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Evaluation of a multi-sector HIV capacity-building program in Nairobi informal settlements

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Evaluation of a multi-sector HIV capacity-building program in Nairobi informal settlements

By

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B.A., Georgia State University, 2010

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An abstract of
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Abstract

Evaluation of a multi-sector HIV capacity-building program in Nairobi informal settlements

By Danielle Purvis

Background: HIV incidence remains high in informal settlements of Nairobi informal settlements compared to the rest of Kenya. Many HIV interventions do not address the causes and the consequences of HIV concurrently, and most programs in informal settlements are not sustainable due to reliance on external donors. The current study is an evaluation of a leadership development program designed to mobilize community assets, develop collaborations, address social structural determinants of HIV, and improve HIV prevention and care practices. **Methods**: Eight multi-sector teams based in Nairobi informal settlements participated in the Faith, Health Collaboration and Leadership Development Program (FHCLDP) from February to August 2015, which utilized a pedagogy that enhances community mobilization through participatory learning, action planning and implementation, and the engagement of stakeholders from multiple sectors. Researchers conducted a thematic analysis of workshop documents, team reports, and site visit field notes to determine the influence of the program on team practices following workshops. **Findings**: Teams effectively mobilized community assets, formed and strengthened collaborations, addressed most social structural determinants of HIV, and implemented HIV prevention and treatment interventions. However, it is unclear how the program influenced HIV prevention and treatment practices, and no teams addressed structural determinants of HIV (e.g., poor infrastructure). **Interpretation**: The FHCLDP demonstrates potential to build capacity in teams in low-resource communities to implement interventions that address the causes and consequences of HIV. Teams alleviated donor dependency by mobilizing local resources and strengthening local stakeholder relationships. In addition, they addressed pressing determinants of HIV while reinforcing care infrastructure in their informal settlements. Recommendations for the FHCLDP are provided.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
CBO	Community-based organization
CDC	Center for Disease Control and Prevention
FBO	Faith-based organization
FHCLDP	Faith, Health Collaboration and Leadership Development Program
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counseling
IGA	Income-generating activity
IHP	Interfaith Health Program
KDHS	Kenya Demographic and Health Survey
MOH	Ministry of Health
MSM	Men who have sex with men
NCSS	Nairobi Cross-sectional Slums Survey
NEPHAK	National Empowerment Network of People living with HIV/AIDS
NGO	Non-governmental organization
NSHPS	Nairobi Slum HIV Prevalence Survey
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan For AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RSPH	Emory University Rollins School of Public Health

SES	Socioeconomic status
SPILL	St. Paul's Institute of Lifelong Learning and Leadership Development Center
SPU	St. Paul's University
STI	Sexually transmitted infection
UNAIDS	United Nations Programme on HIV/AIDS

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Executive Summary

Problem

- HIV incidence and prevalence remain high in residents of Nairobi informal settlements, despite many HIV prevention and intervention programs that already exist in these settings.
- There is limited research on HIV or other health issues in Nairobi informal settlements, thus there is insufficient evidence to determine why HIV incidence and prevalence are still a problem in these settings.
- Many HIV interventions address either the causes or the consequences of HIV, rather than addressing both concurrently.
- Most health programs in informal settlements depend on external donor support, which limits sustainability and creates donor dependency in low-resource communities.

Aim of the Current Study

- To assess the influence of a team-based leadership development program on the capacity to mobilize community resources and networks, address social structural determinants of HIV, and implement HIV interventions in Nairobi informal settlements.
- The current study was conducted as a partial fulfillment of a master degree.

Approach of the Current Study

- Eight teams with members from faith, health, and development sectors participated in the Faith, Health Collaboration and Leadership Development Program (FHCLDP) from February to August 2015.

- Teams attended two workshops and a concluding program meeting. Following each workshop, teams submitted reports of their resultant community-based interventions. Four teams also participated in site visits in their informal settlements.
- The workshop curriculum utilized a pedagogy that enhances community mobilization through participatory learning, action planning and implementation, and the engagement of stakeholders from multiple sectors.
- A thematic analysis of workshop data and team reports was conducted. Themes from each data source were plotted in a timeline of program modules. The analysis compared modules of the FHCLDP and subsequent team practices to determine the influence of the FHCLDP on team capacity and the nature of HIV interventions.

Findings

- Teams successfully mobilized community assets, such as team member expertise in activities, raw materials, and community ownership.
- Teams formed and enhanced collaborations with residents in informal settlements and stakeholders from diverse sectors.
- Team interventions targeted social determinants of HIV, including stigma and discrimination, faith, sociocultural, socioeconomic, and bureaucratic determinants of health. There were no interventions to address structural determinants (e.g., poor infrastructure).
- Teams established or enhanced HIV prevention and care interventions (e.g., hosting HIV testing and counseling events in churches, establishing and reinforcing referral networks to health facilities and defaulter tracing programs).

Conclusions

- The FHCLDP approach shows promise to create more sustainable, less donor-dependent HIV programs that engage informal settlement communities in design and implementation.
- The FHCLDP has the potential to mobilize faith, health, development, civil society, economic, education, and agriculture sectors to address social structural determinants of HIV and improve the overall health of infected and affected communities.
- The FHCLDP enhances HIV prevention and HIV treatment as prevention.

Recommendations for the FHCLDP

- Recruit stakeholders who work with key populations and other vulnerable populations to improve access to and provision of care for vulnerable populations.
- Expand curriculum emphasis to explore commonly stigmatized aspects of HIV (e.g., infidelity, vulnerability of sexual minority populations).
- Provide an additional workshop on grant writing and conduct monitoring and evaluation.
- In future FHCLDP program evaluations, develop new modalities for evaluating the influence of faith in team practices to understand more precisely how faith shapes health-seeking behaviors in informal settlements.

Introduction

Problem Statement

Informal settlements in Nairobi, Kenya have disproportionately high prevalence of HIV compared to the rest of the country. Although there are many health programs operating in informal settlements, these programs face many challenges, such as program sustainability, poverty, messages from some faith community members that discourage health-seeking behaviors, and high rates of HIV-related stigma and discrimination. As such, HIV continues to plague informal settlements throughout Nairobi, despite the extensive effort of health programs to address the issue.

Program Overview

The Faith, Health Collaboration and Leadership Development Program (FHCLDP) is a project developed for multi-sector teams representing faith, health, development, and civil society sectors to develop and implement interventions that address social structural determinants of HIV and improve clinical care in Nairobi informal settlements.

Statement of Purpose

The purpose of the current study was to assess how the FHCLDP can mobilize community resources, form and strengthen stakeholder collaborations, implement interventions that address the social determinants of HIV, and improve HIV testing, linkage, enrollment, and adherence to care.

This evaluation was conducted as a partial fulfillment of a master degree as well as a complement to an evaluation conducted by Interfaith Health Program, Emory University. The analyses for this evaluation were a product of independent work of the author.

Background

Overview of HIV in Kenya

Kenya has made significant progress on the prevention and treatment of HIV, but Kenya continues to be one of the most affected and infected countries in East Africa [1, 2]. In 2013, it was estimated that Kenya a national prevalence of 6% with 1.6 million people living with HIV/AIDS [1]. HIV/AIDS is still the country's leading cause of mortality, accounting for almost 15% of deaths annually [3]. The World Health Organization has determined that HIV, tuberculosis, and malaria comprise Kenya's second largest burden of disease, behind maternal, neonatal, and nutritional causes of disability and mortality [3]. HIV/AIDS is also the ninth highest cause of under-5 mortality [3]. Notably, Kenya has made significant gains towards achieving the Millennium Development Goals to reduce HIV/AIDS–related deaths: Kenya reduced HIV/AIDS-related deaths from 383.9 per 100,000 persons in 2000 to 126.3 per 100,000 persons in 2012 [3]. From 2007 to 2013, there were also 7% and 44% reductions in HIV incidence among adult and children populations, respectively [1]. However, some populations are still underserved; for example, the Ministry of Health (MOH) estimates that only 42% of children living with HIV have treatment coverage [1].

There are geographic and social trends in the dispersion of HIV prevalence in Kenya. Women and key populations have the highest prevalence in the country: 7.6% for women (compared to 5.6% for men), 29.3% for commercial sex workers, 18.2% for men who have sex with men (MSM), and 18.3% for people who inject drugs [1]. Nairobi County holds the country's largest population of people living with HIV/AIDS (PLWHA) with approximately 177,500 PLWHA and a prevalence of 6.8% [1]. The disparity in prevalence between men and women is even greater in Nairobi: 8.4% of women are living with HIV compared to 5.3% of men

[1]. In a survey about the burden of disease in Nairobi, HIV/AIDS accounted for half of premature mortality among people over the age of 5, while HIV/AIDS was the sixth highest cause for under-5 premature mortality [4].

There are similar trends for HIV incidence as well. Across Kenya, heterosexual partnerships (i.e., within a union or regular partnership) account for almost half of HIV incidence, and casual heterosexual sex is responsible for 20% of new cases of HIV [1]. In total, approximately two-thirds of HIV incidence results from heterosexual sex in both civil unions and casual contexts [1, 2]. Consistent with gender trends of HIV prevalence, women have 57% of new HIV cases compared to 43% of new cases among men [1]. In Nairobi, heterosexual partnerships or unions represent 37.4% of new cases, commercial sex workers and clients represent 14.7%, MSM and prison inmates account for 16.4%, People who inject drugs comprise 5.8%, and the remaining 2.7% of incidence occur in health facilities [2].

HIV in Nairobi Informal Settlements

Nairobi has a population of more than 3 million people, and it is estimated that 70% of that population lives in informal settlements (i.e., slums) [4, 5]. Informal settlements in Nairobi were built in response to rapid urbanization and are characterized by abject poverty, high population density and overcrowding, poor water and sanitation hygiene, insecurity, and higher rates of infectious diseases, including HIV and other sexually transmitted infections (STIs) [5]. As such, informal settlement residents are typically less healthy and have fewer resources to promote livelihood, such as education, stable housing, and source of income [4, 5].

There are over 100 informal settlements in Nairobi alone [5], and preventable and treatable conditions are responsible for the majority of mortality burden [4]. The 2012 Nairobi Cross-sectional Slums Survey (NCSS) collected survey-based interviews from 5490 households

living in informal settlements to evaluate population and health indicators that create a picture of social and structural factors affecting health in informal settlements over time and compared to other communities in Kenya [5]. Features of informal settlements that increased HIV risk and treatment barriers include poverty, insecurity, and unsanitary living conditions. Of the immediate basic needs in informal settlements, 10.8% of survey respondents needed stable, suitable housing; 12.5% experienced insecurity issues; 12.9% were unemployed; 22.3% could not access water; 12.4% could not access toilets; and 13.7% did not have garbage or sewer disposal. The most immediate areas of concern were unemployment, adequate housing, and lack of WASH. Youth also reported higher rates of childbearing: 47% of youth in informal settlements compared to 30.5% in other communities in Nairobi gave birth before the age of 18.

The NCSS also assessed HIV and STI knowledge in informal settlements [5]. Although knowledge about HIV prevention methods has increased since the NCSS was collected in 2000, respondents reported misconceptions and lack of knowledge about prevention of HIV and STIs, including a perceived lack of personal risk toward contracting HIV. One-tenth of women in informal settlements were unaware that HIV can be transmitted sexually, and only 75%, 70%, and 12% of women know about the STIs gonorrhea, syphilis, and genital warts, respectively. In addition, less than 90% of women know about mother-to-child transmission. Two-thirds of informal settlement residents receive HIV/AIDS information from different sources of media, a significant reduction from 86% of the population in 2000. The NCSS attributes this reduction to a budget cut in public institutions to promote health messaging. About half of the population received HIV/AIDS information from friends and relatives, and there was a large increase of information provided by health workers from 34.3% of the sample in 2000 to 51.5% in 2012. Almost one-fourth of the population received HIV/AIDS information from churches and

mosques, and less than one-third received information from school and teachers. Both religious and educational institutions have increased as sources of information since 2000, indicating an increased understanding of the importance of informal settlement community stakeholders in HIV information dissemination. Female respondents identified condom use (71.7%), relationship fidelity (55.7%), and sexual abstinence (47.6%) as methods to prevent HIV transmission.

The NCSS also measured sexual health behaviors [5]. Even though the major of respondents knew that condom use effectively prevents HIV, only about 9% used condoms at last intercourse. Overall, sexual risk taking behaviors were higher in informal settlements compared to other communities in Nairobi and Kenya. For example, 7.8% of the unmarried respondents in the NCSS reported having multiple sexual partners compared to 3.3% of the unmarried Nairobi participants and 1.6% of the unmarried participants in the national sample of the 2008/2009 Kenya Demographic and Health Survey (KDHS). The NCSS also identified some gaps in the populations being reached for HIV testing and counseling (HTC). Despite the lifetime testing rate of 93.5% for the total NCSS sample, only 75% of teens aged 15-19 had taken an HIV test. The high rate of testing in informal settlements, compared to rural rates of 54%, may reflect the accessibility of HTC services. Informal settlement residents preferred using mobile clinics and participating in research studies compared to accessing traditional and formal institutions for HTC, which may suggest a negative perception of government and institutional services. The data collected from the NCSS demonstrate many potential points of intervention, such as structural improvements in informal settlements, information dissemination on HIV and STI prevention, a scale-up of HTC for teenagers, and stigma sensitization to promote use of health institutions.

Madise et al. (2012) compared results from the 2006/2007 Nairobi Slum HIV Prevalence Survey (NSHPS) to the 2008/2009 KDHS stratified by Nairobi non-informal settlement residents, urban non-informal settlement residents, and rural residents [6]. Informal settlement residents had the highest prevalence of HIV at 11.8%, compared to 6% prevalence among rural populations and 5.3% prevalence among non-informal settlement urban residents. Women had significantly higher HIV prevalence in all samples: 13.2% versus 9.5% for men in informal settlements; 7.2% versus 4.5% for men in rural communities; and 7.7% versus 2.9% for men in non-informal settlement urban communities. Age distribution patterns also varied in each community. Prevalence in informal settlement areas increased in each age stratum with individuals 45 and older bearing the greatest burden of HIV. Individuals age 25-29 and 35-39 in rural communities had the highest prevalence of HIV, and non-informal settlement urban communities had the highest prevalence in the 30-34 age range. Madise et al. suggested that gradual exposure to the informal settlements environment may increase HIV risk. In addition, the study found a correlation between marriage dissolution and HIV, though it is unclear whether PLWHA are more likely to experience divorce or separation or if individuals are more likely to engage in risky behaviors following a divorce or separation.

These data collectively demonstrate that informal settlements have unique structural and resource challenges and a range of negative health outcomes.

Determinants of HIV in Nairobi Informal Settlements

Determinants of HIV in informal settlements are complex, and there is limited data to explain why HIV prevalence is higher in informal settlements compared to the rest of Nairobi and Kenya [7]. Research has explored many social, structural, and health care factors in the environment that make informal settlements more vulnerable to HIV compared to other

environments in Kenya. The World Health Organization broadly defines social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" [8]. More specifically, UNAIDS defines social drivers of HIV as "the social and structural factors, such as poverty, gender inequality, and human rights violations, that are not easily measured that increase people's vulnerability to HIV infection" [9]. Research on social determinants of HIV in Nairobi informal settlements include socioeconomic factors [10-12], sociocultural factors [6, 13-16], HIV stigma and discrimination [12], and faith and religion [17]. The physical structure of informal settlements and the ways in which residents interact with informal settlements influence vulnerability to HIV and other health consequences [6, 18, 19]. Finally, the extent, type, and quality of health care services are important elements to HIV vulnerability among informal settlements residents [7, 20-24].

Informal settlement residents frequently experience effects of poverty on HIV vulnerability, given that one-fourth of residents (up to half of female residents) are unemployed and approximately three-fourths live below the poverty line [5, 25]. There are many ways poverty mediates HIV risk. Economic hardship may promote HIV risk-taking behaviors, such as transactional sex work [10], which also increases the risk of sexual violence and HIV risk [6, 13]. In a study comparing sexual behaviors and material deprivation for individuals across socioeconomic status (SES) and geographic locations across Kenya, Dodoo et al. (2007) found that "although the poor generally have worse sexual outcomes, the *urban* poor are considerably more disadvantaged than their rural counterparts, a disadvantage that appears accentuated in Nairobi where, even among currently married women, the Nairobi poor have the worst outcomes

compared to all other categories, including the rural poor…. Indeed, the economic circumstances may be so desperate that some parents may be implicated in their daughters turning to the street to help augment household budgets" [10]. Unemployment and underemployment are also associated with increased drug and alcohol abuse, which can directly elevate HIV risk via intravenous drug use or indirectly through lack of antiretroviral therapy (ART) adherence or more frequent unprotected sex [10, 26]. Highly impoverished individuals may not be able to afford general health care, and PLWHA in poverty often choose to buy food when they cannot afford medication [12]. When they cannot afford food, PLWHA sometimes do not take their medication to avoid the unpleasant side effects of ART on an empty stomach [12]. Approximately 85% of informal settlement households are food insecure, and almost half of informal settlement households meet criteria for severe food insecurity [11]. In a sample of 800 PLWHA in Kibera, 19% cited running out of pills as a reason for nonadherence, 25% did not adhere to instructions such as food intake before medication, 3% reported feeling sick or ill [12]. These findings are consistent with the fact that 41% met classifications for living in absolute poverty [12]. SES is a highly impactful and multifaceted determinant of HIV in informal settlements.

Very little data has been collected on sociocultural influences on HIV risk in Nairobi informal settlements, despite substantial evidence that social and cultural norms shape how individuals process information and behave in ways that affect their HIV risk [14-16, 27]. For example, it is unclear if the role of marriage mitigates HIV risk through sexual exclusivity or facilitates HIV transmission, given that the majority of incidence occurs in heterosexual sex [16]. Some data suggest that marriage is protective as it promotes sexual exclusivity and limits the risk of HIV exposure [16]. Other data suggest that men living with HIV will only increase safe sex

behaviors with their female partners when men exhibit symptoms and get very sick [27]. Men cited social norms to not use condoms within marriages and cultural pressure to reproduce as barriers to safe sex behaviors and status disclosure [27]. Further, marriage practices vary according to ethnocultural norms; for example, some Kenyan ethnic groups practice polygamy, which increases the number of sexual partners, and thus risk of exposure to HIV, an individual has [16].

There is also limited data on HIV disparities of vulnerable populations, such as women [6, 13], youth and elderly populations [17, 28, 29], and key populations [30]. Amuyunzu-Nyamongo et al. (2007) conducted survey-based interviews and with women living with HIV key informant interviews in informal settlements to identify unique barriers to prevention and treatment that perpetuate the gender disparity [13]. Women and key informants identified poverty, unavailability of jobs, high rates of commercial sex work and sale of illicit liquor, community insecurity, and environmental exposures as major contributors. However, gender disparities in HIV prevalence may also reflect the low rate of testing and reporting among men [14].

