

**FACTORS INFLUENCING THE SUSTAINABILITY OF
HIV/AIDS CONTROL STRATEGIES BY NON-
GOVERNMENTAL ORGANIZATIONS IN KENYA: A CASE OF
KIBERA SLUMS, LAINI SABA WARD IN NAIROBI COUNTY**

BY

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DECLARATION

This research project report is my original work and has not been presented for an academic award in this or in any other university or institution.

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DEDICATION

This Research Project is dedicated to my husband James Mungai for his love and support through the years and daughter Amy Wambui.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
CBOs	Community Based Organisations
CHWs	Community Health Workers
GoK	Government of Kenya
HBTC	Home-Based Testing and Counseling
HIV	Human Immunodeficiency Virus
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National HIV/AIDS Strategic Plan
KNBS	Kenya National Bureau of Statistics
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Programme
INGOs	International Non-Governmental Organizations
NGOs	Non-Governmental Organizations
PMTCT	Prevention of Mother-to-Child Transmission
PLWHA	People Living with HIV/Aids
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary, Counseling and Testing
WHO	World Health Organization

ABSTRACT

The HIV/AIDS scourge continues to take its toll all over the world. Africa in particular remains the global epicenter for the disease accounting for the high cases of HIV reported around the world. In Kenya, the latest AIDS Indicator Survey preliminary report of 2012 indicates HIV prevalence has decreased over the last years. However, from the survey conducted, 53% of survey participants found to be infected were not aware of their HIV infection. In particular, slums are characterized by scarce resources, making HIV prevention efforts extremely challenging. Kibera, the research area, is a slum where the estimated HIV prevalence rate is 10-25%. Non-Governmental Organizations have continued to compliment the Government's efforts in the fight against HIV and AIDS. Despite the control strategies in place, the interventions used in the fight against HIV/AIDS seem to have a challenge of sustainability in order for the country to meet its objective of 'total war' against HIV/AIDS. The purpose of the study was to find out how community behavior, attitude, NGOs own funding and monitoring and evaluation practices influence the sustainability of HIV/AIDS control strategies. A descriptive survey research design was adopted on a sample of 323 members of the community which was arrived at using Krejcie and Morgan's sample size estimation table and was selected through simple random sampling from a target population of 2000 persons reached by the NGOs in Laini Saba Ward. In addition, 19 NGOs serving in Laini Saba were selected for triangulation. Data collection was done by the use of questionnaires and interview schedules and the data analyzed by the aid of Statistical Package of Social Scientists Program (SPSS). Percentages and frequency counts were the statistical measures used to draw inference from the responses of the respondents. A return rate of 86.7% was realized from the targeted 323 sample size. Out of the 323 questionnaires distributed to the targeted sample 280 questionnaires were returned. According to the findings on the gender of the respondents, majority 188 respondents were female representing (67.1%) while the remaining 92 respondents were male representing (32.9%). On distribution of respondents by age, majority of the respondents (116) were of the age category of 26-35 years representing (41.4%). Furthermore, on marital status, majority of the respondents (157) were married representing (56.1%). On the highest education level attained, majority of the respondents (176) had attained secondary education representing 62.9%. On community's attitude on sustainability of HIV/AIDS control strategies, majority of the respondents 39% had moderate accepting attitudes, 33% had positive attitude while 28% had negative attitude. On influence of behavior, 51% stated behaviour influences sustainability of the strategies. For NGO funding, majority (58%) disagreed that NGO's received adequate funding while 24 (9%) strongly disagreed. On the influence of monitoring and evaluation majority 146 (52.2%) stated they did not fully participate in the process. In addition, the study found that community members' attitude on sustainability of HIV/AIDS control strategies were generally positive despite a few community members stating there was stigmatization for those who sought the services. Community behavior was depicted to influence the sustainability as the study found that the NGOs education on condom use, remaining faithful and undertaking testing counselling and testing were key to ensuring new infections were minimized. Funding was noted to play an important role. However, based on the findings, the NGOs were not adequately funded. This affected their ability to conduct effective monitoring and evaluation activities. The study recommends NGOs increased advocacy on the strategies, increased funding base, and monitoring and evaluation activities to enhance the sustainability of the HIV/AIDS strategies they implement.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

For the past three decades, the Human Immunodeficiency Virus (HIV) infection has spread to every corner of the world. It has killed more than 25 million people since 1981 and more than 30 million people (22 million in sub-Saharan Africa alone) are now infected with HIV, which causes AIDS. Such impact alert international donor agencies to increase resources tremendously to reach significant proportion of people by creating access to basic care and prevention programs in countries worst hammered by the epidemic. Universal access to prevention and treatment for all is an integral part of the global agenda to mitigate the HIV pandemic. However, major challenges exist in combating the current HIV infection with regard to access to treatment, efficiency, quality, and sustainability of existing programs (Abebe, 2012).

Although global commitment to control the HIV/AIDS pandemic has increased significantly in recent years, the virus continues to spread with alarming and increasing speed. By the end of 2005, an estimated 40 million people worldwide were living with HIV infection or disease, a notable rise from the 35 million infected with HIV in 2001 (UNAIDS 2005). In 2005, close to 5 million new HIV infections and 3 million AIDS deaths occurred more of both than in any previous year. Sub-Saharan Africa remains the region most affected by HIV/AIDS; however, the virus is now spreading rapidly in Asia and parts of Eastern Europe.

According to Global Fund (2013), thirty years after AIDS was first reported, HIV continues to spread. Existing prevention efforts, although improving, are often insufficiently comprehensive or inadequately tailored to local epidemics. Epidemiological surveillance systems at the country level also need to be strengthened, particularly where there are key populations at higher risk of HIV infection. For example, studies in Eastern Europe and Central Asia show that many people who inject drugs actively avoid seeking health services due to the risk of ostracism or fears that their health providers will report them to law enforcement authorities. Such obstacles limit individuals' access to basic health services as well as treatment for HIV.

Global efforts have not proved sufficient to control the spread of the pandemic or to extend the lives of the majority of those infected. The desired level of success has not yet been achieved for several reasons. Most people who could benefit from available control strategies; including treatment, do not have access to them. Modelers commissioned by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) determined that existing interventions could prevent 63 percent of all infections projected to occur between 2002 and 2010. Nonetheless, a 2003 survey of coverage revealed that fewer than one in five people at high risk of infection had access to the most basic prevention services, including condoms, AIDS education, MTCT prevention, voluntary counseling and testing (VCT), and harm reduction programs. WHO and UNAIDS estimate that only about 7 percent of the nearly 6 million people in need of treatment receive it and that the number of people who require antiretroviral therapy increases by 8,000 each day (Bertozzie, et al 2006).

