FACTORS INFLUENCING THE EFFECTIVENESS OF SOCIAL PROGRAMS: THE CASE OF TICAH'S SEXUAL AND REPRODUCTIVE HEALTH PROGRAM

BY

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A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER IN ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

2011

DECLARATION

This research report is the outcome of my own original research and has not been submitted for the award of a degree or any other academic award in any other university.

Signature:____________________ Date: 07/08/2012

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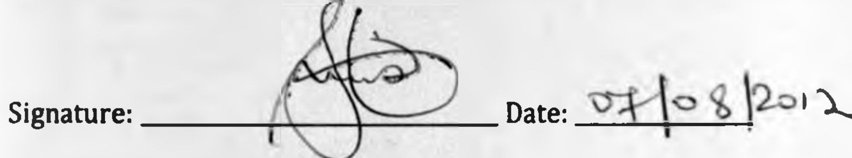
This research has been submitted with my approval as the university supervisor.



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DEDICATION

To my Dad the late Stephen Maina, your hard work and determination to have us get a good education was never lost to me. Your wise advice and counsel is forever remembered. To my Mum and hero Faith Maina, thanks for the faith you have had in me and for the being such a sterling role model. To Thomas Mbewa, your gentle nudge every time I lagged behind schedule got me back on track. To my family, I wish to salute Michael Gathanju, Mercy Maina, Eric Kinyua, Maureen Mutia and Alfred Kogi for always being there for me. Thanks for the encouragement, love and support. It is because of you that I am at this point in life. To my friends Judy, Christine and Elaine; my pillars of strength, you are very much appreciated.

ACKNOWLEDGEMENT

I am most grateful to the Almighty who has enabled me to pursue this course to conclusion. I wish to abundantly thank my supervisor, Mr. Levi Matseshe for his guidance, invaluable assistance and contributions. I am so much grateful for his reliability that enabled me to consult with him severally to enhance the quality of this project. I am also indebted to my lecturers in the MA Project Planning and Management programme. Thanks also to friends Angela and Rosemary for their academic and moral support.

I wish to acknowledge with much appreciation Trust for Indigenous Culture and Health (TICAH) especially Dr. Mary Ann Burris and the wonderful TICAH staff; Angela Okech and Mary Elias, for all the support accorded to me before during and after this project, for the opportunities availed and the space provided for the study and implementation of all the concepts and ideas running throughout this report. I am grateful to the all the respondents for taking time from their busy schedules, and for all the experiences they shared and the learning they made possible.

I wish to dedicate my time and the experience gained towards promoting change and implementing projects in positive sexuality in East Africa.

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LIST OF ABBREVIATIONS

ABC	Abstinence, Being faithful and Condoms
ADA	Alcohol and Drug Abuse
CDC	Centre for Disease Control and Prevention
HIV/AIDs	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IPAR	Institute of Policy Analysis and Research
ISS	Institute for Security Studies
KAIS	Kenya Aids Indicator Survey
NACADA	National Agency for the Campaign against Drug Abuse
NGO	Non-Governmental Organization
NIDA	National Institute on Drug Abuse
TICAH	Trust for Indigenous Culture and Health

ABSTRACT

The purpose of this study was to explore the factors that influence the effectiveness of social programs especially sexual and reproductive health programs aimed at behavior change for purposes of HIV/AIDS prevention.

This study was guided by the following objectives, which also formed the basis of the research questions; to determine the extent to which culture, social media and organizational capacity influenced the effectiveness of behavior change programs. The study also aimed to carry out a thorough analysis of the program components and how far they were appropriate to the achievement of the program purposes and objectives, assess the extent to which culture, social media and organizational capacity affected the effectiveness of social programs, identify key developments and trends in the HIV/AIDS response and suggest remedial measures required.

The research design used was descriptive in nature and focused on the behavior change programs and their effectiveness with a particular reference to the Trust for Indigenous Culture and Health (TICAH) sexual and reproductive health behavior change program. Stratified random sampling was used to select a sample size of 126 respondents. The respondents were male and female between ages 18 years and 50 years. Information was collected using a questionnaire by the researcher and administered by two trained research assistants under the researcher's guidance. Data was analyzed using the Descriptive statistics in particular measures of central tendency and findings presented by the aid of tables.

The study concluded that among the three factors namely; culture, social media and organization capacity; culture had the greatest impact on the effectiveness of the sexual and reproductive health programs, followed by organization capacity and then social media. Further, the determinants of the impact of the program on individual behavior change included; number of meeting attended under TICAH's HIV program, amount of information received under TICAH's HIV prevention change program, and number services received under TICAH's prevention behavior change program.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter provides a background to the study, explores programming, statement of the problem, purpose of the study, its objectives and research questions. It also gives the significance of the study as well as the scope, limitations and assumptions of the study.

1.2 Background to the study

A program is a planned sequence and combination of activities designed to achieve specified goals. Programs involve equipment, money, personnel and time. Sometimes the word 'project' is used interchangeably with the word program and other times it's used to refer to a subset of program (Sebastian, 2007).

While programs in general refer to activities to achieve specified goals, social programs specifically refer to programs intended to advance the social conditions of a community, and especially of the disadvantaged, by providing psychological counseling, guidance, and assistance, especially in the form of social services. Social programs are concerned with the pursuit of social welfare, social change and social justice. The field works towards research and practice to improve the quality of life and to the development of the potential of each individual, group and community of a society. Social programs interventions are mainly through research, policy, community organizing, direct practice and teaching. Research is often focused on areas such as human development, social policy, public administration, program evaluation and international and community development.

Project management is the discipline of planning, organizing, securing and managing resources to bring about the successful completion of specific project goals and objectives (Sebastian, 2007). A project is a temporary endeavor, having a defined beginning and end (usually constrained by date, but can be by funding or deliverables), undertaken to meet unique goals and objectives, usually to bring about beneficial change or added value. The temporary nature of projects stands in contrast to business as usual (or operations), which are repetitive, permanent or semi-permanent functional

work to produce products or services. In practice, the management of these two systems is often found to be quite different, and as such requires the development of distinct technical skills and the adoption of separate management.

There has been a dramatic growth in the number of social programs developed both in developed and developing countries. The total amount of public funds being spent through Non Governmental Organizations (NGOs) has grown dramatically and the proportion of development aid going through NGOs, relative to bilateral or multilateral agencies, has also increased.

Associated with this growth has been a growing concern about identifying the achievements of these social programs. This has been evident in the burgeoning literature on the monitoring and evaluation of NGO activities. There has been a steady stream of experimentation with specific methods, especially those focusing on participatory approaches to Monitoring and Evaluation and impact assessment (Abbott and Guijt, 1998). Some of the reasons that explain why it has been so difficult to come to positive conclusions about the results of various social programs include; ambitious expectations, complexity caused by scale, diversity of activities, vague objectives, the tools being used, the absence of baseline information and adequate monitoring systems, among others. To overcome these challenges, policy makers and Programme planners need the highest quality data to implement, monitor and evaluate the factors that influence the effectiveness of a social program. The primary challenge of project management is to achieve all of the project goals and objectives while honoring the preconceived project constraints. Typical constraints are scope, time, and budget.

The success of a program will depend critically upon the effort care and skill applied in initial planning. A program is deemed to be successful or effective if it achieves its objectives. Particular factors that influence the success or programs include preparation, program design, knowledge, organization, leadership, teamwork, timeliness and effective conclusion. Each one of these factors is equally critical to the successful outcome of any undertaking, and all should be taken very seriously. However other factors such as culture, organizational capacity, social media, community participation, funding are deemed to have a great influence on the effectiveness of social programs such as HIV/AIDS prevention. For the purposes of this study culture, social media and organizational capacity will be will be discussed in greater detail.

Cultural factors such as traditions, beliefs and practices affect people's understanding of health and disease and their acceptance of conventional medical treatment. Culture describes learned behavior affected by gender, home, religion, ethnic group, language, community and age group.

A major aspect of preparing to implement a social program is the organizational capacity building, which includes human and infrastructure capacity. Strengthening the capacity of an organization plays an instrumental role in the implementation of social projects. An organization with capacity to implement the planned project is better placed to achieve the intended objectives. Organizational capacity means sufficient management, human and financial resources (Shover, Job and Carroll, 2001).

The social media is one of the modes of communication and it plays a very important role in influencing community perceptions about social programs' effectiveness. Since communication is also listening, good program managers must listen to community leaders, both professionally and personally. It enables the community to know you are sincerely interested hence trust and confidence, you are able to obtain feedback and beneficiary or stakeholder acceptance is fostered.

1.2.1 Trust for Indigenous Culture and Health (TICAH)

Since its establishment in 2003, the Trust for Indigenous Culture and Health (TICAH) has endeavored to enhance the links between culture and health. Its work includes training and research in comprehensive AIDS prevention and care, publication and documentation to stimulate attention to grassroots solutions, and activist advocacy to raise voices in effective ways that affect policy and programs. TICAH's Sexual and Reproductive Health program called "Our Bodies, Our Choices" was started in 2006. TICAH's sexuality program was started to bridge the gap that existed between the knowledge of HIV transmission and the prevention programs that more or less did not address fully the sexuality issues surrounding it. The fact that HIV is largely a sexually transmitted infection has been known almost since the virus was identified. Nevertheless, because of the shame and silence preventing honest and informed discussions of sexual life, issues related to intimacy, gender power and relations, sexual pleasure and behaviors, sex has not featured as centrally as it should in the efforts to prevent new infections or cater for the needs of the infected and affected. The program

is aimed at HIV/AIDS prevention by incorporating a comprehensive sexual and reproductive health education and information sharing that empowers the individual in making informed decisions. The program is a brave break away from the traditional narrow focused behavior change programs that have specific aspects of the Abstinence, Being faithful and Condoms (ABC) interventions for specific groups. The program is based on the premise that the more one knows about sex, the better they will be at making individual decisions and hence lead to positive sexual behaviors.

Globally, HIV/AIDS is the fourth largest killer with an estimated 42 million people living with HIV, about a third of them aged between 15 and 24 years. Most people do not know they are infected and women are particularly vulnerable. Sub Saharan Africa is the region most affected by the epidemic and HIV is now the leading cause of death. It is estimated that about 11 million children have lost mothers or both parents.

Kenya is home to one of the world's harshest HIV and AIDS epidemics. An estimated 1.5 million people are living with HIV; around 1.2 million children have been orphaned by AIDS; and in 2009 80,000 people died from AIDS related illnesses (UNAIDS 2010). Kenya's HIV prevalence peaked during 2000 and, according to the latest figures, has dramatically reduced to around 6.3 percent. This decline is thought to be partially due to an increase in education and awareness, and high death rate (UNAIDS 2010). It is against this background that TICAH has established its various programs aimed at behavior change.

1.3 Statement of the Problem.

Many people in Kenya are still not being reached with HIV prevention and treatment services. Only 1 in 3 children needing treatment are receiving it. This demonstrates Kenya still has a long way to go in providing universal access to HIV treatment, prevention and care (WHO/UNAIDS/UNICEF (2010). The Kenyan National HIV and AIDS Strategic Plan to reduce the number of new HIV infections has been by using new, evidence-based approaches to HIV prevention. The main prevention strategies have included: Increasing availability and access to counseling and testing, Condom promotion, and more effective and targeted behavior change communication which has included promoting abstinence, safe sex and delayed sex debut among young people (Kenya Aids Indicator Survey 2007)

Behavior change programmes are preventive programs that look at the ABC's of prevention: **A**bstinence, **B**eing faithful and correct and consistent use of **C**ondom. Most youth programs have specifically been abstinence only programs while adults programs have focused more on being faithful and correct and consistent use of condoms. These programs have at times been criticized as being narrow in focus or unrealistic as compared to the lived realities of most Kenyans.

