Plan (PMP)
4. Annual Work Plans
5. Quarterly Reports
6. Semi-Annual and Annual Reports

APPENDIX B. PERSONS INTERVIEWED

MEETINGS – USAID/KENYA/OPH

March 10, 2010
8:00am – 4:30pm

NAME	ORGANIZATION	POSITION
Adrian, Lynn	USAID/Kenya	Office Director
Gavin, Anne	USAID/Kenya	Project Management Specialist
Gichanga, Bedan	USAID/Kenya	Health Management Systems Specialist
Maina, Kiranga	USAID/Kenya	Project Management Specialist
Maina, Maurice	USAID/Kenya	Project Management Specialist
Mwamburi, Emma	USAID/Kenya	Project Management Specialist
Mwangi, John	USAID/Kenya	Controller Officer
O' Donnel, Chris	USAID/Kenya	Agreement Officer
Ojowi, Lize	USAID/Kenya	M&E data Coordinator
Omwomo, Washington	USAID/Kenya	Project Management Specialist
Tiampati, Ruth	USAID/Kenya	Project Management Specialist
Vorley, Kate	USAID/Kenya	OVC Specialist
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETINGS – AED

March 12, 2010

NAME	ORGANIZATION	POSITION
Dolton, Helen	CAP/AED	Country Director
Irungu, Peter	CAP/AED	Senior Program Officer
Mutisya, Caroline	CAP/AED	Grants and Contract Manager
Omuodo, David	CAP/AED	Program Officer
Waweru, Wycliffe	CAP/AED	Monitoring & Evaluation Program Officer
Kioko, Mary	AED	Grants Accountant
Wanyee, Steven	AED	Monitoring & Evaluation Coordinator
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – HANDICAP INTERNATIONAL

March 15, 2010
10:00am – 11:00am

NAME	ORGANIZATION	POSITION
De Beaupius, Gaetan	Handicap International	Programme Administrator
Kananura, Alphonse	Handicap International	Programme Administrator
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – HEART

March 15, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Kamau, Sabina N.	HEART	Administrative Secretary
Masese, Evans	HEART	Project Manager
Njoroge, Lydia Wanjiru	HEART	WEEP Field Officer/FFG Secretariat
Obes, Charles	HEART	Lodge Manager
Wakaba, Charles	HEART	Financial Manager
Winkler, Vickie, RN	HEART	Kenya Rotary HIV/AIDS Officer Founder and Executive Director
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – THE RAPHAELITES – REDHILL PLACE

March 16, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Rodriguez, Renee	The Raphaelites	Administrator
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – YARD

March 16, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Njeri, Rosemary	YARD	Project Officer
Wairimu, Grace	YARD	Assistant Project Officer
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – CHILD WELFARE SOCIETY OF KENYA

March 17, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Mureithi, Irene	CWSK	Executive Director
Maina, Charles	CWSK	Finance Officer
Mwikali, Felistus	CWSK	Program Coordinator
Price, Margaret	GH Tech	Consultant

MEETING – KENYA HIV/AIDS PRIVATE SECTOR BUSINESS COUNCIL

March 17, 2010
2:00pm – 4:00pm

NAME	ORGANIZATION	POSITION
Dr. Magutu, Hellen	KHBC	Program Director
Wachira, Theuri	KHBC	Program Officer
Kamondo, Ephantus M.	KHBC	Programme Accountant
Kasomo, Jenfer	KHBC	Project Facilitator
Price, Margaret	GH Tech	Consultant

MEETING – FRANCISCAN SISTERS OF THE IMMACULATE CONCEPTION OF THE HOLY MOTHER OF GOD (SFIC) AFRICA

March 17, 2010
4:30pm – 6:30pm

NAME	ORGANIZATION	POSITION
Luciano, Sr. Evelinda	SFIC	Program Director
Waihenya, Gregory	SFIC	Administrative/Finance Officer
Shunkur, Michael	SFIC	Field Officer
Price, Margaret	GH Tech	Consultant

MEETING – ST. MARY'S MEDICAL CENTRE & HIV PROGRAM KAPSOYA

March 17, 2010
9:00am – 11:00am

NAME	ORGANIZATION	POSITION
Teresa, Sr.	St. Mary's Medical Centre	
Kemboi, Caroline	St.Mary's Medical Centre	Asst. Accountant Officer
Kiprop, Christopher	St.Mary's Medical Centre	Field Officer
Spaid, Barbara	GH Tech	Consultant

MEETING – NEIGHBORS IN ACTION

March 17, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Sonu, Hosea	Neighbors in Action	Director/Founder
Cherono, Vanessa	Neighbors In Action	Program Management
Spaid, Barbara	GH Tech	Consultant

MEETING – KISUMU URBAN APOSTLE PROGRAM—PANDIPIERI

March 17, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Aluoch, Roselyn	KUAP	Social Worker
Dajoh, Lillian	KUAP	Project Officer – Substance Abuse
Nealon, Sr. Bernadette	KUAP	Program Officer Health
Okello, Paul	KUAP	Accountant
Owino, Seth	KUAP	Social Worker
Kuria, Henry	GH Tech	Consultant

MEETING – COMMUNITY ASSET BUILDING AND DEVELOPMENT ACTION (CABDA)

March 17, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Asaji, Jesica	CABDA	Project Officer
Imabali, Ephy	CABDA	Executive Director
Jepkemboi, Tenai	CABDA	Finance Officer
Kamali, Nereah	CABDA	Field officer WATSAN
Wakisi, Edith	CABDA	Project Officer- OVC
Kuria, Henry	GH Tech	Consultant

MEETING – NAZARETH HOSPITAL

March 18, 2010
8:00am – 10:00am

NAME	ORGANIZATION	POSITION
Mutie, Muthami	Nazareth Hospital	Program Manager
Makena, Julian	Nazareth Hospital	Program Accountant
Nderitu, Michael	Nazareth Hospital	Program Manager
Price, Margaret	GH Tech	Consultant

MEETING – WEM INTEGRATED HEALTH SERVICES

March 18, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Mungai, Wairimu	WEMHIS	Program Director
Price, Margaret	GH Tech	Consultant

MEETING – HOPE VALLEY FAMILY INSTITUTE

March 18, 2010
9:00pm – 12:00pm

NAME	ORGANIZATION	POSITION
Mwangi, Regina	Hope Valley Family Inst.	Finance Assistant
Njeri, Elizabeth	Hope Valley Family Inst.	Program Manager
Spaid, Barbara	GH Tech	Consultant

MEETING – TICH (TROPICAL INSTITUTE OF HEALTH AND DEVELOPMENT)

March 18, 2010
9:00pm – 12:00pm

NAME	ORGANIZATION	POSITION
Kaseje, Prof. Dan	TICH	Project Director and Vice Chancellor, Great Lakes University of Kisumu
Kirwa, Frank	TICH	Accountant
Muga, Miriam	TICH	Project Assistant
Kuria, Henry	GH Tech	Consultant

MEETING – RAFIKI

March 18, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Guagena, Diana	Rafiki	Volunteer, Peace Corps
Kisia, Shila	Rafiki	M/E Officer
Mbazizi, Dorothy	Rafiki	Head of Finance
Otieno, Juliana A.	Rafiki	Head of Community Services
Spaid, Barbara	GH Tech	Consultant

MEETING – TWANA TWITU

March 19, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Penina	Twana Twitu	Finance Officer
Spaid, Barbara	GH Tech	Consultant

MEETING – KENYA NETWORK OF WOMEN WITH AIDS (KENWA)

March 19, 2010
2:00pm – 5:00pm

NAME	ORGANIZATION	POSITION
Maina, Patrick	KENWA	Grants Accountant
Wagura, Asunta	KENWA	Executive Director
Price, Margaret	GH Tech	Consultant

MEETING – BEACON OF HOPE

March 19, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Gichigo, Dennis	Beacon of Hope	Accounts Assistant
Kirema, Judy	Beacon of Hope	Program Officer
Macharia, Jerishon	Beacon of Hope	Social Development
Muchuna, Humphrey	Beacon of Hope	Lead Social Development
Wesonga, Elizabeth	Beacon of Hope	Lead Teacher
Spaid, Barbara	GH Tech	Consultant

MEETING – COLIDEF (COMMUNITY LIBELIHOOD DEVELOPMENT FORUM)

March 19, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Kibwage, Prof.	COLIDEF	Executive Director
Kuria, Henry	GH Tech	Consultant

MEETING – NASCOP (NATIONAL AIDS AND STI CONTROL PROGRAM)

March 25, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Mwololo, Pauline	NASCOP	HBC
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – MINISTRY OF AGRICULTURE

March 26, 2010
9:00am – 12:00pm

NAME	ORGANISATION	POSITION
Kimenyi, Elizabeth W.	Min. of Agriculture	Harmonization
Price, Margaret	GH Tech	Consultant

MEETING – NACC (NATIONAL AIDS CONTROL COUNCIL)

March 29, 2010
9:00am – 12:00pm

NAME	ORGANISATION	POSITION
Orago, Prof. Alloys	NACC	Director
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETING – MINISTRY OF GENDER AND CHILDRE'SN AFFAIRS

March 30, 2010
9:00am – 12:00pm

NAME	ORGANIZATION	POSITION
Ahmed, Hussein	Ministry	Director of Children's Affairs
Vorley, Kate	USAID/Kenya	OVC Specialist
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barbara	GH Tech	Consultant

MEETINGS – USAID/KENYA/OPH

March 30, 2010
8:00am – 4:30pm

NAME	ORGANIZATION	POSITION
Bii, Stanley	USAID/Kenya	Treatment
Batuka, James	USAID/Kenya	HIV/AIDS Treatment
Gavin, Anne	USAID/Kenya	Prevention
Jerusha, Karuthiru	USAID/Kenya	Family Health Team
Kyalo, Joyce	USAID/Kenya	Health Systems
Macharia, Sheila	USAID/Kenya	FP/RH/MCH
Maina, Kiranga	USAID/Kenya	Youth and BCC
Maina Maurice	USAID/Kenya	Project Management Specialist
Micheni, Alice	USAID/Kenya	HSS
Ndele, Steve	USAID/Kenya	Program Office
Ojowi, Lize	USAID/Kenya	M&E Data Coordinator
Omwomo, Washington	USAID/Kenya	Monitoring and Evaluation
Tiampati, Ruth	USAID/Kenya	Project Management Specialist
Vorley, Kate	USAID/Kenya	HIV & Support (OVC)
Yonga, Isabella	USAID/Kenya	Medical Prevention
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barabara	GH Tech	Consultant

MEETINGS – USAID/KENYA/OPH

March 31, 2010
8:00am – 4:30pm

NAME	ORGANIZATION	POSITION
Bii, Stanley	USAID/Kenya	Treatment
Macharia, Sheila	USAID/Kenya	FP/RH/MCH
Maina, Maurice	USAID/Kenya	Project Management Specialist
Omwomo, Washington	USAID/Kenya	Monitoring and Evaluation
Tiampati, Ruth	USAID/Kenya	Project Management Specialist
Vorley, Kate	USAID/Kenya	HIV & Support (OVC)
Yonga, Isabella	USAID/Kenya	Medical Prevention
Kuria, Henry	GH Tech	Consultant
Price, Margaret	GH Tech	Consultant
Spaid, Barabara	GH Tech	Consultant

APPENDIX C. REFERENCES

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AED. *AED CAP 2006 Work Plan CAP Kenya II Program Milestones and Timeline Workplan Sec. 5.* 2006.