Kenya's response to HIV is guided by a strategic plan that aims to harmonize and align the HIV related activities of diverse partners and stakeholders. Coordinated by the National AIDS Control Council, the HIV response builds on the robust engagement of civil society and people living with HIV. The National AIDS and STI Control Programme within the Ministries of Health administer the bulk of HIV-related services in Kenya. The country has developed a series of performance indicators to drive progress and promote accountability in the response. In addition, Kenya has taken steps to implement a unified HIV Monitoring and Evaluation Framework. Improved linkages among diverse sectors are needed to fully implement this approach. Through these and other concrete achievements, Kenya is accelerating progress towards national and global HIV goals and targets. Along with other countries, Kenya has embraced the goal of ensuring universal access to HIV prevention, treatment, care and support. Attaining this goal is essential to usher in the vision of a world with zero new HIV infections, zero AIDS deaths, and zero AIDS discrimination (The Kenya AIDS Epidemic Update, 2012).

HIV and AIDS have been recognized as a serious challenge facing human development and achievement of the Kenya Vision 2030 and the Millennium Development Goals. Under the Social Pillar of Vision 2030, AIDS is listed as one of the preventable diseases that continue to have a significant impact on the health of the Kenyan population. While Kenya has been

implementing and allocating significant resources to high-impact prevention and treatment programmes, over the years, the country has largely relied on donor funding and recommended best practices to spearhead the fight against HIV. To ensure the sustainability of key HIV programmes in Kenya, the government must not only increase its own funding for the HIV response but also allocate and manage the funding more effectively. Kenya's programmes are working to expand coverage and access to HIV interventions in order to achieve the most optimal results (Integration of Efficiency and Effectiveness in HIV and Aids programmes In Kenya –Multi-stakeholder Meeting Report, 2012).

According to the sessional paper number 4 which is the official policy statement on HIV in Kenya, the Government will continue to play its leadership role and will create an environment where AIDS related strategies will be translated into meaningful action to reduce the magnitude of the epidemic, to prevent further spread and to address the impact of AIDS on society. Currently, development partners provide the bulk of the funding for HIV interventions in Kenya. Any significant reduction of this support would negatively affect the implementation of this Strategic Plan. NACC will focus on securing increased funding from the Government, in addition to tapping existing devolved funds operating at the constituency level, among others in an effort to mitigate this risk. Kenya receives support for HIV from the US Government's President's Emergency Plan for AIDS Relief, Global Fund for AIDS, TB and Malaria, World Bank, UK Department for International Development and a number of other bilateral donors and foundations (Kenya National Aids Strategic Plan, 2009).

1.2 Statement of the Problem

Although HIV prevalence in Kenya seems to have stabilized, new HIV infections continue to arise and have been estimated at 166,000 annually, which is unacceptably high (Kenya National AIDS Strategic Plan, 2009). Results from the Kenya Aids Indicator Survey (KAIS) conducted in 2007 indicate that 7.2 percent of Kenyan adults aged between 15-64 are infected with HIV, the virus that causes AIDS. According to the survey, more than 1.4 million Kenyans are living with HIV/AIDS. In 2003, the Kenya Demographic and Health Survey (KDHS) estimated a prevalence of 6.7 percent among 15-49 year olds. The HIV prevalence rates among both women and men in 2007 are higher than the rates observed in 2003 (Kenya AIDS Indicator Survey report, 2007).

The private sector, Faith-Based Organizations and the Civil Society Organizations-Non Governmental Organizations, Community-Based Organizations, Youth Organizations, People Living with HIV/Aids (PLWHA) Organizations have continued to compliment the government's efforts in the fight against HIV and AIDS. In addition, these organizations in the health sector seek to address the Millennium Development Goal (MDG) 6 which is to combat HIV/AIDS, malaria and other diseases. Despite the control strategies in place, the interventions used in the fight against HIV/AIDS seem to have a challenge of sustainability in order for the country to meet its objective of 'total war against HIV/Aids'.

There are several HIV/Aids control strategies which have been developed to curb the spread of HIV/AIDS. These have included the ABCD strategy – Abstain, Be faithful to one partner, Condom use and Diagnosis strategy, Voluntary, Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT) as well as use of Antiretroviral Therapy (ART) for those infected. However, there remains a huge challenge on the sustainability of these strategies both at societal level which forms the roots of HIV/Aids epidemic and at the implementation of the strategies level which is mostly undertaken by Non-Governmental Organizations. There is thus a need to determine what the factors that influence the sustainability of HIV/AIDS control strategies are in the war against the disease. The ideal situation is to have the control strategies significantly reducing the HIV/AIDS cases particularly new infections. The study therefore sought to determine how communities' attitude and behavior as well as NGO financing and monitoring and evaluation influence the sustainability of the control strategies.

1.3 Purpose of the Study

The purpose of the study was to establish the factors influencing the sustainability of HIV/AIDS control strategies by Non-Governmental Organizations in Kenya. The study used Kibera slums, Laini Saba Ward in Nairobi County as its case.

1.4 Objectives of the Study

The objectives of this research were to:

1. To examine how people's attitude influence the sustainability of HIV/AIDS control strategies by Non-Governmental Organizations in Kenya in Laini Saba Ward in Kibera slums.

2. To examine how people's behaviour influence the sustainability of HIV/AIDS control strategies by Non-Governmental Organizations in Kenya in Laini Saba Ward in Kibera slums.
3. To determine the influence of Non-Governmental Organizations funding on the sustainability of HIV/AIDS control strategies in Kenya in Laini Saba Ward in Kibera slums.
4. To establish the influence of Non-Governmental Organizations monitoring and evaluation on the sustainability of HIV/AIDS control strategies in Kenya in Laini Saba Ward in Kibera slums.

1.5 Research Questions

The research was guided by the following research questions:

1. How does people's attitude influence the sustainability of HIV/AIDS control strategies by Non-Governmental Organizations in Kenya in Laini Saba Ward in Kibera slums?
2. To what extent does people's behavior influence the sustainability of HIV/AIDS control strategies by Non-Governmental Organizations in Kenya in Laini Saba Ward in Kibera slums?
3. How does Non-Governmental Organizations funding influence the sustainability of HIV/AIDS control strategies by in Kenya in Laini Saba Ward in Kibera slums?
4. To what extent does Non-Governmental Organizations monitoring and evaluation influence the sustainability of HIV/AIDS control strategies in Kenya in Laini Saba Ward in Kibera slums?

1.6 Significance of the Study

Despite the high levels of HIV prevalence in Africa it is surprising that very little research has been done to find out how the target populations view the HIV prevention campaigns. Literature searches reveal very few studies that have been done in this area despite the numerous programmes that have been implemented. The study added to the knowledge of the stakeholders in the war against HIV/AIDS. This was vital in establishing what could be done to improve the HIV/Aids control strategies that were in place. The study also was to enable the NGOs implement the control strategies to appreciate the view of the community members on the efforts and thus incorporate these views in their day to day administration of the interventions. Finally,

this study would be important to the Government of Kenya National AIDS and STI Control Programme (NAS COP), the National AIDS Control Council and the donor agencies such as USAID's President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund and the Clinton Health Access Initiative (CHAI).