There has been an escalation of social programs over the last several years. This has resulted in an inordinate expenditure of public funds especially by NGOs involved in the implementation of these programs, which has raised questions and concerns about identifying their achievements. A lot of resources and donor funding have been spent on HIV/AIDS education and yet behavioral change has not matched the effort. According to the UNAIDS on the Global AIDS epidemic In 2008/09 total funding for HIV/AIDS in Kenya amounted to $687 million.

Despite the efforts and programs being put in place for awareness and education to promote behavior change, not much has been achieved in individual behaviors. According to Kenya Aids Indicator Survey (KAIS) new HIV infections are currently increasing within married couples and in the youth aged between 15-24. The sexual debut of Kenyan youth is going lower and is currently at the average age of 12.5.

Concerns have been raised as to the effectiveness of the behavior change programs. With the increase of peer pressure, pornographic material, more liberal society the youth are finding it harder to abstain till marriage. The African context that still sees that men and now even women continuously have multiple partners even within the context of marriage, and where condom negotiation is hard or almost impossible. And even then its correct and consistence use is not being adhered to compounded by stock outs of government supply for this very important commodity in the face of HIV prevention.

As much as the treatment program (universal access) is underway, with the number of new infections, Kenya and many other developing countries may not be able to cope with the increasing number of people needing drugs everyday. There is need to strengthen prevention strategies through effective behavior change programs.

This study attempts to examine and explore the effectiveness of the various programs by various organizations, particularly TICAH in changing behaviors regarding sexual and reproductive health and to find possible strategies for enhancing behavior change. It is instructive to note that TICAH's programming is broad based and looks at the agency of the individual.

1.4 Purpose of the Study

The main purpose of the study is to assess the factors that influence the effectiveness of social programs with a particular reference to TICAH's Sexual and Reproductive Health program.

1.5 Objectives of the Study

i. To assess the extent to which Culture affect the effectiveness of social programs
ii. To determine the extent to which social media affect the effectiveness of social programs
iii. To establish the extent to which organizational capacity affect the effectiveness of social programs.

1.6 Research Questions

The study is guided by the following research questions formulated to aid in gathering the information concerning the research topic.

i. To what extent does culture affect the effectiveness of social programs?
ii. To what extent does a social media affect the effectiveness of social programs?
iii. To what extent does organizational capacity affect the effectiveness of social programs?

1.7 Significance of the Study

The rationale for undertaking this study is underlined by the fact that the study has successfully identified and discussed the extent to which some major factors influence the effectiveness of behaviour change programs. This is useful to project sponsors, project management staff and project beneficiaries who are involved in HIV/AIDS prevention through behaviour change programmes. Knowing how these factors

influence the effectiveness of programs makes it possible for stakeholders to plan and implement behaviour change programs with clear mechanisms of promoting their positive influences while mitigating against their negative influences. This will have the overall effect of ensuring a high degree of project success and in turn lead immense savings in terms of resources to individual, organizations and even government agencies. Eventually this has the capacity of making Kenya as a whole begin to realize the much-anticipated reversal of the HIV/AIDS epidemic.

In particular this study aims at assessing TICAH strategies with the express intention of eliminating gaps and hence improving its programmatic efficiency and effectiveness. This study will also provide useful information to other players in the industry so as to enable them identify gaps in their programming and improve their service delivery.

The study is aimed at contributing to the body of knowledge in the field of programming particularly regarding the factors that affect the effectiveness of social programs in behavior change hence it will be of interest to both researchers and academicians who seek to understand the dynamics of behavior change in regard to programming.

1.8 Scope of the Study

TICAH is an important player in the sexual and reproductive health sector endeavoring to change behavior especially through the empowerment of women, men and the youth in making responsible sexual choices. For logistical and efficiency purposes, this study looks at TICAH and focuses on catchment areas in Nairobi, namely Dandora, Kibera and Huruma and will involve women, men, sex workers, gays and lesbians as well as youths between 13 and 18 years who are part of TICAH's "Our Bodies Our Choices" program.

TICAH's "Our Bodies, Our Choices" program has been funded by the Ford Foundation UHAI East Africa and Hivos. TICAH works with other local partners in Kenya namely Carolina for Kibera and Fortress of Hope Africa in this program.

In terms of variables, this research will be confined to only three major factors that affect the effectiveness of social programs, namely; culture, social media and organizational capacity.

1.9 Limitations of the Study

This study will have to contend with the following limitations

i. The nature of the study requires respondents to give largely confidential information about their personal lives; sincerity in answering these questions is of paramount importance, lack of which may lead to some inaccurate answers and findings.

ii. Some of the targeted respondents in this study may not be literate this may pose a problem in the data collection.

1.10 Assumptions of the Study

The study is based on the following assumption

i. The respondents would be sincere in answering the questions.

ii. The respondents will fill and return the questionnaires within the stipulated period.

1.11 Definition of Terms

Drug: A substance used in the diagnosis, treatment, or prevention of a disease or as a component of a medication

Drug abuse: it is the use of illegal drugs, or the misuse of prescription or over-the-counter drugs.

Substance abuse: The excessive use of a substance, especially alcohol or a drug

Social class: Group of people within a society who possess the same socioeconomic status.

Program: A system of services, opportunities, or projects, usually designed to meet a social need.

Project: it is a temporary activity with a starting date, specific goals and conditions, defined responsibilities, a budget, a planning, a fixed end date and multiple parties involved.

Social program: Organized work intended to advance the social conditions of a community, and especially of the disadvantaged, by providing psychological counseling, guidance, and assistance, especially in the form of social services.

1.11 Chapter Summary

This chapter has given a background to the study by expounding on the impact of programming on behavior change. It has addressed the purpose of the study, its objectives, research questions as well as the justification and scope. It has also identified TICAH as a case study.

Chapter two reviews the literature available on the subject of the study with the aim of identifying gaps or lacunae.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review of studies that have been done on effectiveness of social programs. The chapter begins with an overview of social programs. This followed by an overview of Trust for Indigenous Culture and Health, behavior change and HIV prevention, theoretical framework, factors influencing the effectiveness of social programs, research gap and a conceptual framework

2.2 Social Programs

Sexuality is an integral part of the human personality and has biological, psychological, cultural, social and spiritual dimensions. Sexuality education seeks to provide young people with formal opportunities to acquire knowledge and understanding of human sexuality, through processes, which will enable them to form values and establish behaviors, within a. moral, spiritual and social framework. While parents have the primary responsibility for the overall education of their children, it is accepted that the school should play an important role in supporting and complementing them in this task, including sexuality education. The general aim of education is to contribute towards the development of all aspects of the individual. Sexuality education is an important element of the process. It is a lifelong task of acquiring knowledge and understanding and developing attitudes, beliefs and values about sexual identity, relationships and intimacy. In the school setting it is an integral part of general education provision, which seeks to promote the overall development of the person and which includes the integration of sexuality into personal understanding, growth and development (Ajzen and Fishbein, 1980).

There is increasing recognition among many governments and donor organizations that rigorous evaluations of public interventions should feature in the social policy decision making process. As pressures worldwide mount to reduce the size of governments and expand private sector and nongovernmental involvement in social services, it becomes increasingly important to justify public spending and ensure that the funded interventions are achieving intended objectives. Countries from Chile to Indonesia to Sweden have embraced evaluation as a crucial element of good public sector

management. The international community has also turned to more systematic evaluation of its own programs in an effort to make aid and assistance more effective (Glanz et al., 1997).

The single most critical policy question pertaining to a public program is whether in a cost-effective manner it truly helps those who participate in it. This and related questions are addressed by a special class of evaluation known as program impact evaluation. Impact evaluations can provide information on whether a program measurably benefits participants, determine if it is cost-effective relative to other options, and yield insights into why a program may not deliver as intended. Collectively, impact evaluations provide the best evidence on which programs and policies are likely to help a society achieve its social goals. Yet many policy stakeholders, including development organizations, government officials and program proponents in both developed and developing countries, exhibit a reluctance to undertake formal evaluation of social programs. A study by Rubio and Subbarao (2001) found that among a sample of social protection projects supported by the World Bank in 1999, just over 20 percent had well-developed evaluation plans, and only half possessed an information base suitable for evaluation with most having incomplete or no plans to evaluate impacts. There are numerous examples of impact evaluations that have been planned by governments, only to be shelved or cancelled for political or cost considerations or a change in administration.

There are two main reasons for this reluctance. Broadly, the reasons have to do, first, with perceived limitations of the art of evaluation and, secondly, with the political economy of the public policy environment. More specifically, they involve: (i) Confusion and misunderstanding regarding what impact evaluations can deliver. Results are not always available on a timely enough basis for policymakers and they can appear ambiguous and difficult to translate into policy actions; and (ii) Political concerns over the conduct of a formal evaluation and the possible repercussions from the results. Evaluation is assumed to be very costly, particularly in relation to the scarce resources available for social programs. Negative findings have the potential to hinder social agendas and damage political careers (Bandura, 1986)

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2.3 Trust for Indigenous Culture and Health

The Trust for Indigenous Culture and Health (TICAH) is a Kenya-based non-profit trust that was established in 2003 to enhance the links between culture and health. Its work includes training and research in comprehensive AIDS care, publication and documentation to stimulate attention to grassroots solutions, and activist advocacy to raise voices in effective ways that affect policy and programs. It believes that culture matters, gender matters, power matters, pleasure matters, and process matters. It is local in its action and global in its vision.

TICAH's Sexual and Reproductive Health program called Our Bodies Our choicesstarted in 2006. It worked initially with HIV-positive women's support groups. It focused attention on the specific needs and desires of positive adult women in relation to their health, sexuality, and rights. Later on it established groups of men and younger women (youth groups), negative/positive or mixed status, LGBTI (Lesbian, gay, bisexual and transgender) people with disabilities and sex workers. Throughout, its 'aim has been to create a way for people to change behaviours, share their sexual experiences, learn from them, get support from one another, improve their skills, and advocate together for changes to policies, programs, and attitudes which stand in the way of our right to satisfying and **safe** sexual relationships and experiences.

This program focuses on sexuality and sexual health needs and supports participatory peer processes to raise concerns about sexual health, sexual behaviour, and sexual rights, and produce targeted advocacy and educational materials to bring sexuality more forcefully into the HIV/AIDS prevention and care mainstream in Kenya. Over the past one year, some of the program activities include Peer Support Groups, Developing a Facilitators Guide (Curriculum), Publicity and Media with incisive learning outcomes

2.4 Behavior Change and HIV Prevention

As HIV infection is invariably the result of human behavior, change in behavior has long been understood as essential to curbing the spread of infection. In all cases where national epidemics have been reversed, broad-based behavior changes were central to success. Yet numerous questions and controversies have beset efforts to promote behavior change. Because of sensitivities associated with human sexuality and drug use, many political and opinion leaders have shied away from open, frank discussion of how

to change behaviors to prevent transmission. Widespread hostility toward the populations at greatest risk for infection has further undermined support for HIV prevention, and efforts to change behavior have frequently become ensnared in bitter ideological disputes (Basu et al., 2004).