Research has also consistently demonstrated a relationship between age and HIV status, though some inferences are inconclusive [6, 14, 17, 28, 29]. Although Madise et al. (2012) reasoned that longer lifetime exposure to informal settlements increased HIV risk [6], Chepngeno-Langat found that older people in Nairobi cited sexual cessation or partner exclusivity as reasons for minimal personal risk for HIV [26]. Other research found that youth tend to be the least aware of their status and seek HTC services significantly less often than adults [5, 14]. Kabiru et al. (2011) found that as few as 22% of males and 28% of females ages 15-19 had been tested and received results, while only 43% of males and 68% of females ages

20-24 years old received results from an HIV test, which are much more modest figures than the 75% lifetime testing rate among young adults cited in the 2012 NCSS [5, 14]. There are other age-related factors that influence HIV risk. For example, orphans and vulnerable children (OVCs) have greater immunization and health outcomes in households with HIV-negative caregivers, and particularly with non-related caregivers who tend to have the oldest average age of any caregiver [17]. One theory for this finding is that many children born of PLWHA miss their immunizations and primary health care while parents are sick; caregivers who are not related to children tend to have less health concerns and supply children's missed immunizations and primary care [17]. Although informal settlement residents ages 50 and older report the lowest HIV prevalence on average (between 1-4%), their health care needs are often neglected, and the low prevalence estimate may reflect the low HTC rate of older adults [29].

In a systematic review of studies evaluating the structural determinants of HIV for key populations, Baral et al. (2014) concluded that most research focuses on individual-level risks and academics must understand the social and structural factors that promote disproportionately high incidence and prevalence of HIV among MSM, commercial sex workers, and people who inject drugs [30]. Special considerations must be made for vulnerable populations who are disproportionately affected by HIV.

As previously demonstrated, there is a relationship between demographics such as gender and age groups and HIV status awareness or disclosure. Research has found that one of the most influential reasons for the lack of testing, reporting, and disclosure is HIV-related stigma [2, 31]. The National Empowerment Network of People living with HIV/AIDS (NEPHAK) conducted a national survey of 1086 PLWHA to explore how interpersonal and institutional stigma and discrimination impact PLWHA across the country [2]. NEPHAK found that almost 40% of

respondents had experienced some form of HIV-related stigma and discrimination in their lifetimes, ranging from being gossiped about and social excluded to physically assaulted and harassed. More than half of PLWHA respondents perceived stigma and discrimination to be related to HIV-negative persons' lack of knowledge of methods of HIV transmission; almost half of respondents believed HIV was shameful and stigmatized themselves; about 35% of respondents attributed stigma and discrimination to others' fear of infection; and more than one-quarter of respondents perceived religious or moral judgments from others regarding their status. Internalization of stigma and discrimination varied by gender. For example, women felt shame, low self-esteem, suicidal, and the desire to be punished more often than men, whereas men blamed themselves or others and felt guilty more often than women. Regarding institutional stigma and discrimination, almost 30% of the sample had been forced to find new housing due to their status; 40% lost their job or source of income; 30% had to change their job or lost a promotion due to HIV status; and over 30% had been prevented from attending an education institution. Additionally, 37.4% of PLWHA believed they had experienced human right abuses, and 15.5% were unsure if their human rights had been abused. For example, 11% of respondents reported coercion of a medical or health procedure, such as involuntary testing.

There is little research specifically about how stigma and discrimination influences HIV risk in informal settlements, but some studies have evaluated the causes and effects of stigma and discrimination [7, 12, 13]. One study conducted in-depth interviews with 41 PLWHA in informal settlements about their post-diagnosis experiences, and participants mentioned themes of self-stigma, stigmatization of other PLWHA, fear of status disclosure, and the internalization of status as identity rather than a medical label [7]. Individuals who assumed a new identity as a PLWHA were more likely to initiate ART, whereas those who self-stigmatized were less likely

to disclose their status or seek medical care [7]. In another study of in-depth interviews with 20 women living with HIV in informal settlements, they identified multiple ways in which stigma and discrimination negatively impacted their health [13]. Over 60% of women experienced HIV-related stigma and discrimination, which resulted in mental and emotional strain, internalization of shame, social ostracism, economic and employment constraints, and denial to health care services [13]. Each participant also identified rape as a common experience for women in informal settlements, which was often unreported due to stigma [13]. Another study on ART adherence criticized the lack of investment in stigma reduction in Nairobi informal settlement communities because stigma and discrimination still deters PLWHA from the uptake of free ART [12]. Given the frequency with which PLWHA experience stigma and discrimination, there is very little research on how stigma and discrimination shape social determinants of HIV in informal settlements.

Much of the research on the role of faith and religion on HIV relates to how faith shapes HIV-related stigma and discrimination, and there are very mixed results regarding whether faith and religion promote or mitigate HIV-related stigma and discrimination [2, 7, 13]. In the PLWHA Stigma Index, NEPHAK identified common experiences of being excluded from religious activities and places of worship due to stigma, believing that HIV was shameful or immoral due to religious beliefs, and being excommunicated from the church [2]. However, respondents also stated that faith-based organizations (FBOs) and religious entities had the capacity to combat stigma and discrimination, advocate for PLWHA, and provide emotional support, and one-fourth of respondents voluntarily disclosed their status to religious leaders. In another study, more than half of a sample of women living with HIV identified the church as a contributor to HIV-related stigma and discrimination, but many women reported belonging to

religious groups, which contributed to their mental and emotional well-being [13]. In the study on experiences after HIV diagnosis, many PLWHA cited religiosity and prayer as major sources of support to cope with their diagnosis, though some PLWHA preferred prayer and faith healing over ART [7]. These studies demonstrate the potential for religious and faith-based entities to intervene and provide support for PLWHA.

Structural determinants of HIV in informal settlements are particularly important, given that informal settlements are often defined by a lack of infrastructure, poor water and sanitation systems, crime and insecurity, overcrowding, poor housing conditions, and high rates of migration to access employment and housing [5]. Insecure residential status, such as living in temporary or poor quality housing, is correlated with an increase in residents' risk of STIs, HIV, and unwanted pregnancies, in addition to other adverse health outcomes [19]. Several studies have found that informal settlements expose women to frequent insecurity, including sexual violence, which increases women's risk of HIV [6, 13]. In addition, women living with HIV experience high rates of co-morbidities (e.g., cases of upper respiratory tract infections, TB, skin problems, etc.) and cannot manage their health due to poor environmental hygiene and sanitation [13]. Finally, among those who migrate from one informal settlement to another for day labor or new housing, migration is associated with larger numbers of sexual partners and low condom use over time [18].

Aside from social and structural determinants of HIV, another major determinant of HIV in informal settlements is access to health care, including health insurance programs, HIV prevention, ART, and family planning options [7, 20-24]. Out of 60,000 individuals consisting of 23,000 households in informal settlements, the majority of residents (89%) had no health insurance, while 10% partook in a social health insurance program, most of whom were male,

not considered poor, currently in a union, and had relatively high levels of education [21]. These findings advocate for policy reforms regarding the accessibility of health insurance for majority of unemployed, underemployed, or impoverished informal settlement residents [21]. Though the scale-up of ART programs in Nairobi informal settlements have significantly reduced the rate of HIV-related mortality since the introduction of ART around 2003 [22], many PLWHA report poor quality health services in informal settlements as access barriers [7]. Further, health care provision has not incorporated social determinants of HIV, which may influence the uptake of and adherence to ART for some individuals [7]. Finally, the introduction of ART in informal settlements gives PLWHA the opportunity to continue living normal, healthy lives and to utilize family planning options, such as contraception and safe fertility options for the prevention of mother-to-child transmission (PMTCT) [23, 24]. Within informal settlements, one in three PLWHA compared to one in five HIV-negative people had unmet needs for contraception, citing fear of contraception side effects, reduced sexual pleasure, inability or unwillingness to discuss contraception with partner or health care provider, and little or no integration of HIV and family planning services [24]. For PLWHA who reported contraception utilization, approximately 60% used condoms, and only 15% used dual method contraception [24]. In addition, there was no association between PLWHA in informal settlements who have reproductive desires and PLWHA enrolled in ART, implying that HIV care was not a primary factor in the family planning process [23]. Another study found a positive relationship between ART initiation and fertility desires in the East African region, which may underscore the need to integrate HIV and family planning services in Nairobi informal settlements [23]. Otieno et al. (2010) followed 116 mothers living with HIV in Nairobi approximately 17 months after receiving antenatal referrals for highly active ART as a form of PMTCT [32]. About one-quarter did not access care due to

the cost of treatment, lack of confidentiality, and dislike of the facility, and one-third of those enrolled in care discontinued care due to stigma and discrimination, poor quality services, and the cost of treatment. These results parallel the criticisms of health facilities and the social determinants of HIV in informal settlements, including poverty and stigma and discrimination.

Limitations in HIV Interventions in Informal Settlements

Despite major advancements in HIV prevention and treatment, many interventions aren't sustainable or appropriate in the context of informal settlements [1, 5, 13]. The MOH also recognizes that HIV interventions have not adequately addressed structural barriers to behavioral changes for HIV prevention and care [1]. Much of the expertise, funding, and human and health resources are externally supplied, which weakens local capacity and leads to inappropriate program targets and methods [13, 33]. Given how social, structural, and health care determinants of HIV and care in informal settlements are complex and interrelated, there is a great need for interventions to integrate social, structural, and health care approaches to address root causes of HIV while effectively scaling up prevention and treatment.

Informal settlements are typically characterized by the lack of resources in the community [5]. Results from a study of survey-based interviews with PLWHA and key informants found that interventions, though numerous in informal settlements, were not sustainable due to the dependency on donor-supplied resources and funds [13]. Sharma et al. (2013) found that declining PEPFAR funds threaten to disrupt the transition process of program governance to local stakeholders and to end several health programs still dependent upon PEPFAR funds [33].

Another gap in current HIV interventions is poor improvement of clinical outcomes via systems strengthening [13]. Gaps in biomedical and HTC systems include poor condom

distribution chains, weak referral systems, poor access and retention to care, including PMTCT and youth ART, and low screening for and treatment of STIs, particularly among PLWHA and key populations [1, 32]. Some health programs have been criticized for not integrating health education or counseling [32]. Greater treatment adherence correlates with self-esteem and self-efficacy of individuals on ART, identifying a gap in treatment counseling and psychosocial support groups [34]. NEPHAK identified stigma and discrimination as a major barrier to accessing and navigating systems, such as dental health care, family planning services, or sexual and reproductive health services [2]. This institutional discrimination highlights the need for referrals within informal settlements for stigma-free service providers. Finally, there are observed limitations to connect PLWHA to services that promote overall wellbeing, such as nutritional supplements, poverty reduction, legal services, psychosocial and spiritual support, and education and occupation resources [1, 2, 7, 12, 13, 32].

Recommendations for HIV Interventions

There are a variety of recommendations to improve program sustainability and community investment. For example, involving local community members in the design and implementation of interventions ensures program appropriateness, enhances community trust and acceptance, and empowers the community to take ownership over health programs [35]. Interventions can access and mobilize resources more effectively by collaborating with local stakeholders, such as FBOs and non-governmental organizations (NGOs), which are often deeply entrenched in the health sector [35]. For example, in a sample of approximately 800 households living in informal settlements with at least one PLWHA within the household, more than half identified that they received a range of health or complementary services (e.g., HTC, HIV sensitization, treatment, home based care, OVC services) from a governmental organization

or NGO [36]. In addition, local organizations that utilize internal resources have more investment and capacity to change informal settlements internal operations [33]. Excellent treatment adherence outcomes have been observed in other low-resource environments; a community-based HIV program in rural Rwanda demonstrated that community-based treatment support significantly improved rates of adherence [37]. Finally, it is recommended that health facilities conduct adherence, compliance, and consumption research, and make a concerted effort to follow up with people using ART [13]. Ultimately, methods to improve program sustainability may offset the negative impact of withdrawing external support for health programs in informal settlements.

Researchers recommend a comprehensive multi-sector approach commonly referred to as a structural intervention: "Structural interventions differ from many public health interventions in that they locate, often implicitly, the cause of public health problems in contextual or environmental factors that influence risk behavior, or other determinants of infection or morbidity, rather than in characteristics of individuals who engage in risk behaviors" [38]. Structural interventions target social determinants of HIV to change the context in which people affected by HIV can make decisions that promote health [9, 39]. For example, microfinance programs for women in informal settlements alleviate poverty in households, which decreases women's reliance on commercial sex work, may empower women to negotiate condom use, and increases their family income to spend on food and health expenses – all of which decreases HIV risk [40].

The MOH advocates for an HIV structural intervention labeled the "Combination Prevention Approach," which is a mix of behavioral, structural, and biomedical approaches that engage actors from civil society, health, faith, and development sectors to optimize intervention

catchment [1]. NEPHAK also recommends using a multi-sector approach to address social determinants that may preclude several marginalized or high-risk communities from being reached, such as key populations [2]. For example, health care services that integrate community outreach and HIV stigma sensitization can access highly stigmatized populations, such as key populations [13].

In summary, research advocates for programs that mobilize community resources, enhance collaborations, improve systems integration, and utilize multi-sector interventions that address social structural determinants of HIV.

Purpose Statement

The FHCLDP aims to build capacity in eight low-resource informal settlements in Nairobi, Kenya through four objectives: 1) to cultivate common awareness of HIV social vulnerabilities; 2) to enhance collaborative leadership among program participants representing faith, health, and development sectors; 3) to develop a vision for community transformation; and 4) to transform the community through action plan implementation, using collaborative strategies to achieve community-based HIV prevention, treatment, and care [41]. The purpose of the current evaluation is to assess the influence of participation in the FHCLDP on team practices during the duration of the program from February to August 2015 to determine how effectively the FHCLDP achieves its objectives and provide recommendations for future iterations of the program.

Research Questions

The research questions driving this evaluation are as follows:

1. How has participation in the FHCLDP influenced team collaboration and asset mobilization?

2. How has participation in the FHCLDP influenced team practices to address the social structural determinants of HIV?
3. How has participation in the FHCLDP influenced team HIV prevention and care practices?

Methods

Program Overview

The Faith, Health Collaboration and Leadership Development Program (FHCLDP) is a multi-sector team-based program that utilizes curriculum for leadership development through participatory praxes. The FHCLDP was created by St. Paul's Institute of Lifelong Learning and Leadership Development Center (SPILL) at St. Paul's University (SPU) in Limuru, Kenya and the Interfaith Health Program (IHP) at Emory University Rollins School of Public Health (RSPH) in Atlanta, USA. SPILL and IHP formed a collaboration in 2011 with the vision of training leaders from faith and health sectors across the globe to form and strengthen partnerships with other community stakeholders, to identify previously overlooked resources in communities commonly labeled as "low-resource communities," and to develop action plans to address the greatest health disparities in their communities [41].

The IHP developed the original curriculum, Institute for Public Health and Faith Collaborations, which was then adapted for capacity building in Kenyan communities by IHP and SPILL as a part of the FHCLDP [42, 43]. The curriculum utilizes a pedagogy that enhances community mobilization through participatory learning, action planning and implementation, and the engagement of stakeholders from multiple sectors [41]. In 2014, SPILL and IHP conducted a pilot of the FHCLDP in Nakuru County, Kenya with four multi-sector teams [41]. Then SPILL and IHP conducted an evaluation of the pilot and adapted the curriculum [41], which was implemented in 2015. The primary goals of the FHCLDP curriculum are the following:

1. "Cultivate common awareness and commitment: Demonstrate a clear understanding of holistic health that links health care, HIV social vulnerabilities, and development in the local context

2. Cultivate collaborative leadership: Assess leadership capacities in relation to other in the areas of faith, health, and development
3. Cultivate vision for transformation: Identify and align the community assets that promote health and development
4. Create and implement an action plan for community transformation: Develop and implement collaborative strategies that achieve sustainable, community-based HIV prevention, treatment, and care" [41]

The current study will assess the influence of participation in the FHCLDP on multi-sector team practices to build capacity, address social structural determinants of HIV, and reinforce HIV prevention and care infrastructure. Thus, the analyses for the present study included data from the workshops as well as data collected from participants.

Table 1. Program and Data Collection Timeline

Recruitment February-March 31 Team Applications	
Workshop Preparation March 31-April 18 Pre-workshop Assignments	
Workshop 1 April 19-23 Evaluations, Asset Map 1, Network Map 1	
Community Action Learning 1 April 24-June 19 Progress Reports	
Workshop 2 June 20-24 Evaluations, Asset Map 2	
Community Action Learning 2 June 25-August 28 Final Reports	
Team Site Visits July 13-17 Site Visit Field Notes	**Follow-up Meeting** July 29 Network Map 2

Table 1 displays a timeline of the FHCLDP and the data collected during each period. Prior to the first workshop, each of the eight participating teams had team activities and individual reading for workshop preparation. Then teams attended two workshops held two months apart, which consisted of didactic lectures, guided team activities and discussions, individual reflections, the development of vision statements, action planning, and team presentations. Table 2 and 3 provide an overview of workshop activities and processes of

learning. At the end of each workshop, individual participants and small groups evaluated their own learning processes. After each workshop, teams conducted "Community Action Learning" in which they implemented their action plans. At the end of each Community Action Learning period, the teams wrote and submitted reports, received feedback on the reports, and resubmitted a final draft incorporating feedback. Members from SPILL and IHP conducted site visits with four out of eight teams three weeks after the second workshop, from which site visit field notes were recorded. Finally, all teams attended a follow-up meeting five weeks after Workshop 2 to evaluate team progress and challenges in action plan implementation.

Table 2. Overview of Workshop 1.