AED. *Annex 1: CAP Kenya Grantees Affected by Post-election Violence.* April 2008.

AED. *Annex 1: Request for Grant Modification Approval.* February 2007.

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AED. *Annex 3: October 2007 Partners Forum Report.* October 2007.

AED. *Annex 3: 3rd Grantee Quarterly Meeting Report, Report on the CAP Kenya 3rd Quarterly Meeting November.* 2006.

AED. *Annex 3: 4–6 March 2008 Partners Forum Report.* March 2008.

AED. *Annex 5: Nutrition Workshop Report.* October 2008.

AED. *Annex 4: CAP Kenya HIV E-Updates*. October 2008.

AED. *Annex 4: Grant Summaries for ICL, KHBC, and SCAD.* December 2007.

AED. *Annex 4: Institutional Strengthening Strategy.* July 2006.

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AED. *Annex CAP Kenya Pipeline.* December 2006.

AED. *CAP Kenya Sub Partners 2949.* 2009.

AED. *CAP Kenya II 2009 Final Milestones and Timeline.* March 2009.

AED. *CAP Kenya Small Grants and Institutional Strengthening Program II Quarterly Report No. 16 1 October – 31 December 2009*. January 30, 2010.

AED. *Developing Management Systems, Policies and Procedures*, August 1, 2007.

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AED CAP. "Active Grant Tracking Sheet." October 2008.

AED CAP. *Annex 1a: Request for Increase in Obligated Funds*. October 2007.

AED CAP. *Annex 1b: CAP Kenya II Obligation Increase Pipeline (12-10-07).* December 2007.

AED CAP. Annex 2 Capable Partners Program Kenya Report of Partners' Forum, May 21–24, 2007. June 2007.

AED CAP. *Annex 2: Partners Forum Report*. September 2008.

AED CAP. *Annex 2: RFA–HIV/AIDS Prevention with People Abusing Substances.* July 2006.

AED CAP. *Annex 3: Grantee Implementation of Improvement Plans.* April 2008.

AED CAP. *Annex 3: Program Summaries for New Grantees.* April 2007.

AED CAP. *Annex 4: 4th Quarterly Meeting Report.* April 2007.

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AED CAP. *Annex 7: SFIC Psychosocial Survey Abstract*. March 2007.

AED CAP. *Annex 8: List of Institutional Strengthening Technical Assistance Providers/Consultants/Trainers.* September 2006.

AED CAP. *Monitoring and Evaluation for AED CAP Kenya: Assessment and Recommendations.* December 2006.

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AED CAP Kenya. *Annex 8: Ace Communications Organizational Assessment Report.* December 2006.

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APPENDIX D. WORKPLAN

ALL CONSULTANTS: KEY INFORMANTS ITINERARY												
MONDAY 15TH MARCH 2010	**7:00**	**8:30**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with Handicap International				**NAIROBI**								
Meeting with HEART								**NAIROBI**				
TUESDAY 16TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with the Raphaelites		**RUAKA - NAIROBI**										
Meeting with YARD								**THIKA**				

MARGARET PRICE: KEY INFORMANTS ITINERARY												
WEDNESDAY 17TH MARCH 2010	**7:00**	**8:30**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with Child Welfare Society of Kenya		**NAIROBI**										
Meeting with Kenya HIV/AIDS Private Sector Business Council				**NAIROBI**								
Meeting with Franciscan Sisters of the Immaculate Conception of the Holy Mother of God (SFIC) Africa								**NAIROBI**				
THURSDAY 18TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Nazareth Hospital		**KIAMBU**										
Meeting with WEM Integrated Health Services								**THIKA**				

MARGARET PRICE: KEY INFORMANTS ITINERARY												
FRIDAY 19TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with Twana Twitu		**MWINGI**										
Meeting with Kenya Network of Women with AIDS (KENWA)								**NAIROBI**				

BARBARA SPAID: KEY INFORMANTS ITINERARY												
WEDNESDAY 17TH MARCH 2010	**7:30**	**8:30**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with St. Mary's Medical Centre & HIV Program, KAPSOYA			**ELDORET**									
Meeting with Neighbors In Action								**ELDORET**				
THURSDAY 18TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with Hope Valley Family Institute			**NYAHURURU**									
FRIDAY 19TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with Beacon Of Hope			**KAJIADO**									

HENRY KURIA: KEY INFORMANTS ITINERARY												
WEDNESDAY 17TH MARCH 2010	**7:30**	**8:30**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with KUAP		**KISUMU**										
Meeting with CABDA								**KAKAMEGA**				
THURSDAY 18TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with TICH		**KISUMU**										
Meeting with Rafiki								**BONDO**				
FRIDAY 19TH MARCH 2010	**7:00**	**8:00**	**9:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**
Meeting with COLIDEF		**KISII - NYANZA**										

APPENDIX E: MAP: AREAS VISITED BY THE EVALUATION TEAM

All consultants together

Consultants individually

APPENDIX F. EVALUATION MATRIX

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
1.Overall Project Performance	Did CAP Kenya activities focused on institutional strengthening and small grants to local organizations contribute to meeting mandated targets?		Quantitative & qualitative targets and accomplishments	Project performance evaluation reports Annual PMPs	Desk review; request info from AED	Compare achievements against targets. Trend analysis
	How appropriate have the strategies employed by CAP Kenya been for the local organizations that the project targets?		Procedures & strategies developed & employed	AED records and reports; needs assessment records of grantees; grantee procedures and processes. Org. dev. plans of grantees	Desk review; content analysis of documents. Ask AED for list & copies. Ask grantees how useful they are.	Summarize feedback. Compare
	Relationship to government plans and policies Are project activities aligned to the Kenya NSF, National OVC Policy, National Gender Policy, and National Youth Initiative? How does the program facilitate the subgrantees to be up to date with government policies? Does AED play a part in national programs? What is the nature of its involvement in national programs?	Which local government offices do subgrantees work with? How do subgrantee annual workplans reflect national policies and priorities? (OVC, Youth Initiative, Gender, Handicapped, etc.) What was the local government's technical contribution in the preparation and submission of the proposal and budget, and how can this be improved?	AED and subgrantee activities in relation to national policies, strategie,s and guidelines Evidence of involvement Evidence of involvement	National plans priorities and objectives; OVC policy, gender policy, National Youth Initiative, Ministry of Health guidelines, etc. Project documents – program descriptions, approved workplans, and quarterly reports. Quarterly reports	Desk review; key informant interviews with stakeholder and subgrantees. Desk review	Comparative analysis

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
3. Grants Management	To what extent has the project established an effective infrastructure to solicit, monitor, and graduate subgrantees effectively?	How did subgrantees benefit from the pre-award assessment site visit and what could have been improved? How did the organization benefit from the proposal development workshop and what could have been improved? What are the key advantages and disadvantages of the one year subgrant relationship that is renewed annually? Any recommendations for improvement? On what dates were the last three requests for disbursement submitted and on what dates were funds received in the bank account ? Has AED's "Feedback Report" on subgrantees Quarterly Narrative Reports been timely? Is their feedback useful? What TA has AED outsourced? Was it satisfactory? How did you benefit from the external audits and TA provided by the external auditor and how can the process be improved? How did you benefit from the external audits and TA provided by the external auditor and how can the process be improved?	Effectiveness, benefits, issues, and challenges of the grants management procedures and systems, and how they can be improved. Evidence of approval of subsequent disbursement or withholding of funds. Subgrantees' views on procedures used and any recommendations for improvement Close- out, termination, and graduation criteria or reasons for termination	Technical Review Reports, Pre- Award Assessment Reports, Financial and program management reports.	Desk review of documents; Key informant interviews	Content Analysis

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
		[Where applicable] What were the key issues behind the suspension or /termination of the subgrant and how can the critical issues be avoided in future?	Evidence of quality control measures being implemented at grantee and subgrantee levels			
		[Where Applicable] How did the AED's subgrant closeout guidelines streamline the subgrant closeout process and how can the guidelines be improved on in future programs?	Evidence of membership on national, local, or other donor partnership forums and involvement of district technical leadership in the solicitation process.	AED records and reports; key informant interviews with current and previous subgrantees		
	How are subgrantees graduated? or what are reasons for termination from the program? To what extent were quality control structures integrated into subgrantee programs to ensure continued quality improvement? How does the project ensure against duplication of funding sources (multiple donor sources) for the same activity?			AED/subgrantees/ local government records and reports Relevant district and local decision-making and coordinating bodies.	Document review; key informant interviews Key informant interviews	
4. Institutional Strengthening	What have been the achievements and impact of institutional strengthening approaches and strategies for	*Leadership and governance* What TA has AED provided to subgrantee to improve leadership?	Evidence of change Reasons for TA? Nature and benefits of TA given/received	AED and subgrantee records and reports	Key informant interviews	Computation of change

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
A.Management Capacity	subgrantees in the areas of: *Leadership and governance* Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result? Any lessons learned? Any recommendations for improvement? *Strategic Planning and Decision Making* Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result? Any lessons learned? Any recommendations	Was it timely? (When you needed it?) Who provides leadership and how is it provided? How has leadership changed over the grant period? What lessons have been learned in leadership? What recommendations would you make to improve AED's input in this area? *Strategic Planning* What TA has AED provided in strategic planning? Is there a written strategic plan? How was the plan developed? How are decisions made within the organization? How has strategic planning/decision- making changed during the grant period with AED assistance? Please give an example of this change. Any lessons learned? Any recommendations for improvement in AED's TA in strategic planning? Were funds disbursed by AED on a timely basis?	Demonstrated changes in management structure, function, and performance as a result of TA Appropriateness/ relevance of TA? Was TA provided to the subgrantee in a timely manner?			

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
		Were there gaps in funding between grant modifications?				
	Financial Management (FM)	*Financial Management*				
	Was TA provided to subgrantee? Reason/s for TA? Nature of TA given and perceived changes as a result?	How has FM changed over the grant period with AED's TA?				
		[Probe Examples of budgeting, internal controls, frequency of internal and external audit, timeliness and completeness of reporting				
	Any lessons learnt? Any recommendations for improvement?	Any lessons learned?				
		Any recommendations for improvement in AED's TA in FM?				
	Human Resource Management (HRM)	*Human Resources Management*				
	Was TA provided to subgrantee? Reasons for TA? Nature of TA given, and perceived changes as a result?	What TA has AED provided in this area?				
		Is there an HR manual that sets forth recruitment, hiring, orientation, and supervision?				
	Any lessons learned? Any recommendations for improvement?	Is there a system in place for staff IST?				
		Is there a system for performance monitoring, evaluation, and feedback?				
		How is supervision carried out?				
		How has HRM changed over the grant period with AED assistance?				
		Any lessons learned?				