While the epidemic has expanded over the past quarter-century, some have questioned whether it is possible to accomplish marked and sustained changes in behavior sufficient to alter the epidemic's trajectory. The suggestion has been made that factors unrelated to prevention programming may account for the favorable behavior shifts seen in some countries. Moreover, recent years have witnessed an increase in risk behaviors in some settings where HIV prevention successes were first documented, calling into question the sustainability of favorable behavior shifts and highlighting the need for better understanding of how human behaviors might change in response to an ever-evolving epidemic.

In addition, HIV is no longer a new threat. There are doubts in some quarters about whether strategies or program models that may once have worked remain relevant in settings that have undergone important social and economic changes. Whether HIV prevention can remain effective as rates of HIV-related illness and death fall is a topic of debate in the HIV field. In addition, some commentators have argued that core HIV prevention strategies, such as condom promotion and treatment of sexually transmitted infections, are unlikely to significantly lower transmission rates in high-prevalence settings (Bertrand et al., 2006).

At the beginning of this decade, the global community embraced a set of ambitious development goals for the new millennium. Among these was the commitment to halt and begin to reverse the global HIV epidemic by 2015. Because behavior change remains the world's primary tool for achieving this goal, clarity is urgently required regarding the optimal means of producing needed behavior changes. In particular, clearer understanding is needed regarding the best strategies to reduce the number of new HIV infections in hyperendemic settings, where modest favorable changes in individual risk behavior are likely to have only limited effect due to such structural factors as partnership concurrency and gender inequity that magnify transmission risks associated with low levels of risk behavior.

This latest report by the Global HIV Prevention Working Group (PWG) focuses specifically on behavior change, surveying the evidence for behavioral HIV prevention to identify what is known and not known about generating and sustaining behavior change. The report describes the elements of successful behavioral initiatives, the limitations of current approaches, key outstanding questions, and research needed to strengthen the evidence base for behavior change. It ends with suggested next steps for moving forward with a clear and more focused strategy for using behavior change in HIV prevention efforts (Brieger et al., 2001).

Assessing the effectiveness of HIV prevention is intrinsically challenging. Understanding why something did not happen is typically more complicated than understanding an event or phenomenon that can be observed, studied, and measured. The totality of evidence, however, indicates that available HIV prevention strategies have the potential to significantly reduce the rate of new HIV infections—in all regions, among diverse populations, and at different stages of national epidemics.

Indeed, available strategies have the capacity to achieve in the field of HIV prevention what antiretrovirals have accomplished in the clinical setting, as the parallels between HIV prevention and treatment are striking. Like antiretroviral therapy, HIV prevention is lifelong, and its impact must be continually monitored and the prescribed regimens revised as circumstances and needs change. Just as a single pill cannot eradicate HIV, one-shot prevention efforts will not achieve the magnitude or sustainability of behavior change required to alter the epidemic's course.

Like treatment, effective HIV prevention requires a combination of strategies. Evidence-based approaches to prevent infection include programs targeting individual behavior; broad-based efforts to alter social norms and address the underlying drivers of the epidemic; and effective use of biomedical or technological tools, such as treatment of sexually transmitted infections (STIs), medical male circumcision, substitution therapy for chemical dependence, and programs that provide access to clean injecting equipment (Broadhead, 2006).

Existing models of behavioral interventions are based on various cognitive behavioral theories that assume individuals will take steps to avoid risks if they are fully informed and sufficiently motivated. While such approaches may work well for many people, they

are unlikely to address the needs of the myriad populations at risk of infection. Because human sexuality and drug dependence are phenomena that are not always subject to cognitive control or mediation, cognitive approaches alone will not produce behavior change in many people.

Moreover, many individuals confront exceptionally elevated risk of infection not primarily as a result of their own risk behavior, but rather because of the behavioral characteristics of their partners or the particular structure and functioning of the social networks to which they belong. Influencing individual behavior in such cases will have only a limited impact on infection rates.

Examples of this paradox of high risk in the context of low-risk behavior are numerous. Although heterosexuals in Africa are no more sexually active than their counterparts in other regions and are no more likely to have multiple partners, the region has the world's most severe HIV epidemic, driven primarily by heterosexual intercourse (Wellings 2006). Similarly, while young African-American MSM (Men who have sex with men) are 4.5 times more likely to be infected than young white MSM (CDC 2001b), surveys indicate that they are less likely to have unprotected anal intercourse than their white counterparts (Crosby 2007; Millett 2006).

To reduce new infections in such cases, HIV prevention must alter social norms or the functioning of social networks. In general, however, relatively few validated prevention strategies operate at a community level. Likewise, the evidence base for HIV prevention includes comparatively few policy (or structural) interventions that aim to reduce risk by altering the social, legal, or physical environments in which risk behavior may occur (Wohlfeiler and Ellen 2007).

With respect to relationships or social networks with characteristics that increase collective risk, HIV prevention initiatives must persuade social groups to examine and alter long-established values, assumptions, and behavioral patterns. There is growing recognition, for example, of the role of concurrent partnerships in facilitating the rapid spread of HIV, especially in endemic settings (Epstein 2007). To disrupt the dynamics of transmission in many high-prevalence countries in Africa, programs are needed that alert individuals to the risks associated with concurrency and that forge new social

norms that reduce the frequency of concurrent partnerships (Campbell and MacPhail, 2002).

2.5 Programming

Over the last decade there has been a dramatic growth in the number of NGOs involved in development aid, in both developed and developing countries. The total amount of public funds being spent through NGOs has grown dramatically and the proportion of development aid going through NGOs, relative to bilateral or multilateral agencies, has also increased.

Associated with this growth has been a growing concern about identifying the achievements of NGOs. This has been evident in the burgeoning literature on the monitoring and evaluation of NGO activities. There has been a steady stream of experimentation with specific methods, especially those focusing on participatory approaches to M& E and impact assessment (e.g. 11RR, 1997; Goydev et al, 1997, Abbott and Guijt, 1998, Guijt, 1998). On a smaller scale, a number of NGOs have produced their own guides on monitoring and evaluation (Gosling and Edwards, 1995; Platt, 1996; Roche, 1999). Recent books on NGO management are giving specific attention to assessing performance (Fowler, 1997) and the management of information (Powell, 1999). As well as doing their own evaluations, some NGOs are now doing meta-evaluations (of Methods) and syntheses (of results) of their evaluations to date (Mansfield, 1996; Evison, 1999; Plan International, 2000). Similar but larger scale studies have been commissioned by bilateral funding agencies (Riddell et al, 1997; AusAID, 2000). Both sets of studies have attempted to develop a wider perspective on NGO effectiveness, looking beyond individual projects, a cross sectors and country programmes. They have been more critical and analytic, when compared to the more prescriptive and normative approach of the method literature. Overall, NGOs have become much more aware of the need for evaluation, compared to the 1980s when there was some outright hostility (Howes, 1992).

In contrast to this operational literature, there are relatively few examples of a more independent literature, which steps back and looks at the institutional context in which monitoring and evaluation activities are taking place (e.g. Carlson, et al, 1994). So far the main focus has been on bilateral and multilateral donor influences, within a wider

perspective than monitoring and evaluation alone (Wallace, et al, 1997, Edwards and Hulme, 1996). Less evident are more economic perspective, looking at NGOs as agent in a market place (Maven, 1995; Sogge, 1996), although most large NGOs have marketing departments and these pre-date and exceed in size other units dealing with government funding. Further afield, but growing in number, are the very public criticisms of NGOs as a whole, which contain implicit and explicit judgments about NGO performance (de Waal, 1998; Shawcross, 2000; Bond, 2000). At the other extreme of involvement are the more biographical accounts of NGO work, which include insiders' perspective on monitoring and evaluation practices (Morris, 1991). One small but emerging genre is the organizational ethnography (Harper, 1998; Crewe and Harrison, 1999). These have been widely used in research into the application of information technology, and more generally in the sociology of science (Anderson, 1994).

Riddell et al, 1997 in the study "Searching for impact and Methods: NGO Evaluation synthesis study" Posit the most comprehensive overview of NGO impact, and impact evaluation methods to date. This study looked at evidence from 60 separate reports of 240 projects undertaken in 26 developing countries.

In their executive summary, the authors report that: 'A first over arching, conclusion – confirmed by data and interviews in all the different case study countries – is that in spite of growing interest in evaluation, there is still a lack of reliable evidence on the impact of NGO development projects and programmes'.

In their conclusions about enhancing impact in the future they note that a repeated and consistent conclusion drawn across countries and in relation to all clusters of studies is that the data are exceptionally poor. There is a paucity of data and information from which to draw firm conclusions about the impact of projects, about efficiency and effectiveness, about sustainability, the gender and environmental impact of projects and their contribution to strengthening democratic forces, institutions, and organizations. There is even less firm data with which to assess the impact of NGO development interventions beyond discrete projects, not least those involved in building and strengthening institutional capacity, a form of development intervention whose incidence and popularity have grown rapidly in the last five years.' (Riddell, et al. 1997).

Similar conclusions were reached by the Danida - funded study of 45 Danish NGO projects in four counties (Oakley, 1999). These two multi - country studies raise serious doubts as to whether many NGOs know what they are doing, in the sense of their overall impact on people's lives. NGOs may or may not be having a positive impact, but their ability to scale up that impact must be limited by the ability to evidence those achievements (and their limitations) and communicate this information to others with more resources and/or influence.

Given the hundreds or thousands, of Millions of pounds and dollars that have been spent by NGOs over the last several years it is necessary to understand why it has been so difficult to come to persuasive conclusions about the results of their work. Several different reasons are examined because, including those proposed by fowler (1997) and Riddell et al. (1997).

2.6 Theoretical Framework

The following section reviews some of the major theories of behavior and behavior change that may be pertinent to behavior change, including theories and concepts from mainstream psychology.

2.6.1 Social Cognitive theory

Social Cognitive Theory explains human behaviour in terms of a triadic, dynamic and reciprocal model in which behaviour, personal factors, and environmental influences interact. It addresses both the psychological dynamics underlying behaviour and their methods for promoting behaviour change. It is a very complex theory and includes many key constructs. Self-efficacy is one of the key concepts. Self-efficacy refers to one's confidence in the ability to take action and persist in action. It is seen by Bandura (1986) as perhaps the single most important factor in promoting changes in behavior. Measures of self-efficacy and some of the other key concepts from Social Cognitive Theory have also been identified as key determinants of movement through the stages of change, (Oldenburg, 1999).

Social cognitive approaches combine aspects of social psychological theories with components of both social learning theory and cognitive behavioral approaches. Social-

cognitive approaches emphasize the person's subjective perceptions and interpretations of a given situation or set of events, and argue that these need to be taken into account if we are to understand adequately both behavior and the processes of behavior change. A number of social psychological concepts have been found to be consistently related to behavior change across a wide range of situations. For example, the social reality of a the group (e.g. peer group, school group, family group etc.) will affect an individual's behavior. All groups are characterized by certain group norms, beliefs and ways of behaving, and these can strongly affect the behavior of the group members.

Expectations of significant or respected others can also have a strong influence on a person's behavior. This phenomenon has been most consistently demonstrated in the early research on self-fulfilling prophecies, which showed that teachers' expectations of their students were consistently related to the students' subsequent performance, even when these expectations were based on falsified information. Thus, support and encouragement, or conversely, low expectations from significant or respected others, can affect and bring about, (or not), changes in individual behavior.

2.6.2 Theory of Interpersonal Behavior

Habit strength is another concept that has been found to be important in predicting or changing behavior. Habit is an important element of the theory of interpersonal behavior, which proposes that the likelihood of engaging in a given behavior is a function of: the habit of performing the behavior, the intention to perform the behavior conditions which act to facilitate or inhibit performance of the behavior.