1.7 Delimitations of the Study

Research surveys in HIV/Aids particularly in the slum areas had been conducted to determine the HIV prevalence in Kenya by the Government of Kenya. This research was hence not new and it was envisaged that it would boost the researcher's ability to collect data.

The study was delimited to Kibera slums. The population was further sampled to get a representative sample from Laini Saba, Ward in Kibera. The results of the study were however generalized to the area of study.

1.8 Limitations of the Study

Sensitivity of the study: All studies on the HIV/AIDS were deemed to be sensitive due to the high levels of stigma associated with infection; this would affect the willingness of the respondents to complete the questionnaire. The researcher countered this by using Community Health Workers who worked with the community members and NGOs on the strategies.

Financial resources and time: The researcher further anticipated limitations of financial constraints that made it difficult for the researcher to gather information from a larger sample. There was a limitation of time since the study was to be carried out within the set duration of time for a Masters study. Further, the outcome of this study was as per the time of study and was therefore subject to change. The researcher overcame this limitation through the use of two research assistants during data collection and experience of working with the NGOs before to provide data in a timely manner.

1.9 Assumptions of the Study

The success of the project depended greatly on the data collected from the field. It was therefore assumed that respondents were willing to respond to the questions given the sensitivity of the topic. Further the researcher assumed that the data provided by the respondents were accurate

and truthful. The researcher also assumed that the research instruments were valid and that they would measure the desired constructs for achieving the research objectives.

1.10 Definition of significant terms

Attitudes - An expression of favour or disfavor against people or things in relation to HIV/AIDS. This can be positive or negative.

Behaviour - Actions and mannerisms made by human beings in response to various stimuli.

Control strategies - Any activity or interventions undertaken to prevent spread of HIV/AIDS infection, provide care and treatment to those infected or mitigate on the effects of the infection to the community of the country.

HIV and AIDS - HIV is an abbreviation to Human Immuno Deficiency Virus; it is a virus that interferes with the immunity of the human body. AIDS, an acronym for Acquired Immuno Deficiency Syndrome, is a condition that results when the HIV virus destroys body defense mechanism to an extent that it considerably weakens when attacked by other pathogen or disease causing organisms.

HIV Prevalence - The proportion of people in a population who are HIV positive at a given time.

Monitoring and Evaluation - The regular observation, analysis and recording of activities taking place in a project or programme and determining value on what a project or programme has achieved particularly in relation to activities planned and the overall objectives. The process attempts to assess as objectively as possible the relevance, effectiveness and impact of a project or programme.

Non-Governmental Organizations - Non-governmental organizations (NGOs) are non-profit organizations that are neither governmental nor inter-governmental. NGOs are generally established to bring the like-minded individuals committed to achieving particular objectives.

Sustainability- Capacity to maintain programme services at a level that will provide ongoing prevention and treatment of HIV/AIDS interventions long after donors stop funding.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The literature review section outlines and analyses published articles and journals written by accredited scholars and researchers with reference to the topic that is being studied. In this particular case, the literature review examined the following sections: The introduction which covers the impact of HIV/AIDS and fighting AIDS, the role of the NGOs in the fight against the disease, the factors that influence the sustainability of HIV/AIDS control strategies, the theoretical framework and conceptual framework.

2.2 Impact of HIV/AIDS on the economy of a country

AIDS can reverse gains made in the health sector on key indicators such as life expectancy. For example at the turn of the twenty-first century, life expectancy in Haiti was 49 years, whereas before AIDS it had been predicted to be 57 years. Botswana was expected to have had a life expectancy of 71 years by 2001; instead, with AIDS, it was estimated to be 39 years. AIDS is also affecting another key indicator: the under-five child mortality rate. To take Zimbabwe as an example, in 2000 the child-mortality rate was three times higher than would have been expected without AIDS. About 70% of deaths among children under the age of five were due to AIDS (Holden, 2004). AIDS remains one of the central impediments to national health, development and well-being. AIDS has lowered life expectancy, deepened poverty in Kenya, reduced economic growth, exacerbated hunger, and worsened basic health indicators. In 2011, at least 1.1 million children in Kenya had lost one or both parents to AIDS (NACC and NASCOP, 2012).

AIDS has various impacts on the health of the remaining population, the people who are not infected with HIV. One way is via the general impoverishment that AIDS brings to households and communities, leading to more work, poorer nutrition and less access to health care. Another route is via other infectious diseases, primarily tuberculosis, which opportunistically infect HIV-positive people. Having HIV makes the development of active TB ten times more likely. AIDS can also affect general standards of health care, as institutions try to respond to the increasing numbers of people who need treatment and care due to AIDS. For example, in Botswana,

hospital admissions doubled in only six years, with at least half of all patients having an HIV related condition. Staffing is being affected not only by illness and death among health workers, but also because health professionals are escaping the stress by taking jobs in private practice or in other countries (UNDP, 2000).

AIDS has become a tragedy of devastating proportions in Kenya. The lives of infected individuals, their families and communities and the company they work for and country as a whole have been affected by HIV/AIDS epidemic (Aids in Kenya, 1996). HIV/AIDS affects all aspects of social and economic life in Kenya. Among the sectors that are most severely affected and that can play an important role in combating the epidemic are health, education, military, transport, communications and information as well as agriculture. The health sector is affected by increasing burden of caring for those infected with HIV. It is responsible for delivering effective treatment, providing compassionate care and implements many prevention programmes. The education system is affected by AIDS in many ways. Children infected with HIV at birth do not live to enroll in school. Many drop out of school when they become orphans or tend to sick family members. HIV prevalence is particularly high among soldiers in countries around the world. Military service often places young men in risky environments away from their families. Long distance truck drivers and other transport workers often spend many nights away from home. On communications, people need to know about the risks of unsafe sex and the means by which to protect themselves. In agriculture, AIDS will most certainly have adverse effects on both small holder and commercial agriculture, including loss of skilled and unskilled labour supply, decline in productive labour and loss of remittance income because of AIDS-related death of income earners (Ministry of Health, 2001).

2.3 Response to the HIV/AIDS Struggle

The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002 to attract and disburse additional health resources to those in need. In the last ten years it has helped countries launch unprecedented responses to the three diseases – HIV, Tuberculosis and Malaria with the aim of reaching the Millennium Development Goals by 2015 (The Global Fund To fight AIDS, Tuberculosis and Malaria, 2013).

At the end of 2011, an estimated 34 million people were living with HIV worldwide, with two-thirds of them living in sub-Saharan Africa. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. The number of people dying of AIDS-related causes fell to 1.7 million in 2011, down from a peak of 2.2 million in the mid-2000s; in 2012 alone 700,000 AIDS related deaths were averted. However, HIV continues to spread – in 2011, 2.5 million people were newly infected with HIV. Although this number remains sobering, it is also important to note that 25 countries have seen their numbers of new infections drop by 50 percent or more, and that half of the infections averted worldwide were among newborns, demonstrating that it is possible to eliminate new infections in children (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2013).