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
		Any recommendations for improvement of AED's input into HRM?				
	Resources Mobilization,	*Resources Mobilization*				
	Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result?	What other resources has the subgrantee benefitted from with AED's support?				
		Was it timely and appropriate?				
	Any lessons learned? Any recommendations for improvement?	Any lessons learned?				
		Any recommendations for improvement?				
	Coordination and Collaboration	*Coordination and Collaboration*				
	Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result?	Does subgrantee collaborate with government and other organizations implementing similar activities in their location?				
		How have collaboration and coordination changed over the grant period with AED's assistance?				
	Any lessons learned? Any recommendations for improvement?	Any lessons learned? Any recommendations for improvement?				
	Procurement Management	*Procurement Management*				
	Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result?	Is there a policy and procedures manual for procurement, waivers, storage, and distribution of commodities?				
		What issues are encountered in procurement and storage?				
	Any lessons learned? Any recommendations for	How has commodity				

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
	improvement?	management changed over the grant period with AED's assistance? Any lessons learned? Any recommendations for improvement?				
	Monitoring and Evaluation Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result? Any lessons learned? Any recommendations for improvement?	*Monitoring and Evaluation* What TA has AED provided in M&E? How timely was it? Describe your data collection system, including tools and methods, people responsible for data collection, frequency and data storage procedures. What procedures do you use to test data validity? (How do you test?) How do you use the data/info to improve the quality of services provided? Give an example. How do you measure the *quality* of the services you provide? Give an example. How has M&E changed over the grant period with AED assistance? Lessons learned? Recommendations for improvement?				
B. Technical Capacity	*Quality Assurance (QA) System* What QA system has been	*Quality Assurance System* What TA has AED provided to improve staff knowledge of				

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
	put in place by AED? How is it implemented? Was TA provided to subgrantee? Reasons for TA? Nature of TA given and perceived changes as a result? Any lessons learned? Any recommendations for improvement? To what extent have institutional strengthening activities resulted in improved HIV/AIDS service delivery and community level HIV/AIDS care and support services? Was the TA successful in improving the quality of services provided? How successful has AED been is assisting CBOs to shift the paradigm of home-based care? What technical support is AED providing to subgrantees involved in the basic care package? What has been the impact of AED's inputs on services provision?	HIV/AIDS and other topics appropriate to your programs? Do you have a QA strategy? May we see it? Has it been timely and adequate? When was your staff assessed with the "HIV/AIDS Self-Assessment Tool"? What technical training did your staff receive and how useful was it? (How have they been able to use information gained in the training?) Give examples. How useful were the quarterly E-Updates on technical subjects? Which subjects were most useful to you and your staff? How did you use this information? How useful were the Partners Quarterly meetings and Partners Forum in improving knowledge in technical areas? What changes have occurred in service delivery over the grant period with AED's assistance? What was a most significant improvement in service delivery as a result of AED assistance? How has AED's TA in institutional strengthening allowed staff to improve the way services are provided?				

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
		How has AED's TA in HIV/AIDS topics resulted in improved quality of the services provided? Is the community better off as a result of services provided under AED's grant? How? Has there been a change in service utilization by the community? What challenges/obstacles were faced? Any lessons learned? Any recommendations for improvement of AED's input into the services provision area?				
	Project Impact					
	What can be clearly identified as impacts of the project: A. On program management of subgrantee projects? B. On services delivery by subgrantee modalities? C. On behavior of beneficiaries? D. On services utilization by beneficiary groups?	**BENEFICIARY QUESTIONS** 1. Kind of services received? 2. Length of time services were received? 3. Benefits of services to: health/ quality of life/ school attendance / income generation / knowledge of HIV prevention, etc? 4. Any changes noticed in the services over the past year (or	Facts List of project outputs Baseline data on key performance indicators Progress reports. Information on interventions by any other donor/project. Beneficiaries' perception of project success and factors identified as contributing to	Records and reports Beneficiaries	Desk review; key informant interviews.	

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
	What factors contributed to success? What factors contributed to lack of success? What challenges, obstacles were faced? How were challenges addressed? What lessons were learned?	two—whatever the grant period) 5. How can the services be improved?	success or lack of success			
5A. Sustainability	As a result of AED's intervention, has subgrantee demonstrated ability to stand on own feet in terms of -sourcing resources? -building capacity of staff? -establishing strong management structure?	*Sustainability* Did AED provide any TA in sustainability or resource mobilization? Was it timely? Useful? Over the grant period, has your funding base diversified? Do you have a written sustainability plan? What aspects of AED's TA have best prepared you to "stand on your own feet"? How would you expand your service delivery if you could generate/mobilize additional funds?				

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
5B. Replicability	Has AED empowered subgrantees to replicate?	Has subgrantee been able to develop any projects on its own, or to help anyone else develop a project using the process followed in its own development? Was the rationale for said project based on sound analysis? Were stakeholders included in the design? Were core beneficiaries identified? Did the project incorporate lessons learned from previous projects? Did the project avoid duplication of efforts with other projects? Were the project interventions well- planned and appropriately sequenced? How well did the project design address local needs and priorities? Were strategies appropriate to the local setting? Did the project identify relevant risks and provide safeguards and/ or risk reduction?	Project development process. Role of stakeholders. Consistency with stakeholder objectives; government sectoral plans; any risk reduction measures	Project documents; key informant interviews with stakeholder representatives	Desk review; key informant interviews	

Area Of Focus And Objective	Key Questions		Information Required	Source	Data Collection Method	Method Of Analysis
	AED	**Subgrantee**				
5C. *Scale-up*	Has AED's input resulted in the scaling-up or potential for scaling-up of services provided by sub grantees?	Has the subgrantee demonstrated the ability to successfully scale up its services with AED's input? What is the nature of the scaling-up done by subgrantee? Does subgrantee have a plan for scaling up if It gets more resources?	Concrete examples of actual or planned scaling-up of activities by subgrantees.	Reports and proposals of subgrantees.		

APPENDIX G. TABLE OUTLINING SAMPLE SELECTION

ORGANISATION	TYPE OF ORGANISATION	PROJECT DESCRIPTION	PROVINCE	GEOGRAPHICAL LOCATION	CONTACT PERSON & NUMBER	CONSULTANT ASSIGNED
BEACON OF HOPE (BOH)	FBO	Empowerment for community self- sustainability and participatory OVC care to mitigate the effects of HIV and AIDS	RIFT VALLEY	RIFT VALLEY	Jane Wathome 020-2020793 / 0722-871 737 info@beaconafrica.org Beacon of Hope Centre on Gataka Road (2nd Gate on the right) off Magadi Road (1st Stage Rongai) in Ongata Rongai	BARBARA SPAID
CHILD WELFARE SOCIETY OF KENYA	NGO	Strengthening the community capacities, youth and children in order to provide an enabling environment for OVCs and protection	NAIROBI	NAIROBI	Irene Mureithi 020-603 301 / 606 391 cwsktoto@yahoo.com Child Welfare Building, along Langata Road	MARGARET PRICE
COMMUNITY ASSET BUILDING AND DEVELOPMENT ACTION (CABDA)	NGO	OVC and caregiver support project	WESTERN	KAKAMEGA	Ephy Imbali 0723-713022 communityassetbuilding@yahoo.com Murram next to Kasarani Estate, off Mumias-Kakamega Road Kakamega Town	HENRY KURIA
COMMUNITY LIVELIHOOD DEVELOPMENT FORUM (COLIDEF)	NGO	Economic empowerment of caregivers and integrated support of OVC in Suneka division of Kisii South district.	NYANZA	KISII	Sylvia Morumbwa 057-2023611 colidef_2004@yahoo.com SIFA House, 1st floor, Room 9, Kakamega Road	HENRY KURIA

FRANCISCAN SISTERS OF THE IMMACULATE CONCEPTION OF THE HOLY MOTHER OF GOD (SFIC) AFRICA	IFBO	The support of essential services to orphans and children and women made vulnerable because of HIV and AIDS in the four SFIC mission sites	NAIROBI	NAIROBI	Sr. Evelinda Luciano 020-233 7743/238 5689 slinsfic@yahoo.com 157 Chuueya Road Ngei Phase I, Otiende Next to St. Michael	MARGARET PRICE
HANDICAP INTERNATIONAL (HI) MONDAY 15/03/2010 10:00AM –11:00AM	INGO	Enhanced access to quality, comprehensive HIV and AIDS prevention and care of services for PWD, youth, and PLWHA in Nairobi, Trans Nzoia, West Pokot, and Garissa districts	NAIROBI	NAIROBI	Gaetan de Beaupuis & Alphonse Kananura 020-271 6500/6445 gaetantour@yahoo.fr / administrator@handicap-international.or.ke Hospital Road, Upper Hill, Africa Re Centre 3rd floor	MARGARET PRICE BARBARA SPAID HENRY KURIA
HEALTH EDUCATION AFRICA RESOURCE TEAM (HEART) MONDAY 15/03/2010 2:00PM – 3:00PM	NGO	COPE (Community Orphan Prevention through Education)	NAIROBI	NAIROBI	Vickie Winkler 020-851 2596 vickie@africaheart.com #3 Ridgeways Drive, Ridgeway Estates	MARGARET PRICE BARBARA SPAID HENRY KURIA
HOPE VALLEY FAMILY INSTITUE	NGO	Strengthening care and support for children affected and infected with HIV/AIDS and their families in Nyandarua and Laikipia Districts	CENTRAL	NYAHURURU	Benard Ngamau 0722-863 509 hopevalley2006@yahoo.com Nyahururu – Nyeri 4Km from Nyahururu town	BARBARA SPAID