In turn, intentions are said to be shaped by a cognitive component, an affective component, a social component, and a personal normative belief. The theory of interpersonal behaviour argues that as behaviors are repeated, they become increasingly automated, and occur with little conscious control. That is, while individuals must first intend to participate in a given behaviour or activity, as the end requires little conscious intervention. Driving a car along a familiar street is cited as an example. To date, this model has not been tested as extensively as have the theory of reasoned action or the theory of planned behaviour. However, major components of the model appear to be consistent with the processes Prochaska and DiClemente to

underlie the five stages of behavior change - i.e. precontemplation, contemplation, and preparation, action and maintenance - and described earlier (Campbell and Mzaidume, 2001).

In addition to stage theories, in the research literature a number of other psychological theories have been proposed for explaining various aspects of human behavior and behavior change. While a number of different psycho-social theories and models have been developed over the past decades, these are by no means incompatible with a stage-based approach to understanding behavioral change. Neither are the major theories used in considering behavior change incompatible with each other. While each theory tends to offer unique concepts and insights, differences seem to be more a matter of emphasis, focusing on different aspects of behavior, rather than complete contradictions.

2.6.3 Theory of Planned Behavior

The theory of planned behavior suggests that behavior is dependent on one's intention to perform the behavior. Intention is determined by an individual's attitude (beliefs and values about the outcome of the behavior) and subjective norms (beliefs about what other people think the person should do or general social pressure). Behavior is also determined by an individual's perceived behavioral control, defined as an individual's perceptions of their ability or feelings of self-efficacy to perform behavior. This relationship is typically dependent on the type of relationship and the nature of the situation (Cooper and Hedges, 1994).

Intention has been shown to be the most important variable in predicting behavior change, suggesting that behaviors are often linked with one's personal motivation. This suggests that it may be important to present information to help shape positive attitudes towards the behavior and stress subjective norms or opinions that support the behavior. For perceived behavioral control to influence behavior change, much like with self-efficacy, a person must perceive that they have the ability to perform the behavior. Perceived control over opportunities, resources, and skills needed is an important part of the change process.

Social-cognitive theory, theory of interpersonal behavior and theory of planned behavior can be used to explain behavioral change.

2.7 Factors Influencing the Effectiveness of a Social Program

Largely, the success of any social program is assessed in terms of its ability to meet set objectives and targets, which may relate to changing behavior or generally improving the circumstances of a given community or society. Since programs are undertaken in certain environments, they tend to be inordinately influenced by various factors, some of which may be within the organization while others are from outside the organization. Discussed below are some of the factors that influence the effectiveness of a social program.

2.7.1 Culture

Over the years many scholars have attempted to define culture. Well over 100 years ago, for example, Taylor (1865) defined culture as all capabilities and habits learned as members of a society. Linton (1936) referred to culture as social heredity. Rohner (1984) defined culture as the totality of equivalent and complimentary learned meanings maintained by a human population, or by identifiable segments of a population, and transmitted from one generation to the next. Jahoda (1984) argued that culture is a descriptive term that captures not only rules and meanings but also behavior. According to them, culture consists of patterns, explicit and implicit, of and for behavior acquired of symbols, constituting the distinctive achievements of human groups. Including their embodiments in artifacts; the essential core of culture consists of the traditional (that is the historically derived and selected) ideas and especially their attached values.

Socio-cultural factors concern community norms, values and beliefs. Cultural factors that present barriers to delivery of services include racism, sexism, homophobia, attitudes about drug use and other marginalized groups, stigma associated with HIV/AIDS, shame/secretiveness about sexuality, absent or poor social networks, language and literacy difficulties (Bernard, 2000).

Since culture primarily relates to the way people interact with each other, it can only be learned through fieldwork and first hand observation in that society (Dennis 2007). Human social behavior is often complicated. In trying to comprehend the interaction between people, it is useful to think in terms of a distinction between ideal, actual and believed behavior. Ideal behavior is what we think we should be doing and what we want others to believe we are doing. Actual behavior is what is really going on. Believed behavior is what we honestly think we are doing. In reality, people's actions are often different from what they believe them to be at that time (Dennis 2007).

In as much as culture influences social program's effectiveness, culture is also influenced by such factors as ecological, social and biological. Cultural factors such as traditions, beliefs and practices affect people's understanding of health and disease and their acceptance of conventional medical treatment. Culture describes learned behavior affected by gender, home, religion, ethnic group, language, community and age group. Culture can create barriers that prevent people, especially women from taking precautions. For example, in many societies/cultures, domestic violence is viewed as a man's right, which reduces a woman's control over her environment. This means she cannot question her husband's extra marital affairs, cannot negotiate condom use and cannot refuse to have sex. At the same time ascribed gender roles mean that men can or are expected to have many sexual relationships. In most communities, cultural beliefs supersede any influences on learning hence culture greatly affects the way communities receive and perceive various programs or any social intervention measures. Any social program deemed to be at variance with local cultural practices is bound to perform dismally or meet a lot of resistance (Gao et al., 2002).

Several efforts have been made by researchers, mainly anthropologists, to understand culture and its complexities. However, not much has been done to establish the linkage between culture and learning outcomes and more particularly how it affects the effectiveness of social programs in behavior change. This study will therefore fill this gap by assessing the extent to which Culture affect the effectiveness of social programs by focusing on TICAH's Sexual and Reproductive Health program.

2.7.2 Organization Capacity

A top-down approach focuses on an organization's capacity to be more responsive to existing and emerging challenges. Organizational capacity can be transformed by a variety of activities, including organizational restructuring, redevelopment or implementation of protocols and policies, and coordination and planning to ensure that staff, facilities, equipment, and other resources can be mobilized as needed. The top down organizational approach includes an organization's board of directors, since the board members play a vital role in the functioning of the organization. Examples of this approach include: training of board members, organizational development, strategic planning, staff development, and quality assurance activities (Basu et al., 2004).

At the community level, capacity can be built through a partnership development approach involving organizations or organized groups of people. This is based on the premise that a two-way flow of knowledge can lead to partnerships through which the resources required to plan and implement health programs may emerge. Partnerships can be fostered between community members and local practitioners, members of the same community, or two or more organizations in a given community. This approach is an integral part of the HIV prevention community planning process (Broadhead, 2006).

HIV prevention programs seek to accomplish their mission by working with partners throughout the nation and the world to monitor, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

A major aspect of preparing to implement a social program is human organizational capacity. In resource – constrained settings, planning for human capacity development must take place in the challenging context of health care systems that are struggling to cope with HIV as well as deal with continuing high maternal, infant and overall disease mortalities. It is critical that efforts to prepare and support health care workers, nurses, doctors, clinical officers and others who care for people living with HIV/AIDS be tailored to the settings in which they are implemented. (Hutton, 2003).

The implications for service delivery are many, including the need for a cadre of providers. A team of professionals from health care and other fields, as well as community groups - often from various institutions and programs - must work together to provide and share quality care, prevention and support. Training from this perspective can help programs achieve these goals (Leonard, 2000).

Increasingly, program identification and implementation is taking a participatory approach unlike in the years past. With increased information communities are becoming more discerning and demanding in terms of service delivery. Social programs must be tailored to the needs of the communities for which they are intended so as to avoid the pitfalls of working at variance with community expectations which impacts negatively on program perception, reception and effectiveness. It has been realized that when communities do not feel adequately involved or represented in programs, they always pose resistances and barriers to their implementation. Since perception is key to the effectiveness of any social program, it is important that adequate participation by beneficiaries assured, which helps to seal the gaps between expectations and outputs.

Organizational barriers include unwieldy or overly bureaucratic structures, weak leadership, staff burnout or turnover and lack of resources. Staff characteristics, whether positive or negative, seem to be most important in determining the success of access and delivery of services. Having staff members from the populations being served creates problems and difficulties. These individuals may lack other important attributes for the job such as appropriate academic background. Absenteeism due to illness for those living with HIV/AIDS is sometimes a problem as are boundaries and over identification with the population being served (Morin, S.F. 2000).

The literature above clearly shows that organizational capacity affects the effectiveness of social programs. There are no studies known to the researcher that have been done to show the influence of organizational capacity in the effectiveness of HIV prevention social programs in Kenya. This study will fill the gap by assessing the extent to which organizational capacity affects the effectiveness of TICAH's Sexual and Reproductive Health program.

2.7.3 Social Media

Proper communications are vital to the success of a program. Communication is the process by which information is exchanged of which it can be written formal, written informal, oral formal or oral informal. The communication process is more than simply conveying a message, it is also a control. Communication must convey both information and motivation. The six steps for effective communication are; think through what you wish to accomplish, determine the way you will communicate, appeal to the interest of those concerned, give playback on ways others communicate to you, get playback on what you communicate and test effectiveness through reliance on others to carry out your instructions (Morisky, 2005).

The social media is a common mode of communication and it plays a very important role in influencing community perceptions about social programs' effectiveness. Since communication is also listening, good program managers must listen to community leaders, both professionally and personally. This enables a community to feel a sense of sincerity and hence build trust and confidence, one is able to obtain feedback and beneficiary or stakeholder acceptance.

Interactive community – focused online tools like Skype, Twitter, Facebook, YouTube, blogs, wikis have become so dominant in peoples lives that it is hard to imagine life without them, Brown, J.D; Bobkowski, P.S. (2011). The universe of social media is rapidly expanding and this has a lot of impact on social lives.

Peer education strategies are a frequently utilized strategy in preventing HIV and other sexually transmitted infections (STIs) worldwide. Such interventions select individuals who share demographic characteristics (e.g. age or gender) or risk behaviors with target groups (e.g. commercial sex workers or drug users) and train them to increase awareness, impart knowledge and encourage behavior change among members of the same group. Peer education can be delivered formally in structured settings or informally during the course of every day interactions.

Peer education programs are based on the rationale that peers have a strong influence on individual behavior (Population Council, 2000). As members of the target group, peer educators are assumed to have a level of trust and comfort with their peers that

allows for more open discussions of sensitive topics (Campbell and MacPhail, 2002). Similarly, peer educators are thought to have good access to hidden populations that may have limited interaction with more traditional health programs (Sergeyev et al., 1999). Peer education programs may be more empowering to both the educator (Milburn, 1995; Oakley,2002) and to the target group by creating a sense of solidarity and collective action (Campbell and Mzaidume,2001). Interventions using peers can also be more cost effective than interventions that rely only on highly trained professional staff (Huton, Wyss and N'Diehor,2003), although the costs of these interventions are often underestimated (Population Council,2000).

Social media interventions have been used with a number of target populations in developing countries, including youth (Agha and Van Rossem,2004), commercial sex workers (Basu et al.,2003; Morisky, Stein and Chaio,2006) and injection drug users (Broadhead,et al., 2006). Yet to date, there has been no systematic evaluation of the effectiveness of these interventions in changing HIV related knowledge, attitudes and behaviors in these settings.