Workshop Day	Activity in Curriculum	Activity Purpose	Nature of Activity
Day 1, April 19	Self-introduction, participant describes item/symbol that represents self	To introduce participants and recognize human capital in 8 teams	Individual presentations in large group
Day 2, April 20	Handouts, *Dynamics of Working Commitment* and *Collaborative Leader Quilt*	To identify the self-assets and build team relationships	Team activity and discussion
	Discussion about purpose for individual participation and contributions	To unify team purpose, identify self-assets	Team discussion
	Presentation on the Nature of HIV and Social Disparities; Handout, *Making Sense of Health Disparities in Context*	To introduce and reflect upon social determinants of health and their impact and implications: 1. Stigma and discrimination 2. Social status, ethnicity, sociocultural norms 3. Gender, marital status, sexual orientation 4. Individual health risks and behaviors 5. Family and community relationships 6. Poverty and income 7. Physical structural environment	Lecture, Team guided activity and discussion
	Handout, *Leadership Profiles*	To identify participants' behavioral profiles and maximize their leadership potential	Individual participant activity and discussion
	Self-awareness Leadership Conversation	To discuss realizations about personal leadership potential and challenges	Team discussion

Day 3, April 21	Realities and Uses of Conflict	To explore different sources of conflict: 1. Scarce resources 2. Confusion of symbols (e.g., authority figure doesn't model principles defining authority) 3. Conflicting constituency 4. Changing external contexts; To reflect on how participants respond to conflict and use conflict as an asset	Team discussion
	Handout, *A Case Study of Community Disparity*	To introduce social determinants and disparities in complex, adaptive challenges through a case study	Team activity and discussion
	Community Asset Mapping, Part 1	To identify previously invisible assets, including key public entities and organizations, on team's community map; To identify the most important ways that community assets contribute to addressing health disparity factors	Team activity and discussion
	Network Mapping, Part 1	To map existing and potential relationships with stakeholders and illustrate relationship strength	Team activity
Day 4, April 22	Handouts, *Guided Reflection Worksheet* and *Personal Statement of Commitment and Responsibility*	To reflect on collaborative leadership and declare a commitment to individual responsibility in team practice	Individual reflection
	Handout, *Agreement Instructions/Worksheets*	To create a team working agreement integrating participant leadership assets	Team activity
	Handout, *Leading with Collaborative Leader Vision! Focusing the Vision Worksheet*	To create a team vision for present and future team plans	Team activity
	Handout, *Moving Vision to Implementation: Action Planning*	To create an action plan driven by the team vision to promote collaboration, and address community determinants of HIV	Team activity
Day 5, April 23	Teams present visions and action plans	To reflect, celebrate, share, and learn curriculum objectives	Team presentations in large group

Table 3. Overview of Workshop 2.

Workshop Day	Activity in Curriculum	Activity Purpose	Nature of Activity
Day 1, June 21	Self re-introduction, participant describes the rock that represents obstacle and bean that represents growth	To reflections on challenges and successes from previous community action learning period	Individual presentations in large group

Day 2, June 22	Recap and Summary of Core Learning Concepts and Program Values	To review collaborative leadership values: 1. Mutually interdependent relationships 2. Leadership self-awareness 3. Positively channeled conflict 4. Adaptive leadership to challenges 5. Resource of committed faith, development, and health leaders	Lecture
	Team Presentations	To acknowledge and affirm teams' accomplishments during community action learning. Knowledge integration.	Team presentations in large group
	Handouts, *Case Study and Reflection Questions*	To apply personal and team experience to a case study; To identify vulnerable populations in community, determinants of vulnerability, what can be done, and who should do it	Team activity and discussion
	The Nature of HIV and Social Disparities and the Role of Religion; Handout, *Making Sense of Health Disparities and Religion*	To reinforce knowledge of social determinants of HIV and put religion and faith-based entities into context; To learn ways in which religion impacts health: 1. Religious beliefs and behaviors 2. Structure and polity of religious traditions 3. Informal beliefs and formal policies that relate religious tradition to broader societal organizations 4. Power between individuals and religious institutional authorities	Lecture
	Community Asset Mapping, Part 2	To understand and identify tangible and intangible religious health assets in teams' communities	Team activity
Day 3, June 23	Community Circles of Causality	To view community as complex community systems and promote systems thinking; To create a case study of a vulnerable community member and map the systems that affect the person and how these systems relate to and affect one another	Lecture; pre-workshop reading Peter Senge's *The Laws of the Fifth Discipline* and *A Shift of Mind* Team activity
	Understanding Stigma and Discrimination at Individual and Social Structural Levels of Influence	To understand how individual, community, and societal-level stigma and discrimination influence HIV social disparities; To link HIV stigma to systems thinking	Lecture
	Action Planning and Vision Implementation	To provide input and guidance on how to develop action plans; To integrate new insights and tools to form new vision statement, strategic directions, objectives, measurable outcomes, specific actions, and action timeline	Lecture; Team activity
Day 4,	Teams present visions	To reflect, celebrate, share, and learn	Team

June 24	and action plans	curriculum objectives	presentations in large group

Study Population

Eight teams participated in the FHCLDP, starting with five members per team (Workshop 1, $n = 40$). Two participants from two teams withdrew participation before Workshop 2, and two participants missed the second workshop due to illness and family emergency (Workshop 2, $n = 34$). Overall, the two teams replaced their missing members and one team expanded their team size to seven members after Workshop 2, bringing the total number of participants to 46, (total $n = 46$). There are missing data for two members who did not submit applications. The average age of participants was 40.43 years old, and the average years of education was 14.23 years, which includes some college education. Half of the total participants were female. In addition, at least one member on each team was living with HIV.

The distribution of participants in organizations were as follows: 11 (25.6%) represented FBOs, five (11.6%) represented churches, two (4.7%) represented faith-based hospitals, 12 (27.9%) represented community-based organizations (CBOs), one (2.3%) represented a civil society organization (CSO), nine (20.9%) represented government organizations or the MOH, two (4.7%) represented international NGOs, and one (2.3%) represented a university. Examples of positions in the faith sector included FBO program coordinators, church pastors, spiritual counselors, and community health workers in FBOs. Examples of positions in health care organizations, such as MOH hospitals and CBOs, included HTC counselors, nursing officers, psychologists, community health extension workers, and social workers. Development positions included youth peer counselors, CBO chairladies, NGO counselors, and CBO income-generating activity (IGA) program coordinators. Most participants' work or volunteer responsibilities

encompassed health promotion (e.g., HIV, nutrition, mental health), though some responsibilities were solely faith (e.g., spiritual counseling) or development-oriented (e.g., coordinating income generation activities). Each team comprised of representatives of both the faith and health sectors, and most teams had at least one member from the development sector in CBOs, NGOs, or CSOs.

Participants were recruited via a call for applications circulated throughout program stakeholder organizations, including NEPHAK, the Christian Health Association of Kenya, the National AIDS Control Council, Kenya Networks of Religious Leaders Living with HIV and AIDS (KENERELA+), and Kenya HIV/AIDS NGO Consortium. Eligibility for multi-sector teams include the following:

> "1. Evidence of commitment to engage in collaborative action to address recognized social health disparities (inequalities) in your community that affect long term HIV care and treatment.
>
> 2. Team composition of five members from different organizations or groups that represent faith based organizations, health care, community development, and civil society organizations.
>
> 3. Experience working in the community with a willingness to deepen that experience and have a good knowledge and understanding of the community.
>
> 4. Representative of different organizations and community groups that if mobilized have a reasonable chance of enhancing health equity in their covered geographic area" [44].

The application for participation in the FHCLDP included the participant's name and age, organization name, position, roles, and responsibilities within the organization, participant's source of activity support and funding, and a personal statement regarding motivations for health

and faith promotion and participation in the FHCLDP. SPILL and IHP reviewed team applications submitted prior to the deadline and selected eight teams using the eligibility criteria. Participants or organizations supporting participants paid a registration fee of 1500 Kenya Shillings, and the FHCLDP program provided lodging, food, transport, and materials for learning and technical assistance.

Data Collection

A timeline of data collection is displayed in Figure 1. Data collected from Workshop 1, Workshop 2, and the follow-up meeting included curriculum, team asset and network maps, and individual post-workshop evaluations completed at the end of both workshops. Tables 2 and 3 describe the activities, their objectives, and the nature of learning for each activity for Workshop 1 and 2 curricula, respectively. The curricula utilize activities with various learning methods, which makes the curricula adaptable to myriad learning styles of participants (for review, see Table 1). During the workshops and the follow-up meeting, teams prepared asset maps, network maps, and individual and small group evaluations under the guidance of workshop facilitators and SPILL staff. Teams created a map of their communities and plotted potential assets to mobilize in Workshop 1, and then they added colored stickers, which represented religious health tangible (e.g., FBOs) and intangible (e.g., spaces for prayer or communion) assets in their communities, to their asset maps during Workshop 2. In Workshop 1, teams created maps to represent their stakeholder organization networks and indicated the strength of relationships by drawing single-lines for new or weak relationships and double-lines for strong relationships. Teams updated their network maps during the follow-up meeting with new relationships and triple-lines to indicate stronger relationships within existing collaborations. Individual evaluations collected at the end of each workshop measured the magnitude of commitment to the

aims of the FHCLDP and efficacy for action plan implementation, the extent to which participants believed that health, faith, and development sectors contribute to the alleviation of health disparities, and the level of various competencies that participants learned as a result of the workshop.

Data that teams submitted included in the analyses comprised individual member applications submitted by the team, pre-workshop assignments, progress reports, and final reports. Prior to the first workshop, teams submitted a pre-workshop assignment, which illustrated a profile of the unique social structural determinants of HIV within their informal settlements. Two months after Workshop 1, teams prepared and submitted progress reports to synthesize the accomplishments and challenges of Community Action Learning period 1. Likewise, the final report comprised accomplishments and challenges of Community Action Learning 2, which teams submitted two months after Workshop 2. The instructions for the pre-workshop assignments and reports were open-ended, and teams' assignments varied from bulleted points to narrative summaries of social structural determinants of HIV, team activities, and barriers to activities.

Finally, SPILL and IHP staff collected and synthesized site visit field notes from site visits conducted with four teams in their informal settlements. SPILL and IHP staff selected the four participating teams due to their engagement in HIV treatment and clinical care, such as developing referral networks with health care facilities or conducting adherence counseling. The site visit discussions, led by SPILL and IHP staff, explored the unique community challenges of PLWHA to enroll into care and adhere to treatment, how the teams formed referral networks and treatment support, the role of religion and FBOs as facilitators or barriers to HIV care in teams' communities, and case studies of team success. SPILL and IHP conducted the site visits to

contextualize some of the team activities reported in the progress and final reports and provide depth for the barriers and facilitators to program success.

Definition of Variables

The conceptual analysis of data from the pre-workshop assignments, progress reports, final reports, and site visit field notes yielded themes that were grouped into three major categories: determinants of HIV, team practices, and barriers to team practices. Each category contained several themes, which are described below.

Determinants of HIV

The Determinants of HIV category included influences identified by teams from their informal settlements that increase residents' risk for HIV and other poor health outcomes. These influences include health care barriers, stigma and discrimination, and faith, policy/bureaucracy, sociocultural, socioeconomic, and structural determinants that enhance individuals' risk for HIV or present challenges or barriers to access and adherence to care among PLWHA. Barriers to health care deter individuals from seeking or accessing affordable, quality health care, including preventive services and resources, diagnostics, treatment, and retention to care. Stigma and discrimination include perceived or experienced unfavorable attitudes or treatment toward a particular population (e.g., PLWHA, ethnic minorities) that contributes to HIV risk, low access of or retention to HIV care, and/or poor quality of life. Faith-related determinants are religious, spiritual, or faith-based factors, including beliefs, norms, and practices. Policy or bureaucratic determinants are legal, political, or policy-related factors within their specific environment. Sociocultural determinants include social and/or cultural factors, such as social status or ethnicity, gender, marital status, sexual orientation, family or community relationships and norms, lack of knowledge or access to information, and lack of social support. Poverty and the

negative effects resulting from poverty define socioeconomic determinants of HIV. Structural environmental determinants of HIV include poor infrastructure, physical environment, geographic location, and insecurity issues.

Team Practices

Themes under team practices describe the activities and interventions that teams implemented during Community Action Learning periods 1 and 2. These themes include collaborations, identifying community and team assets, HIV care and prevention, reduction of stigma and discrimination, and faith, policy, sociocultural, and socioeconomic practices to address social determinants of HIV and improve HIV prevention and care capacity. Collaborations include relationships with faith-based, development, or civil society organizations, community members, or community groups. Identifying tangible (e.g., raw materials from dumpsites) or intangible (e.g., community pride) assets that they access or have the potential to access within their team or community improves team capacity address HIV. HIV prevention practices include health-specific actions teams take to reduce barriers for individuals to get tested and facilitate individual risk reduction practices and supportive community practices, and HIV care practices include all team actions related to improving HIV treatment access, retention, and adherence. Faith-based enhancement practices address religious, spiritual, or faith-based disparities in HIV prevention, care, and support or utilize religion to strengthen or encourage health practices. Policy enhancement practices address legal, political, or policy-related disparities in HIV prevention and care and psychosocial support. Sociocultural enhancement practices improve sociocultural relations or address sociocultural disparities, and socioeconomic enhancement practices improve socioeconomic or occupational situations for individuals and community. Practices that reduce stigma and discrimination on the individual,

community, or systemic level include program development, awareness campaigns, and improving nondiscriminatory practices in the community.

Barriers to Team Practices

Barriers to Team Practices included themes that describe the obstacles that teams experienced when implementing certain activities or interventions. These themes are different from Determinants of HIV codes because they pertain specifically to barriers that teams faced during program implementation, whereas Determinants of HIV describe general barriers to health that increase HIV risk. Barriers to Team Practices codes include challenges to collaboration, policy or bureaucratic barriers, and sociocultural, socioeconomic, and structural challenges that prevent team practices.

Collaboration barriers include organizations, institutions, or entities that refuse to participate with teams, withhold resources, or regard the team as competition. Organizational or government bureaucratic processes that disrupt or prevent action plan implementation define policy or bureaucratic barriers. Sociocultural barriers to team practices identify social or cultural factors, socioeconomic barriers identify socioeconomic factors, and structural environmental barriers identify infrastructure or physical environmental factors within their specific environment that prevent teams from implementing action plans.

Data Analysis

Data analysis was conducted separately for each type of data. The researcher analyzed team data (i.e., pre-workshop assignments, progress reports, and final reports) utilizing the applied thematic analysis approach outlined by Guest and colleagues [45]. After checking the quality of the team data, the researcher read through data completely and inductively generated themes. Then, she drafted a codebook to list all themes, and used the codebook to code several

reports. She then edited the codebook iteratively by checking coded segments with code definitions and consulted with the research team to refine code definitions. Once the codebook was completed, she coded the data using MaxQDA11 software [46]. Using an exploratory analysis method, she summarized main points from each code to create a narrative for each theme.

Among data collected during workshops, average scores and standard deviations were calculated for responses on post-workshop surveys. Scores were compared to determine how participants rated each aspect of the FHCLDP. Then, the researcher organized curricula by objectives of each activity (see Tables 2 and 3), and the researcher coded activity objectives utilizing the codebook developed for the team data. Main points were summarized for curricula as well.

Finally, the researcher developed a timeline to map the main points from each source of data chronologically and evaluate how team practices change over time in order to determine how each component of the program influences the quality and quantity of team practices. Determinants of HIV that teams identified in pre-workshop assignments were compared to their corresponding Team Practices (e.g., socioeconomic determinants were compared to socioeconomic practices) to establish the influence of identifying determinants on the focus and method of interventions. Tables organized main points from workshop and team data chronologically to evaluate the influence of Workshop 1 curriculum on Community Action Learning period 1, Workshop 2 curriculum on Community Action Learning period 2, and how team practices altered across Community Action Learning periods (for example, see Table 6). In addition, community asset maps and network maps were compared to the main findings of community assets and collaborations, respectively.

Results

This analysis aimed to identify how the FHCLDP influenced team implementation of HIV interventions that addressed determinants of HIV, built community capacity, and improved clinical care of HIV in Nairobi informal settlements. Two primary FHCLDP exercises aimed to influence team capacity and improve the quality of teams' HIV interventions: identifying unique determinants of HIV in the pre-workshop assignments and comprehension of key curriculum concepts during Workshop 1 and 2. Thus, the current evaluation compared the determinants of HIV that teams identified and the key curriculum concepts with the team practices conducted during the Community Action Learning periods. Ultimately, the current evaluation aimed to assess how the program influenced teams' capacities to implement interventions that addressed determinants of HIV and to integrate key curriculum concepts. The results are organized by participants' perceptions of the FHCLDP, the influence of the determinants of HIV on team interventions, the influence of the workshop curriculum on team interventions, and the barriers that teams faced in program implementation.

Participants' Perceptions of the Program

Tables 4 and 5 below summarize the results from the post-workshop surveys, which were distributed at the end of both workshops. The surveys measured the change after each workshop on individual and collaborative leadership development, the value gained from the program, the overall experience of the program, and a comparison of participants' comprehension of key workshop curriculum concepts before and after the workshops. More generally, the post-workshop surveys assessed participants' perceptions of the capacity for the FHCLDP to achieve its programmatic aims. Both pre- and post-workshop curriculum concept comprehension were assessed at the end of each workshop, and the ratings were compared. Participants rated each

question on a 5-point Likert scale, with a score of 1 indicating strong disagreement and 5 indicating strong agreement.

There were no significant differences between Workshop 1 and Workshop 2 results on the post-workshop survey regarding workshop effectiveness on leadership development, value gained from the workshops, and the experience of participating in the program (see Table 4). The pace of the workshop received the lowest score, which participants indicated in an open-ended section of the survey that the pace of the workshop was too fast for the complexity of topics being covered. However, most elements of the workshop were well received, including the value gained from the workshops, improved individual and team commitment to community action, and the positive learning impact of pre-workshop activities. In addition, most participants would recommend the program to other people in the field. No demographic data were included on the post-workshop surveys, therefore no group differences were analyzed.

Table 4.

Post-workshop survey assessment of workshop effectiveness on a 5-point Likert scale, with 1 representing strong disagreement and 5 representing strong agreement	Wksp 1 Avg (SD), *n*=37	Wksp 2 Avg (SD), *n*=31	Wksp Avg
Our team was strengthened through our experiences at the workshop.	4.68 (0.53)	4.48 (0.51)	4.58
I am more committed to faith-public health-development collaborations now than when I arrived at the Workshop.	4.75 (0.60)	4.45 (0.68)	4.60
I am confident that the gains I have received from the Workshop are worth the time I invested.	4.76 (0.49)	4.84 (0.37)	4.80
I increased my appreciation for what contributions the health, faith, and development communities can make to reduce health disparities.	4.76 (0.43)	4.45 (0.55)	4.60
I am confident that our team will take concrete steps to implement our plan for community action when we get home.	4.67 (0.47)	4.58 (0.50)	4.62
I would recommend the workshop to others.	4.76 (0.43)	4.77 (0.43)	4.76
The overall pace of the week was good.	3.81 (1.17)	3.60 (1.28)	3.71
The pre-workshop assignments and team activities contributed to my learning experience.	4.53 (0.51)	---	---

The April and May Community Action Learning Team Activities contributed to my learning experience.	---	4.40 (0.97)	---
Communication with program staff during the Community Action Learning was helpful.	4.70 (0.51)	4.67 (0.48)	4.68
Communication with program staff during the Workshop was helpful.	4.78 (0.42)	4.67 (0.48)	4.72
Materials I received before and during the Workshop were useful.	4.64 (0.49)	4.67 (0.48)	4.65

Table 5 displays the results of the pre- to post-workshop curriculum comprehension questions. One participant did not complete one side of the post-Workshop 2 survey, thus only 30 participants' responses were included for the pre- to post-workshop curriculum comprehension assessment. Across all survey variables, there was a pre- to post-survey improvement in participants' self-efficacy to understand concepts and utilize skills from the curriculum. Participants made the largest improvements after Workshop 1 regarding collaborative leadership, understanding conflict as an asset, leaders' abilities to adapt to changing circumstances, and their abilities to mobilize assets to accomplish their team vision. The role of stigma and discrimination as internal and external barriers to treatment received the highest pre-workshop rating and one of the lowest post-workshop ratings, representing the smallest change after Workshop 2. Thus, participants felt the least self-efficacy to describe stigma and discrimination as barriers to treatment.