In countries with generalized epidemics, a combination of behavior changes, including reductions in numbers of sexual partners, increases in condom use, and delayed age of first sex, have reduced new infections in several countries. However, some regions are seeing their rates of infection grow significantly. For example, the number of new infections in the Middle East and North Africa region has grown by more than 35 percent. And Eastern Europe is seeing infection rates climb, particularly among most-at-risk populations. New tools for prevention are being implemented, as can be seen by large-scale circumcision campaigns, particularly in sub-Saharan Africa. The increase in coverage of antiretroviral treatment will also aid in slowing new infections. Studies have shown that putting a person on treatment as soon as they are diagnosed can reduce the risk of transmission of the virus by up to 90 percent (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2013).

In Uganda, AIDS was first identified in 1982 in a fishing village on the western shores of Lake Victoria. Since then, the epidemic has had a devastating effect on the demographic, economic and governance structures of the country. By the late 1980s, the country was experiencing a full-blown epidemic, the virulence of which was exacerbated by social dislocation and insecurity related to economic crisis and war. By 1997, the health system was strained to breaking point in a country where the per capita health expenditure at its best was under \$31. Patients with

HIV/AIDS-related illnesses occupied more than 55 per cent of the hospital beds, and by 2000 the occupancy rate had increased to 70 per cent (Tumushabe, 2006).

In 1998, an estimated 1.9 million people were living with HIV/AIDS (UNAIDS 1999). AIDS had overtaken malaria as a leading cause of death among people aged 12–49 years and was responsible for 12 per cent of all deaths. MacAdam (2003) reported that more than 800,000 people in Uganda had lost their lives to the HIV/AIDS epidemic, leaving behind an estimated two million orphans who had lost one or both parents. Extended family systems were hard pressed to care for this vast number of uprooted children. As the epidemic continued to spread and intensify in Africa and other areas of the world in the early and mid-1990s, prevalence rates in Uganda were reported to be declining, especially starting around 1993. International and bilateral aid agencies that provide large sums of money for HIV prevention used Uganda as an example to argue that, with sufficient resources and appropriate prevention messages, HIV/AIDS could be controlled. The international community focused on two elements of Uganda's strategy: (i) the important role of the political leadership in speaking publicly about the epidemic at an early stage; and (ii) the government's assumed use of the approach of abstinence, being faithful and condom use (ABC) as a combination that reduced HIV prevalence (Tumushabe, 2006).

Much has been done in Kenya to fight the AIDS epidemic in the last 15 years. Through the Sessional Paper on AIDS in Kenya, the government has established a clear policy framework. The National AIDS Control Council working with AIDS Control units in the Ministry of Health and other ministries is organizing the government response including disseminating information about the epidemic, coordinating research, ensuring safe medical practices and implementing intervention and treatment programmes. A large number of NGOs provide prevention, counseling and care services. Organizations from all parts of the society are participating, including church and community groups and the commercial sector. Political, commercial and community leaders are speaking out about AIDS and are encouraging people to protect themselves (Aids in Kenya, 2001). Though the HIV prevalence rate has been on the decline in the last few years, the number of people living with HIV and AIDS has been on the increase, and is currently estimated at 1.6 million. This number is projected to increase due to improved

survival (reduced mortality due to HIV) attributed to ART program (National AIDS Control Council, 2014).

The National AIDS Control Council (NACC) recognizes the need to shift the characterization of its HIV response from “crisis management” to “strategic and sustainable.” NACC understands the importance of engaging scientists, policymakers, programme managers, and activists in its efforts to take a long-term approach to the epidemic and do what is needed to achieve better outcomes by the year 2030—the year that Kenya aims to achieve its economic, social, and political goals. With regards to health, the government is looking to maximize its limited resources by identifying and implementing the most efficient and effective HIV programmes. NACC, with the assistance of the Health Policy Project, is conducting quantitative and qualitative analysis using a participatory approach to identify (1) financing options for HIV services, (2) the most effective HIV programmes, and (3) related policy implications. The information will help policymakers to prioritize and implement cost-effective, equitable programmes under Kenya’s next National AIDS Strategic Plan (NACC, 2012).

2.4 Role of the NGOs in the fight of HIV/AIDS

It is estimated that more than 16,000 community organizations as at end to 2010 engage in AIDS activities of some kind. In addition, numerous international NGO’s deliver HIV services, undertake research, engage in policy analysis and advocacy, and play other important roles in Kenya’s AIDS response. Especially vital are the critical contributions made by people living with HIV, as well as groups that serve, support and advocate for key populations. The active engagement of diverse stakeholders at all levels in HIV efforts both reflects and deepens Kenya’s vibrant civil society. The critical contribution of civil society is specifically recognized in Kenya’s national strategic HIV plan, which devotes one of its four pillars to enhancing the coordination of community participation in the response. In addition to providing essential community based services, civil society participates as part of the institutional architecture of the HIV response, serving on the NACC and the Global Fund’s Country Coordinating Mechanism, participating in Constituency AIDS Coordination Committees and Community Partnership Forums, participating in annual reviews of the national strategic plan, and assisting in biennial

reviews of the national response as part of the monitoring process for the 2011 Political Declaration on HIV/AIDS (The Kenya Aids Epidemic update, 2011).

2.5 Factors influencing the sustainability of HIV/AIDS control strategies

There are many factors that can influence the sustainability of HIV/AIDS control strategies by NGOs. However due to time constraint, these research focused on four main factors which are the community attitude, the community behavior, NGOs funding and NGO's monitoring and evaluation.

2.5.1 Community Attitude

Changes in attitude and policy positions have not been arrived at easily. HIV/AIDS has divided Kenyan Society. Rather than collectively responding to the epidemic, some Kenyans have questioned key prevention approaches and their views have received wide media and public attention. In other instances, people with HIV-infection or those considered at risk of infection have been discriminated against (AIDS in Kenya, 1996).

Stigma is the prejudice, discounting and discrimination directed to people perceived to have HIV/AIDS and individual groups and community with which they are associated. HIV is an infection which many people have fears, prejudices or negative attitudes about. Stigma can result in people with HIV being insulted, rejected, gossiped about and excluded from social activities. Fear of this happening can lead to people with HIV being nervous about telling others that they have HIV or avoiding contact with other people. They may end up suffering in silence instead of getting the help they need (Pebody, 2012).