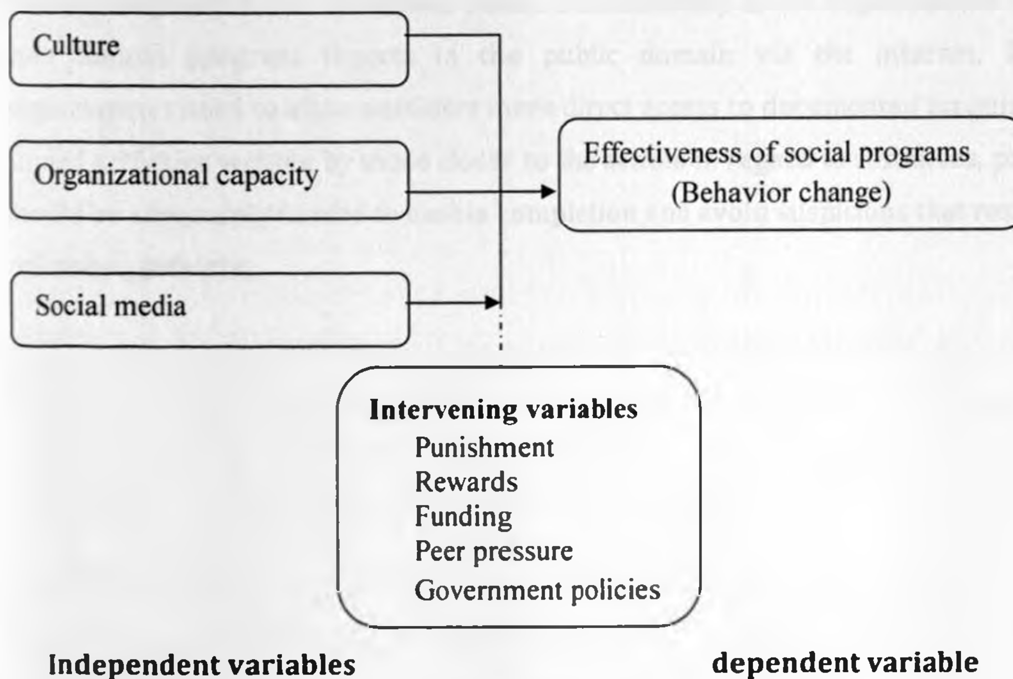
The literature above clearly brings out the effects of social media on the effectiveness of social programs. However there are no studies known to the researcher that have been done to show the effects of social media on the effectiveness of social programs in Kenya. This research study will therefore fill the gap by investigating the extent to which social media affect the effectiveness of TICAH's Sexual and Reproductive Health program among target groups.

2.8 Conceptual Framework

This study was motivated to assess the factors that influence the effectiveness of social programs with a particular reference to TICAH's Sexual and Reproductive Health program. The independent variables will be culture, organizational capacity and social media. This study will therefore evaluate the effects of the independent variables on the effectiveness of social programs.

There is need to discuss the other variable; ie the dependent variable (behavior change). What consists of effectiveness of a social program. How will we measure behavior change?

Figure 1: Conceptual Framework



Independent variables **dependent variable**

Source: Author (2011)

Figure 2. 1: Conceptual framework

Culture greatly affects people in terms of their beliefs, attitudes and behaviors, all of which have a great influence on learning and perception. Naturally, people appreciate more social programs that are in line with or closely related to their cultural inclinations. It is important that organizations attempt to be sensitive to local cultures

in identifying and implementing social programs so as to achieve high levels of success and effectiveness.

Organizational capacity highly influences the effectiveness of social programs. Organizational capacity can be in terms of resources such as finances, human resource, skills or even knowledge. A part from local needs, programs should be tailored to the organizations abilities to adequately deliver.

Social media has a lot of influence on the effectiveness of social programs. The structure of information flows from programs is now open to the possibility of radical change, because of the increasing accessibility of the internet. The main step forward in transparency and more immediate public accountability is for organizations to place their annual progress reports in the public domain via the internet. Program implementers need to allow outsiders more direct access to documented accounts of aid funded activities written by those closer to the action. In regard to resources, programs should be adequately funded to enable completion and avoid suspicions that result from unfinished projects.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methods that were used in the collection of data pertinent in answering the research questions. The chapter begins with a description of the study area followed by research design, population and sample, research instruments, data collection procedure and data analysis

3.2 Research Design

This study used a descriptive research design. This research design entails presenting questions to the respondents and recording their responses for analysis and subsequent interpretations and describing findings as accurately as possible. Descriptive studies portray the variables by answering who, what, and how questions (Babbie, 2002). Its advantage is that, it is used extensively to describe behavior, attitude, characteristic and values. As noted by Miller (1991), descriptive design is the precise measurement and reporting of the characteristics of the phenomena under investigation, and describes phenomena, situations and events. In this regards, since this study is investigating the factors that influence the effectiveness of social programs, descriptive research becomes the most appropriate approach.

This study also took a cross-sectional approach because it undertook to study the research variables at a particular point in time (at the time of the study). In essence it did not involve the studying of the variables over a long period of time.

Finally, this study was quantitative in nature especially with regard to the type of data that was collected, the methods that were used to collect data, and the way data was analysed and presented.

3.3 Target population

Mugenda and Mugenda (2003) described population as, the entire group of individuals or items under consideration in any field of inquiry and have a common attribute. The

target population in this study was the TICAH programme beneficiaries who were stratified as shown in the table below:

Table 3.1: **Target Population**

Category	No.
Program Managers	3
Girls (13-18 years)	40
Boys (13-18 years)	30
Gay men	10
Lesbian women	15
Sex workers	40
Women with Disability	15
HIV Positive Men	15
HIV Positive Women	15
Total	**183**

Source: TICAH, (2011)

3.4 Sample Size and Sampling Design

The researcher used stratified random sampling since the population was the beneficiaries of the TICAH programme and TICAH staff. The study used both probability and non-probability sampling. Probability sampling was used to obtain sample units from the total number of TICAH beneficiaries, for this purposes random sampling was used.

In non-probability sampling the required number of sample units is normally selected deliberately depending on the purpose of the research. In which case, only units that bear true characteristics of the population (Dooley, 1995) are included in the sample. Thus purposive sampling was used to select the 2 TICAH program managers that were involved in this study.

In arriving at the sample of 126 respondents as shown in Table 3.2 below the study used the formula proposed by Yamane (1967); for determining the appropriate sample size for research.

$$n=N/\ (1+N\ (e^2))$$

Where N was the target population, n was the sample size and e will be the precision level (0.05)

$$n=183/\ ((1+183*0.05^2)) = 126$$

Based on the above sample size (126), the proportion of sample size for every stratum was:

Proportion=126/183=0.68

The research used stratified random sampling to select respondents from each of the strata based on the proportion of 0.68 as shown in the table below:

Table 3.2:**Sample Size**

Category	No.	Sample size
Program Managers	3	2
Girls (13-18 years)	40	28
Boys (13-18 years)	30	21
Gay men	10	7
Lesbian women	15	10
Sex workers	40	28
Women with Disability	15	10
HIV Positive Men	15	10
HIV Positive Women	15	10
Total	183	126

Source: Author (2011)

3.5 Research Instrument

Primary data was used in this study. According to Ochola (2007), primary data refers to what is collected directly by the researcher for the purpose of the study. The questionnaire was used to collect the primary data. The researcher used different questionnaires for the program managers, sex workers, boys and girls, lesbians and gay men, HIV positive men and women and women with disability. The questionnaires included structured (close-ended) and unstructured (open-ended) questions and were administered through drop and pick method to respondents. The structured questions were used in an effort to conserve time and money as well as to facilitate easier analysis as they are in immediate usable form; while the unstructured questions were used so as to encourage the respondent to give an in-depth and felt response without feeling held back in revealing any information. With unstructured questions, a respondent's responses gives an insight to his feelings, background, hidden motivation, interests and decisions and give as much information as possible without holding back. At the same time, with the use of structured questions, if the researcher is after information that he

finds easier for administration purposes, he would use this method since the questionnaires and interviews are followed by alternative answers. Mugenda and Mugenda (2003) observed that, the pre-requisite to questionnaire design is definition of the problem and the specific study objectives.

3.6 Validity

Mugenda and Mugenda (2003) asserted that, the accuracy of data to be collected largely depended on the data collection instruments in terms of validity. Validity as noted by Robinson (2002) as the degree to which result obtained from the analysis of the data actually represents the phenomenon under study. The validity of the research questionnaires that were used in this study was obtained by use of content validity. According to Dooley (1995), we assess the content validity by judging how well the test's sample of questions represents the entire domain of what is being studied. Using this method, the researcher assessed the validity of the questionnaire by inspecting its content, and assessing if the sample questions that were used fairly represented the whole domain of all possible questions about a particular variable. The questionnaire was then passed to other research experts who confirmed that the items were indeed valid.

3.7 Reliability

Reliability refers to a measure of the degree to which research instruments yield consistent results after every repeated trial; (Mugenda & Mugenda, 2003). In this research, reliability was obtained by the use of test-re-test method, which entails the measuring of reliability of scores or results by administering an instrument two or more times to the same group of respondents. The researcher administered the questionnaire twice to a group of 10 respondents who had been selected randomly from the population. Then, the scores from the two were correlated to establish the reliability of the tool. The scores were found to have had a high correlation and this confirmed that the tool was reliable.

3.8 Data Analysis

The study was quantitative in nature; hence descriptive statistics was employed. Once the data was collected it was checked for completeness ready for analysis. The data from the

field was first coded according to the themes researched on the study. Statistical tools of measures of central tendency such as percentages, mean scores and frequencies were used for analysis. The results of quantitative data have been presented in charts and tables. Analysis was done with aid of the statistical package for social sciences (SPSS) package.

3.9 Ethical Considerations

According to Kerridge, Lowe and McPhee (2005), ethics involves making a judgment about right and wrong behavior. Ethics as noted by Minja (2009) is referred to, as norms governing human conduct which have a significant impact on human welfare. Indeed as observed by Devettere (2000), ethics is about choice between good and bad. In this study, confidentiality was of concern. In this regard, individuals consent to participate in the study was sought before they filled in the questionnaire and the names of the respondents was not to be disclosed.

3.10 Operationalization of Variable

Table 3.1 has been used to illustrate the operationalization of the variables that were used in this study. The table captures the details that relate to independent and the dependent variables only.

Table3.3: Operationalization of Variable

	Objective	Variables	Indicators	Measurement	Measuring scale	Type of Analysis	Tools of analysis
1.	To assess the extent to which Culture affect the effectiveness of social programs	**Independent variable:** Culture **Dependent variable:** Behavior Change	Beliefs Attitudes Behavior Practices		Likert 5 point scale Content	Quantitative analysis	SPSS version 17 Ms excel
2.	To assess the extent to which social media affect the effectiveness of social programs	**Independent variable:** Social media **Dependent variable:** Behavior change	Internet Face book Twitter SMS PEER PEP Talk		Likert 5 point scale Content	Quantitative analysis	SPSS version 17 Ms excel
3.	To assess the extent to which organizational capacity affect the effectiveness of social programs.	**Independent variable:** Organizational capacity **Dependent variable:** Behavior change	Financial resources Facilities Management capacity Leadership Technical Knowledge in operational areas such as project management Relationships with stake holders etc		Likert 5 point scale Content	Quantitative analysis	SPSS version 17 Ms excel

CHAPTER 4

DATA ANALYSIS AND PRESENTATION

4.0 Introduction

This chapter presents the findings of the study. The study aimed at establishing whether culture, social media and organizational capacity affects the effectiveness of social programs which are being implemented by TICAH health. The results are presented in both tabular and graphical formats.

4.1 Response Rate

4.2 Demographic Characteristics

This section presents the demographic characteristics of the study. Among the characteristics includes gender, age, marital status, highest level of education and marital status.