Table 5.

Pre- to Post-workshop 1 assessment of participant self-efficacy on a 5-point Likert scale, *n*=37	**Before Wksp 1 Avg, *x***	**After Wksp 1 Avg, *y***	**Difference (*y* – *x*)**
Describe the major HIV social health disparities in your community.	2.75	4.58	1.83
Understand your own personal leadership tendencies.	3.06	4.67	1.61
Understand the contribution and impact of leadership tendencies of others.	2.83	4.51	1.68
Understand the role of collaborative leaders in eliminating HIV social health disparities.	2.64	4.78	2.14

Discuss how conflict is both a reality and an asset.	2.35	4.83	2.48
Describe the skills needed by leaders for responding to changing and complex circumstances that arise in collaborative work.	2.33	4.49	2.15
Identify and restructure community resources to accomplish a vision.	2.50	4.67	2.17
Create and implement a shared vision for a healthy community.	2.56	4.62	2.07
Identify community assets and develop strategies for mobilizing and activating those assets to reduce health disparities.	2.64	4.65	2.01
Pre- to Post-Workshop 2 assessment of participant self-efficacy on a 5-point Likert scale, *n*=30	**Before Wksp 2 Avg, *x***	**After Wksp 2 Avg, *y***	**Difference (*y* – *x*)**
Describe how reflection action is an important leadership tool for learning and leading that creates change.	2.68	4.24	1.56
Identify the potential contribution of religion and the faith community in addressing HIV social disparities.	2.93	4.45	1.52
Identify the underlying complex systemic factors that lead to HIV social disparities.	2.75	4.41	1.66
Understand the role of collaborative leaders in community systems change.	2.75	4.38	1.63
Describe the role that both stigma and discrimination play as internal and external barriers to treatment.	3.29	4.31	1.02
Identify community assets and develop strategies for mobilizing and activating those assets to assure long-term treatment and support for those most vulnerable.	3.04	4.34	1.31
Identify elements of successful action plan - objectives, activities and measurable outcomes - that brings about a vision of eliminating HIV disparities	2.93	4.52	1.59

Influence of Determinants on Team Practices

Within the pre-workshop assignments, teams identified social structural determinants of HIV and health care barriers that increased the risk of HIV for residents of informal settlements. The analysis compared the determinants that teams identified in the pre-workshop assignments to the interventions they implemented in Community Action Learning periods 1 and 2. This subsection includes the comparison of the social structural determinants and interventions, the health care barriers and interventions, and limitations in team practices to address determinants.

Social Structural Determinants of HIV

The majority of social structural determinants were sociocultural, socioeconomic, faith-related, and stigma and discrimination, although some teams identified bureaucratic and structural determinants of HIV as well. Common examples of sociocultural determinants included HIV myths and misinformation and cultural factors that contributed to the vulnerability of women and children. Socioeconomic determinants were comprised of poverty and its effects. Faith-related determinants included religious diversity in informal settlements, faith-based restrictions on health-seeking behaviors, and faith-related HIV stigma and discrimination. More generally, teams identified stigma and discrimination to disrupt HIV health care processes on the individual, community, and institutional levels. Bureaucratic determinants included policies and the bureaucracy of government health facilities, and structural determinants described physical environmental factors contributing to HIV risk, including poor infrastructure in informal settlements and crime. For example, Team B described poor sanitation as "challenges [that] expose PLWHIV to opportunistic diseases which are bad for their immune [system]" {Team B, pre-workshop assignments}.

Many team activities targeted social structural determinants of HIV during Community Action Learning periods 1 and 2, which demonstrated a range of intervention target audiences, goals, methods, and the sectors involved in the intervention. Among the social structural determinants that teams identified, they exhibited the greatest capacity to address HIV myths and misinformation and provide education about social disparities of health via health talks, support groups, and meetings with the community and stakeholders. One team described meeting teenagers on clinic day at a health center to conduct a health talk: "Meeting with the youths/adolescents… Discussed on HIV social disparities affecting the youths (stigma and

discrimination, individual health risks and behaviors, barriers to care, relationships.). This was aimed at reducing HIV social disparities among the youths and adolescents" {Team W, progress reports}. Teams also engaged in HIV sensitization events with churches and pastors to address their perpetuation of HIV stigma and discrimination, to promote correct HIV information from the pulpit, and to reject faith-based restrictions on health-seeking behaviors. For example, one team found that positive messages about HIV/AIDS from religious leaders in the pulpit are "more powerful than having even the HTC counselor speak" {Team C, site visit field notes}. In addition to mitigating the cultural myths and misinformation surrounding HIV, sensitization campaigns and health talks also addressed the HIV disparities and stigma and discrimination of women, youth, OVCs, MSM, and other vulnerable groups.

Among socioeconomic practices, teams addressed the high rates of underemployment and unemployment via IGAs, economic skills training, and employment services. In addition, some team activities addressed the byproducts of poverty, such as support groups and stakeholder meetings about substance abuse in the community, nutritional interventions, and leveraging hospitals and local administration to provide food supplements.

All three teams that identified bureaucratic or policy determinants of HIV engaged in practices to address those determinants, such as addressing bureaucratic barriers to care access and increasing political leader investment in team practices by creating reciprocal relationships. One team described this relationship:

> "The church also invites the local administrators during their community outreaches and even to provide security when the church is having activities. The government wants to partner with them. These partnerships allow churches to influence government policies" {Team H, site visit field notes}.

They also navigated bureaucratic barriers to care access by assisting clients with the completion and delivery of health care facility transferal paperwork, which allowed clients at government facilities to transfer to local community facilities.

Health Care Barriers

Health care barriers within teams' informal settlements primarily consisted of weaknesses among health care facilities and workers, challenges for PLWHA to access and adhere to care, and community influences. Examples of facility weaknesses include negative perceptions of facilities, poor facility infrastructure or capacity, and HIV-related discrimination. Teams described health care worker weaknesses as being overburdened with their caseloads and thus having poor relationships with their clients. For example, youth do not access health care because they say "the services 'are not very friendly' so they 'shy away'" {Team K, site visit field notes}. The health care challenges of PLWHA included overcoming HIV-related stigma to seek HTC and treatment, dependency on or expectancy of free handouts at health facilities, and financial constraints to pay for food and medication. Finally, teams described institutional stigma and discrimination from faith, traditional, and medical healers and commercial entities as deterrents to seeking HTC and treatment.

Teams' care practices addressed many health care facility weaknesses. Several teams improved comprehensive care center client tracking capacity by developing defaulter programs for PLWHA, and some teams conducted treatment literacy programs to address adherence challenges for PLWHA. One team met with a comprehensive care center to ensure their commitment to offer indiscriminant health services to MSM.

Teams also targeted prevention and care challenges that informal settlement residents face, including individual and institutional stigma. For example, one team tested the pastor and

his wife for HIV on the pulpit prior to an HTC event held in a team member's home. The team specifically targeted men in the congregation to overcome HIV stigma and discrimination and get tested. Another team spoke with retailers about placing condoms in less hidden, stigmatizing areas of the store in order to reduce institutional stigma and discrimination. The team described the rationale for addressing retailers:

> "Teaching [retailers] that discriminating against people purchasing condoms will lower their sales profit margin" {Team N, site visit field notes}.

These interventions aimed to promote access to testing and treatment services by reducing institutional and community perpetuation of stigma and discrimination, providing education about HIV, and reinforcing health care facility capacity.

Limitations to Address Determinants

Team interventions did not address some determinants of HIV. Diversity of attendees in team activities was one gap in team practices. Although seven out of eight teams identified diverse cultural, ethnic, and religious groups in informal settlements as unique determinants to HIV, only two teams explicitly incorporated minority communities (i.e., Muslim and Sudanese communities) in their activities. Despite identifying disparities in HIV risk among MSM, commercial sex workers, and people who use drugs, only one team worked with a key population (i.e., MSM). There were additional challenges to address socioeconomic determinants of HIV. No teams conducted activities that specifically addressed commercial sex work, the most commonly cited socioeconomic determinant. Community poverty, which is compounded by donor dependency and leads informal settlement residents to expect free services, was a challenge to address. Only one team reported lobbying for funds for team activities, and another

team suggested that seed funds or a grant would allow their programs to generate "a revolving fund to curb the issue of dependency on handouts" {Team K, site visit field notes}.

One team that did not identify faith-related determinants in their community also did not engage in faith-related practices. Although several teams identified underdevelopment of informal settlement infrastructure and its byproducts (e.g., insecurity, petty crime, substance abuse, high population density), no teams implemented structural interventions. Structural determinants are unique due to the amount of resources and time required to make a significant, lasting impact on infrastructure, which may reflect the lack of structural practices during Community Action Learning periods 1 and 2. This is the only social structural determinant of HIV that team practices neglected to address.

There were also some limitations to interventions to address health care barriers. No interventions specifically focused on health care worker weaknesses, such as poor provider-client relationships. In addition, one team could not implement an HTC event due to a lack of testing kits, which is a common health care barrier in informal settlements.

Influence of Curriculum on Team Practices

In addition to anchoring team practices to address determinants of HIV, many teams incorporated curriculum principles into Community Action Learning practices as well. This analysis utilized a timeline to chronologically map the curriculum principles from Workshop 1 to 2 and team practices from Community Action Learning periods 1 and 2 in order to explore the influence of curriculum on team practices. This subsection is organized by the influence of curriculum on asset mobilization and collaboration, social structural practices, and HIV prevention and care practices and concludes with an exploration of curriculum limitations.

Asset Mobilization and Collaborations

To determine the influence that participation in the FHCLDP had on team collaborations and asset mobilization, the following documents were coded for team assets, community assets, and collaborations: curriculum, asset maps, and network maps from Workshop 1 and 2, progress reports, final reports, site visit field notes, and the network maps from the follow-up meeting. Table 6 utilizes the timeline conceptual framework to organize the main points from the data chronologically to establish an evolution of team practices after Workshop 1 and again after Workshop 2.

The Data Source column lists the stage of the FHCLDP chronologically with parentheses around the type of data collected. The columns to the right of the Data Source column represent the codes of interest for the research question, and the main points for each code are organized by data source. For example, the main points for the Team Assets in the Workshop 1 curriculum include identifying self-assets, leadership styles, conflict as an asset, and team vision.

Table 6. Influence of Curriculum on Assets and Collaborations

Data Source	Team Assets	Community Assets	Collaborations
Workshop 1 (curriculum)	- Self-assets - Leadership styles - Conflict as an asset - Team vision	- Community asset mapping - Community assets address health disparities - Resources to alleviate HIV disparities	- Community asset mapping - Network mapping - Collaborations to alleviate HIV disparities
Community Action Learning 1 (progress reports)	- Division of labor - Challenges as strengths - Teams represent visible community assets	- Community asset mapping in 3 teams - Identified raw materials in community for IGA	- Contacted stakeholders - Health events with collaborators
Workshop 2, Follow-up Meeting (curriculum)	- Collaborative leadership values	- Community assets to aid vulnerable populations - Community asset mapping, religious health assets	- Stakeholders to reach vulnerable populations - How religion influences health - Systems thinking - Network mapping (during follow-up meeting)
Community Action Learning 2	- Inter-team collaborations - Team assets: personal testimony, social capital	- Community asset mapping in 5 teams - Identified tangible and	- All teams used collaborations - Activity implementation and resource mobilization

(final reports, site visit field notes)	- Adaptive leadership to challenges	intangible assets	- Planned future collaborations
Barriers (reports, site visit field notes)	- One team lacked team coherence	- Financial barriers - Infrastructure barriers	- Financial barriers - Lack of cooperation with other organizations

The Workshop 1 curriculum focused on individual leadership, identifying assets within oneself and the community, and building team capacity to address health disparities by mobilizing assets and forming collaborations (see the Workshop 1 row in Table 6). Workshop 2 shifted the understanding from identification of assets and networks to the complexities of relationships between networks and how to utilize community assets and collaborative leadership to support vulnerable populations (see the Workshop 2 row in Table 6). In addition to the curriculum, teams created community asset maps and network maps in Workshop 1, added tangible and intangible religious health assets to the community asset maps in Workshop 2, and expanded the network maps with new relationships and relationship strength indicators during the follow-up meeting.

There is a clear evolution of asset mobilization and collaborations from Community Action Learning period 1 to 2, and some team practices demonstrated the evolution of the key curriculum concepts. As displayed in the Team Assets column of Table 6, most teams focused on forming a division of labor and promoting themselves as community assets in Community Action Learning period 1, whereas teams started forming inter-team collaborations (e.g., a referral directory that integrates all participating teams' referrals, inviting a member of another team to speak at a sensitization event) and using novel approaches to address team challenges in Community Action Learning period 2, expanding team size:

"We started as 5 members which later got expanded to 7 since we are very much aware of the effect of HIV in our community…. And that certain groups of people may be more vulnerable to interaction and needs quality services (key population)" {Team J, final report}. This demonstrates the curricular shift from understanding individual strengths and team members' leadership styles as team assets to engaging in collaborative leadership.

Community assets also demonstrated an evolution: three teams identified raw materials and other tangible assets through community asset mapping in Community Action Learning period 1, whereas five teams initiated or expanded their community asset mapping following the second workshop (see the Community Assets row in Table 6) and expanded their awareness to tangible and intangible assets existing in informal settlements. This is a reflection of the community asset mapping activity that teams began in Workshop 1 and continued in Workshop 2 (see Figure 1). In Workshop 1, teams created a map of their community and identified assets in the community that influence health, and then they added yellow and green stickers to represent tangible religious health assets (e.g., faith-based hospitals) and intangible religious health assets (e.g., spiritual counseling, places of prayer), respectively (for more examples of community asset maps, see Appendix). In addition, most teams included an emphasis on community engagement, richness,

Figure 1. Community Asset Map in Workshop 2. Yellow and green stickers represent tangible and intangible religious health assets, respectively.

livelihood, and empowerment as a result of the process of identifying community resources in their final reports and during site visits: “The community is not as poor as it seems. There is more available than people realize” {Team N, site visit field notes}. In addition, almost all teams improved efficiency of team practices via asset identification, organization, and delegation: “The first days training we got at the St. Paul University Spill programme empowered us and made us to identify the tangible and intangible assets within our community which culminated in to coming up with a reason and action plan as a road map to our future engagement through networking” {Team J, final report}.

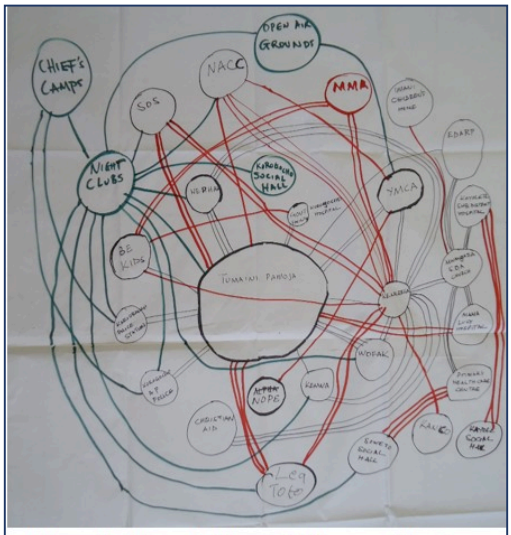

Figure 2. Network Map in Follow-up Meeting. Green lines and circles represent new relationships since Workshop 1, single lines are weak relationships, and triple lines are strong.

Five out of eight teams worked with collaborators after Workshop 1, whereas all teams formed, expanded, and utilized collaborations after Workshop 2. Each team visually mapped the evolution of their collaborative networks in the network maps that they initiated in Workshop 1 and added to in Workshop 2. Figure 2 displays Team C’s network map, which shows the stakeholder they primarily collaborate with in the center of the map. All of the circles represent organizations or entities that belong in Team C’s network, and the lines represent the relationships between each organization with triple-lines indicating stronger relationships. In addition, all of the circles and lines in black and red represent the network of Team C prior to Workshop 1, whereas all circles and lines in green represent the expanded network of Team C during the follow-up meeting three months later.

Not only did the team networks expand, the number and types of collaborations also expanded. Teams engaged diverse sectors and stakeholders: government and community health facilities, faith communities and FBOs, financial institutions, CBOs and NGOs, local or national bureaucratic figures, education, members of the community, and the agriculture sector. Initial engagement with organization or community stakeholders involved input for action plan development in various ways: some stakeholders influenced the plan, some teams shared the plan with stakeholders, and some teams collaborated with stakeholders to draft an action plan. In all cases, there was an exchange of information, which led to a plan, the diffusion of responsibility for different activities, messages to spread in the community, and the mobilization of resources. During Community Action Learning period 2, teams formed more reciprocal relationships with stakeholders through an exchange of information, support, and resources, and teams bridged collaborations between stakeholders, such as multilateral event collaborations and referral networks. For example, one team developed a referral network between a church offering spiritual counseling and a comprehensive care center offering HIV treatment. These practices exemplify the systems thinking approach to mobilize assets and form collaborations, a major component of the Workshop 2 curriculum.

Many collaborations emphasized marginalized communities, including key populations. One team developed collaborations to reach MSM through churches, health facilities, and other CBOs, though there was no data to determine how many MSM were reached:

> "Outreaches held in [Town] and [Town] in which MSM's were involved. MSM's are rarely mobilized for such activities…. It was a joint activity, done by organizations that deal with sexual reproductive health issues, namely WOFAK, MAXFACTA, NEPHAK,

Centre for adolescent's studies, AMREF, Child line Kenya, Nairobits, FHOK and African alive" {Team J, final report}.

Most commonly, teams designed programs for youth and OVCs, such as organizing HIV sensitization events led by local comedians. Most collaborations were developed with organizations; however, one team integrated youth into the design of their program rather than regarding them as beneficiaries: "We captured proposals given by the youth in the community to government and community transformation agents" {Team C, progress reports}.

Social Structural Practices

Table 7 displays data for the social structural determinants and practices to address determinants, which are organized chronologically by the timeline conceptual framework. The researcher analyzed the curriculum for Workshop 1 and 2, progress reports, final reports, and site visit field notes to determine the influence that Workshop 1 and 2 had on team social structural practices in Community Action Learning periods 1 and 2. The main themes for each source of data are listed in Table 7 and organized chronologically in the same fashion as Table 6.