Stigmatizing attitudes among health care workers can be especially dangerous, given their potential deterrent effect on utilization of essential health services. A national survey of health care workers in 2005 found that 15% of physicians believed health workers had the right to reduce care to people living with HIV. (NASCOP, 2006). Negative attitudes regarding people living with HIV may be abating somewhat overtime. From 2003 to 2008–2009, increases were reported in the percentage of both women and men who expressed willingness to care for a

relative with HIV, a willingness to buy food from an HIV-infected vendor, and a belief that HIV-positive teachers should be allowed to continue to teach. However, stigmatizing attitudes persist. Nearly half of all Kenyan women surveyed in 2008–2009 said they would want to keep a family member's HIV infection secret (Kenya National Bureau of Statistics, 2010).

Sainab in 2007 conducted a research study that sought to investigate the challenges facing effective implementation of HIV/AIDS control strategies in Navakholo division in Kakamega Central, Kenya. In her study, Sainab was guided by the following objectives: People's attitude towards the use of condoms, cultural practices, stigmatization, lack or inadequate technical capacity in management of HIV/AIDS, economic factors and weakness in facilities. The researcher used descriptive survey and collected data from the population by questionnaires and interviews. Random sampling was used in selection of the required sample that consisted of 370 respondents. The findings revealed that people's attitudes influenced the use of condoms in the Division. In addition, cultural practices posed challenges to the use of HIV/AIDS control strategies. Stigmatization, which was highly exhibited on people living with HIV/AIDS as well as lack of medical professionals and insufficient finances were the challenges to the use of control measures on HIV/AIDS (Sainab, 2007).

Institutionalized discrimination and stigmatizing attitudes contribute to the disproportionate risk and vulnerability experienced by sex workers, men who have sex with men, and people who inject drugs. These three populations are estimated to have HIV prevalence of 29.3%, 18.2%, and 60.4%, respectively. Other groups – such as prisoners, long distance truck drivers, and fishing communities – also experience elevated risk of HIV infection. While the vast majority of new infections in Kenya are the result of sexual behaviour, a small fraction of new infections stem from inadequate adherence to standard infection control practices during health care delivery (NACC and NASCOP, 2012).

Awareness of HIV, an understanding of how it may be transmitted, and a perception of individual risk are essential to sexual risk reduction, although they are often insufficient on their own to prevent transmission. Nearly all Kenyans have heard of HIV, although only 73% of adult women and 79% of adult men surveyed in 2008–2009 knew that condoms could prevent HIV

transmission. HIV-related knowledge has increased over the last decade in virtually every age cohort (Kenya National Bureau of Statistics, 2010).

2.5.2 Community Behaviour

Because AIDS is an epidemic is so firmly rooted in human behavior, driven by economic, cultural and social conditions, the behavioral and social sciences have much to offer toward identifying solutions for its control. All African counties have implemented various forms of prevention and education campaigns to combat the spread of HIV. However, there is considerable variation in the design and execution of these programs. Good evaluations are scarce, but there are some early signs that certain prevention strategies have achieved limited success. For those programs that appear effective on a limited scale, the big questions are whether they are sustainable and whether they can be replicated successfully. Changing human behavior to slow the speed or limit the extent of transmission will always remain the first and probably the most important line of defense against HIV/AIDS. Effective prevention of the disease requires enormous and continued commitment in order to achieve lasting changes in human behavior. No one set of interventions – behavioral or medical – will be sufficient by itself to combat the HIV/AIDS epidemic (Preventing and Mitigating Aids in Sub Saharan Africa, 1996).

Based on the western concept of ideal sexual behavior, monogamy has been advocated to curb the spread of HIV. The battle ground in the African and the Asian countries may be quite different. Their sexual behaviors rooted in tribal traditions may prove to be obstacles to AIDS control in cultures where marital fidelity must be viewed outside the Judeo Christian model of monogamy. For example in the Zambian tradition, when a man dies, his many relatives must have sex with the widow to cleanse her from the ghosts of her husband (Sakala, 1996) Similar practices can be found in the Nilotes Luo community of Kenya where wife inheritance is still widely practiced among brothers of the deceased (Luginnah et.al,2005). HIV prevalence in the area where this community lives is estimated to be the highest in the country followed by high prevalence in the Kenyan's capital Nairobi (Kenya Demographic Survey, 2003).

While stigma is sometimes hard to pin down (it may be found in people's attitudes or beliefs), discrimination is a little easier to describe. It is about actual behaviour. Discrimination means treating one person differently from another in a way that is unfair – for example, treating one person less favorably simply because he or she has HIV (Pebody, 2012)

A research study was conducted in Kibera by Oballa in 2007. The objective of this study was to identify relevant HIV prevention programmes implemented in Kibera among the youths. It also sought to find out the youths perception and experiences with the HIV prevention campaigns implemented among them. The findings stated the level of knowledge on HIV was 99.5%, however this was mere knowledge of HIV as it did not correspond with factual knowledge on basic facts of the same. There were over 40 organizations and faith based institutions working in the slum on issues related to HIV prevention. Many emphasized on being a resource to reach out the youths with messages on HIV prevention. The youths however reported that they got most of the information from teachers at school, followed by media while faith based organizations and NGOs come last as a source of information on HIV to the youths (Oballa, 2007).

Condoms were perceived as a way of preventing HIV but not effective among the youth. In their experiences condoms burst, reduce pleasure, has a bad oil, has a bad smell and are too expensive. Majority did not think it was effective in preventing HIV. Myths and misconceptions about condoms also hindered their acceptance among the youths. Abstinences was viewed by the organization and the youths (53%) as the best effective way to prevent HIV, yet the youths reported that it was not easy to abstain from sex. The organization also reported that abstinence only campaigns had failed. Being faithful to one trusted partner was seen as another way to prevent HIV, yet problems related to poverty made it hard for women to stay faithful to one man as they sought ways to get money. Prostitution then became an option. Men were also accused of changing partners. They believe it was the only way to remain a real man and a hero among their peers. The study used was a cross sectional study using triangulation of research methods. Quantitative data was collected from 217 youths aged 13-24 years. Qualitative interviews was conducted with 20 youths and also discourses with 10 organizations and institution that have worked in Kibera slum for more than 2 years on issues related to HIV prevention among the youths (Oballa,2007).

Although Kenyans exhibit high levels of HIV-related knowledge and have collectively adopted notable changes in sexual behaviours, substantial unsafe sexual behaviour still persists. Condom use remains sub-optimal, and many Kenyans have multiple sexual partners. Certain behaviours – such as concurrent sexual partnerships or alcohol use during sex – enhance the risk of HIV transmission. Various biological factors – such as a man’s circumcision status, the presence of an untreated sexually transmitted infection, or very recent HIV infection – also increase the likelihood that any single instance of unsafe sexual behaviour will result in HIV transmission.

In addition, due to their heightened physiological susceptibility to sexual HIV transmission, women and girls confront an array of social, legal, economic and cultural disadvantages that compound their HIV-related risks and vulnerabilities. On average, Kenyan women and girls are less knowledgeable than males regarding HIV and are less likely to use condoms. The large number of sexually transmitted cases of HIV in Kenya indirectly contributes to substantial transmission of the virus from mother to child. Each year, more than 20,000 children become infected after exposure to the virus during pregnancy or delivery or as a result of breastfeeding (NACC and NASCOP, 2012).