Table 4.4 Demographic Characteristics

Characteristics	n	%
Gender		
Male	29	42.6
Female	39	57.4
Age		
Less than 20 Yrs	19	27.9
20 – 30 Yrs	47	69.1
31 – 40 Yrs	2	2.9
Marital Status		
Single	51	75.0
Partner	12	17.6
Married	3	4.4
Separated/Divorced	1	1.5
Widowed	1	1.5
Have Children		
Yes	15	22.1
No	53	77.9
Education Level		
Primary	26	38.2
Secondary	18	26.5
College	22	32.4
Graduate	2	2.9

Source: Research Data, 2011

According to the above table, 57.4% of the respondents interviewed were female while the rest (42.6%) were males. Further, 69.1% of the respondents were aged between 20 and 30 years old while 27.9% were aged less than 20 years and only 2.9% of the respondents were aged more than 30 years old. In addition, 75% of the respondents interviewed were single,

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17.6% were partners, and 4.4% were married, while 1.5% was either separated/divorced or widowed. Also, the results showed that 77.9% had children of their own while only 22.1% didn't have children. Finally, 38.2% of the respondents were primary school leavers, 32.4% were college graduates, and 26.5% were secondary school leavers while only 2.9% were graduates. Respondents are a mix ages, gender and profile representative of the populations and target group of TICAH.

Table 4.5: Knowledge of Social Programme

Knowledge of Social Program	Percent
Yes	86.8%
No	13.2%

Source: Research Data, 2011

The results displayed in Table 4.5 above show that 86.8% of the respondents interviewed were aware of an existence of a social program dealing with sexual and reproduction health, while the rest (13.2%) were not aware of the same. Further, among the respondents who knew about an existence of a social program that deals with sexual and reproduction health only 61.8% claimed to be members of these programs while 23.5% were not members.

4.3 Culture

This section presents the respondents view towards the behavior, attitudes, values, and practices based on their culture. The respondents were asked how they view the various statements which they were asked. The responses to these statements were given a five point scale namely, strongly agree, agree, not sure, disagree and strongly disagree. These responses were ranked in such a way that strongly agree was give value 1, agree was given value 2, not sure was given code 3, while disagree was given code 4 and strongly disagree was given value 5. Thereafter, the mean score of every statement was calculated where a value of between 1 and 2.5 was classified as agree with the statement, 2.5 to 3.5 was given a neutral ground and a value of above 3.5 was considered to be disagree. The results are displayed in Table 4.3 below:

Table 4.6: Cultural View towards Behavior, Attitude, Practices and Values

Statement	GENDER			
	Male		Female	
	Mean	Standard Error	Mean	Standard Error
Men/Boys can have multiple partners	2.75	*0.27*	2.72	*0.24*
Women/Girls can have multiple partners	3.75	*0.22*	4.18	*0.16*
The man should suggest condom use	2.03	*0.23*	2.43	*0.21*
The woman should suggest condom use	2.73	*0.26*	3.14	*0.22*
Adolescent boy or girl should use condoms if they cannot abstain	2.46	*0.26*	3.30	*0.21*
Wife inheritance is okay	3.17	*0.28*	3.05	*0.27*
Polygamy should be allowed	2.78	*0.28*	2.75	*0.23*
Male circumcision should be used as a way of HIV prevention	3.51	*0.25*	3.27	*0.21*
Early marriage are allowed	3.51	*0.25*	3.19	*0.23*
A man beating his wife is condoned	3.24	*0.30*	3.19	*0.23*
A woman beating her husband is condoned	3.34	*0.31*	3.67	*0.21*
Teaching children about sex is a very important aspect of our culture	2.65	*0.27*	2.83	*0.21*
Talking freely about sex is a taboo	3.20	*0.25*	2.35	*0.21*

Source: Research Data, 2011

The results in the above table show that both male and female respondents agreed with the statement that in their culture 'the man should suggest condom use'. This is because the mean for the two was 2.03 (±0.23) and 2.43 (±0.21) respectively. Further, the following statements were rated as neutral in respect to what the culture perceives them 'men/boys can have multiple partners', 'the woman should suggest condom use', 'adolescent boy or girl should use condoms if they cannot abstain', 'wife inheritance is okay', 'polygamy should be allowed', 'a man beating his wife is condoned', 'teaching children about sex is a very important aspect of our culture' and 'talking freely about sex is a taboo'. These statements were ranked as neutral since their mean score was between 2.5 and 3.5. In addition, according to the study, boys disagreed with the following statements while their female counterparts remained neutral. 'male circumcision should be used as a way of HIV prevention' and 'early marriage is allowed', this is because the mean male rank of these statements was above 3.5 while the same for females ranged between 2.5 and 3.5. This was an important finding where the results showed that male disagreed with the fact that male circumcision should be used as a way of HIV prevention. Finally, female disagreed with the statement that 'a woman beating her

husband is condoned' while male remained neutral on the same issue. The average score for this statement was 3.67 (±0.21) and 3.34 (±0.31) for female and males respectively.

Table 4.7: Effect of Culture on People Behavior

Effect of Culture on People Behavior	Percent
Very Great Extent	50.8%
Moderate Extent	36.9%
Low Extent	9.2%
No Extent at All	3.1%

Source: Research Data, 2011

According to Table 4.7 above, majority (50.8%) of the respondents interviewed felt that cultural attitudes, values, believes and practices have a very great impact on the way the people behave, 36.9% felt the impact was moderate, 9.2% felt that it was low while only 3.1% who felt that there is no impact at all. This according to the study show that most of the respondents felt that culture had a great impact on the behavior of people. Further, according to the Program Staff who were interviewed, they all agreed that culture has a great impact on the people behavior. This result is in agreement with Gao et. al. (2002) where social programs deemed to be at variance with local cultural practices is bound to perform dismally or meet a lot of resistance.

Table 4.8: Culture in Relation to TICAH Sexual and Reproductive Health Program

Statement	Mean	Standard Error
Open and Frank Conversations about Sex between Sexual Partners	2.86	0.16
Condom use within Marriage	3.23	0.17
Condom use for Adolescents who are Sexually Active	2.98	0.19
Open and Frank Conversations about Sex between Parents and children	3.24	0.16
Couple HIV Testing and Counseling	2.45	0.16

Source: Research Data, 2011

Based on the above table, only the statement 'couple HIV testing and counseling' was rated as having cultural acceptance in relation to TICAH's sexual and reproductive health program. This is because the mean mark approval was 2.5 (±0.16). All the other statements were ranked as having moderate to no acceptance. Their mean ranking score was between 2.5 and 3.5.

Table 4.9: Cultural Factors Impact on the Effectiveness of HIV Prevention Behavior Change Programs

	Percent
Very Great Extent	41.5%
Great Extent	30.8%
Moderate Extent	15.4%
Low Extent	6.2%
No Extent at All	6.2%

Source: Research Data, 2011

Using the Principal Component Analysis (PCA) the variable cultural impact was generated. The statements which were used by PCA to generate the cultural impact factors were 'beliefs (taboo against talking about sex)', 'attitudes towards condom use', 'behavior (e.g. multiple partners, not using condoms)' and 'practices (FGM, wife inheritance and polygamy'. According to the Table 4.9, 41.5% of the respondents interviewed agreed to a very great extent that cultural factors affect the effectiveness of HIV prevention behavior change programs, 30.8% agreed to a great extent, 15.4 agreed to a moderate extents while 6.2% agreed to a low extent or did not agree at all. This according to results indicates that the cultural factors have a great impact on the effectiveness of the HIV prevention behavior change programs. To further, get the gender perspective towards the same issues, the researcher compared effect of cultural factors by gender and the results are displayed below Table below:

Table 4.10: Gender and Cultural Factors Impact on the Effectiveness of HIV Prevention Behavior Change Programs

Gender	Percent
Male	
Very Great Extent	40.7%
Great Extent	33.3%
Moderate Extent	18.5%
Low Extent	7.4%
No Extent at All	0.0%
Female	
Very Great Extent	42.1%
Great Extent	28.9%
Moderate Extent	13.2%
Low Extent	5.3%
No Extent at All	10.5%

Source: Research Data, 2011

According to the above results, the study showed that there was no significant difference between the way the different gender on how they perceived cultural factors to affect the effectiveness of the HIV prevention behavior change program (χ=3.36, p=0.49).

4.4 Social Media

Proper communications are vital to the success of a program. Communication is the process by which information is exchanged of which it can be written formal, written informal, oral formal, or oral informal. The social media is a common mode of communication and it plays a very important role in influencing community perceptions about social programs' effectiveness. The section presents the results pertaining how social media affect the effectiveness of HIV prevention behavior change program.

Table 4.11: Access to Social Media

Gender	Percent
Male	
Facebook	96.2%
Twitter	71.4%
SMS	69.6%
Peer PEP Talk	50.0%
Female	
Facebook	69.0%
Twitter	48.5%
SMS	80.0%
Peer PEP Talk	35.7%

Source: Research Data, 2011

According to Table 4.11 above, 96.2% of the male respondents were members of Facebook, 71.4% were members of Twitter, 69.6% were members of SMS and 50.0% were members of Peer PEP Talk. In addition, 69% of the female respondents were members of Facebook, 48.5% were members of SMS and 35.7% were members of Peer PEP Talk. In addition according to the results, more men reported being members to all the above social media groups apart from SMS where more female were found. However, this difference in membership to different social media groups was found to be insignificant (χ=2.35, ρ=0.351). Further, facebook and SMS had the highest members among the respondents for both genders.

Table 4.12: Exposure to Media

Statement	Gender			
	Male		Female	
	Mean	Standard Error	Mean	Standard Error
How often do you Read a Newspaper or Magazine	2.19	0.18	2.92	0.20
How often do you Listen to Radio	1.79	0.17	1.39	0.09
How Often do you Watch TV	1.71	0.20	1.32	0.10
Access to Social media such as Facebook	2.14	0.21	2.54	0.24

The results in Table 4.12 above show that the male respondents were exposed to the above media on daily basis. According to the study, the average rank score for each exposure to any of the above social media was less 2.5 which mean that they had access of the same on daily basis. Further, their female counterparts were exposed only to radio and TV on daily basis. In addition, the female respondents revealed that they were exposed to newspaper/or magazines and facebook on weekly basis. This is because the average rank score of the two was between 2.5 and 3.5. Therefore, the study revealed that males had an access to social media daily while female had access to only radio and TV's on daily basis. In terms of usage of the media, the figure below summarizes the usage of the various media by the target population. On comparing the social media and mainstream media, the findings show that the social media was more used by both male and female than the mainstream media.

Table 4.13: Comparison between the social media and the main stream media

Gender	Percent
Male	
Social Media	82.4%
Mainstream Media	17.6%
Female	
Social Media	68.2%
Mainstream Media	31.8%

Source: Research Data, 2011

According to Table 4.13 above, 82.4% of the male respondents were using social media as compared to 68.2% of the female respondents in the social media. Further, 31.8% of the female respodents were using main stream media as compared to 17.6% male respondents

who were using mainstream media. This shows that more male than female were using social media. The findings also show that social media was used more by both female and male as compared to mainstream media.

Table 4.14: Uses of Mainstream Media

	Percent
Newspaper	64.5%
Radio	71.9%
T.V.	73.2%

Source: Research Data, 2011

The results in the above table shows that 73.2% of the respondents who use the mainstream media use TV, 71.9% use the radio, while 64.5% use the print media. Therefore, according to the above results, TV was the mainstream media which was used by most of the respondents who were interviewed.

Table 4.15: Social Media Impact on the Effectiveness of HIV Prevention Behavior Change Programs

	Percent
Very Great Extent	21.1%
Great Extent	22.8%
Moderate Extent	38.6%
Low Extent	8.8%
No Extent at All	8.8%

Source: Research Data, 2011

According to Table 4.15, 38.6% of the respondents interviewed felt that social media networks influences the effectiveness of HIV prevention behavior change programs to a moderate extent, 22.8% felt that the impact was to a great extent, 21.1felt that it was to a great extent. This means that there was a general feeling among the respondents that social media influences the effectiveness of HIV prevention behavior change programs.