Table 7. Influence of Curriculum on Social Structural Practices

Data Source	Faith and religion	Policy and bureaucracy
Workshop 1 (curriculum)	- Faith as potential source of conflict - Community asset mapping, faith assets - Collaborations with faith entities	- Case study, role of gov't in complex health issues - Mapping local/national assets
Community Action Learning 1 (progress reports)	- Bidirectional referral system between church and clinic	- Support from local administration and political leaders
Workshop 2, Follow-up Meeting (curriculum)	- Determinant and intervener of stigma and discrimination - How faith shapes health - Community asset mapping, religious health assets - Collaborations with faith entities	- Case study, role of gov't/local leadership in care for vulnerable populations - Faith influences on policy making - Bureaucracy shapes societal-level stigma and discrimination - Mapping local/national assets

Community Action Learning 2 (final reports, site visit field notes)	- Referral systems - Identifying pastors for HIV sensitization - Church influence on policy development	- Civic education on women's rights - Bureaucracy to enhance team support - Streamlined team procedures
Barriers (reports, site visit field notes)	- Pastor canceled all appointments with team regarding MSM issues	- Lack of team registration - Bureaucracy as a barrier
Data Source	**Sociocultural factors**	**Socioeconomic factors**
Workshop 1 (curriculum)	- Cultural beliefs as potential source of conflict - Sociocultural disparities of HIV - Case study, sociocultural disparities in complex health issue - Community asset mapping, sociocultural assets	- Poverty and income create HIV disparities - Case study, SES in complex health problem - Address HIV via poverty alleviation - Community asset mapping, livelihood assets
Community Action Learning 1 (PR)	- Health talks with women and youth - Collaborations to provide sociocultural services	- IGA - Nutritional intervention - Collaboration with financial institutions, local admin
Workshop 2, Follow-up Meeting (curriculum)	- Case study, sociocultural determinants of vulnerability	- Case study, SES determinants of vulnerability
Community Action Learning 2 (final reports, site visit field notes)	- Community outreach - Stakeholder meetings - Addressed substance abuse and domestic violence - Sports facilitated community outreach	- IGAs - Economic skills training - Connecting community to services/products - Support groups about substance use
Barriers (reports, site visit field notes)	- Language barriers - Programs culturally inappropriate	- No funds for activities - Limited access to youth
Data Source	**Stigma and discrimination**	**Physical environmental structure**
Workshop 1 (curriculum)	- Stigma and discrimination as a determinant of HIV	- Physical structural environment as a determinant of HIV - Community asset mapping, structural environmental assets
Community Action Learning 1 (progress reports)	- Meetings, health talks about stigma and discrimination - Stakeholder meetings, addressing stigma and discrimination	---
Workshop 2, Follow-up Meeting (curriculum)	- Case study, stigma and discrimination toward vulnerable populations - Stigma and discrimination on individual, community, societal levels - Linking stigma and discrimination to systems	- Case study, vulnerability and structural environmental disparities

Community Action Learning 2 (final reports, site visit field notes)	- Meetings, health talks, support groups - Stakeholder meetings - Stigma and discrimination sensitization at churches - Individual outreach	---
Barriers (reports, site visit field notes)	---	- Poor infrastructure - Lack of homeownership

Workshop 1 curriculum introduced the social structural determinants of HIV (for review, see Table 2), and teams used a case study to explore the influences of each determinant on a complex health issue. Then, teams identified existing social structural assets in the community through community asset mapping. Teams followed another case study in Workshop 2 to explore the relationships between social structural determinants of HIV, their contributions to vulnerability to HIV, and the potential of social structural factors to alleviate vulnerability.

In addition, the curriculum utilized diverse activities to enrich participants' understanding of specific determinants (curriculum learning objectives for each determinant displayed in Table 7) and explore practices to address these determinants (see Community Action Learning period 1 and 2 in Table 7). For example, Workshop 1 described faith as a social structural determinant of HIV, whereas Workshop 2 described the influences of faith on health, the potential for faith to perpetuate and mitigate HIV stigma and discrimination, and awareness of the tangible and intangible religious health assets through community asset mapping. Three teams reported developing and utilizing referral networks to and from churches in Community Action Learning period 1. In Community Action Learning period 2, teams expanded upon their referral networks, conducted practices to address faith-related determinants of HIV (e.g., pastor HIV sensitization), and integrated multilateral faith engagement with health care, local leadership, government, and financial sectors. One team describes the work of churches in informal settlements, including the partner church of Team H:

> "[We] are now running health facilities that address matters HIV and gender issues and are working with NGOs such as World Vision" {Team H, site visit field notes}.

Regarding policy and bureaucracy, Workshop 1 briefly touched on the role of government and local leadership in health and HIV care, and in Community Action Learning period 1, only one team mobilized local administration and political leaders to provide social, nutritional, financial, and political support. Workshop 2 curriculum explored religious traditions' influence over shaping policy and how government and bureaucratic processes contribute to societal-level HIV stigma and discrimination, and three teams mirrored the Workshop 2 curriculum objectives and engaged local and national political leaders in team activities held in churches in order to influence policy development in exchange for church support.

Workshop 1 curriculum explored sociocultural disparities in HIV and sociocultural assets available in the community for mobilization, whereas Workshop 2 explored sociocultural factors influencing vulnerability toward HIV in Workshop 2. In Community Action Learning period 1, five teams formed collaborations with stakeholders to elicit program support or held health talks or IGAs that integrated general social support and wellness promotion for participants. However, all but one team organized health talks, support groups, or meetings focusing on the overall health of vulnerable populations in the community: three teams met with stakeholders from multiple sectors to discuss social disparities of HIV; two teams addressed domestic violence toward women in meetings; four teams used sports and games to reach the general community (e.g., families) as well as marginalized communities (e.g., MSM); two teams supported OVC programs with partner churches; and several teams created or improved their referral systems for psychosocial and spiritual counseling or support groups. Team J described an HTC, STI screening, and cancer screening event held outside a football tournament: "We reached 300males

and 100 females reason being there was a tournament football that attracted men" {Team J, final report}.

The Workshop 1 curriculum explored stigma and discrimination as a determinant of HIV, and teams identified stigma and discrimination as a priority determinant of HIV. However, only half of the teams conducting stigma and discrimination reduction practices targeted primarily at self-stigma in Community Action Learning period 1. Meanwhile, the Workshop 2 curriculum placed a greater emphasis on stigma and discrimination at the individual, community, and institutional level and among faith institutions, and almost all teams engaged in stigma and discrimination activities with a greater breadth of activities. Unique to Community Action Learning period 2, teams conducted sensitization with churches and more peer outreach to counsel, facilitate referrals, and enroll PLWHA into care. During a site visit, one team included a congregant's testimonial of the positive effect of the team pastor to reduce her self-stigma and improve her health: "Through my pastor who really showed me the real meaning of salvation. I came to understand myself. And now HIV is no longer a curse. So through church I am free" {Team H, site visit field notes}.

Health Care Practices

Learning objectives related to HIV prevention and care were analyzed within the Workshop 1 and 2 curriculum, and then HIV prevention practices (e.g., health talks about prevention, HTC events) and HIV care practices (e.g., referrals for PLWHA, treatment, adherence) were explored separately within progress reports, final reports, and site visit field notes. Table 8 summarizes the main findings chronologically for HIV prevention and HIV care. The Community Action Learning practices were analyzed separately by HIV prevention and HIV care practices, therefore the Community Action Learning 1 and 2 rows were split to

represent HIV prevention and HIV care practices. In addition, this subsection will explore prevention and care practices separately.

Table 8. Influence of Curriculum on HIV Interventions

Data Source	HIV prevention	HIV care
Workshop 1 (curriculum)	- Influence of HIV social disparities on access, adherence, and retention to care - Community asset mapping, health care assets in community - Network mapping, team collaborations	
Community Action Learning 1 (progress reports)	- Health talks, HIV prevention - HTC events - Stakeholder meetings	- Health talks, ART and barriers - Referral networks - Counseling - Meeting with health care institutions
Workshop 2, FUM (curriculum)	- Influence of HIV social disparities on access, adherence, and retention to care - Understanding relationship between health care and religious entities - Community asset mapping, religious health care assets - Case study, role of health care organizations' in care of vulnerable population	
Community Action Learning 2 (final reports, site visit field notes)	- Health talks - HTC events - Peer support groups	- Community sensitization about treatment - Referral networks, defaulter tracing - Treatment literacy training - Counseling and support groups

Although the curriculum focused very little on teams' provision of HIV prevention and clinical care services (e.g., diagnostic testing, antiretroviral medication), a primary aim of the FHCLDP was to address social determinants of HIV as a precursor to improving community access and adherence to care, as demonstrated in Table 8 [41]. In Workshop 1, teams mapped health assets in the community and networks with health facilities and organizations. In Workshop 2, teams explored the relationship between health and religion, mapped religious health assets, and worked through a case study to examine the role of health care organizations' relationships to other sectors regarding the care of vulnerable populations.

Teams expanded their HIV prevention practices throughout the FHCLDP, which reflected the curriculum's emphasis on addressing determinants of HIV in order to improve prevention and care practices. The number of health talks and HTC events expanded from

Community Action Learning period 1 to 2, while teams in Community Action Learning period 2 identified PLWHA to conduct community sensitization on testing: "Identified resource persons (HIV+) using them to do community sensitization on testing and where to access it" {Team K, site visit field notes}.

Most teams engaged in HIV care practices, some of which reflected the values of the curriculum. More generally, Community Action Learning 2 practices expanded the first period's practices. For example, six teams in Community Action Learning period 2, compared to three teams in period 1, conducted community sensitization toward treatment access and adherence. The sensitization events targeted vulnerable populations (e.g., elderly population, children) and resulted from collaborations with churches, faith-based and government health facilities, and CBOs. Multilateral interventions targeting vulnerable populations were an important concept in the second curriculum, which Team B demonstrates in their intervention for PLWHA:

> "Eleven (11) health talks have been held at [health center] and [CBO]... before the patients are seen by a medic…. In giving Health talks, we have partnered with two (2) Community Health Workers and four (4) peer educators from the Health Center" {Team B, final report}.

Other teams also expanded the number of referral networks in the second Community Action Learning and utilized community health workers more often.

About half of HIV prevention and care activities incorporated religious health assets or spiritual activities, such as offering spiritual counseling in conjunction with HTC, developing a referral network with an FBO, or a pastor hosting an HTC event at a church. For example, Team E described targeting religious organizations for HTC events: "we offered HTC services in the community where we targeted ,churches, mosques , learning institutions and the community at

large" {Team E, final report}. There was no disparity in the reported incorporation of religious and spiritual assets by timeframe, thus it is unclear how the curriculum influenced faith-related team practices.

Curriculum Limitations

Not all team practices reflected the curriculum. There was a disparity in the emphasis of Workshop 1 curriculum on poverty and the number of teams who conducted socioeconomic activities during Community Action Learning period 1. The curriculum emphasized the roles of poverty and income as determinants of HIV and other complex health issues, and teams identified poverty alleviation as a primary method to address HIV during Workshop 1. Despite these exercises, only three teams engaged in socioeconomic practices (i.e., an IGA, a nutritional intervention, and collaborations with financial institutions) in Community Action Learning period 1. In Workshop 2, teams discussed SES as a determinant for vulnerability and used a case study to explore how to address SES as an intervention to HIV risk among vulnerable populations. Seven out of eight teams engaged in socioeconomic activities in Community Action Learning period 2, and more than half of teams hosted IGAs, provided economic skills training, and connected the community to socioeconomic services and products (e.g., food donations). It is not clear if the curriculum had any effect on team socioeconomic practices, or if these activities took more time to implement.

There were also no structural team practices. Workshop 1 curriculum included the community infrastructure as a determinant of HIV, and teams mapped structural assets (e.g., roads, clean water sources) in their communities. In Workshop 2, teams explored structural disparities of vulnerability (e.g., threat of violence in insecure informal settlements). Regardless

of the exploration of structural determinants in the curriculum, no teams conducted structural practices in Community Action Learning period 1 or 2.

Barriers to Team Practices

Most challenges to team asset mobilization and collaboration were financial barriers, such as not having compensation for community health workers or funding for collaborative activities. Structural barriers for community asset identification and mobilization were often uncontrollable, such as the challenges of accessing the neighborhood due to insecurity or roads flooding during the rainy season. Some teams experienced collaboration challenges with uncooperative CBOs or NGOs: "There were some Community Based Organizations (CBOs) that were not willing to open up and give us information on what they do for the community" {Team B, progress report}. A team made several appointments with a pastor to discuss MSM issues, but the pastor canceled each appointment. Some of the practices were also not clear as to when they occurred in the timeline; thus, we cannot infer that these practices were directly influenced by the curriculum content.

Barriers to team practices reflected many of the determinants of HIV identified in the pre-workshop assignments. For example, one team had program language barriers, and three teams had challenges providing culturally appropriate and appealing activities for specific groups. Bureaucracy continued to be a barrier for legally unregistered teams, and several teams tried to engage with unresponsive or unreliable bureaucrats. Six teams identified a lack of funds for activities, human resources, or incentives for community members as the main socioeconomic barrier, just as community poverty is a major limitation to organizational capacity to provide HIV programs. Underdevelopment of infrastructure (e.g., non-navigable roads due to heavy rain, lack of homeownership, and insecurity) was a barrier to team practice, just as it was a

determinant of HIV in teams' communities. For example, Team W described its community as "densely populated this hindered us in completing our community assets of individuals and identifying the vulnerable groups in our community as it will require a door to door approach to all the homesteads" {Team W, progress reports}.

It was also challenging for teams to identify when stigma and discrimination presented barriers to their process of implementation because no team reported overt stigma and discrimination but speculated that stigma limited the opportunity for or impact of activities. For example, one team had a pastor cancel appointments three separate times to discuss MSM-related issues, which is consistent with the faith-based perpetuation of HIV stigma and discrimination that half of the teams reported in their pre-workshop assignments.

Discussion

Overall, this study suggests that the FHCLDP was an effective platform to build community capacity to develop multifaceted HIV interventions with limited resources in order to reduce HIV risk in informal settlements. In general, the pre-workshop assignments anchored team interventions to address many of the determinants of HIV in their informal settlements. In the post-workshop surveys, participants reported high self-efficacy to understand and apply FHCLDP curriculum principles and rated the workshops favorably. The program curriculum was also appropriate for a range of education levels and demonstrated adaptability in a variety of community settings, and it exhibited the greatest potential to promote asset mobilization, collaborations, and the implementation of interventions that address policy, sociocultural, socioeconomic, and stigma and discrimination determinants.

The FHCLDP demonstrates potential to facilitate community-based teams to creating sustainable HIV prevention and intervention programs. Teams mobilized assets that already existed in their informal settlements, which could reduce teams' dependency on external donor supplies. They also identified intangible assets in the community, such as community pride, as important components to the success of their activities. Through community asset mapping, teams extended their scope of previously invisible assets in the community to a range of tangible and intangible health, economic, social, educational, and religious assets. According to previous research, community asset mapping successfully helps communities identify social capital, promote program ownership, build relationships, and mobilize resources [47].

Teams formed collaborations with informal settlement community residents and engaged the expertise, social networks, and experiences of their own members and the members of other FHCLDP teams to enhance team activities. To overcome challenges with working in informal

settlements, van de Vijver et al. (2015) suggested that staffing diverse local informal settlements residents will ensure "access, acceptability, ownership, participation, and indirect financial support of the neighborhood…. And ensure that cultural, religious, and language barriers are broken" [35]. These practices encourage local residents infected or affected by HIV to provide program input and take ownership over the team programs. In addition, stakeholders from faith, health, development, civil society, education, bureaucratic, economic, and agriculture sectors collaborated with teams to create multilateral interventions and form reciprocal resource and communication networks.

The FHCLDP also promoted teams' practices to address social structural determinants of HIV, including stigma, discrimination, and social, cultural, socioeconomic, and bureaucratic determinants. Teams exercised their awareness of local determinants of HIV to structure many of their team practices during the Community Action Learning periods 1 and 2. Teams also provided support to communities infected and affected by HIV via sociocultural, socioeconomic, and stigma-reducing activities. Most activities targeted three disproportionately vulnerable populations: women, children, and PLWHA. However, teams reported limited faith-related practices, despite the curricular emphasis of the influences of faith on health. In addition, teams did not conduct any practices to address infrastructure or physical environmental determinants of HIV.

The FHCLDP also promotes teams to reinforce and expand HIV prevention and care practices in their communities, despite the limited curricular emphasis on prevention and treatment methods. This may reflect existing prevention and care methods that participants engaged in within their organizations, though the curriculum may have also influenced teams to improve HIV care practices. Instead, teams demonstrated their understanding of systems

thinking approaches by collaborating with organizations from myriad sectors (e.g., health, faith, economic, education, government) to design multilateral HIV prevention and treatment interventions that promote holistic health and support. For example, teams developed reciprocal referral networks between clinics and organizations that offer psychosocial and spiritual counseling. Teams often mobilized stakeholders to enrich prevention and treatment activities, exchange resources, fortify referral networks, and support marginalized communities. Teams' understanding of health-seeking deterrents also facilitated teams to conduct community sensitization prior to providing prevention and treatment services. Multifaceted interventions demonstrated a sophisticated understanding of the causes and consequences of HIV in their communities and the need for novel approaches.

Many successful team practices reflected the type of activities that have historically worked well in informal settlements and other low-resource communities and may already exist in teams' informal settlements. For example, a study with women living with HIV in informal settlements demonstrated that women benefited from IGAs in informal settlements to offset the extreme poverty in which they live [13], just as over half of the FHCLDP teams facilitated IGAs. In addition, many teams provided support groups and health talks regarding HIV-related health, substance abuse, and domestic violence, which were common forms of support for the sample of women living with HIV in informal settlements [13]. In response to the stigma around comprehensive care centers, several teams promoted home-based and community-based HIV care. Previous research has demonstrated the latter method to be an effective intervention for retention to care [37]. A community-based HIV program in rural Rwanda demonstrated promise for community-based treatment support, including access to treatment, tuberculosis screening, nutritional support, and social support [37]. This community-based HIV program demonstrated

excellent retention and adherence outcomes at a community facility [37]. All of the aforementioned practices reflected the teams' understanding of the unique and complex determinants of HIV and deterrents of care in their informal settlements.