2.5.3 NGO Funding

In most countries the health sector has less than 5% of the national budget, and per-person annual expenditure on health in Africa is US\$4–11.37. There is very little evidence about the influence of political will on disease control and prevention but anecdotally it appears to be a major factor in the success or failure of disease-control programmes. For example lack of political support for malaria-control measures and subsequent deterioration of services has led to re-emergence of malaria in some areas from which it had previously been eradicated, such as the North Korea, Tajikistan, northern Iraq, and Turkey. Political efforts to change rates of malaria, tuberculosis, and HIV infection will be sustainable only if governments maintain their commitment to control programmes (Bates, Fenton, & et.al, 2004).

Despite having a growing economy, Kenya is heavily dependent on donors to fund its HIV response. Kenya is expected to achieve middle income country status by 2030 with an average gross domestic product growth of 6.5% per annum expected between 2010 and 2030. According

to Brody, a recent study conducted in 2005 found that if the country achieves its projected economic growth and allocates a higher share of government expenditure to HIV it should be able to make the transition to sustainable domestic funding. However, it will still require continued external support, complemented by alternative sources of funding during this transition period (Brody, 2005). Although Kenya has greater than average potential to fund its HIV response, the funding gap is significant. It is estimated that the cost of the HIV response will increase by 114% between 2010 and 2020 and that the funding gap will reach US\$1.75 billion between 2010/11 and 2019/20, comprising 0.3% of GDP by 2020. By 2015, the gap may equal 25% of the HIV budget (UNAIDS, 2013).

Sustainable financing for HIV/AIDS is one of the emerging challenges of the response to the epidemic. The changing phases of the epidemic in Kenya have brought into focus the need for sustainable financing given the emerging long-term interventions required within the population. These interventions include treatment, care and support of people living with HIV/AIDS as support to increasing number of orphans and community level coping mechanisms. Much of the focus on financing of the HIV/AIDS interventions has been on securing funds for the scale-up of prevention, care and treatment services, the source and long term reliability of those funds was a secondary issue. Furthermore the effective engagement of decentralized levels in planning and resource allocation has tended to be taken for granted. Now, as more and more people are put on lifelong anti-retroviral treatment (ART), the commitment to long-term financing becomes more and more a central issue. Equally, the need to ensure that sectoral strategies and resource allocation at national level is informed by what is happening at lower level is crucial (Kenya HIV and AIDS Monitoring and Evaluation Annual 2006 report).

Micro-finance projects, or savings and credit schemes, can help households to increase their incomes and to build up their assets, so reducing their vulnerability and particularly for women, lowering their susceptibility to HIV infection by reducing the need to exchange sex for favors. The gains made are likely to be modest, but may be sufficient to make a difference in the quality of life, and to improve resilience to survive crises (Holden, 2004). Allied to micro-finance is the idea of support for group-based micro enterprises or income-generating activities. This strategy

is used by NGOs to help groups of HIV-positive people to raise money, and to help community groups to raise money to fund safety-net projects for people affected by AIDS (Holden, 2004).

2.5.4 NGO Monitoring and evaluation

In the early years of the HIV/AIDS epidemic, programme managers had little information about what interventions were likely to work in reducing the spread of the virus, and little idea of how they might measure the success of their interventions beyond simply tracking HIV or AIDS. What's more, it was widely believed that sensitive behaviours such as sex and drug injection – known to spread the virus– could not be reliably measured at all. There was an urgent need to respond in any way possible. Measuring the success of the response was not high on the list of priorities for most programme managers. Over the last decade, this thinking has changed. Much more is known about how HIV spreads through a population, and what changes are needed to slow the spread. It has been amply demonstrated that people will answer questions about their sex lives, and there is growing evidence that their answers give a fairly reliable picture of trends in behavior over time .As the body of knowledge surrounding HIV grows, so does the interest in monitoring and evaluating, the success of programmes designed to reduce the spread of infection and the impact it has on the lives of families and communities. This interest comes from national governments as well as from the taxpayers, programme directors and international donors who support their efforts (UNAIDS, 2000).

The need for better monitoring and evaluation has also spawned a growing number of data collection instruments and indicators. Many different countries and institutions have contributed to the current understanding of how best to monitor and evaluate HIV and AIDS programmes. Monitoring and evaluation of programmes designed to improve health and promote development are old news. Basically, M&E systems track what is being done and whether the programme is making a difference. M&E systems allow programme managers to calculate how to allocate resources to achieve the best overall result (UNAIDS, 2000).

Suitable means of measuring progress in terms of process, outcomes, and impact need to be generated by practitioners, to fit the work that they are doing and the things that they are trying to achieve. Monitoring and Evaluation needs not only to seek and record indicators of process

and outcomes, but also to assess impact. NGOs can by virtue of their monitoring and evaluation confidently identify their success and failures as well as share their experiences if they are to learn from each other (Holden, 2004).

The Kenya HIV/AIDS Program Monitoring System (KePMS) is a Microsoft Access based indicator monitoring database for use in the management, monitoring and evaluation of HIV/AIDS treatment and prevention programs supported by PEPFAR. It is designed to operate at the level of in-country implementing partners who manage program specific data and forward it to national level where it is aggregated automatically by USG program managers. The KEPMS can reduce the burden of reporting and improve the quality of data by standardizing the collection of data. The KEPMS also allows partners to monitor their own performance and make decisions informed by the data.

Monitoring and evaluation of health programs funded by international donors and working with the Kenya Ministry of Health (on issues such as HIV and AIDS, malaria, child survival, and others) have historically been highly vertical, using both international programmatic data tools and Ministry of Health tools in a parallel, overlapping fashion. This was a burden for health workers required to implement both sets of tools within these programs. The Kenya HIV/AIDS Program Monitoring System is an access-based indicator monitoring database used to manage, monitor, and evaluate PEPFAR-supported HIV and AIDS prevention and treatment programs. This system operates through in-country implementing partners who manage specific data and forward them to the national level, where U.S. Government program managers automatically aggregate the data (EngenderHealth, 2009).

According to Kenya Red Cross Society in Kenya, Monitoring and Evaluation is key component of Performance Based Funding. Through M&E, the programme results at all levels (impact, outcome, output, process and input) can be measured to provide the basis for accountability and informed decision making at both programme and policy level. Each Global Fund grant agreement includes a Performance Framework, a legal document through which the recipient organization and the Global Fund commonly agree the indicators to be used and the targets to be

achieved to demonstrate performance and consequently, ensure continued funding. The M&E plan is an essential document, as it describes how the M&E system should be run (KRCS,2011).