4.5 Organization Capacity

This section will present the respondents views towards organization capacity on the effective of HIV prevention behavior change programs

Table 4.16: Organizational capacity Impact on the Effectiveness of HIV Prevention Behavior Change Programs

	Percent
Very Great Extent	12.2%
Great Extent	42.1%
Moderate Extent	24.8%
Low Extent	12.1%
No Extent at All	8.8%

Source: Research Data, 2011

According to Table 4.16, 42.1% of the respondents interviewed felt that organizational capacity influences the effectiveness of HIV prevention behavior change programs to a great extent, 12.2% felt that the impact was to a very great extent, 24.8% felt that it was to a moderate extent. This means that there was a general feeling among the respondents that organizational capacity influences the effectiveness of HIV prevention behavior change programs.

Table 4.17: Perception towards TICAH's HIV Prevention Behavior Change Program

Statement	Mean	Standard Error
TICAH's activities are Always Very Well Planned	1.64	0.07
TICAH's activities are Adequate in Terms of the Number of Meetings	1.94	0.09
TICAH's activities are adequate in Terms of the Information they Give	1.73	0.08
TICAH's staff have Adequate Knowledge in the Area of Sexual and Reproductive Health	1.58	0.08
You Feel Like you Have a Good Relationship with TICAH Staff	1.81	0.12

Source: Research Data, 2011

The results in the above table display the respondent's views towards HIV prevention behavior change program implemented by TICAH. According to the results above, the respondents strongly agreed with each of the statement above. This is because in all the statements the average rank score of each was below 2.5.

Table 4.18: Program impact on Individual Behavior Change

Statement	Mean	Standard Error
Number of Meeting Attended under TICAH's HIV Program Behavior Change Program	1.77	0.11
Amount of Information Received under TICAH's HIV Prevention Change Program	1.71	0.09
No of Services Received under TICAH's HIV Prevention Behavior Change Program	1.92	0.11
Relationship Fostered with TICAH Staff	2.70	0.44

Source: Research Data, 2011

According to Table 4.18 above, the statements (Number of meeting attended under TICAH's HIV program', 'amount of information received under TICAH's HIV prevention change program', and 'No services received under TICAH's prevention behavior change program) were found to strongly determine the individual behavior change. This is because the average rank score for the above statements was found to be below 2.5. However, the statement (relationship fostered with TICAH staff) was found to moderately determine the individual's behavior change (Mean=2.70, Standard Error=0.44). Finally, the study establish that among the three factors namely; culture, social media and organization culture; culture was ranked as the one which had the greatest impact on the effectiveness of the sexual and reproductive health programs, this was followed by organization culture and then social media. The qualitative data showed that majority of the respondents who were beneficiaries of the program reported that they had benefited from the program. Majority of the respondents were for the views that the program should continue as it was impacting the beneficiaries positively. In addition, the respondents were for the views that there should be a discussion session where the beneficiaries would give their views towards how their groups are organized in the community. Further, there was a proposal for more training to be added. On the level of impact among the three variables, the study established that culture played the key role, followed by the social media and then the organization capacity as shown in the figure below. Finally, the overall rating of the TICAH program was above average.

Table 4.19: Variables impact on TICAH's Programmes

	Percent
Culture	42.1%
Organizational Capacity	34.8%
Social Media	23.1%

Source: Research Data, 2011

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the summary of the findings, conclusion drawn from the findings highlighted and recommendation made there-to. The conclusions and recommendations drawn were focused on addressing the purpose of the study, which was to assess the factors that influence the effectiveness of social programs with a particular reference to TICAH's Sexual and Reproductive Health program. The objectives of this study were to assess the extent to which Culture affect the effectiveness of social programs, to determine the extent to which social media affect the effectiveness of social programs and to establish the extent to which organizational capacity affect the effectiveness of social programs.

5.2 Summary of the Findings

Among the respondents demographic characteristics that the researcher sought to know were gender, age, marital status, highest level of education and marital status. In this study, majority of the respondents were female aged between 20 and 30 years. Further the study found that majority of the respondents were single but they had children. On the level of their education, the study found that most of the respondents were primary school leavers.

It was established in this study that majority of the respondents were aware of an existence of a social program dealing with sexual and reproduction health. Further, among the respondents who knew about the existence of a social program that deals with sexual and reproduction health most of them claimed to be members to be members of these programs.

5.2.1 Culture

In relation to culture, there was a general agreement by the respondents that the man should suggest the usage of culture. The study also established that the respondents approved wife inheritance, polygamy and teaching children about sex. In addition, the respondents disapproved wife battering, and having multiple sexual partners outside marriage. Further, the boys disagreed with the statements that male circumcision should be used as a way of HIV prevention and, still the boys disagreed that early marriage should be allowed. This shows that the male respondents disagreed with the fact that male circumcision should be used as a way of HIV prevention. The female respondents in this study disagreed with the statement that a

woman beating her husband is condoned. However the male were neutral on the same issue. These findings correlate with Gao et al., (2002) argument that in many societies/cultures, domestic violence is viewed as a man's right, which reduces a woman's control over her environment. This means she cannot question her husband's extra marital affairs, cannot negotiate condom use and cannot refuse to have sex. At the same time ascribed gender roles mean that men can or are expected to have many sexual relationships. In most communities, cultural beliefs supersede any influences on learning hence culture greatly affects the way communities receive and perceive various programs or any social intervention measures.

The study further established that culture had a great impact on the behavior of people. Majority of the respondents interviewed felt that cultural attitudes, values, believes and practices have a very great impact on the way the people behave According to the Program Staff who were interviewed, the results showed that culture had a great impact on the people behavior. This result is in agreement with Gao et. al. (2002) where social programs deemed to be at variance with local cultural practices is bound to perform dismally or meet a lot of resistance.

It was also revealed that couple HIV testing and counseling culturally had an impact in relation to TICAHs sexual and reproductive health program. The study also established that the cultural factors that have impact on the Effectiveness of HIV Prevention Behavior Change Programs include; beliefs (taboo against talking about sex), attitudes towards condom use, behavior (e.g. multiple partners, not using condoms) and practices (FGM, wife inheritance and polygamy). It was revealed that there is no significant difference between the way the different gender perceive cultural factors to affect the effectiveness of the HIV prevention behavior change program.

5.2.2 Social Media

This study established that social media networks influence the effectiveness of HIV prevention behavior change programs to a moderate extent. In relation to social media, the study found that majority of the male respondents' were members of Facebook, Twitter, SMS and Peer PEP Talk. On comparing male respondents in social media with female respondents in social media the study found that male respondents had the majority in Facebook, Twitter, SMS and Peer PEP Talk. Further, Facebook and SMS had the highest members among the respondents for both genders. This result is in agreement with Bobkowski (2011) who found

that social media and in particular Skype, Twitter, Facebook and YouTube have become so dominant in people's lives that it would be hard to imagine life without them.

On the respondents' exposure to social media, the study found that the male respondents were exposed to the above social media on daily basis. Further, their female counterparts were exposed only to radio and TV on daily basis. In addition, the female respondents were exposed on newspaper/or magazines and Facebook on weekly basis. The males had an access to social media daily while female had access to only radio and TVs on daily basis.

5.2.3 Organization Capacity

This study established that organizational capacity had a great impact on TICAHs HIV program. Most of the respondents said that organizational capacity has impact on their behavior change to a great extent. This study also found that TICAHs activities were always very well planned, adequate in terms of the number of meetings, adequate in terms of the information they give, adequate knowledge in the area of sexual and reproductive health and there was a good relationship among TICAH staff (M=1.81).

The study also found that the determinants of the impact of the program on individual behavior change included: number of meeting attended under TICAHs HIV program, amount of information received under TICAH's HIV prevention change program, and number of services received under TICAH's prevention behavior change program. Relationship fostered with TICAH staff' was also found to moderately determine the individual's behavior change.

Basu et al., (2004) had earlier indicated that a top-down approach focuses on an organization's capacity to be more responsive to existing and emerging challenges. Organizational capacity can be transformed by a variety of activities, including organizational restructuring, redevelopment or implementation of protocols and policies, and coordination and planning to ensure that staff, facilities, equipment, and other resources can be mobilized as needed.

5.3 Conclusion

This study concludes that among the three factors namely; culture, social media and organization capacity; culture has the greatest impact on the effectiveness of the sexual and reproductive health programs, followed by organization capacity and then social media. Majority of the respondents who were beneficiaries of the program reported that they had

benefited from the program and hence anticipated that program should continue as it was impacting the beneficiaries positively.

This study also concludes that there is a perception in both male and female that a man should suggest condom use. Cultural factors having impact on the Effectiveness of HIV Prevention Behavior Change Programs include; beliefs (taboo against talking about sex), attitudes towards condom use, behavior (e.g. multiple partners, not using condoms) and practices (FGM, wife inheritance and polygamy. There is no significant difference between the way the different gender perceive cultural factors to affect the effectiveness of the HIV prevention behavior change program.

This study also concludes that there are more men in Facebook, Twitter, SMS and Peer PEP Talk than women. Men are exposed to Facebook, Twitter, SMS and Peer PEP Talk on daily basis, while women are exposed only to radio and TV on daily basis. Further, the female are exposed on newspaper/or magazines and facebook on weekly basis. The males had an access to social media daily while female had access to only radio and TV's on daily basis. It was established in this study that social media influences the effectiveness of HIV prevention behavior change programs.

This study concludes that TICAH's activities are always very well planned, adequate in terms of the number of meetings, adequate in terms of the information they give, adequate knowledge in the area of sexual and reproductive health and there was a good relationship with TICAH staff. The determinants of the impact of the program on individual behavior change include; number of meeting attended under TICAH's HIV program, amount of information received under TICAH's HIV prevention change program, and number services received under TICAH's prevention behavior change program.

5.4 Recommendations

This study found that culture had the greatest impact on the behavior of people and the effectiveness of social programs. Majority of the respondents had a wrong perception on who should suggest the use of a condom, circumcision, wife inheritance, polygamy, FGM and other cultural taboos. This study therefore recommends that any social programs should address cultural practices that impact on its programmes. There is need to take the initiative to train the community on the effects of cultural believes and taboos. To have long-term impacts social programmes should concentrate on positive attitude and cultural change both at a

personal and a community level. For sustainable progress in complex social behaviour, not least for sexual and reproductive behaviour and its many deeply rooted social drivers, an integrated, comprehensive approach is strongly warranted

The study also found that social media had a great impact on the effectiveness of social programs and behavior change. This research study therefore recommends that social programs should look to tap into the potential presented by new technology and create social accounts in Facebook, Twitter, Skype and Peer PEP Talk which were found to be very popular with both male and female respondents. This would further be beneficial as most of the new technology is less expensive as compared to mainstream media. Ideas on how to reach rural communities with new technology should however still be explored.

The study established that the determinants of the impact of a social program on individual behavior change include; number of meetings attended, amount of information received, and number services received. This study therefore recommends that social programs should increase the frequency of meetings held per a specified duration of time, make information shared in such meetings be as comprehensive as possible and link the information shared with services. Social programs should also address organizational capacity concerns.