However, teams were limited in their abilities to address some complex issues contributing to HIV risk in their communities. Despite identifying ethnic, cultural, and religious diversity as a determinant of HIV in informal settlements, most team events were not inclusive of diverse ethnic, cultural, or religious participants. Some communities, such as Muslim communities, were not accessible to nonmembers of their communities, whereas teams also reported language barriers in team activities that prevented members of other ethnicities or nationalities from participating. Additionally, all but one team neglected key populations, including MSM, commercial sex workers, and people who inject drugs. This may reflect the ongoing community stigma toward key populations and a low prioritization of the health of these neglected communities, but there are other potential explanations for this. The informal settlement community might be aware of the existence of some key populations, such as commercial sex workers or people who inject drugs, but the community may not know where to find key populations or how to access them. Another possibility is that teams were working with key populations indirectly through the inclusion of all women or all members of the community. For example, Team J described coordinating HIV, STI, and cancer screenings at large community events to attract MSM without forcing men to self-identify as MSM. Though it is probable that teams mobilized commercial sex workers in events targeted toward women, none of the team practices addressed the unique challenges that commercial sex workers face, such as condom negotiation with clients [48]. This is consistent with the findings of a systematic review of studies on HIV responses for key populations in low- and middle-income countries [30]. The

authors found limited research on key populations in low- and middle-income countries, which is a major gap needs to be addressed among disproportionately affected communities [30].

Although teams reported limited faith-related practices to address HIV, it is necessary to interpret this finding with caution. Religion, which ter Haar (2009) describes as "part of the social fabric and full integrated with other dimensions of life" in Africa [49], is embedded in African culture and subtly shapes the beliefs, motivations, and behaviors of people throughout Africa. For example, motivations for participants, stakeholders, and community members to participate in the FHCLDP may be influenced by their religious "calling" to make communities healthier and thus more able to devote themselves to faith. Team N demonstrates their motivation to conduct sensitization with other churches in their informal settlement: "People should have great health, live longer, and tithe more – 'Church need people to live longer, and bring all the tithe'" {Team N, site visit field notes}. Though the example of Team N is explicit, teams may not have reported faith-based practices as such because the "faith-based" approach is embedded, not distinguished. Thus, it is likely that faith-based practices were underreported.

It was not clear what effect HIV stigma and discrimination had as a barrier to team practices, though previous research has found stigma and discrimination to be a significant challenge to HIV program implementation in informal settlements [13]. It is likely that stigma and discrimination moderated which informal settlement residents voluntarily attended team programs such that community members and organizations with strong HIV-related stigma and discrimination would not participate in team practices. For instance, a pastor refused to uphold several scheduled meetings with a team advocating for nondiscriminatory services for MSM, a severely neglected population in Kenya. These experiences mimic the findings from a study conducted in the Kibera informal settlement in Nairobi, which found that FBOs still need to

expand their programs to key populations, despite their implementation of successful multilateral interventions [50].

In addition to reaching neglected or diverse communities, teams did not develop interventions to address structural environmental determinants of HIV, such as poor infrastructure and crime. Most teams identified structural environmental determinants in their informal settlement, and the curriculum explored the role of structural systems, such as infrastructure, to address community vulnerability to HIV. However, no teams engaged in practices to address structural determinants, such as infrastructure or crime. This brings into question the ability for teams to design interventions that address structural determinants, which require the largest amount of financial, human, and temporal resources to implement and measure [51]. This presents a challenge for teams comprised of volunteers with little to no funding who may not have the time or expertise to address barriers, such as crime, insecurity, and poor infrastructure. Many organizations have identified crime and threat of violence as barriers to health interventions in informal settlements [13, 35]. Additionally, some of the environmental challenges, such as the challenge of reaching the whole community due to flooding from heavy rains and the high population density, were beyond the control of teams. As such, structural environmental interventions may not be appropriate in the context of the FHCLDP.

Of the financial barriers that teams experienced, they reported that many community members and organizations would not participate in team activities, such as community asset mapping, without some incentive. This expectation of free handouts has been described in the literature to reflect the rampant donor dependency in informal settlements. Highly impoverished informal settlements rely on the donor-supplied HIV services and resources, though the supply is

not sustainable and creates this donor dependency [13]. Amuyunzu-Nyamongo et al. (2007) found that 93% of their sample of women living with HIV received external support from NGOs and CBOs, most commonly in the form of food donations and health care [13]. In fact, many of the women in their sample attributed their survival to the supply of resources from external donors [13]. However, they found these donated goods to be unsustainable and recommended that program implementers develop sustainable programs fortified by stakeholder networks and increased access to public health care resources [13]. Sharma et al. (2013) described some outcomes of a systems strengthening framework developed for resource-constrained settings, and they found that the framework influenced local organizations to draw on internal resources and primarily utilized international partners for their technical assistance [33]. They also highlighted the impending issues that declining PEPFAR funds will cause to future local organization practice, which emphasizes the importance of internal asset mobilization [33].

Teams also found community poverty and raising funds to be particularly challenging; only one team successfully lobbied funds. This may reflect the competitive funding environment or the total lack of funds available for community activities and programs, or perhaps teams did not have the technical capabilities to apply for grants and funds.

Public Health Implications

The FHCLDP's comprehensive community-based approach to HIV prevention and care has been endorsed in previous research [9, 13, 39] and is a major goal of the MOH's Combination Prevention Approach, a mix of behavioral, structural, and biomedical approaches to HIV prevention [1], as well as NEPHAK's goal to use a multi-sector approach to address social determinants of HIV [2]. The FHCLDP supports the well being infected and affected

communities while altering the context in which HIV exists to create healthier, more resilient communities.

Changing the socio-contextual environment that propagates HIV also addresses general health inequities [8]. For example, women who participate in IGAs have more dispensable funds to pay for other health care costs in addition to ART [13]. Research has found a link between improving the total health of impoverished communities and residents' capacities to improve levels of education, delay pregnancy, give birth to HIV-negative children, and escape the cycle of poverty [52]. Therefore, the FHCLDP curriculum has great implications for improving the SES, access to health-promoting resources, and the total health of informal settlement communities.

In addition, building capacity of local community programs with limited resources increases the likelihood of program sustainability and more consistent access to HIV care in informal settlements [13]. The CDC describes the public health implications of improved access and adherence to treatment as a form of prevention:

> "[ART] reduce the amount of virus in the body which keeps the immune system functioning and prevents illness. Another benefit of reducing the amount of virus in the body is that it helps prevent transmission to others through sex, needle sharing, and from mother-to-child during pregnancy and birth" [53].

Thus, improving consistent access to treatment prevents HIV incidence in informal settlements and improves the health status of the entire community.

Limitations of the Current Study

One of the limitations of the current study is the ability to draw conclusions from the data, given that this assessment was developed after data collection began. Aside from the

participant applications, no baseline data were collected regarding the practices of the participants' representative organizations. This limits the conclusions the evaluation can make on the influence of the FHCLDP on team practices; therefore, members of a team may have already been engaged in certain practices that they continued as a team. Future iterations of the FHCLDP evaluation design must strengthen subjective reports submitted from teams by collecting more objective data, such as observational and outcome data, to improve data validity. In addition, the current evaluation was conducted shortly after the completion of the program, which limited its ability to measure long-term outcomes of the FHCLDP on team practices and health outcomes in the community. The lack of outcome data limits the interpretation of program effectiveness and merely reflects the curriculum's ability to influence team practices.

There were also challenges with the quality of data. Teams received guidelines on the reports to produce during the pre-workshop and Community Action Learning periods, but the guidelines were not rigid in order to alleviate the pressure for teams to meet program expectations. There was also no standardization in data collection, thus team timelines and activity descriptions were not always clear. There was also variability in the quality of self-reported pre-workshop assignments, progress reports, and final reports. As such, there were challenges in understanding, comparing, and categorizing the data. In addition, self-report data are subject to social desirability and recall biases [54].

There were also some limitations with the site visits. First, site visits were conducted with half of the teams who were selected to participate in site visits due to the referral networks they formed. This may represent a bias of teams' capacities to develop HIV prevention and care practices. Second, site visit field notes are more subject to bias than recording and transcribing site visit focus group discussions.

Recommendations for the FHCLDP

- Recruit stakeholders who work with key populations and other vulnerable populations. Integrate their programmatic experiences and expertise to enrich conversations around accessing and serving vulnerable and neglected communities.
- Within the curriculum, identify additional ways in which faith is a point of intervention. Integrate more applied ways to understand the role of faith in the fight against HIV in the curriculum. For example, the case studies could incorporate a larger role of community faith leaders.
- Expand curriculum emphasis to include explorations of commonly stigmatized aspects of HIV, such as heterosexual transmission within and outside marriage, commercial sex work, and other issues unique to key populations.
- Provide an additional workshop for one member of each team to learn how to write grant applications and conduct monitoring and evaluation, including qualitative methods and analyses. This could improve the standardization of reports, ensure that teams achieve desired outcomes, how to measure monitoring and outcome indicators. Specifically, teams should conduct needs assessments with the communities to assure that the needs of the community are addressed.
- In future FHCLDP program evaluations, develop new modalities for evaluating the influence of faith in team practices to understand more precisely how faith shapes health-seeking behaviors in informal settlements.

Conclusion

Despite financial limitations to team practices, the FHCLDP teams effectively orchestrated myriad of community-based HIV interventions directed toward high-risk

communities in economically deprived informal settlements. These practices were aimed at engaging community members and stakeholders, promoting community ownership over HIV programs, identifying previously invisible assets, promoting health-seeking attitudes and behaviors, and fortifying mental and physical health care systems.

The FHCLDP is an effective tool for multi-sector teams to mobilize local assets, form collaborations, address social structural determinants of HIV, and reinforce HIV prevention and care infrastructure in low-resource communities. The curriculum demonstrated success at promoting critical thinking about the causes and consequences of HIV in informal settlement communities, as exemplified by the evolution of team practices. Although there were no outcome data to identify the long-term effects of the FHCLDP on community health, the capacity for teams to address a range of social structural determinants of HIV and barriers to care existing within each team's informal settlement suggests that the FHCLDP curriculum is adaptable to building capacity in other low-resource communities.

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Appendix A: Call for Applications [44]

ST. PAUL'S UNIVERSITY
P.O BOX PRIVATE BAG, 00217
LIMURU

CALL FOR APPLICATIONS FOR TRAINING OF COMMUNITY TEAMS ON COLLABORATIVE LEADERSHIP TO SUPPORT HIV CARE AND TREATMENT IN THE COMMUNITY

Deadline: TEAM applications must be received by **6th March 2015**

Who may apply: Community members who have a common vision for addressing HIV care and treatment in their community. The program only accepts applications from teams that comprise of 5 members. The TEAM application should include each individual member's application.

Ways to apply:

1. Email your team application to emoryspillprogram@spu.ac.ke and copy directorspill@spu.ac.ke (Prefer)

2. (OR) Typed or handwritten TEAM applications should be mailed or hand delivered to:

The Program Coordinator
Faith, Health Collaboration and Leadership Development Program
St. Paul's University, P.O. Box Private Bag -00217
Tel No. 020 2086306
Limuru, Kenya

Team Eligibility Criteria:
Eight teams each comprised of 5 members from different organizations or community groups in Nairobi County will be selected for the training. The teams will include those in positions and a part of groups or organizations with the capacity to influence, inspire and mobilize collaborative action among community networks for desired change.

Most important will be the team's readiness and ability to engage in collaborative/joint action that will address HIV social health disparities in their community. **The program is for teams whose members are already actively involved in community activities.**

The trainings will be conducted in English.
A TEAM application should include an application for each individual team member. The individual must complete his/her own application indicating their profile and responding to each question to show how they meet the eligibility criteria.

Criteria for Team Selection:
(Each of the following criteria should be addressed in the application form. Incomplete applications will not be considered)

1. Evidence of commitment to engage in collaborative action to address recognized social health disparities (inequalities/gaps) in your community that affect long term HIV care and treatment.

2. Team composition of five members from different organizations or groups that represent faith based organizations, health care, community development, and civil society organizations. This could include a pastor, a PLWHIV, Community Health Extension Workers (CHEWS), nurse, HTC Counselors etc) (a mix of these as well as gender balanced is preferred)

3. Experience working in the community with a willingness to deepen that experience and have a good knowledge and understanding of the community. This should be outlined in the application form.

4. Team composition should reflect the community interests and needs.

5. Representative of different organizations and community groups that if mobilized have a reasonable chance of enhancing health equity in their covered geographic area.

6. A commitment to participate <u>in the entire program period</u> which includes:

   - A 4-day workshop, from 6.00 PM Monday, 20th April through Friday, April 24th 12.00 PM.
   - Community Action Learning and Implementation April- June
   - A 3-day workshop, from 6:00 PM Sunday, 14th June through Wed., 17th June 2:00 PM
   - Community Action Learning and Implementation Report June - August

7. Individual recommendation letters from your employer and an administrator or pastor that shows their support for your participation and the benefit to their organization's mission and community health goals.

All participants will pay a registration fee of 1500 Kshs (organizations are encouraged to pay for their employees)

The program will provide lodging, food, all learning and technical assistance materials plus transport. Participants will gain valuable knowledge and skills to support strong and sustainable community initiatives that support the health of community members living with HIV.

TEAM application form addressing all of these criteria should be submitted to:

emoryspillprogram@spu.ac.ke and copy **directorspill@spu.ac.ke**
For any clarifications, call 020 2086306

INDIVIDUAL APPLICATION FORM (each team member should complete this form and send it to emoryspillprogram@spu.ac.ke and copy directorspill@spu.ac.ke)

1. Name Age

2. Educational Background

3. Name of organization Position

4. Describe your roles, responsibilities and activities related to HIV/AIDS work in the community.

5. Who supports the activities that you undertake? Are you funded?

6. Write a personal statement on what motivates you to do what you do in the community?

7. Give reasons why you would like to participate in this particular Faith Health Collaborations and Leadership Development Program.

8. List your team members, their organization or community group and describe each of them and what unique experience and commitments you think they each bring to achieving success in a joint effort addressing HIV/AIDS challenges in your community.

*** Make sure your recommendation letter accompanies your complete application form.

Appendix B: Curriculum Overview [55]

2015 Curriculum

PROGRAM DESCRIPTION
The St. Paul's and Emory relationship continues to grow through academic endeavors as well as in responses to community health priorities in Kenya. This program integrates both as well as aligns SPU's strengths and leadership role in Kenya and East Africa with Emory's key stakeholder interests in faith-based leadership capacity necessary for sustaining HIV/AIDS efforts and other critical community health and development concerns. It draws on the following curricula and training successes in both institutions: SPU's MACC and Masters in Development Studies programs; SPILL's NGOTI; Emory Interfaith Health Program's *Institute for Public Health and Faith Collaborations*; and the SPU/Emory course, Religion, Health and Development.

A considerable effort has been made by faculty and staff at both universities – to address key stakeholders interests such as the recommendations that were made in the May 2012 PEPFAR consultation on the role of FBO's in sustaining essential HIV/AIDS efforts; to assess learner needs (focus group workshop held in August of 2012); and to redesign and contextualize Emory's *Institute for Public Health and Faith Collaborations* (October 2012 curriculum workshop). A small scale version of this model is currently being implemented between November 2013 and September 2014. Pending demonstrated success and additional resources, the expectation is that it could be replicated at a larger scale in additional priority geographic areas impacted by HIV/AIDS and have limited access to training and capacity building resources.

The purpose of the Program is t**o enhance the capacity of key players in faith, health, & development to facilitate community transformation.** Through multi-sector team-based, learning the aim is to build partnerships among FBOs, clinical programs, and civil society at the community level with the capacity to collaborate across sectors on achieving sustainable community-based HIV prevention, treatment, and care services. The one-year curriculum goals and objectives of the Program are as follows:

Goal 1 Cultivate common awareness and commitment
Objective*:* Demonstrate a clear understanding of holistic health that links health care, HIV social vulnerabilities & development in the local context
Goal 2 Cultivate collaborative leadership
Objective: Assess their leadership capacities in relation to others in the areas of faith, health, and development
Goal 3 *Cultivate vision for transformation*
Objective: Identify and align their community assets that promote health and development
Goal 4 *Create and implement an action plan for community transformation*
Objective: Develop collaborative strategies that achieve sustainable HIV community-based HIV prevention, treatment, and care.

PARTICIPANT LEARNERS

The target audience for this Program is grassroots, community level formal and informal leaders who share a commitment to working on the holistic health of the entire community, particularly those impacted by HIV/AIDS. Identification of these leaders has occurred primarily through established networks and partners, such as NGOTI, the Christian Health Association of Kenya, the National AIDS Control Council (NACC), and KANCO. This is to ensure that participants are the best fit with the Program goals and lays the ground for sustainability and success of their work. Recruitment of teams with 4 to 5 participants each began in November and December of 2013.

PROPOSED SCHEDULE/TIMETABLE

The Program has been conducted in the format of two workshops, the first 4 days and the second 3 days, with implementation and action learning occurring during the time periods in between the first two workshops and following the second. It was held at a facility with lodging so that the team participants are fully engaged in the learning and community planning activities. The first workshop was held 9 – 13 March 2014 and the second two months later 25 – 28 May. Following the second workshop, an action learning time period, and evaluation activities, the program will conclude in September 2014.

FACULTY/INSTRUCTORS

The design of this model has three distinctive personnel features. One is the role of a trainer(s) who guides the teams in a significant amount of experiential learning activities and is responsible for integrating conceptual pillars of the curriculum along with expert content input. The second is one or two lead instructors who provide lecture input that anchors values and core concepts of leadership and community transformation at critical points in the workshops. The third are instructors, usually 3 or 4, who provide expert input at designated times during the workshops.

EVALUATION

Each workshop was evaluated in two ways using feedback cards at the end of each day and a survey instrument based on the learning objectives administered at the conclusion of the workshop. The Community Action Learning and Team Final Reports were designed to generate team documentation of achievement of goals and objectives and assess learning as well. A follow up evaluation was conducted at the end of the Program to assess overall learning and application of leadership tools.

PROGRAM CONTENT

The Program curriculum is built with the following seven values that function as the central conceptual pillars for integration of the content throughout the workshops and community action learning activities.

Collaborative Leadership

Collaborative Leadership for cultivation of webs of transformative relationships

Transformative Relationships

Transformative Relationships for emergence of a new vision

Vision

Vision of healthier communities through faith, health, and development alignment

Faith, Health, and Development Alignment

Faith, Health, and Development Alignment for the elimination of disparities and nurturing of common hope

Eliminate Disparities/Nurture Common Hope

Elimination of Disparities and Nurturing of Common Hope for transformation of community

Community Transformation

Community Transformation for a deeper calling and new accountability

Calling and Accountability

Calling and Accountability for the cultivation of *Collaborative Leadership*

I. Team Preparation

This takes place once the teams are selected at least a month prior to the first Workshop. They receive a packet in the mail/in person and follow up phone calls to review the expectations and answer questions.