Kenya adheres to the “Three Ones” principles, which calls for a single national strategy to guide the HIV actions of all country-level. Stakeholders, one coordinating authority to oversee the work of country partners, and one monitoring and evaluation system with a unified set of agreed indicators. In light of the large number of national ministries and sectors, development partners, and service providers engaged in the HIV response, however, effective coordination remains a challenge. Kenya has taken steps to implement a unified HIV monitoring and evaluation framework. An improved linkage among diverse sectors is needed to fully implement this approach. HIV monitoring and evaluation is a responsibility shared by a number of arms of the national government, coordinated by the KNASP III Oversight and Monitoring Committee.¹ Kenya has developed a series of 55 concrete, time-bound indicators to track implementation of its national AIDS strategy and to drive accelerated progress (NACC and NASCOP, 2012).

2.6 Measures to enhance HIV/AIDS Control strategies

From the empirical literature examined from various research studies, it is noted that the measures currently in place to control the spread of HIV/AIDS and reduce new infections need to be up scaled. More needs to be done to defeat the virus particularly in research and development for new products. Even as progress is made in these areas of prevention and treatment, other challenges remain. With financial resources stretched thin in the wake of the ongoing global economic crisis, the need to identify and replicate proven, effective, and efficient service delivery and prevention models is greater than ever. Resources must be marshaled for the fight, not only from external partners but also from country governments and other sources. (U.S. President’s Emergency Plan for AIDS Relief , 2012).

In May 2012, The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) convened The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. This East African regional forum was held to examine the critical capacity of FBOs for HIV prevention, care, and treatment and to generate recommendations for collaborative, sustainable impact. Based on the dialogue and outputs from

the Consultation, the following was noted as contributors to sustainable control strategies: t reflects the unique contributions they offer: 1. well-established and deep-rooted service delivery networks; 2. clear commitments to serve local communities; 3. a wide range of programs, skills, experiences, and knowledge that contribute to a strong, sustainable, multi-sectoral response; 4. the abiding trust of local communities; and 5. a capacity to mobilize an army of volunteers in any corner of the globe. FBO's who included the NGOs were noted to be able to have these characteristics hence integral in the fight against the HIV/AIDS (U.S. President's Emergency Plan for AIDS Relief , 2012)

As people all over the world begin to grasp the dimensions of the tragedy of HIV/AIDS, they are also beginning to realize that currently the most promising response lies in prevention. Prevention involves changing the individual behaviours that spread the disease, and in working to develop environments that make preventive action the preferred behaviour both for individuals and groups. Education is a powerful, proven tool for prevention. Since education for all is both necessary for battling the disease and threatened by the spread of the disease, it has an inextricable relationship with HIV/AIDS. Education alone cannot unleash massive behavioural and environmental changes. But without education those changes are highly unlikely to take place.

2.7 Theoretical Framework

In this research study the Theory of Planned Behavior was used. According to the theory, human behavior is guided by three kinds of considerations: beliefs about the likely consequences of the behavior (behavioral beliefs), beliefs about the normative expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or impede performance of the behavior (control beliefs). In their respective aggregates, behavioral beliefs produce a favorable or unfavorable attitude toward the behavior; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioral control. In combination, attitude toward the behavior, subjective norm, and perception of behavioral control lead to the formation of a behavioral intention. As a general rule, the more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behavior in question (Ajzen, 2006).

2.8 Conceptual Framework

A conceptual framework is made up of the following variables: independent variables, moderating factors and dependent variables. The independent variables are the variables which a study seeks to examine in order to determine their impact on a particular subject matter (Creswell, 2002). In this particular case, the following were the independent variables: community attitude, community behaviour, NGO funding and NGO monitoring and evaluation. The intervening variables are the factors that can adversely affect the outcomes of the independent variables in a study. The intervening variables for this study were: legal policy and frameworks by National Aids Control Council. The dependent variables are influenced by independent variables and in this particular case, the dependent variable for the study was sustainability of HIV/AIDS control strategies such as condom use, prevention of mother to child transmission (PMTCT) and anti-retroviral therapy. Figure 1 below presents a figurative representation of the conceptual framework of the study.