5.5 Suggestion for Further Studies

From the study and related conclusions, the researcher recommends further research in the area of the role of social programs in enhancing behavior change in HIV patients. The study also recommends further studies in the area of the effects of culture on the effectiveness of social reproductive health programs in Kenya.

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Appendix I: Letter of Introduction

Dear Respondent,

RE: Support on MA Thesis

I am an masters student at the University of Nairobi and in my final year of study. As part of the requirement for graduation, I'm undertaking a research to establish the factors influencing the effectiveness of social programs: the case of TICAH's sexual and reproductive health program.

In this regard, I'm kindly requesting for your support in terms of time, and by responding to the attached questionnaire. Your accuracy and candid response will be critical in ensuring objective research. It will not be necessary to write your name on this questionnaire and for your comfort, all information received will be treated in strict confidence.

Thank you for your valuable time on this.

Yours faithfully

Maina Jedidah Muthoni

APPENDIX

Appendix I: Program Staff Questionnaire

Answer the following questions as honestly as possible. This questionnaire is for purposes of learning how useful TICAH's HIV prevention programs are to the participants who take part in them. This questionnaire is anonymous and confidential. The information you share will be used for purposes of an academic report and to improve the sexuality programme. The questionnaire will take about 30-45 minutes to fill. Your consent will be sought before you start filling in the questionnaire.

Personal Information

1. Please indicate your gender

   Male [ ] Female [ ]

2. Please indicate your highest level of education

3. Primary [ ] Secondary [ ] college [ ] University diploma/ degree [ ] Post graduate

4. For how long have you been working in the program?

   Below 2 years [ ]

   2 to 4 years [ ]

   4 to 6 years [ ]

   Above 6 years [ ]

5. What is your age group

   Less than 20 Yrs [ ] 20 – 30 Yrs [ ]

   31 – 40 Yrs [ ] 41 – 50 Yrs [ ]

   More than 50 Yrs [ ]

6. How do you rate the effectiveness of TICAH's sexuality program?

Excellent [ ]

Good [ ]

Moderate [ ]

Bad [ ]

Poor [ ]

7. To what extent do the following strategies affect the effectiveness of social programs

	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Outreach interventions					
School based interventions					
Social influence and social network interventions					
Condom promotion and social marketing					
Community empowerment and participatory action research					

Culture

8. To what extent do cultural factors (e.g. gender roles, attitudes towards condom use, polygamy, wife inheritance, early marriages, circumcision, multiple sexual partners, taboo in open discussions on sexuality) affect the effectiveness of social programs?

To a very great extent [ ]

To a great extent [ ]

To a moderate extent [ ]

To a low extent [ ]

To no extent at all [ ]

9. To what extent do the following cultural factors affect the effectiveness of TICAH's sexuality program?

Cultural factors	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Beliefs					
Attitudes					
Behavior					
Practices					

Social Media

10. In your opinion to what extent do social media (e.g internet, facebook, twitter) affect the effectiveness of TICAH's sexuality program?

To a very great extent [ ]

To a great extent [ ]

To a moderate extent [ ]

To a low extent [ ]

To no extent at all [ ]

11. How often do you use the following media

Media	Every day	Almost everyday	At least once a week	Less than once a week	Not at all
How often do you read a newspaper or magazine?					
How often do you listen to radio?					
How often do you watch television					
How often do you access social medial such as facebook, twitter					

12. In your opinion, to what extent do the following social media networks influence the effectiveness of sexual and reproductive health programs?

Social media	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Internet					
Face book					
Twitter					
SMS					
PEER PEP talk					

13. In your opinion, to what extent do the following media networks influence the effectiveness of sexual and reproductive health programs?

Media	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Newspapers					
Magazines					
Radio					
Television					

Organizational capacity

1. How many program staff work under the Sexual and Reproductive Health at TICAH?

   [ ] less than 5

   [ ] 5 to 10

   [ ] Above 10

2. Is the leadership structure well understood by all staff at TICAH

   [ ] very well understood

   [ ] moderately understood

[ ] not well understood

3. Are roles and responsibilities clearly defined within the organization?

   [ ] very well defined

   [ ] moderately defined

   [ ] not well defined

4. The person (s) heading the sexuality program has some form of training regarding project management

   [ ] Adequate training

   [ ] Some training

   [ ] No training

5. What is the reach of beneficiaries under the Sexual and Reproductive Health Program within a year?

   [ ] less than 50

   [ ] 50 – 99

   [ ] 100-200

   [ ] over 200

6. What are the total meetings for participants within the program?

   [ ] less than 5

   [ ] 5- 10 meetings

   [ ] above 10 meetings

7. The program funding for the Sexual and Reproductive Health programme is

   [ ] More than adequate

   [ ] Adequate

   [ ] Less than adequate

   [ ] there is no funding

8. What in your opinion is the relationship between the organization and the community stakeholders?

   [ ] Great

   [ ] good

   [ ] not so good

[ ] poor

9. To what extent does organizational capacity affect the effectiveness of social programs?

To a very great extent [ ]

To a great extent [ ]

To a moderate extent [ ]

To a low extent [ ]

To no extent at all [ ]

10. To what extent do the organizational capacity factors affect the effectiveness of social programs?

Organizational capacity	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Financial resources					
Facilities					
Management capacity					
Leadership					
Technical Knowledge in operational areas such as project management					
Relationships with stake holders					
Technical knowledge in sexual and reproductive health					

11. In your own opinion, what causes peoples' behavior changes most? Rank from the most important by writing the number 1, 2 or 3. (1 being the most important)

Factor	Rank
Cultural Factors	
Social Media	
Organization Capacity	

Appendix II: Beneficiaries questionnaire

Answer the following questions as honestly as possible. This questionnaire is for purposes of learning how useful HIV prevention programs are to the participants who take part in them. This questionnaire is anonymous and confidential. The information you share will be used for purposes of an academic report and to improve the sexuality programme. The questionnaire will take about 30-45 minutes to fill. Your consent will be sought before you start filling in the questionnaire.

Personal information

1. Please indicate your gender

   Male [ ] Female [ ]

2. How old are you?

   Less than 20 Yrs [ ] 20 – 30 Yrs [ ]

   31 – 40 Yrs [ ] 41 – 50 Yrs [ ]

   More than 50 Yrs [ ]

3. Marital status?

   [ ] Single [ ] Partner [ ] Married [ ] Separated / Divorced [ ] Widowed

4. Do you have any children?

   [Y] or [N] No. of children? ________

5. Highest level of education achieved

   Primary [ ] Secondary [ ] college [ ] University diploma/ degree [ ] Post graduate

6. Do you know of any social program dealing with sexual and reproduction health?

   Yes [ ] No [ ]

If yes, are you a member?

Yes [ ] No [ ]

Culture

7. How does your culture view the following behaviour, attitudes, values and practices

Cultural factors	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Men/ boys can have multiple partners					
Women /girls can have multiple partners					
The man should suggest condom use					
The woman should suggest condom use					
Adolescent boy or girl should use condoms if they cannot abstain					
Wife inheritance is ok					
Polygamy should be allowed					
Male circumcision should be used as a way of HIV prevention					
Early marriages are allowed					
A man beating his wife is condoned					
A woman beating her husband is condoned					
Teaching children about sex is a very important aspect of our culture					
Talking freely about sex is taboo					

8. To what extent do you think cultural attitudes, values, beliefs and *practices (e.g. gender roles, attitudes towards condom use, polygamy, wife inheritance, early marriages, circumcision, multiple sex partners, practices and taboos around sex and sexuality)* determine how people behave?

[ ] Very great extent

[ ] Moderate extent

[ ] Low extent

[ ] No extent at all

9. To what extent does your culture agree with the following in relation to TICAH'S sexual and reproductive health program?

	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Open and frank conversations about sex between sexual partners					
Condom use within marriage					
Condom use for adolescents who are sexually active					
Open and frank conversations about sex between parents and their children					
Couple HIV testing and counseling					

10. To what extent do the following cultural factors affect the effectiveness of HIV prevention behaviour change programs?

Cultural factors	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Beliefs (taboo against talking about sex)					
Attitudes towards condoms use					
Behavior (e.g Multiple partners, not using condoms)					
Practices (FGM, wife inheritance, polygamy)					

11. How often have you gotten messages about Sexual and Reproductive Health (Especially on HIV prevention) from the your cultural setting?

Very often [ ]

Often [ ]

Not so often [ ]

Very rarely [ ]

Not at all [ ]

12. In your experience have the messages received from your cultural setting agree with the messages received from TICAH's HIV behaviour prevention program?

Yes, to a great extent [ ]

Yes, only to some extent [ ]

To a low extent [ ]

No, all messages received are contrary to what was learnt [ ]

13. To what extent do the above named cultural factors determine your individual behavior change?

[ ] Very great extent

[ ] great extent

[ ] Moderate extent

[ ] Low extent

[ ] No extent at all

Social media

14. Are you a member of any of the following social media networks?

Face book	Yes	No
Twitter	[ ]	[ ]
SMS	[ ]	[ ]
PEER PEP Talk [ ]	[ ]	

15. How often do you use the following media

Media	Every day	Almost everyday	At least once a week	Less than once a week	Not at all
How often do you read a newspaper or magazine?					
How often do you listen to radio?					
How often do you watch television					
How often do you access social medial such as facebook, twitter					

16. How often have you gotten messages about Sexual and Reproductive Health (Especially on HIV prevention) from the social media (like Facebook, twitter, peer pep talk, etc)?

Very often [ ]
Often [ ]
Not so often [ ]
Very rarely [ ]
Not at all [ ]

17. In your experience has the message received from the above mentioned social media re-enforced the messages received from TICAH's HIV behaviour prevention program?

Yes, to a great extent [ ]
Yes, only to some extent [ ]
To a low extent [ ]
No, all messages received are contrary to what was learnt [ ]

18. To what extent do the above named social media determine your individual behavior change?

[ ] Very great extent

[ ] great extent

[ ] Moderate extent

[ ] Low extent

[ ] No extent at all

19. To what extent do the following social media networks influence the effectiveness of HIV prevention behaviour change programs?

Social media	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Internet					
Face book					
Twitter					
SMS					
PEER PEP talk					

20. To what extent do the following media networks influence the effectiveness of HIV prevention behaviour change programs?

Social media	Very great extent	Great extent	Moderate extent	Low extent	No extent at all
Newspaper					
Magazines					
Radio					
Television					

Organizational capacity

21. What is your view of the HIV prevention behaviour change program that TICAH runs

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
TICAH'S activities are always very well planed					
TICAH's activities are adequate in terms of the number of meetings					
TICAH's activities are adequate in terms of the information they give					
TICAH's staff have adequate knowledge in the area of sexual and reproductive health					
You feel like you have a good relationship with TICAH staff					

22. To what extent do the following program aspects determine your individual behavior change

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Number of meetings attended under TICAH'S HIV prevention behaviour change program					
Amount of information received under TICAH'S HIV prevention behaviour change program					
No of services received under TICAH'S HIV prevention behaviour change program					
Relationship fostered with TICAH staff					

23. In your own opinion, what causes peoples' behavior changes most? Rank from the most important by writing the number 1, 2 or 3. (1 being the most important)

Factor	Rank
Cultural Factors (e.g beliefs and attitudes that people in your community have, belief of how men and women should behave within the community)	
Social Media (e.g. Facebook, Twitter, pep talk)	
Organization Capacity (e.g. the type of program that one was involved in, the kind of teaching they received from the organization, IEC materials provided by the organization, counseling provided by the organization, the approach of topics, number of meeting they have attended e.t.c)	

24. Do you have any other comments? Please write them here

____

____

____

____

____