1) Development of case study that describes pressing HIV/AIDS disparities in their community.
2) Reading that familiarizes them with some of the core concepts to be covered during the workshop.
   - Integrative Program concept paper
   - Chapters 1 & 9 of *Deeply Woven Roots*
   - Chapters 15, 16 &17 of *Reframing Organizations: Artistry, Choice, and Leadership*.
   - Chapters five & six of *The Fifth Discipline: The Art and Practice of The Learning Organization*
3) Identification of items to bring that represent their work in the community.

II. Workshop I

[Day, Date]

Opening Session

This session establishes the opening of the Program, clarifies the expectations and purpose, and fosters an understanding among the participants about the value and resources that they all bring to their community.

6:00-7:00 PM	Dinner
7:00-7:30 PM	Welcome Large group "icebreaker"
7:30-8:45 PM	Self-introductions using item/symbol each brought that represents their work
8:45-9:00 PM	Closure and direction for workshop

[Day, Date]

This day provides an introduction to the core concepts of the program and an approach to create community transformation and a sustainable HIV/AIDS response. Participants are introduced to the first theoretical framework that they then use as a tool to understand the complexity of social

forces that contribute to HIV/AIDS disparities and challenges in their community. Thirdly they begin the discovery of their own leadership strengths and capacities that could be applied to these community challenges.

8:30-9:00 AM	Program Introduction
9:00-10:30 AM	Presentation - lecture Content - Introduction to the values, Program concepts and the leadership capacities that enable collaborative leadership, i.e.: the resource of leadership relationships, the resource of leadership self-awareness, the resource of positively channeled conflict, the resource of adaptive leadership to simultaneous challenges, the resource of untangling and leading complex community systems, the resource of committed faith, development, and health leaders.
10:30-11:00 AM	Tea Break
11:00- 1:00 PM	Introductory Stories - facilitation Teams identify the diversity of personal and leadership resources within the team and establish group dynamic norms.
1:00- 2:00 PM	Lunch
2:00 - 3:00 PM	The Nature of HIV and Social Disparities - lecture Content - A theoretical framework integrating the CCC model with the social determinants of health for understanding the community and social factors underlying HIV disparities and sustainable care challenges
3:00 – 4:00 PM	Application of the Theory – facilitation, team activity Teams use this framework to analyze their community case study to increase their understanding of all the contributing factors and begin to identify leadership and community resources can affect them.
4:00 – 4:30 PM	Tea Break
4:30 – 6:00 PM	Personal Leadership – facilitation and lecture Individual inventory assessment completed using a leadership profile tool. Lecturer guides scoring and interpretation, linking it to collaborative leadership assets.
6:30 – 7:30 PM	Dinner
7:30 – 8:30 PM	Leadership Conversation – teams on their own with guidelines for further interpretation and sharing is provided.

[Day, Date]

Building on yesterday's understanding of the challenges in their community contexts, this day gives the participants hands on experience with tools to use to strengthen leadership, understand and engage organizational and community assets to address those challenges.

8:30-10:30 AM	Realities and Uses of Conflict for Community Transformation – facilitation Teams work on identifying sources of conflict in their own community and are guided to think about how it is impacting the HIV social disparity in their community and how they can transform that conflict to a practical and operational asset.
10:30-11:00 AM	Tea Break

11:00- 1:00 PM	Adaptive Challenges – facilitation Teams work through a case study that simulates the need for adaptive leadership.
1:00 - 2:00 PM	Lunch
2:00 - 3:30 PM	Reframing, (Bolman and Deal) Understanding Organizational Dynamics through New Leadership Lenses Lecture
3:30 – 4:00 PM	Application – facilitation (by lecturer) Teams revisit the conflict issue they identified in the earlier session and examine it through the four different lenses (political, structural, human resource, and symbolic) to identify strategies that could assist in addressing the HIV social disparit(ies).
4:00 – 4:30 PM	Tea Break
4:30 – 6:00 PM	Community Health Asset Mapping – lecture and facilitation Content (IRHAP/de Gruchy and McKnight) – introduction to the theory of asset mapping to identify resources in their community that contribute to the holistic health of the community. Teams draw their community and identify assets using a set of questions to entities that would be important to include in the strategies discovered during the previous exercise.
6:30 – 7:30 PM	Special Dinner

[Day, Date]

The third day of the first workshop engages the participants in integrating new learning through the sequence of making a shared commitment, visioning, and action planning.

8:30-10:30 AM	Responsibility and Commitment – facilitation There are 2 stages to this, first individual reflection and then team work together to draft a team pledge/agreement that reflects a shared accountability for transformation in their community.
10:30-11:00 AM	Tea Break
11:00- 1:00 PM	Formulation of a Vision – facilitation Teams are guided and supported in the development of a vision and an action plan to achieve that vision. They are given action planning tools that structure achieving objectives and reporting for the Program evaluation and achievement of the Program objectives.
1:00 - 2:00 PM	Lunch
2:00 - 4:00 PM	Formulation of a Vision – facilitation Teams are guided and supported in the development of a vision and an action plan to achieve that vision. They are given action planning tools that structure achieving objectives and reporting for the Program evaluation and achievement of the Program objectives.
4:00 – 4:30 PM	Break
4:30 – 5:30 PM	Teams work on finalizing their presentations
6:00 – 7:00 PM	Dinner
7:30 – 8:30 PM	Community Celebration A gathering to name discoveries, hopes, and possibilities.

[Day, Date]

9:00 – 11:00 AM	Plenary – Teams Present their Plans Receive information and direction for Community Action Learning and Implementation of Plans Closing and Departure

III. Community Action Learning – Implementation of Team Action Plans

Time Period between Workshop I and II – preferably 2 to 3 months

Action Learning 1A
Teams begin to implement their action plans and engage new community allies and partners. Through these activities their leadership capacity is affirmed and community resources are seen in new ways.

Action Learning 1B
Teams begin integrating new leadership and community change tools, test their vision for community transformation, and identify additional leadership learning needs. They begin to assume agency for their own leadership learning. The teams are given guidelines for reflection and reporting that includes a presentation to be made at the next workshop.

IV. Workshop II

[Dates]

This second workshop is one day shorter than the first. It provides an opportunity for the participants to examine what they have accomplished, reinforce and further integrate theory and tools from the first workshop, and learn new tools and knowledge that assist them in addressing challenges they met during the first Action Learning time period as well as undertaking long term systemic change.

[Day, Date]

6:00 – 7:30 PM	Opening gathering and honoring of leadership accomplishments

[Day, Date]

8:30 – 9:00 AM	Welcome and Workshop II overview
9:00 – 9:45 AM	Recap and Summary of core Program concepts and values (lecture)
9:45 – 10:30 AM	Team presentation (1) Teams integrate knowledge and collaborative leadership learning and make publicly visible their own calling and accountability
10:30-11:00 AM	Tea Break
11:00 – 1:00 PM	Team presentations (3) Teams integrate knowledge and collaborative leadership learning and make publicly visible their own calling and accountability

1:00 - 2:00 PM	Lunch
2:00 – 4:00 PM	Reflection and Action - facilitation Using a case study and the current version of their action plans, teams are guided in - reflection on knowledge and tools from Workshop I; how to meet challenges they have encountered; and applying these tools to assure success in achieving their objectives.
4:00 – 4:30 PM	Break
4:30 – 6:30 PM	The Nature of HIV and Social Disparities and the Role of Religion Lecture and facilitation Teams establish a deeper understanding of the role of religion as an influence and important partner along with care, treatment, and other social, economic, and cultural factors. Identify community social and faith-based assets in their community that can positively affect health disparities.

[Day, Date]

8:30 – 10:30 AM	Systems Thinking, Community Circles of Causality – lecture Content (P. Senge) – Viewing community as complex systems, seeing the relational dynamics of the assets they have identified and what kind of causal influences contribute to the HIV social disparities.
10:30-11:00 AM	Tea Break
11:00 – 1:00 PM	Application of Systems Thinking – facilitated Teams identify among themselves an individual who represents the poignant results of HIV social disparities in their community. They then revisit their community asset map and re-construct a relational map that represents these assets aligned so as to create a different and transformational trajectory for that person and others.
1:00 - 2:00 PM	Lunch
2:00 – 4:00 PM	Stigma and Discrimination - lecture (Content for this session selected based on participant identification of challenges and barriers to achieving their goals.) Understanding stigma and discrimination at individual and social structural levels of influence
4:00 – 4:30 PM	Tea Break
4:30 – 6:00 PM	Action Planning and Vision Implementation – lecture and facilitation Participants are provided with more input and guidance on action planning and work as teams with facilitation to integrate new insights into their action plans – with more of an emphasis now on systemic drivers of social disparities, the role of religion, and tackling stigma and discrimination at community scale.

[Day, Date]

8:30 – 10:30 PM	Action Planning – facilitation

	Teams are supported in work on their own to refine and enhance their community action plans as they prepare for the workshop presentation and implementation upon returning home to their communities.
10:30-11:00 AM	Tea Break
11:00 – 1:00 PM	Team presentations Articulate in public a short and long term plan for advancing their joint vision and its implementation. Program participants become leader/teachers of collaborative leadership.
1:00 - 2:00 PM	Lunch
2:00 – 4:00 PM	Workshop evaluation Teams receive information and direction for Community Action Learning and Implementation of Plans and final reporting Closing

V. Final Reporting and Evaluation
Teams submit reports to SPILL July 11
Follow up evaluation conducted by SPILL (surveys, focus group interviews) with support from Emory Interfaith Health Program

Appendix C: Case Studies

Cancer Prevalence Among Kenyans [56]
Cancer is a growing public health crisis across the globe, but perhaps most acutely in low- and middle-income countries (LMIC), where 70% of the global cancer burden is found. The leading causes of cancer deaths among women in urban areas in Kenya, one such LMIC, are breast (34 per 100,000) and cervical (25 per 100,000). Among men, prostate (17 per 100,000) and esophageal cancers (9 per 100,000) are to blame. In Kenya each year, an estimated 39,000 new cases of cancer will be diagnosed, while 28,000 people will die from cancer. It is the third highest cause of death in Kenya. With only four radiation machines to treat cancer operating in Nairobi, there are many hurdles to treatment, especially for rural Kenyans. These include lack of awareness, few diagnostic and treatment facilities in rural settings, high cost of treatment, lack of transportation to urban centers, and a high poverty index. *Several factors are identified with cancer, including age (60% of cases are in Kenyans younger than 70 years), poverty, poor nutrition, smoking, substance abuse, family history, early sexual debut (cervical cancer in girls), and duration of lactation (breast cancer in women). Improved access to screening, early detection, and treatment can prevent cancer-related mortality. Poverty, which affects the ability of people in rural counties to access healthcare, contributes to poor health outcomes.* *Within your community the cancer rate is 25% higher than the national average. You realize that many of these cancers (especially cervical in women and prostate in men) are easily detectable and curable in the early stages. In your community, the cervical and prostate cancer rates have escalated by 8% and 12% respectively in the last 10 years, whereas, nationally the rate has been on the decline. Governments at all levels have funded comprehensive programs for rural populations at risk of cervical and prostate cancer. Your community is the recipient of Kshs. 600,0000 in unrestricted funds from the district health office to develop a cancer awareness outreach program that focuses on community health workers providing information to rural areas. You are asked to develop such a program for Kasarani Sub County in Nairobi County.*
Questions for reflection: 1. How does this information frame the issue of cancer from a faith-based perspective and from a health or development perspective? 2. Imagine that these statistics and information are relevant to your community. From your perspective, what risk factors do you feel most capable of addressing….what risk factors do you feel least capable of addressing? 3. As a group, outline a plan to address the rising cancer rate in your community. Briefly describe the proposed plan and include both an allocation of financial resources and human resources. The group must have consensus on the final plan.

Reflection Action Case Study [57]

Jane is a 12 year old girl who lives with her aged and ailing grandmother and uncle in Lare village. She lost both her parents to AIDS when she was two years old. Unfortunately she also tested positive for HIV. Jane works in the neighbour's shamba for casual work. Occasionally she comes down with ailments associated with HIV and is unable to earn a living. And she is not on treatment.

A married man in the village has begun making advances on her and has been luring her with small pocket money and buying sodas and mandazi's. It is rumoured that she was seen leaving a lodging with him.

At the home front, Jane avoids playing with other children because they keep reminding her that she has the "bad" disease and should not get close to them. She also does not have a birth certificate and when her grandmother tried to register her, she did not succeed as she did not have all the required documents hence she gave up. Hence Jane has not been in school. Her parents did not leave a will.

Her uncle is an alcoholic who sells anything at any price to buy alcohol. Whenever he is drunk, he becomes violent to both Jane and her grandmother threatening to kill them and sell the shamba. He has been reported to the village elders but this has not stopped him from being violent.

Reflection Action Case Study

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Her uncle is an alcoholic who sells anything at any price to buy alcohol. Whenever he is drunk, he becomes violent to both Jane and her grandmother threatening to kill them and sell the shamba. He has been reported to the village elders but this has not stopped him from being violent.

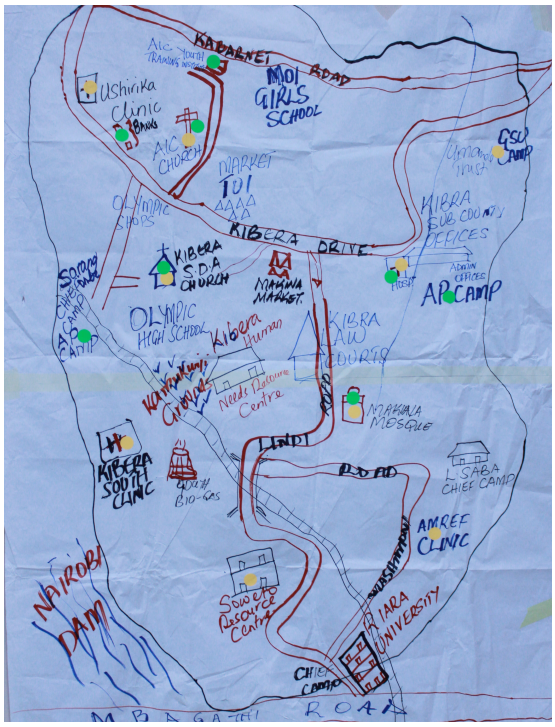
Reflection Action Case Study Questions - Part II

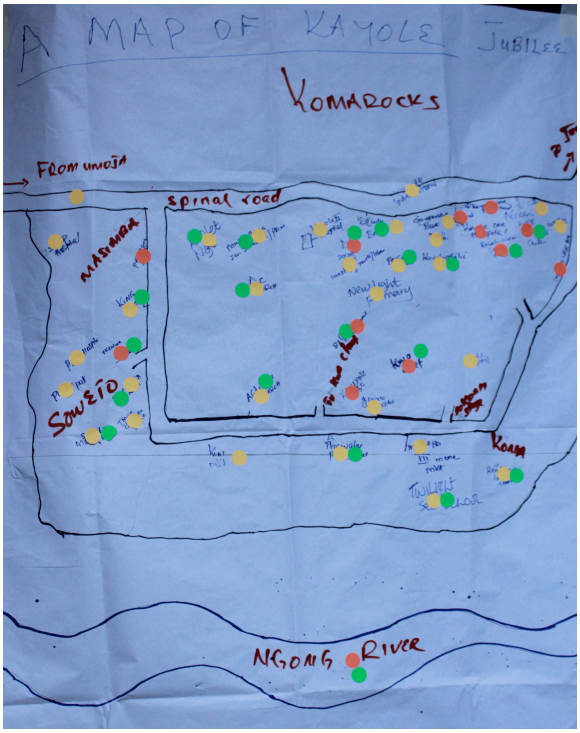
You are a group of leaders from different organizations that have a commitment to addressing HIV social health disparities for those most vulnerable. You have recently attended a collaborative leadership development workshop where you examined these kinds of community HIV challenges and learned some leadership tools and ideas that could be helpful.

Discuss and answer the following questions together based on what you have been doing in your community or propose doing to address similar kinds of issues as experienced by Jane, her family, and community:

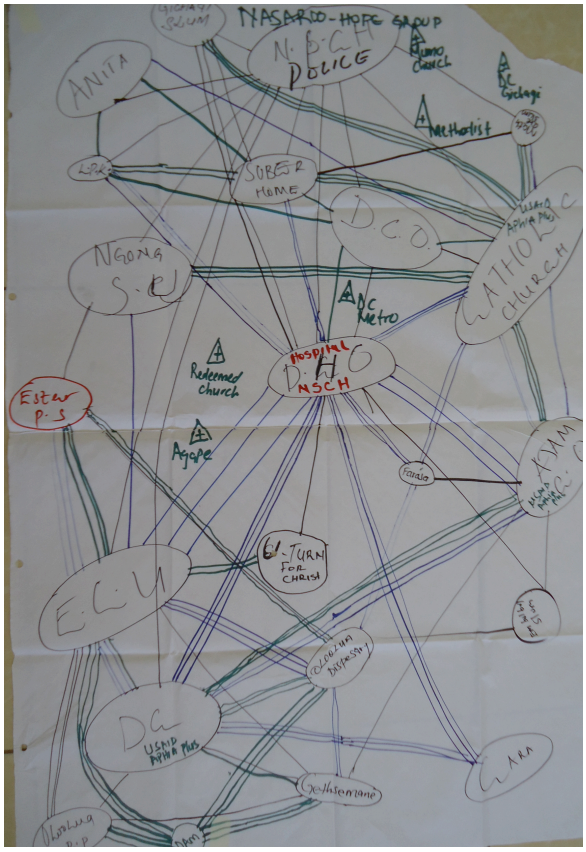
1) There are many factors which impact the well-being of HIV positive young girls and women, their families and community. Think back and remember **the framework outlining different social factors** – stigma and discrimination; social status and ethnicity; gender and/or marital status; individual health risks and behaviors (such as alcohol and drug abuse); barriers to treatment; family and community relationships; poverty and income.
    a. How have you used your understanding of these factors to plan and implement action steps in your community? Which factors and why?
    b. What impact has this approach had on assuring that persons like Jane could have a chance at living a long healthy productive life? How?
    c. How could your understanding of any particular social factors in this framework assist you in addressing the most pressing HIV long term treatment needs in your community?
    d. Based on your current actions and thinking, which factors will be critical for the priority group in your community to find the support they need to be healthy and productive 10 years from now?
2) Another framework of ideas you learned about during the leadership development workshop was about recognizing and identifying your own **leadership strengths as well as community health assets** that could be tapped to address HIV social disparities.
    a. How have you or would you use these tools or ways of thinking in your planning and action steps to mobilize community resources that can support persons in long term treatment?
3) One of the factors that is important to sustaining leadership and organizational capacity to provide the support needed for those with HIV is **leadership and organizational relationships**. As a team of leaders during the workshop you explored the nature of your individual commitments and how as a team you would commit to working together.
    a. Discuss your "agreement" and how that has had an impact on your work.
    b. In what ways could it help support and sustain your work as a team and with other leaders and organizations in your community?
4) Your team learned about several other sets of ideas during the workshop – adaptive leadership (necessary when things change – resources, environmental changes, etc.); dealing with conflict in the community as a means of community transformation; and reframing organizations (seeing the potential of organizations and leadership that have political, structural, human resource, and symbolic characteristics).
        a. If you have time, select ones to discuss that you think have been useful or could be useful to bring about the changes needed in your community to assure long term treatment and support for those with HIV.