KENYA HIV/AIDS PRIVATE SECTOR BUSINESS COUNCIL	NGO	Strengthening the Kenya HIV/AIDS Private Sector Business Council to support 60 small and medium enterprise (SMEs) responding to HIV/AIDS at the workplace	NAIROBI	NAIROBI	Dr. Hellen Magutu 020-445 1252/3 hmagutu@khbcnetwork.org Talbot Court, Flat No. 4, Off David Osieli Road, Off Waiyaki Way Westlands	MARGARET PRICE
KENYA NETWORK OF WOMEN WITH AIDS (KENWA)	NGO	Scaling up care and support for orphans & children made vulnerable by HIV/AIDS	NAIROBI	NAIROBI	Asunta Wagura 020-676 6677 asunta@kenwa-ke.org City Gate House, 2nd Floor, Murang'a Road	MARGARET PRICE
KISUMU URBAN APOSTOLE PROGRAM - PANDIPIERI (KUAP)	FBO	Providing outreach and treatment and addiction counseling services	NYANZA	KISUMU	Sr. Bernadette Nealon 0722-840644 fmsj2@africaonline.co.ke Along Nyalenda Ring Road off Nairobi Road, next to Pandipieri Primary School	HENRY KURIA
NAZARETH HOSPITAL	FBO	Social and economic support for PLWHAs and their households	CENTRAL	KIAMBU	Muthami Mutie 020-6750945 / 0722-690 199 muthamim@gmail.com Holy Family Centre, Riara Ridge Road, Limuru	MARGARET PRICE
NEIGHBOURS IN ACTION (NIA)	NGO	Community-based project to highlight and respond to educational, psychosocial, protection, and health needs for OVC and their caregivers in the Burnt Forest area	RIFT VALLEY	BURNT FOREST	Hosea Some 053-35037 / 0722-651 264 ruralhealth2001@yahoo.com Burnt Forest	BARBARA SPAID

RAFIKI WA MAENDELEO TRUST	NGO	Holistic health and life-skills empowerment for OVC and their guardian families in central Uyoma	NYANZA	BONDO	Michele Ostertag 0733-883325 michele@iconnect.co.ke	HENRY KURIA
ST. MARY'S MEDICAL CENTRE AND HIV PROGRAM, KAPSOYA	FBO	St. Mary's Orphans and Vulnerable Children Program	RIFT VALLEY	ELDORET	Sr. Patricia 0724 354907 Before Eldoret, right turn, Kapsoya Primary School, left 1st turn near Kapsoya Secondary School	BARBARA SPAID
THE RAPHAELITES - REDHILL PLACE TUESDAY 16/03/2010 9:00AM –10:00AM	FBO	TUANGAMIZE ULEVI NA UKIMWI (TUNU) PROJECT	NAIROBI	NAIROBI	Renee Rodriguez 0722-714 300 theraphaelites@wananchi.com After Village Market Ruaka, Turn to rd to Banana Mushapa Shopping Centre Turn right	MARGARET PRICE BARBARA SPAID HENRY KURIA
TROPICAL INSTITUTE OF HEALTH AND DEVELOPMENT (TICH)	NGO	Scaling-up of an integrated community-based care and support (ICBS) package for OVC in Nyanza Province,Kenya	NYANZA	KISUMU	Frank Kirwa 0721 627357 Opposite CARE Kenya, Kisumu	HENRY KURIA
WEM INTEGRATED HEALTH SERVICES (WEMIHS)	NGO	Greater access to psychological support for OVC (GAPSS-OVC)	CENTRAL	THIKA	Ms. Wairimu Mungai 067-21808 / 22992 / 21808 wmungai@iconnect.co.ke Section 2, Workshop Road, opposite Gatumaini Primary School, Thika	MARGARET PRICE
YOUTH ACTION FOR RURAL DEVELOPMENT (YARD) TUESDAY	CBO	Gatanga Integrated Home-based Children Support Project Phase III	CENTRAL	THIKA	Sebastian Maina 0721-584891 yardcommunitydev@yahoo.com Mabanda Trading Center near	MARGARET PRICE BARBARA SPAID HENRY KURIA

16/03/2010 9:00AM –10:00AM					Gatanga Chief's Camp, in Gatanga, Thika	
TWANA TWITU	NGO	Scaling-up and support and quality of care for OVC in Kenya	EASTERN	MWINGI	Sara Onyango 0722 527067 WestlandsMpaka road Madonna House	MARGARET PRICE

APPENDIX H. QUESTIONNAIRE AND GUIDELINES

CAP KENYA II EOP EVALUATION

Questions for USAID—March 10 and 11, 2010

USAID O/PH

1. Project history, stakeholders, and ownership:
   - How did the CAP Kenya II project come to be developed?
   - What stakeholders were involved?
   - Who owns the project?
   - How did PEPFAR influence the development of the project?
   - Did the design build on lessons learned from the previous project?
2. Development process and appropriateness:
   - What strategies were used in development of the project?
   - How were NGOs and the GOK involved?
   - How does this project fit into the National Strategic Framework and Kenya's MDGs?
3. How satisfied is O/PH with the project design? How could the design have been improved?
4. Implementation:
   - What is O/PH's assessment of how project implementation has progressed?
   - What could AED be doing better?
5. Monitoring and evaluation:
   - Does O/PH monitor accomplishments annually against revised PMP indicator targets?
   - How else does O/PH measure AED's performance?
   - What are O/PH's specific concerns regarding data quality, commodities management, and sustainability?

USAID PROGRAM DEVELOPMENT AND ANALYSIS OFFICE

1. What role does your office play in design/re-design, monitoring ,and evaluation of the CAP-Kenya II Project?
2. What are your major observations and/or concerns with the project?
3. Do you have thoughts, concerns, about the design of the intended Kenya-CAP II follow-on?

USAID CONTROLLER'S OFFICE

1. What are your major observations and concerns on the CAP Kenya II project?
2. How is the Controller's Office involved in development and approval of AED's Grant Management Model?

3. How is the Controller's Office involved in grantee financial audits? Have you noticed changes/improvements in the grantees' financial reporting over the course of the process?
4. What is the most recent OMB A133 audit submitted to USAID by AED and what are the significant findings on the grants management process?
5. What suggestions and/or concerns do you have for any follow-on to CAP Kenya II?

[Objective of above questions is to evaluate Controller's level of involvement, comfort, and concerns with AED's financial and grants management systems]

USAID'S REGIONAL CONTRACTS OFFICER

1. How satisfied has the Contracts Office been with this Associate Award process and mechanism?
2. Have there been any contractual concerns since 2006 with AED or CAP Kenya II (timeliness and completeness of financial and technical reports? compliance issues?)? If so, how have they been addressed?

SUB GRANTEE QUESTIONNAIRE

SUBGRANTEE QUESTIONNAIRE **CAP KENYA II EVALUATION**

Subgrantee Name: **Period of AED grant funding:**

Persons Interviewed:

Interviewer(s):

Date:

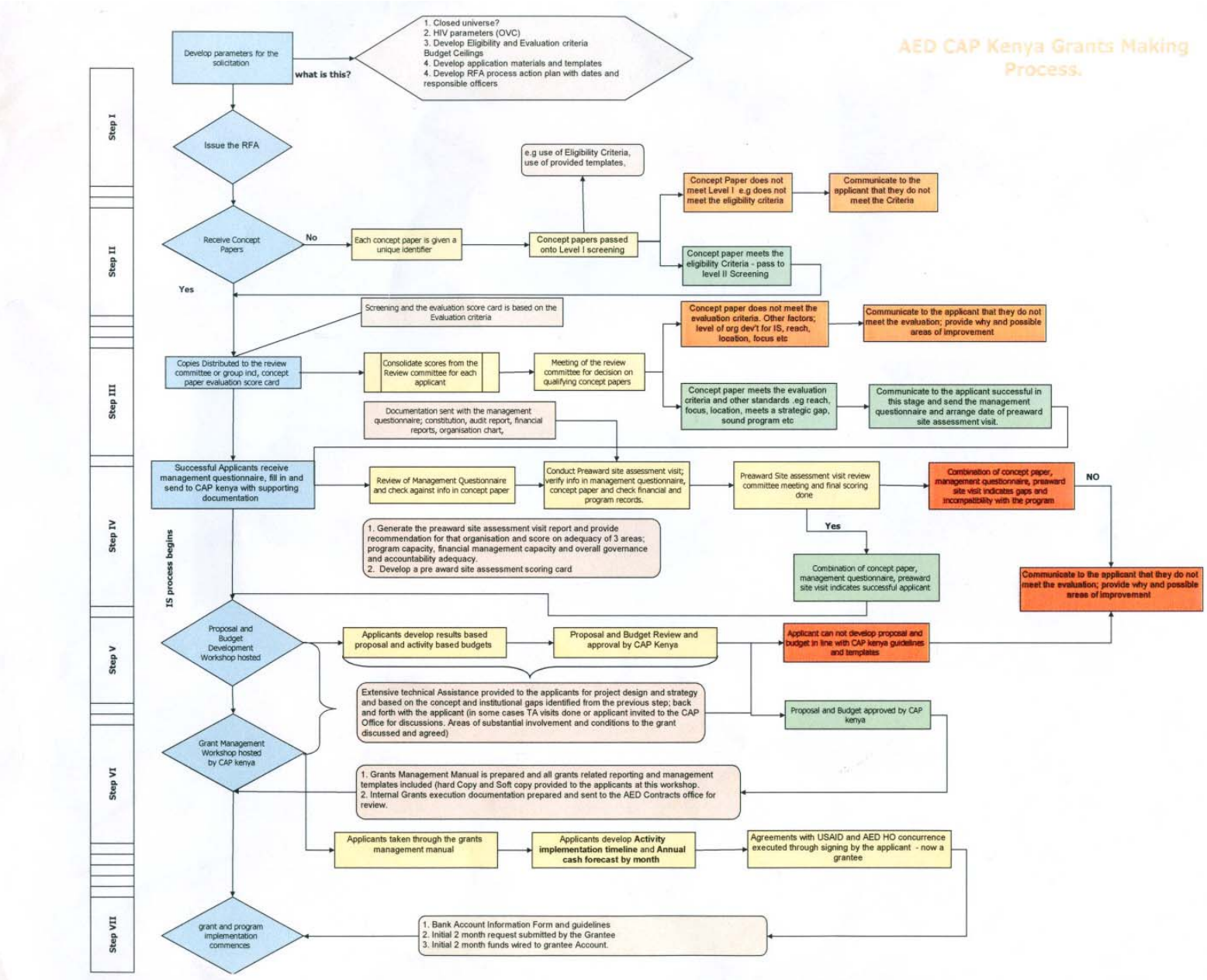
Evaluation Topic	Key Question
Overall Project Performance—Relationship/ Alignment with GoK policy	1. Which local government offices do you work with?
	2. How does your annual workplan reflect national policies and priorities? (OVC, Youth Initiative, hender, handicapped, etc.)
	3. What was the local government's technical contribution in the preparation and submission of the proposal and budget, and how can this be improved?
	4. How did your organization benefit from the proposal development workshop and what could have been improved?
	5. How did your organization benefit from the pre-award assessment site visit and what could have been improved?
	6. Highlight the key advantages and disadvantages of the one year subgrant relationship that is renewed annually by AED and state any recommendations for improvement.
	7. Provide the dates when you submitted last three requests for disbursement and state the dates when you received the funds in your bank account (*Verify information by obtaining a copy of the disbursement request as well as the bank statement showing receipt of the funds.*).
	8. Has AED's Feedback Reporton your Quarterly Narrative Reports been timely? Is the feedback useful?
	9. What TA has AED outsourced? Was it satisfactory?
	10. How did you benefit from the external audits and TA provided by the external auditor and how can the process be improved?
	11. **[Where applicable]** What were the key issues behind the suspension [termination] of the subgrant and how can the critical issues be avoided in future?
	12. **[Where Applicable]** How did the AED's subgrant close-out guidelines streamline the subgrant close- out process and how can the guidelines be improved on in future programs.

Evaluation Topic	Key Question
Institutional Strengthening	
A. Management *Leadership*	13. What TA has AED provided you to improve leadership?
	14. Was it timely? When you needed it?
	15. Who provides leadership and how is it provided?
	16. How has leadership changed over the grant period?
	17. What lessons have been learned in leadership?
	18. What recommendations would you make to improve AED's input in this area?
Strategic Planning (SP)/ Decision Making (DM)	19. What TA has AED provided to you in strategic planning?
	20. Do you have a written strategic plan? Can I see it?
	21. How was the plan developed? 22. How are decisions made within the organization?
	23. How has strategic planning/decision making changed during the grant period with AED assistance?
	24. Can you give an example of this change?
	25. Lessons learned?
	26. What recommendations would you make to improve AED's strategic planning TA?
Financial Mgmt. (FM)	27. What TA has AED provided in FM?
	28. Were funds disbursed by AED on a timely basis?
	29. Were there gaps in funding between grant modifications?
	30. How has financial management changed over the grant period with AED TA?
	31. *[Probe* Examples of budgeting, internal controls, frequency of internal and external audit, timeliness and completeness of reporting?]
	32. Lessons learned?
	33. What recommendations would you make to improve AED's input in FM?
Human Resources Mgmt. (HRM)	34. What TA has AED provided in this area?
	35. Is there an HR manual that sets forth recruitment, hiring, orientation, and supervision? (Can I see it?)
	36. Is there a system in place for staff In Service Training? Show and/or explain.

Evaluation Topic	Key Question
	37. Is there a system for performance monitoring, evaluation, and feedback? Show and/or explain.
	38. How is supervision carried out?
	39. How has human resource management changed over the grant period with AED assistance?
	40. Lessons learned?
	41. What recommendations would you make to improve AED's input into HRM?
Coordination and collaboration (C&C)	42. How do you collaborate with government and other organizations implementing similar activities in your location?
	43. How have collaboration and coordination changed over the grant period with AED assistance?
	44. Lessons learned?
	45. What recommendations would you make to improve AED's input in C&C?
	46. What recommendations would you make to improve AED's input into C&C?
Procurement Management (PM)	47. What TA and management tools has AED provided in this area?
	48. What commodities do you manage?
	49. Do you have a policy/procedures manual for procurement, waivers, storage, distribution of commodities? *[Probe* Bidding*]*
	50. What are your guidelines for ordering?
	51. Have you run out of stock of any commodity in the last six months? What? Why?
	52. What issues do you encounter in procurement and storage?
	53. How has commodity management changed over the grant period with AED assistance?
	54. Lessons learned?
	55. What recommendations would you make to improve AED's input in PM
M&E and QA	56. What TA has AED provided in M&E? How timely was it?
	57. Describe your data collection system, including tools and methods, people responsible for data collection, frequency, and data storage procedures.
	58. What procedures do you use to test data validity? (How do you . . . ?)
	59. How do you use the data/info to improve the quality of services provided? Give an example.
	60. Do you have a QA strategy? May we see it?
	61. How do you measure the *quality* of the services you provide? Give an example.

Evaluation Topic	Key Question
	62. How has M&E changed over the grant period with AED assistance?
	63. Lessons learned? Recommendations for improvement?
B. Technical	64. What TA has AED provided to improve staff knowledge of HIV/AIDS and other topics appropriate to your programs?
Technical Capacity	65. Has it been timely and adequate?
	66. When was your staff assessed with the HIV/AIDS Self-Assessment Tool?
	67. What technical training did your staff receive and how useful was it? (How have they been able to use information gained in the training?) Give examples.
	68. How useful were the quarterly E-Updates on technical subjects? Which subjects were most useful to you and your staff? How did you use this information?
	69. How useful were the Partners Quarterly Meetings and Partners Forum in improving knowledge in technical areas?
	70. What changes have occurred in service delivery over the grant period with AED assistance?
	71. What was a most significant improvement in service delivery as a result of AED assistance?
IMPACT	72. How has AED's TA in institutional strengthening allowed your staff to improve the way you provide services**?** Examples?
	73. How has AED's TA in HIV/AIDS topics resulted in improved quality of the services you provide?
	74. Is the community better off as a result of services provided under AED's grant? How?
	75. Has there been a change in service utilization by the community
	76. Of the changes you instituted (in service provision) over the grant period, which worked particularly well? (*Best Practices*)
	77. What challenges/obstacles did you face?
	78. Lessons learned?
	79. What recommendations would you make to improve AED's input into the services provision area?
Sustainability, Replicability, and Scale up	80. Did AED provide any TA in sustainability or resource mobilization?
	81. Was it timely? Useful?
	82. Over the grant period, has your funding base diversified?
	83. Do you have a written sustainability plan?
	84. What aspects of AED's TA has best prepared you to "stand on your own feet"?
	85. How would you expand your service delivery if you could generate/mobilize additional funds?

APPENDIX I. FLOW CHART



APPENDIX J. ANALYSIS OF SELECTED SUB GRANT DISBURSEMENTS REQUESTED AND RELEASED

Sub Grantee	Reporting Month	Date Requested (A)	Amount Requested (B)	Date Received (C)	Amount Received (D)	Observations	
						A-C (Days)	B-D (Kshs)
Health Education Africa Resource Team (HEART)	April 2007	March 16, 2007	1,050,493.00	April 17, 2007	884,193.00	31	166,300.00
	June 2007	May 04, 2007	172,114.00	June 27, 2007	172,114.00	54	0.00
	November 2009	December 4, 2009	865,572.00	January 7, 2010	265,572.00	33	600,000.00
	December 2009	January 11, 2010	1,357,415.00	February 12, 2010	1,357,415.00	30	0.00
Kisumu Urban Apostolate Program (KUAP)	March 2007	April 5, 2007	200,347.00	April 17,07	200,347.00	12	0.00
	April 2007	May 15, 2007	184,447.00	N/A	N/A*	N/A	184,447.00
	November 2009	December 7, 2009	1,389,879.00	January 6, 2010	1,124,072.00	29	265,807.00
	December 2009	January 5, 2010	850,594.00	February 11, 2010	382,337.00	35	468,257.00
Rafiki wa Maendeleo	March 2007	April 5, 2007	641,227.00	April 18, 2007	641,227.00	13	0.00
	April 2007	May 14, 2007	566,640.00	April 23, 2007	561,477.00	9	5,163.00
	November 2009	December 3, 2009	466,051.00	January 6, 2010	466,051.00	33	0.00
	December, 2009	January 5, 2010	679,352.00	February 15, 2010	679,352.00	40	0.00
Raphaelites	December,2007	January 5, 2007	401,555.00	January 9, 2007	401,555.00	4	0.00
	January, 2007	February 5, 2007	252,885.00	February 9, 2007	101,054.00	4	151,831.00
	September 2009	October 5, 2009	637,540.00	October 22, 2009	272,903.00	17	364,637.00
	October 2009	November 5, 2009	972,900.00	November 11, 2009	882,955.00	6	89,945.00
Twana Twitu	February 2006	March 23, 2006	507,967.00	May 3, 2006	507,967.00	40	0.00
	April 2006	May 25, 2006	273,952.00	June 6, 2006	273,952.00	11	0.00
	October 2009	November 5, 2009	807379.32	November 11, 2009	712,198.00	6	95,181.32

Sub Grantee	Reporting Month	Date Requested (A)	Amount Requested (B)	Date Received (C)	Amount Received (D)	Observations	
						A-C (Days)	B-D (Kshs)
	December 2009	January 5, 2010	409,516.40	March 3, 2010	137,646.00	58	271,870.40
Youth Action for Rural Development (YARD)	March 2007	April 16, 2007	378,696.00	N/A	N/A*	N/A	378,696.00
	April 2007	May 4, 2007	353,616.00	May 23, 2007	433,164.00	17	-79,548.00
	October 2009	November 04, 2009	484,832.00	N/A	N/A*	N/A	484,832.00
	November 2009	December 05, 2009	484,832.00	January 06, 2010	484,832.00	62	0.00

Source: Subgrantee Financial Reports, March 15, 2010.

NOTES

1. *The four disbursements selected per subgrantee comprise two at the beginning of the subgrant and two at the end.*
2. *The six subgrantees selected comprise three from Nairobi/Central Province and three from other provinces.*
3. *N/A* No funds were disbursed because of unutilized balances from the prior month.*

APPENDIX K. SUBGRANTEE TRAINING TO SEPTEMBER 2009

	Organiza-tion	Strategic Plan Dvpt/ Review	Financial Policy Manual	HR Policy Manual	Policy & Procedure Workshop	M & E Training	Resource Mobiliza-tion Strategy	Resource Mobiliza-tion/Fund-raising Strategy	Advocacy	Staff Team Building	Board Skills Dvpt	Staff Skills Dvpt	Acctg Software	Admin Policy Manual	Program Evaluation	Leadership Dvpt/FF	Financial/ HR Systems Dvpt
1	**Ace Africa**	√	√	√	√	√	√			√		√	√		√	√	
2	**Ace Commun-ications**		√		√												
3	**Africa Focus**		√			√		√									
4	**Asumbi**		√	√	√	√		√						√			
5	**Beacon of Hope**	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√
6	**CABDA**	√	√	√	√	√	√	√	√		√	√	√	√		√	
7	**COLIDEF**	√	√	√	√	√						√	√			√	
8	**CREADIS**	√	√	√		√	√	√			√	√	√	√		√	
9	**CWS**		√			√					√	√					
10	**CWSK**	√	√	√		√					√	√		√			
11	**FHOK**					√				√			√				
12	**Handicap Interna-tional**	√	√	√		√			√			√	√	√			√
13	**HCI**	√	√	√	√	√	√	√			√	√		√			
14	**HEART**	√	√	√	√	√	√	√		√	√	√	√	√		√	√
15	**HelpAge**			√		√		√				√	√	√			
16	**HVFI**		√	√	√	√	√	√		√	√	√	√	√	√	√	
17	**HWWK**	√	√	√	√	√	√	√		√		√		√	√		
18	**Impact RDO**	√	√	√	√	√						√	√				