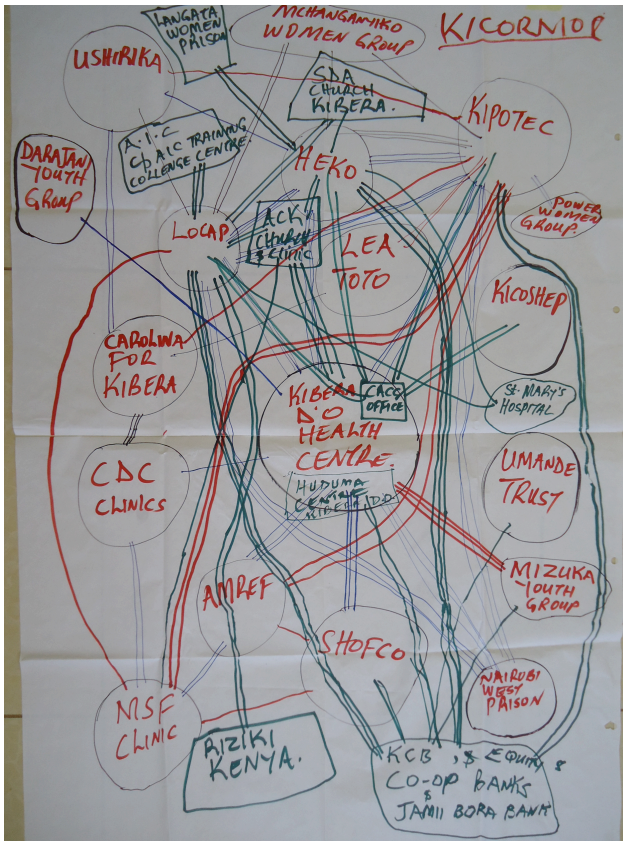
Appendix D: Community Asset Maps [58]

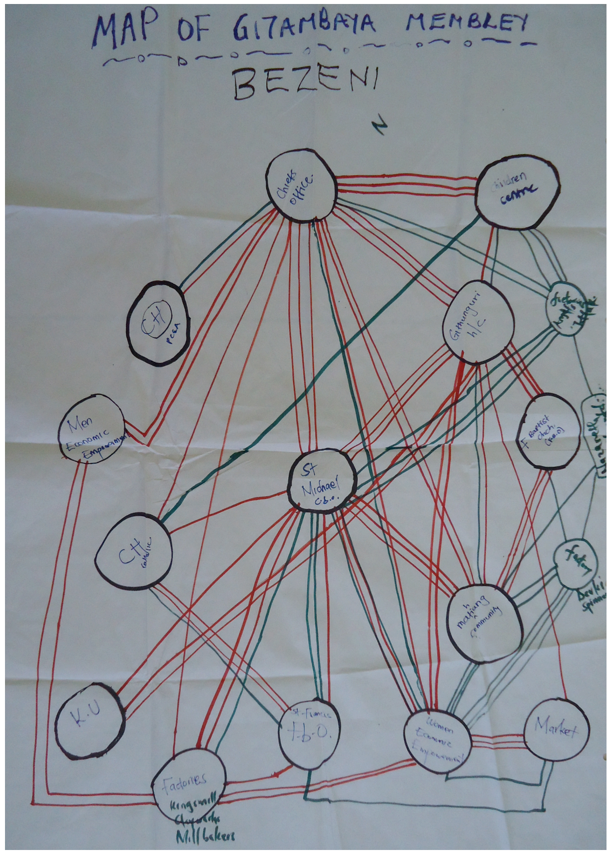


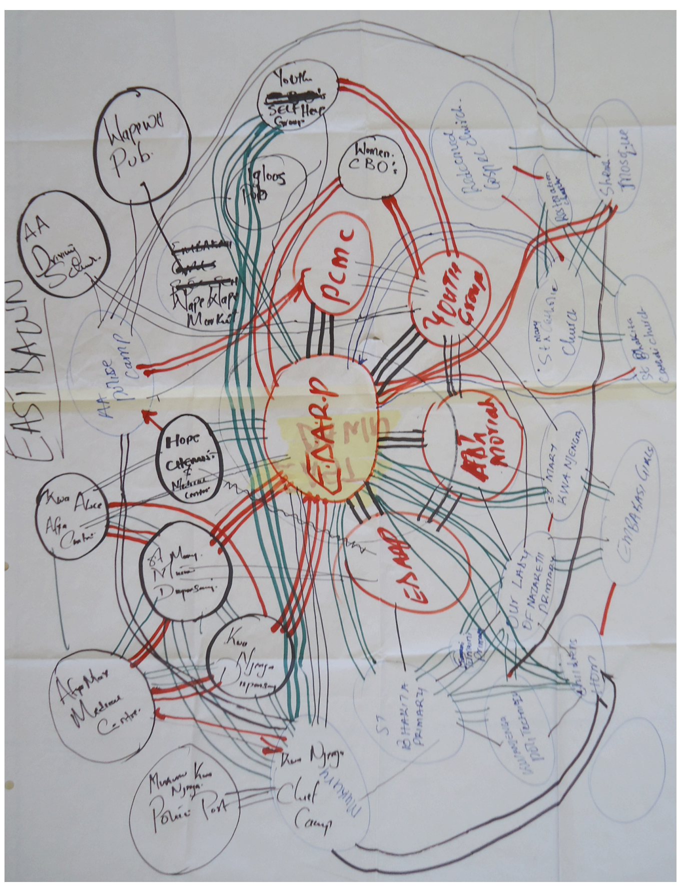


Appendix E: Network Maps [59]






MAP OF GITAMBAYA MEMBLEY
BEZENI
K.U
St Michael CBO
Market
Factories


Wapewe Pub
Women CBO's
PCMC
Youth Group

Appendix F: Post-Workshop Surveys

Faith, Health Collaboration Leadership Development Program
Post-Workshop Survey
April 2015 [60]

Purpose

The purpose of this survey is to find out your opinions about Workshop I of the Faith, Health Collaboration Leadership Development Program and what you learned as a participant. We will use the information you provide to improve future Workshops.

Confidentiality

All of the information you provide is anonymous. The survey does not ask for any personal information that would allow us to link your responses with your name or the name of your community. You do not have to answer any questions that you do not wish to answer. Your answering the survey is taken as your consent to participate.

Part 1: Your Background and Opinions

1. What discipline do you primarily represent within your team? (Select only one please)

Select one
_ Health
_ Faith
_ Civil Society
_ Other _PLWHA/Youth and Children/Empowerment_____

2. Please indicate how much you agree or disagree with each statement listed below:
CIRCLE ONE FOR EACH

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
a. Our team was strengthened through our experiences at the Workshop.	1	2	3	4	5
b. I am more committed to faith-public health-development collaborations now than when I arrived at the Workshop.	1	2	3	4	5

c. I am confident that the gains I received from the Workshop are worth the time I invested.	1	2	3	4	5
d. I increased my appreciation for what contributions the health the faith and the development communities can make to reduce health disparities.	1	2	3	4	5
e. I am confident that our team will take concrete steps to implement our plan for community action when we get home.	1	2	3	4	5

3. The following are additional statements about the Workshop. Please indicate the extent to which you agree or disagree with each of these statements:

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
a. I would recommend the Workshop to others.	1	2	3	4	5
b. The overall pace of the week was good.	1	2	3	4	5
c. The pre-Workshop assignments and team activities contributed to my learning experience.	1	2	3	4	5
d. Communication with program staff before the Workshop was helpful.	1	2	3	4	5
e. Communication with program staff during the Workshop was helpful.	1	2	3	4	5
f. Materials I received before & during the Workshop were useful.	1	2	3	4	5

Part 2: Your Gains

4. Each statement below describes a skill or a topic that was addressed in the Workshop. We would like you to rate your confidence that you could have performed that skill on the day that you arrived for the Workshop. Then we would like you to rate your confidence that you could perform the same skill today, the last day of the Workshop. For this section, use the following rating scale:

1 Not at All Confident **2** **3** **4** **5 Completely Confident**

	Rate your confidence that you could have	Rate your confidence that

Skill/Content Area	performed this skill **the day you arrived** for this Workshop.	you can perform the skill **today, the last day** of the Workshop.
a. Describe the major HIV social health disparities in your community.		
b. Understand your own personal leadership tendencies.		
c. Understand the contribution and impact of leadership tendencies of others.		
d. Understand the role of collaborative leaders in eliminating HIV social health disparities.		
e. Discuss how conflict is both a reality and an asset.		

5. Each statement below describes an additional skill or topic that was addressed in the Workshop. Please rate your confidence that you could have performed that skill on the day that you arrived for the Workshop. Then, rate your confidence that you could perform the same skill today, the last day of the Workshop. For this section, use the same scale you used in the previous section:

1 2 3 4 5
Not at All Confident **Completely Confident**

Skill/Content Area	Rate your confidence that you could have performed this skill **the day you arrived** for this Workshop.	Rate your confidence that you can perform the skill **today, the last day** of the Workshop.
a. Describe the skills needed by leaders for responding to changing and complex circumstances that arise in collaborative work.		
b. Identify and restructure community resources to accomplish a vision.		

c. Create and implement a shared vision for a healthy community.		
d. Identify community assets and develop strategies for mobilizing and activating those assets to reduce health disparities.		

2. What are the top 2 to 3 things you gained from your participation in the Workshop?

1. Collaborative leadership
2. Asset mapping
3. Conflict as an asset
4. Knowledge/understanding/skills
5. Courage/confidence
6. Creating a shared vision
7. Action planning
8. Looking at the community in a new way
9. Networking
10. Team building
11. Self awareness
12. Adaptive Leadership
13. Passion/commitment

Thank you for taking the time to complete this survey! Feel free to use the space below and the back of this page to share any additional thoughts you have about the Workshop.

Faith, Health Collaboration Leadership Development Program
Post-Workshop II Survey
June 2015 [61]

Purpose

The purpose of this survey is to find out your opinions about **Workshop II** of the Faith, Health Collaboration Leadership Development Program and what you learned as a participant. We will use the information you provide to improve future Workshops.

Confidentiality

All of the information you provide is anonymous. The survey does not ask for any personal information that would allow us to link your responses with your name or the name of your community. You do not have to answer any questions that you do not wish to answer. Your answering the survey is taken as your consent to participate.

Part 1: Your Background and Opinions

1. What discipline do you primarily represent within your team? (Select only one please)

Select one

- ☐ Health
- ☐ Faith
- ☐ Civil Society
- ☐ Other _____

2. What are the top 2 to 3 things you gained from your participation in **Workshop II**?

14. _____

15. _____

16. _____

3. Please indicate the extent to which you agree or disagree with each statement listed below:

	Strongly Disagr	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**

	ee				
f. Our team was strengthened through our experiences at **this Workshop**.	1	2	3	4	5
g. I am more committed to faith-public health-development collaborations now than when I arrived at **Workshop II**.	1	2	3	4	5
h. I am confident that the gains I received from **this Workshop** are worth the time I invested.	1	2	3	4	5
i. I increased my appreciation for what contributions the health community can make to reduce health disparities.	1	2	3	4	5
j. I increased my appreciation for what contributions the faith community can make to reduce health disparities.	1	2	3	4	5
a. I increased my appreciation for what contributions the development community can make to reduce health disparities.	1	2	3	4	5
b. I am confident that our team will take concrete steps to implement our plan for community action when we get home.	1	2	3	4	5

4. The following are additional statements about **Workshop II**. Please indicate the extent to which you agree or disagree with each of these statements:

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
g. I would recommend this program to others.	1	2	3	4	5
h. The overall pace of **this Workshop** was good.	1	2	3	4	5
i. The April and May Community Action	1	2	3	4	5

	Learning team activities contributed to my learning experience.				
j.	Communication with program staff during the Community Action Learning was helpful.	1	2	3	4	5
k.	Communication with program staff during this Workshop was helpful.	1	2	3	4	5

Part 2: Your Gains

5. Each statement below describes a skill or a topic that was addressed in **Workshop II**. We would like you to rate your confidence that you could have performed that skill on the day that you arrived for **Workshop II**. Then we would like you to rate your confidence that you could perform the same skill today, the last day of the Workshop. For this section, use the following rating scale:

1 2 3 4 5
Not at All Confident **Completely Confident**

Skill/Content Area	Rate your confidence that you could have performed this skill **the day you arrived** for Workshop II.	Rate your confidence that you can perform the skill **today, the last day** of Workshop II.
f. Describe how reflection action is an important leadership tool for learning and leading that creates change.	1 2 3 4 5	1 2 3 4 5
g. Identify the potential contribution of religion and the faith community in addressing HIV social disparities.	1 2 3 4 5	1 2 3 4 5
h. Identify the complex underlying systemic factors that lead to HIV social disparities.	1 2 3 4 5	1 2 3 4 5
i. Understand the role of collaborative leaders in community systems change.	1 2 3 4 5	1 2 3 4 5

j. Describe the role that both stigma and discrimination play as internal and external barriers to treatment.	1 2 3 4 5	1 2 3 4 5
k. Identify community assets and develop strategies for mobilizing and activating those assets to assure long term treatment and support for those most vulnerable.	1 2 3 4 5	1 2 3 4 5
g. Identify elements of a successful action plan – objectives, activities, and measureable outcomes – that brings about a vision of eliminating HIV disparities.	1 2 3 4 5	1 2 3 4 5

Thank you for taking the time to complete this survey! Feel free to use the space on the back of this page to share any additional thoughts and recommendations for future programs like this.

Appendix G: Community Action Learning Guidelines

Community Action Learning Team Guidelines and Assignments [62]

The time after each workshop is when real learning takes place in the environment of the hard realities in your community. This gives you the opportunity to be intentional about integrating your new leadership skills in your day to day life. And, perhaps most importantly, the hands-on learning and reflection you do together as a team carried out while directly engaging the realities of your community will build enduring and vital collaborative leadership relationships.

During this 2 month time period, we ask that you do the following:

First Month – April to May

Implementation of Your Team Action Plan

1. Follow through on activities and action steps you decided during the workshop need to be carried out during this time period.
2. Meet together as a team at least once to review and assess action taken and responsibilities for implementation of your action plan.
3. Schedule the meeting time(s) and determine responsibilities for carrying out the activities and assignments for the second month.

**Community Action Learning reading assignment #1- The de Gruchy chapter from ARHAP.

Second Month – May to June

Team Dialogue, Assessment, and Presentation Planning

1. Continue implementing action steps that extend into this time period
2. During 1 or more team meetings, review together your progress to date and use the following reflection questions to understand your work and continue learning (discuss, raise questions, and record):
   a) What is working well?
   b) How are we implementing our new leadership tools? – social determinants of health thinking, conflict transformation, adaptive leadership,, and community asset mapping …
   c) In what additional ways could we be implementing our new leadership tools that would make our work even more successful?
   d) What challenges are we facing? And what additional learning would help us address those challenges?
   e) How are we using our collaborative leadership strengths to work effectively as a team?
3. Write a 2 page progress report for the program leaders at SPILL following the guidelines provided at the end of this document.
4. Prepare a 30 minute team presentation to be made the first day of the Workshop II on 21st to 24th June. Include in the presentation:
   a) Part I. Overview of your vision and action plan
   b) Part II. What leadership tools have you and your team found to be particularly important (now and expect in the future) to address challenges and bring about transformative change in your community? Describe how you have applied these new tools and/or plan to use them in further action steps.

** Community Action Learning Reading Assignment #2 – Senge's Systems Thinking

GUIDELINES FOR REPORT WRITING (*Include photos of activities)*

i. Introduction (Summary of your action plan)
ii. Details on activities implemented- What was achieved during the reporting period
Use this format:
Objective 1
Activity1.1
Details on Implementation
Objective 1
Activity 1.1
Details on Implementation
Objective 2
Activity 2.1
Details on Implementation
NB
- Be specific on the activities implemented; what was done, purpose, number of people reached- male and female (where possible) and location.
- If awareness or training was conducted what was the topic, how many people were reached and what was the outcome

iii. Challenges *(Please indicate what additional learning would help us address those challenges)*
iv. Lessons learnt
v. Future Plans/ Way forward

COMMUNITY ACTION LEARNING, EVALUATION, AND REPORTING GUIDLEINES FOR SECOND PHASE [63]

Remember the time after each workshop as you are dealing with the hard realities in your community is when real learning and your own leadership development takes place. This time is an opportunity to be intentional about using your new leadership skills in your everyday life. And, perhaps most importantly, the hands-on learning and reflection you do together as a team carried out while working in your community will build enduring and vital collaborative leadership relationships. These are key to sustainability.

During June, July, and August, your team will be continuing to implement your action plans, reflect on your actions, and build your Collaborative Leadership skills. You will be expected to participate in some cross team learning and follow up evaluation activities and to submit a final report for your time in the overall program.

JULY

Action Plan Implementation and Participation in Feedback Learning Event:

1. Continue implementing activities as agreed upon by your team during Workshop 2.
2. Schedule your meetings as planned. Meet and discuss activities in the action plan and assess your progress, challenges, and brainstorm possible solutions.
3. Share your success stories, what is working well. Consider together, what are the most promising program activities that will have an impact on systemic factors linked to HIV/AIDS social disparities?

Program Evaluation Activities and Learning Across the Teams:

1. Together SPILL and Emory will be conducting evaluation activities for the purpose of improving the Program and deciding how it can best achieve the goal of helping communities support persons in long term treatment and care.
2. We are holding a "*Follow Up Feedback Day"* on **Wednesday July 29th**. In addition to fulfilling Program evaluation goals, this day is designed for you to do 2 things: 1) reflect on both what is working well and on the challenges in making your vision a reality and 2) take the time to share with other teams what you are doing and learn from and be inspired by other's commitments. Full participation by all the teams and team members is expected.
3. We anticipate scheduling several site visits during July when we will learn more about what you are working on together.

AUGUST

Final Report Expectations:

1. Continue with implementation of your team Action Plan activities.
2. Prepare for your final report by reviewing progress and assessing your accomplishments for the overall program. You will receive detailed instructions for this report at the July 29th gathering.
3. **You will be expected to send this to SPILL**, emoryspillprogram@spu.ac.ke **no later than August 21**.

4. A graduation event when you will receive your certificate of completion is scheduled for **August 28**. Together we will celebrate accomplishments and inspire each other with hope represented by this large circle of committed collaborative leaders!!