	Organiza-tion	Strategic Plan Dvpt/ Review	Financial Policy Manual	HR Policy Manual	Policy & Procedure Workshop	M & E Training	Resource Mobiliza-tion Strategy	Resource Mobiliza-tion/Fund-raising Strategy	Advocacy	Staff Team Building	Board Skills Dvpt	Staff Skills Dvpt	Acctg Software	Admin Policy Manual	Program Evaluation	Leadership Dvpt/FF	Financial/ HR Systems Dvpt
19	**KBSF**		√	√	√	√		√		√				√			
20	**KHBC**	√	√	√			√	√			√	√	√	√	√		
21	**KENWA**	√	√	√		√	√	√		√	√	√			√	√	√
22	**KUAP**		√	√		√			√			√					
23	**MCC**	√	√	√	√	√					√	√	√			√	
24	**MICOBA**					√									√		
25	**MORCA O**		√	√		√		√						√			
26	**Nazareth**	√	√	√								√					
27	**Neigh-bors in Action**	√	√	√		√		√		√	√	√	√	√	√	√	
28	**The Omari Project**	√	√	√	√	√		√				√	√	√		√	√
29	**Rafiki**	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√
30	**RAPADO**	√	√	√		√	√		√			√	√		√	√	
31	**Raphael-ites**	√	√	√	√	√			√	√		√					
32	**Reachout**		√	√	√	√		√				√		√			√
33	**Ripples Interna-tional**	√	√	√		√		√	√		√	√		√		√	√
46	**SAPTA**	√	√	√		√				√	√	√		√		√	
34	**SCAD**	√	√	√						√			√	√			√
35	**SFIC**	√	√	√	√	√		√		√		√	√		√		
36	**St. Camillus**	√	√	√		√				√		√	√				
37	**St. Mary's**		√	√	√	√				√		√	√				
38	**Tesia**	√	√	√	√	√		√				√	√	√			

	Organiza-tion	Strategic Plan Dvpt/ Review	Financial Policy Manual	HR Policy Manual	Policy & Procedure Workshop	M & E Training	Resource Mobiliza-tion Strategy	Resource Mobiliza-tion/Fund-raising Strategy	Advocacy	Staff Team Building	Board Skills Dvpt	Staff Skills Dvpt	Acctg Software	Admin Policy Manual	Program Evaluation	Leadership Dvpt/FF	Financial/ HR Systems Dvpt
	Isanga																
39	**TICH**					√				√		√					
40	**Twana Twitu**	√	√	√		√		√		√	√	√	√	√	√	√	
41	**WASDA**		√	√	√	√				√	√	√		√			
42	**WAYAAP**	√	√	√	√	√	√	√		√	√	√	√			√	√
43	**Wema Centre**		√	√		√		√	√	√	√	√		√		√	√
44	**WEMHIS**					√		√					√			√	
45	**YARD**		√	√	√	√		√			√	√	√	√		√	
	TOTAL	**28**	**40**	**40**	**23**	**43**	**13**	**28**	**7**	**21**	**20**	**38**	**26**	**26**	**12**	**21**	**11**
	Percen-tage	**62%**	**89%**	**89%**	**51%**	**96%**	**29%**	**62%**	**16%**	**47%**	**44%**	**84%**	**58%**	**58%**	**27%**	**47%**	**24%**

Source: AED Cap Kenya.

APPENDIX L. TECHNICAL TRAININGS AND WORKSHOPS

Training/ Workshop	Date	Length (days)	Topics Covered	Number of Participants	Cadre Trained
Nutrition Care for PLWHA: Community Perspective	July 2008		To expose service providers to knowledge and skills needed to implement nutrition interventions for PLWHAs and to pretest the nutrition training manual	12	Mid-level program mgrs. and implementers, i.e., field-based health workers and community volunteers
Nutrition Care for PLWHA: Community Perspective	October 2008		To train health workers in importance of nutrition care for PLWHAs and to empower PLWHAs with nutritional care plans, assessment, PS counseling, social interaction, and food security	34	
Mitigating HIV and AIDS Among Orphans and Vulnerable Children	November 2008	5	To facilitate a forum for CAP Kenya CBOs and develop technical skills necessary to build stronger programmatic approaches and interventions serving OVCs	32	OVC program managers, coordinators, or similar
Child Status Index (CSI) Workshop	June 2009		To enable participants to develop a working knowledge of the CSI and how to use it to measure individual child status and as a program level decision-making tool	57	Middle and lower level program implementers
Skills Building Workshop: Integrating HIV Prevention into Substance Abuse Programs	Sept. 2009	3	To develop implementing partners' skills to integrate HIV prevention into their programs based upon an appropriate understanding of what HIV prevention is, what methodologies and technologies are available, and the development of relevant service packages that respond to actual risks and vulnerabilities	18 (SAP Grantees)	Program managers, VCT counselors, and outreach/field workers
Skills Building Workshop: Integrating HIV	November 2009	3	To develop implementing partners' skills to integrate HIV prevention into their programs based upon an appropriate	25 (OVC Grantees[1])	Program leads and community health

[1] One of two regional workshops, this one capturing Nairobi, Coast, Eastern and Central Provinces; the second, scheduled for May 2010, targeting Rift, Nyanza, and Western Provinces.

Prevention into OVC Programs			understanding of what HIV prevention is, what methodologies and technologies are available, and h the development of relevant service packages that respond to actual risks and vulnerabilities		workers
The Omari Project Team Skills Development Workshop	December 2009	2	To strengthen the HIV testing component through a better understanding of referral systems, confidentiality and disclosure between VCT and addictions outreach, and mitigating barriers to HIV care and treatment services	18	Outreach workers, addictions counselors, VCT counselors and program leads
The Reachout Centre Trust Team Skills Development Workshop	March 2010	2	To improve technical skills in mitigating stigma and barriers to HIV service access, mitigating issues related to ART adherence, and confidentiality and disclosure between VCT and addictions outreach	24	Outreach workers, addictions counselors, VCT counselors and Program leads

APPENDIX M. HIV E-UPDATES

AED CAP KENYA PROGRAM

HIV E-Updates: Electronic Learning Newsletter

TOPICAL INVENTORY 2008	
TOPIC	**DATE**
1. UNAIDS Report and IAC 2008 Summaries (pt1)	August 2008
2. KAIS Report and IAC 2008 Summaries (pt2)	August 2008
3. HIV/AIDS Responses with Children and Youth	August 2008
4. Peer Education	September 2008
5. Behavior Change	September 2008
6. HIV Counseling and Testing: Skill Building and QA Resources	October 2008
7. Engaging Men as Partners in HIV Responses	October 2008
8. HIV/AIDS – Taking on a Human Rights Approach to Programs	December 2008
TOPICAL INVENTORY 2009	
TOPIC	**DATE**
1. Male Circumcision as Part of HIV Prevention	January 2009
2. Understanding and Responding to the Factors that Shape Sexual Behaviors in Youth	February 2009
3. Treatment Adherence Support in Community-Based HIV-Responses	March 2009
4. Prevention with Positives (PwP)	April 2009
5. Home and Community-Based Care	June 2009
6. Understanding Gender and HIV/AIDS	June 2009
7. Taking on Evidence-Based HIV Prevention for Adolescents	July 2009
8. HIV/AIDS Workplace Policies	September 2009
9. Demystifying Palliative Care for PLWHA	September 2009
TOPICAL INVENTORY 2010	
TOPIC	**DATE**
1. HIV Testing for Infants and Children	February 2010
2. Understanding and Responding to Most at Risk and Vulnerable Populations	March 2010
3. Deconstructing the Kenya National AIDS Strategic Plan III	March 2010

APPENDIX N. AGAINST PEPFAR INDICATORS

APPENDIX X.3 AED CAPABLE PARTNERS PROGRAM (CAP) KENYA											
Kenya Small Grants and Institutional Strengthening Program II											
2006–2010 Targets vs Actual Summary											
PEPFAR Program Area	**Program Area Indicators**	**Oct'05 - Sept 06**		**Oct'06-Sept'07**		**Oct'07-Sept'08**		**Oct'08-Sept'09**		**Oct'09-Sept'10**	
		Target	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***
Prevention - abstinence and/or being faithful	2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	5,000	20,200	10,000	9,000	7,000	26,794	60,000	37,912	65,000	
	2.1b.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence [this is a subset of the total reached with abstinence and/or be faithful – indicator #2.1]		11,770						161		
	2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	0	0	18	0	70	456	300	843	400	
Prevention – injection and noninjecting drug use[2]	Number of individuals trained									500	
	Number of DU/IDUs reached									2,500	
Prevention – voluntary male circumcision (CIRC)[3]	Number of grantees provided TA to integrate VMMC into their programs									14	

[2] This is new indicator and target in the 2009 COP, previously not reported on.
[3] This is a new indicator and target in the 2009 COP, previously not reported on under PEPFAR.

APPENDIX X.3 AED CAPABLE PARTNERS PROGRAM (CAP) KENYA											
Kenya Small Grants and Institutional Strengthening Program II											
2006–2010 Targets vs Actual Summary											
PEPFAR Program Area	**Program Area Indicators**	**Oct'05 - Sept 06**		**Oct'06-Sept'07**		**Oct'07-Sept'08**		**Oct'08-Sept'09**		**Oct'09-Sept'10**	
		Target	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***
Prevention – other prevention beyond AB	5.1 Number of targeted condom service outlets	0	0	0	10	16	423	30	682	150	
	5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	72,000	69,153	18,000	29,671	75,000	58,639	75,000	64,751	60,000	
	5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	0	153	468	134	680	578	5,500	207	500	
Palliative care for HIV (incl. TB)	6.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)	0	0	13	1	13	97	0	80	11	
	6.2 Total number of individuals provided with HIV-related palliative care (including those HIV-infected individuals who received treatment for tuberculosis, Indicator 6.2.A) disaggregated by sex	3,290	890	6,350	944	6,350	13,331	4,900	19,350	2,900	
	6.3 Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed), that includes those trained in facility-based, community-based, and/or home-based care, including TB/HIV	770	954	1,154	443	1,500	822	450	413	200	

APPENDIX X.3 AED CAPABLE PARTNERS PROGRAM (CAP) KENYA											
Kenya Small Grants and Institutional Strengthening Program II											
2006–2010 Targets vs Actual Summary											
PEPFAR Program Area	**Program Area Indicators**	**Oct'05 - Sept 06**		**Oct'06-Sept'07**		**Oct'07-Sept'08**		**Oct'08-Sept'09**		**Oct'09-Sept'10**	
		Target	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***
Orphans and vulnerable children	8.1A Primary direct support [3 or more services]				12,858		14,725		13,933		
	8.1B Supplemental direct support [1 or 2 services]				13,254		14,517		20,750		
	8.1 Total number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex	9,429	14,072	26,500	26,112	31,500	29,458	40,000	34,743	40,000	
	8.2 Number of providers/caregivers trained in caring for OVC	1,187	2,294	14,205	696	7,825	10,276	10,000	3,699	3,600	
	8.3 Number of OVC receiving **food and nutritional supplementation** through OVC programs						16,349		11,065		
	8.4 Number of children tested and received results[4]									36,000	
	8.5 Number of children on CTX treatment[5]									2,880	
Counseling and testing	9.1 Number of service outlets providing counseling and testing according to national or international standards	0	0	3	40	6	249	6	345	50	
	9.2 Number of individuals who received counseling and testing for HIV and received their test results, disaggregated by sex	580	1,761	5,000	1,437	6,000	18,241	12,000	31,441	20,000	
	9.3 Number of individuals trained in counseling and testing according to national or international standards	0	46	20	258	16	7	25	0	25	

[4] This is a new PEPFAR Indicator previously not reported on.
[5] This is a new PEPFAR Indicator in the 2009 COP previously not reported on

APPENDIX X.3 AED CAPABLE PARTNERS PROGRAM (CAP) KENYA											
Kenya Small Grants and Institutional Strengthening Program II											
2006–2010 Targets vs Actual Summary											
PEPFAR Program Area	**Program Area Indicators**	**Oct'05 - Sept 06**		**Oct'06-Sept'07**		**Oct'07-Sept'08**		**Oct'08-Sept'09**		**Oct'09-Sept'10**	
		Target	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***
	9.4 Number of individuals who received counseling and testing for HIV and received their test results, disaggregated by sex (excluding TB)	0							22,895		
Strategic information (surveillance, HMIS, M&E)	13.1 Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS).						88		69		
	13.2 Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)						108		168		
Policy Analysis and Systems Strengthening.	14.1 Number of local organizations provided with technical assistance for HIV-related policy development	0	20	22	20	85	157	0	121	72	
	14.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building	20	34	45	43	45	220	0	65	101	
	14.3 Number of individuals trained in HIV-related policy development	0	0	50	14	50	110	0	167	400	
	14.4 Number of individuals trained in HIV-related institutional capacity building	0	0	55	0	220	145	0	391	400	
	14.5 Number of individuals trained in HIV-related stigma and discrimination reduction	0		213		850	225	0	143	150	
	14.6 Number of individuals trained in HIV-related community mobilization for prevention, care, and/or treatment	0		1,250		5,000	99	0	5	400	
OVC core	Food and nutritional support						16,349		11,065		

APPENDIX X.3 AED CAPABLE PARTNERS PROGRAM (CAP) KENYA											
Kenya Small Grants and Institutional Strengthening Program II											
2006–2010 Targets vs Actual Summary											
PEPFAR Program Area	**Program Area Indicators**	**Oct'05 - Sept 06**		**Oct'06-Sept'07**		**Oct'07-Sept'08**		**Oct'08-Sept'09**		**Oct'09-Sept'10**	
		Target	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***	***Target***	***Actual***
services[6]	Shelter and care						4,305		2,245		
	Protection						5,150		8,299		
	Healthcare						10,180		14,890		
	Psychosocial support						21,362		24,266		
	Education and vocational training						13,112		14,860		
	Economic opportunity						2,234		3,044		

Notes on Targets:

i) Targets are based on the PEPFAR Country Operational Plan and in the CAP Kenya workplan for the respective year.

ii) Targets for October 2009–September 2010 as contained in the CAP Kenya workplan have been adjusted as follows:

PEPFAR Program Area	PEPFAR Program Indicator	Change in target
Prevention – abstinence and/or being faithful	2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	The target in the 2009 COP for this indicator is 170,000. This was adjusted to fit the reality of grantees CAP Kenya working with in this area and changing PEPFAR trends
Prevention – other prevention beyond AB	5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	The target in the 2009 COP for this indicator is 95,000. It was adjusted as CAP Kenya was not working with Ace Communications, a grantee expected to reach a large number with BCC information and education

[6] CAP Kenya has been providing this information on a quarterly basis in these periods using the KePMS system. Please note these numbers are not cumulative for the entire year.

PEPFAR Program Area	PEPFAR Program Indicator	Change in target
Policy analysis and systems strengthening	All the indicators	There were no targets in the 2009 COP for this program area. The targets here are based on CAP Kenya achievements in the 2008 implementation period

NOTES ON REPORTED DATA:

Data Reporting Analysis (Oct 2007–September 2008)[7]

PEPFAR Program Area	Comments/Remarks
Prevention – Abstinence and/or being faithful	CAP Kenya has met the targets in this program area. The addition of SCAD as a partner working with young people in high schools has contributed to realization of these targets. Also, support to grantees implementing OVC programs to integrate age-appropriate prevention messages and approaches has enhanced the numbers to meet this target.
Prevention – Other Prevention beyond AB	Whereas targets for condom outlets have been realized, the overall target for people reached with prevention messages and number of people trained has not been reached. Ace Communications was expected to contribute to realizing the majority of these targets. In the implementing period, Ace Communications' major partner in the discordant-couple campaign ended its work and changed its emphasis to ensuring that proper post-test services were available to couples tested. The program approach was geared more toward strengthening the post-test services and forming and strengthening post-test groups. In addition, in the period when Kenya experienced post- election violence, programming was heavily impacted, and outreach workers were less able to access the populations with whom they were working.
Palliative Care for HIV (including TB)	The number of people reported as receiving palliative care increased in the last quarter of the implementing period as all programs clearly understood the indicator and reported on it. However, the number of people trained remained low as a number of programs had not integrated home-based- care training into their programs. Rather, they were working with other service providers in their localities. The grant with Nazareth Hospital, an important partner for this program area, has been suspended since March pending outstanding financial issues, and this has affected the numbers of people trained.
Orphans and Vulnerable Children	Nearly 80% of the CAP Kenya grantees report under this indicator. In the FY07 implementing period, these organizations were provided with intensive TA to ensure not only that they are reaching vulnerable children, but also that their caregivers are provided with the necessary skills for everyday care and support of the children. In

[7] This can be found in CAP Kenya QNR # 11

PEPFAR Program Area	Comments/Remarks
	the period after the post-election violence, there was a surge in the number of children reached as programs dealt with internally displaced children. As the situation in the country returned to normal, the need for emergency services decreased, then stabilized at levels reported in the last quarter. The numbers for this quarter are down from the last quarter. This can be attributed to the fact that three of the grantees reaching a significant number of children either were suspended or were pending modification and so did not report for this quarter. It is expected that once the issues have been resolved, services to these children and their households will resume.
Counseling and Testing	All organizations reaching out to substance-using populations have embraced counseling and testing as a way to provide support to this population. This has led to more people being tested through mobile VCT activities as well as concerted and supportive follow-up for those referred for counseling and testing. CAP Kenya has encouraged these organizations to focus more on creating linkages with service points that have a comparative advantage in this area rather than training people; hence the lower number of people trained under this program area. This has proved to be a better strategy for these organizations, as it gives them more room to design programs geared toward sustained behavior change, including strengthening post-test services.
Strategic nformation (surveillance, HMIS, M&E)	In this program area, various activities have been undertaken by three grantees, which also made sub-grants to smaller organizations. Within the sub-programs, the ability to link support groups with various resources including training, funding opportunities, income generation, and start up business capital means that these support groups have formed stronger self-help groups and only rely on the main organizations for technical support.
Policy Analysis and Systems Strengthening	This continues to be an area where more support is needed for the organizations we are working with to be able to accurately and completely report on their activities. Whereas the number of institutions provided with HIV-related capacity building, including policy development, has increased over the year, this has not been accurately reported by grantees and by CAP Kenya. Improved reporting by the grantees after the indicators and reporting workshop accounts for the upsurge in the numbers in the last quarter for this program area.

Data Reporting Analysis (Oct 2008 – September 2009)[8]

PEPFAR Program Area	Comments/Remarks
Prevention – Abstinence and Being Faithful	CAP reached 63% of the Prevention/Abstinence and Being Faithful target. Providing correct numbers for this program area has been an ongoing challenge throughout the year. The majority of the grantees did not report any results under this indicator. Our analysis is that grantees have some programmatic challenges in understanding what prevention activities are, and so even the majority who are providing prevention services are not reporting them. It is also a reporting issue for those who are knowingly providing prevention services but may not be sure how to report them.
OVC	For the OVC program area, an almost 16% increase in services is recorded in the fourth quarter. However, the number of children receiving more than three services has decreased and the number receiving less than three increased by almost the same number (~5,000) that was recorded as the overall increase. This mainly raises data quality issues (proper use of the CSI, etc.), which will be addressed in program meetings with the grantees.
Counseling and Testing	Even though we have surpassed our annual targets for the Counseling and Testing program area, there remain questions about whether the same individuals have been included in the Prevention – Other Behavior Change results. This is an area that CAP will address in the next quarter, especially in extended reference to palliative care, with the larger question being, if grantees have counseled, tested, and provided results to so many individuals, are they also providing palliative care to all of those who are HIV-positive?

[8] This can be found in CAP Kenya QNR # 15

APPENDIX O. LEVEL OF PROGRAM HIV/AIDS TECHNICAL CAPACITY

GRANTEE	SCORE 2008
CABDA	0
TIO	0
MCC	0
RAPADO	0
YARD	0
Ripples	0
HEART	10
Rafiki Wa Maendeleo	10
HWWK	10
St. Camillus	10
Twane Twitu	10
HCI	10
SFIC	10
NIA	20
ACE Africa	20
BoH	10
COLIDEF	20
WEMIHS	30
CREADIS	30

GRANTEE	SCORE 2009
WASDA	20
YARD	10
BoH	30
Twane Twitu	20
HEART	20
Ripples	20
ACE Africa	20
Helpage International	40
NIA	20
KENWA	40
CREADIS	30
MCC	40
HWWK	40
RAPADO	20
SFIC	40
St. Camillus	40
Rafiki wa Maendeleo	40
CABDA	40

% TRAINED	NO OF GRANTEES
0%	6
1-25%	8
26-50%	3
51-75%	2
75%-100%	0

% TRAINED	NO OF GRANTEES
0%	0
1-25%	1
26-50%	7
51-75%	2
75%-100%	8

APPENDIX P. COMMUNITIES BETTER OFF

	IMPACT SEEN AT COMMUNITY LEVEL COMMENTS
Handicap International	Don't have good data on this. A 2008 community impact evaluation was supposed to have taken place, but it didn't. While they don't have data, they have observed that people with disabilities are speaking out more and going for more services. HIV+ DPs are speaking out at conferences and meetings; they are forming support groups and going for more CT services in project areas.
HEART	They are seeing more children staying in school longer, especially older girls –19,000 girls provided with monthly packets of sanitary towels and underpants (Freedom for Girls [Sanitary Towels] Project, now turned over to the Lion's Club for implementation). Keeping more mothers alive through WEEP (Women's Equality and Empowerment Project) has enabled them to feed and take care of their families—see this as "orphan prevention." Women are making bed nets and school uniforms to generate income. HEART does sourcing for them, often through other CAP Kenya partners; but women are also learning to source for themselves based on some entrepreneur skills training. Kids for School: each OVC given a school uniform and a goat for milk and income. In time they pay back one goat when there are offspring. This program alone has helped 100 of 800 OVCs in the village. Also started food security program by renting land for villagers to farm and grow own produce.
Raphaelites Redhill Place	There is an increased number of persons abusing substances coming for services. Community comes for information—sees them as a resources center. There are sufficient numbers in "recovery" to be able to track retention in services to better document outcomes of contacts for impact at community level. See success stories.
YARD	Community has been engaged in support of OVCs. Community groups have been trained in income generation, life skills, and food security. Community now much more involved—feeling that OVCs belong to community and all have a responsibility for them. Now supporting 1,150+ OVCs Children feel more hopeful, increased self-esteem from Kids' Club interventions. Success Story: Older OVCs: 13 older girls supported for hairdressing course. Began program with low self-esteem because they hadn't done well in secondary school. All 13 completed the course and had much higher self-esteem at end. With their certificates of completion, can seek employment. Two of the YARD-supported girls came in first and second in the class. At least three of the 13 girls had found positions within the area within a month of completing the course.

	IMPACT SEEN AT COMMUNITY LEVEL COMMENTS
St. Mary's Medical Centre	Christopher felt that the quality of the lives had drastically improved in that each child had a counselor and a care-giver. School attendance had improved, as had performance. Kids' Clubs had resulted in improved self-esteem among the children—as documented on the CSI. 20 older students who had not done well in school were given vocational training. He remains in touch with all 20 to date and 15 have succeeded in making a living for themselves; five have not yet gotten the hang of "standing on their own feet." One boy from Siylus was trained as a mechanic and after graduation in 2009 was given tools. Help was provided in attaching him to a garage in Eldoret, where he continues to work and do well. He supports six siblings back in Siulus. He is 19. He stops by St. Mary's monthly just to stay in touch. One young woman received tailoring training and a sewing machine was purchased for her by St. Mary's after her training. She now sits on a side-street near St. Mary's with her machine and makes her living stitching for area residents.
Neighbors in Action	School attendance and performance has improved over the four years. OVCs staying in school longer with focused attention/program activities. Food club responsible for original increase and then Kids' Club. Gardening skills training provided to OVCs who work in school gardens. Improves their self-esteem and they produce food to eat and sell to obtain school fees. Some replicate gardens at home with caregivers to increase HH food supply and income.
Hope Valley Family Initiative	--More children attend school --More OVCs cared for --Improved community response to needs of OVCs --Students themselves are mobilizing efforts to assist OVCs by collecting used HS uniforms and passing them on to those OVCs who need them. --Teachers have become more sensitized to needs of OVCs and are now responsive to those who are withdrawn, or performing or attending poorly; before they didn't even know which students were OVCs. HVFI trained them with AED training tools. GREATER COMMUNITY INVOLVEMENT: The community has been brought in to the point where they own OVC outcomes in the community. They support the OVCs and have initiated activities of their own, e.g., gardening assistance, gifts of food, soap, and other useful items to children-headed HHs.
Beacon of Hope	Income/skills dev. for care-givers & older OVCs have had a real impact: people feel empowered and more hopeful about their futures—living with hope instead of fear; more feel they can disclose their status (and that of younger OVCs in their charge) and better deal with stigma and discrimination (which has decreased in community). Increased use of VCT.
CABDA	Now the community has coordination committees for OVC as well as trained caregivers.
COLIDEF	[no info collected]

	IMPACT SEEN AT COMMUNITY LEVEL COMMENTS
KUAP	The outreach workers trained by support from AED are part of the community and will remain after the end of the KAUP subgrant.
Rafiki	Yes: There are families who have reported increase in income for their farming (see beneficiary responses below). Kids participating in PSS are more active in class. More guardians are able to express themselves. The community is slowly developing a trend of raising contributions, for example providing in-kind contribution for the projects thaty require support from Rafiki.
TICH	Question not asked.
Twana Twitu	Improved quality of life for OVCs and caregivers – see improved service delivery appendix.
Child Welfare Society of Kenya	Now that community chiefs, police, judges, hospital staff, local children's officers, and communities are trained, there is more recognition of the rights of the child and the communities are more involved. Community chiefs are now protecting orphans' rights to property, preventing disinheritance; protecting childrens's identity and protecting orphans from abuse.
Franciscan Sisters (SFIC)	Educational support for OVCs has resulted in more of them attending school. Community gardening groups have been mobilized and vegetables are sold to the school food program at lower cost. Some earnings from community gardens are used for school fees. Fish farming and water harvesting have been started. Stigma toward PLWHA has been reduced through life skills program for caregivers.
KBNSC	Less stigma in workplaces as a result of information/awareness training; condoms are available in the workplace. Mobile CT units are arranged for the workplace.
KENWA	Question not asked.
Nazareth Hospital	There is less stigma now that families and communities have been educated; there is improvement in the quality of life for PLWHAs. They now receive PSS and holistic care through the referral system. Their income is improved through IGA and their nutritional status has improved through household gardening; households are improved with their care. More people are accessing services and getting to know their HIV status because they hear treatment is available. Hospital staff and community members are more knowledgeable about HIV/AIDS.
WEMHIS	Question not asked (closed out)

APPENDIX Q. FIELD DATA: CHANGES IN SERVICE DELIVERY AS A RESULT OF IS AND TECHNICAL CAPACITY DEVELOPMENT

	CHANGE IN SERVICE DELIVERY COMMENTS
Handicap International	Thanks to increased understanding of all the components that need to go into the OVC Package and their synergistic role (6+1), OVC programs have become more comprehensive. Learned importance of factoring gender perspective into programs for disabled. Improvement in their ability to manage sub-grants and improvements in their financial management system has improved their ability to expand services to the handicapped in HIV awareness, prevention, treatment, and care.
HEART	With AED assistance, developed a disclosure strategy & program in coordination with the district health office to encourage care-givers to tell those OVCs who are HIV+ of their status and to help them seek medication and appropriate treatment. An enabling activity within this program was training community leaders about stigma and discrimination. PLWHAs helped to facilitate these sessions and sensitize the community. Developing capability to develop age-appropriate, culture-appropriate, and gender-specific prevention and life-skills messages. Programs are now more comprehensive—feel this makes for better overall service.
Raphaelites Redhill Place	Benefits from AED CAP in IS were enormous—improved policies, procedures, and more efficient operating systems meant that staff are no longer overwhelmed and multitasking. Each program now has its own manager and this allows each program to be more focused. Services have improved as a result. Staff have greatly increased their understanding of the relationship and interaction between HIV/AIDS and substance abuse. They are now able to link clients, once sober and recovered for a period, with income-generation/micro-finance schemes in the area as they have come to realize how important this is in keeping clients on the recovery path. They receive a lot of information from AED through e-mail and frequent visits. AED has been very responsive to their questions and requests for assistance. Have been able to develop and maintain smoother system of client tracking for improved client follow-up and interaction.
YARD	Staff feel they have grown in HIV/AIDS knowledge, HIV/AIDS programming capacity, and as individuals, and that this is reflected in better work.
St. Mary's Medical Centre	Lasting impact of TA: They continue to use what they learned from AED TA in their on-going OVC projects, particularly the use of "voluntary" care-givers from within the community that AED assisted them in introducing successfully. These volunteers continue to serve the community and to serve as care-givers for OVCs.

	CHANGE IN SERVICE DELIVERY COMMENTS
Neighbors in Action	Services focused to the individual OVC or caregiver—improved quality of program services. By using the schools as the entry point to the community, they were able to attract more OVCs into program—have expanded their coverage from 48 to 978 OVCs and are serving an additional 400 through other funding. Diversified funding base has resulted from work done with AED CAP.
Hope Valley Family Initiative	Early OVC activities were primarily nutrition and PS support only: with AED's TA they have expanded to all 6+1 service areas; involved the community, schools, and churches; and expanded to more children and caregivers. Community Kids' Clubs had a huge impact. It turned out to be a much better way of providing PSS. Now there are 24 Kids' Clubs and one dedicated school providing PSS support. AED taught them to work with the individual child, identifying and addressing individual needs with the help and support of the community. As a result of AED's TA, they were able to identify "protection issues" (birth registration for school attendance and property inheritance, child labor, defilement) as major challenges for these kids and work with individual children on specific needs with local support. With the Dept. of Childrens' Services, HVFI was able to recruit and train Volunteer Children's Officers from the community. Through the Community Advisory Councils on which HVFI sits, they can bring up quarterly issues on specific children raised through the Kids' Clubs. Issues can then be handled at District level if necessary. AED's TA helped them identify, prioritize problems .and develop and implement programmatic solutions.
Beacon of Hope	Learning from other AED partners during Partners Forums and incorporating new ideas into own program activities: using drama in school outreach activities for older OVCs; community veg. gardens; learning about focusing on individual child and his or her specific needs resulted in better program results. Emphasis is on client orientation and comprehensive service delivery. Look at improved counseling content; self-assessments focus on quality of counseling episode. Track student (OVC) performance and can pick out those falling behind for assistance. Use teacher checklists and get testimonies from OVCs and caregivers.
CABDA	Yes, we now have care givers and coordination committees. We emphasize supporting the community to take care of the OVC. Behavioral change communication component in HIV prevention has strengthened services. With new system of staff appraisals, each sets his own performance objectives and more is getting done. People are working harder, better motivated.
COLIDEF	[no data collected]
KUAP	Improved M&E capacity has enabled KUAP to use information to ensure that outreach workers are assigned a reasonable and appropriate number of clients. The project is more focused and change is easy to measure because the project now targets specific individuals with the interventions. Better results when working with one SA at a time instead of in groups.

	CHANGE IN SERVICE DELIVERY COMMENTS
Rafiki	At the beginning, people insisted on being provided with food and money to attend Rafiki meetings. Advocacy encouraged the community to contribute for Rafiki-funded projects. Community is now encouraged to contribute, for example, the children bring firewood and the caregivers cook the food and get clean cooking water, then Rafiki provides food and plays with the children. Rafiki requests community contribution prior to providing support for better community buy-in. The team building workshop helped them decide on this approach.
TICH	TICH has learned about community involvement in the OVC programming; community involvement is greatest improvement.
Twana Twitu	Now OVCs are being referred to hospitals as needed; more comprehensive services mean better quality of service delivery for OVCs and caregivers: IGAs, life skills training, PSS, resource center for OVCs, better OVC protection within community; better community involvement.
CWSK	See community impact data sheet.
Franciscan Sisters (SFIC)	More organized now and feel more confident working with the community. Can see what they are doing is effective. Teachers who have received PSS training are relating to OVCs with more compassion.
KHBC	Companies are now mobilized with a menu of possible activities in which they can get involved, e.g., national testing campaigns.
KENWA	Use of CSI allows services to be child-focused; quality of reporting has improved.
Nazareth Hospital	PLWHAs were involved with stigma/discrimination reduction training, and this made it more effective.
WEMHIS	Question not asked (closed out).

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