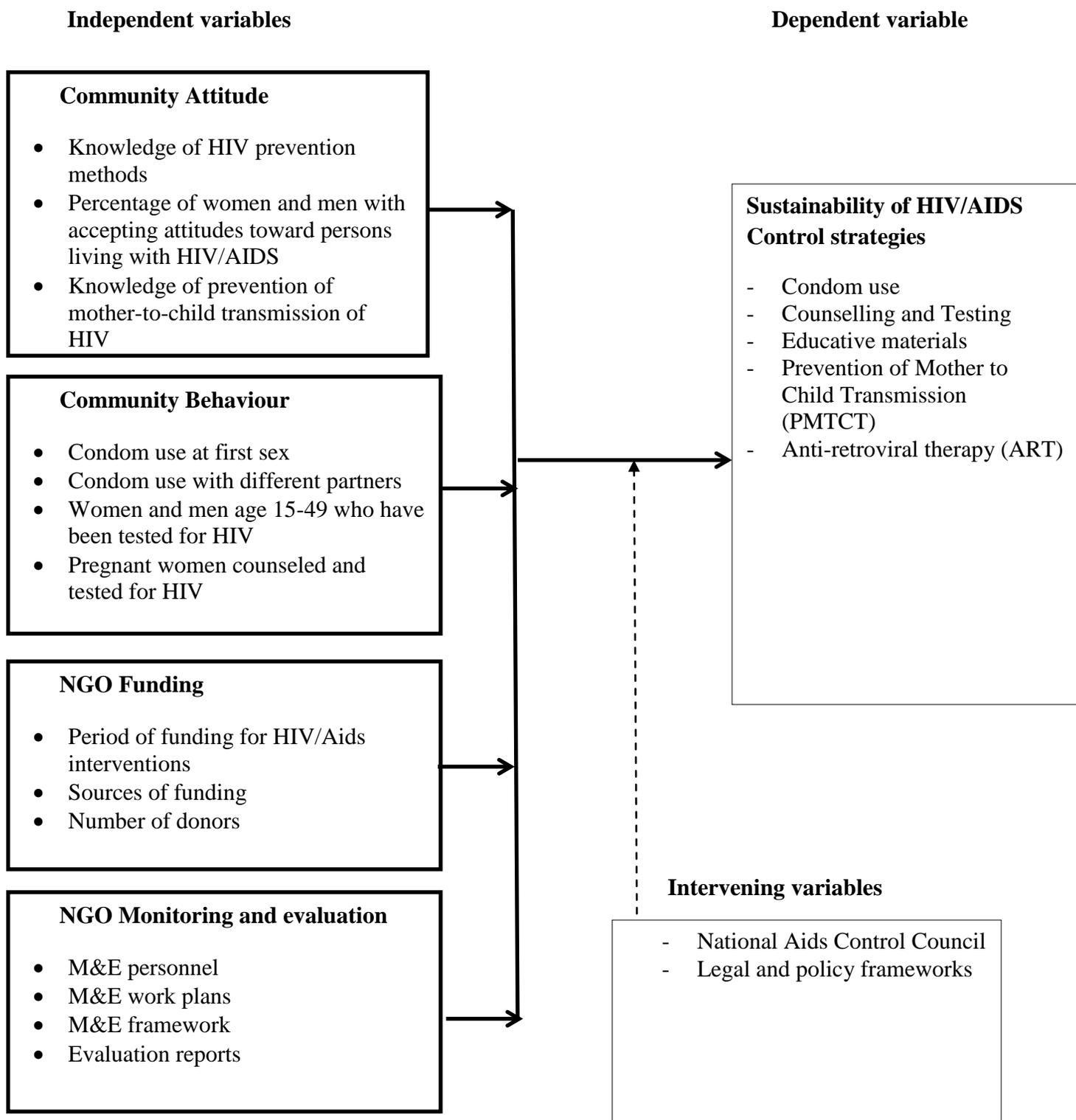


Figure 1- Conceptual framework

2.9 Summary of Literature Review

Research has shown that well designed programmes can yield adequate results and change behavior hence reducing the HIV prevalence's in Africa. America has drastically reduced its HIV prevalence yet it was the first country where HIV was first diagnosed. Uganda, though under a lot of controversy has also shown remarkable success in its HIV prevention programme. Kenya has been reported to have had a reduction in the HIV prevalence in the last few years though the success is not like that of Uganda or Europe and still a large number of people are not willing to know about their HIV status.

A lot of funds and resources have been used in the HIV prevention campaign and at least 98% of Kenyans are said to know about HIV. The NGOs involved in implementation of HIV/AIDS control strategies are increasing day by day. With the high knowledge level of HIV/AIDS and the significant numbers of NGOs involved, there is a gap on sustainability of these control strategies. This research sought to find the factors that influence sustainability of the HIV/AIDS control strategies by the NGOs.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses research design, target population, sample selection and sample size, operational definition of variable, data collection methods, data collection instruments, validity of the instruments, reliability of the instruments and data analysis techniques.

3.2 Research Design

This study adopted a descriptive survey design. According to Kombo and Tromp (2009), a research design is the structure of research. It shows how all of the major parts of the research project work together to try to address the central research questions. Descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals. Descriptive survey was preferred to other methods for it seeks to obtain information that describes existing phenomena by asking individuals questions about their behaviour and or values (Kothari, 2008). The main difficulty in using this type of research design is getting the respondents to answer the questions thoughtfully and honestly and ensuring their responses are clear and not misleading. To overcome this challenge, the researcher undertook a pilot study to ensure the questions are clear to the respondents. The method was used to determine the people's attitudes and behaviour as the well as the nature of NGO funding and the monitoring and evaluation aspect conducted by NGOs in the implementation of the HIV/AIDS control strategies.

According to the Association for Educational Communications and Technology (2001), descriptive survey design gathers both quantitative and qualitative data at a particular point in time and analyses the data to describe the relationship between variables. The study sought to describe the relationship between the HIV control strategies by NGOs and the factors that influence their sustainability.

3.3 Target Population

According to Mugenda and Mugenda (2003), a population is described as the total number of elements or individuals under investigation by a research study. The target populations of this study were the people who were served by the NGOs involved in HIV/AIDS control strategies in Kibera. There were 73 NGOs in Kibera that provided HIV/AIDS related services that include prevention, care and support. From these, 19 operated in Laini Saba ward (Population Council, 2009). The 19 NGOs had an average of 100 people that they served on a monthly basis. The target population was therefore 1900.

3.4 Sample Size and Sampling Method

A sample is described as a proportion of the population that is under investigation by a research study (Mugenda & Mugenda, 2003). A researcher is allowed to use a sample when the target population for a study is too big and the researcher is limited in terms of resources. For this study, a sample size of 323 persons was randomly selected from Laini Saba Ward. Randomization provided the ability to generalize to the population. The 323 sample was based on the target population of approximately 2000 people who were served by the NGOs of Laini Saba ward. The sample size was arrived at by the use of Krejcie and Morgan's table (1970) as shown in Appendix A. From the 19 NGOs, the researcher targeted at least 17 persons referred by each organization based on calculation of proportions from the target population.

Table 3.1 Sample Size and Sampling Method

NGOs	Target population	Sample Estimate	Sample Size
Amref youth group	100	17% of 100	17
Carolina for Kibera organization	100	17% of 100	17
Center for viable development (CVDRII)	100	17% of 100	17
Expect for Kibera	100	17% of 100	17
Ghetto light youth group	100	17% of 100	17
Ghetto Development center	100	17% of 100	17
Good life for all (GLIFA)	100	17% of 100	17
Institute for development of welfare services (IDEWES)	100	17% of 100	17
Kibera community Youth Program	100	17% of 100	17
Kibera community self help programmes Kenya(KICOSHEP)	100	17% of 100	17
Kibera Santiago resource center	100	17% of 100	17
Lindi Usafi Ushirika na Maendeleo (LUUM)	100	17% of 100	17
Maji na ufanisi	100	17% of 100	17
Makina Umoja Usafi Maendeleo (MUUM)	100	17% of 100	17
Rehma ta allah community development group (RCGD)	100	17% of 100	17
Soweto Usafi Group	100	17% of 100	17
Undugu Society of Kenya	100	17% of 100	17
Uzima foundation Africa	100	17% of 100	17
Umande trust	100	17% of 100	17
TOTAL	1900		323

To obtain the sample size per NGO, this was calculated as:

$100 \times \frac{323}{1900} = 16.84$; hence an approximate of 17 persons per NGO

1900

For the NGOs, all the 19 NGOs working in the area and providing HIV/AIDS interventions were interviewed.

3.5 Research Instruments

Data for this study was gathered through questionnaires and interviews. A questionnaire is a research instrument that gathers data over a large sample Kombo and Tromp (2006). The advantages of using questionnaires are: the person administering the instrument has an opportunity to establish rapport, explain the purpose of the study, explain the meaning of items that may not be clear and they give respondents freedom to express their views or opinions and also to make suggestions. Given the sensitivity of the research study, the researcher used the questionnaires particularly to the community members living within Laini Saba Ward. The questionnaire captured the person's general information which included gender, age, level of education and how long they have lived in the area of study, Laini Saba, Kibera. It also captured the attitude and behavior of each respondent through the ordinal measurement scale.

Face to face interviews were conducted for their likelihood to achieve a high response rate because they were useful to obtain detailed information about personal feelings, perceptions and opinions. The questionnaires that were used for the data collection process were semi-structured. The researcher conducted a number of interviews particularly with project managers of the targeted NGOs. The interviews provided the researcher with more insight on the factors that influence the sustainability of HIV/AIDS control strategies from the NGO's perspective and in particular the influence of funding and monitoring and evaluation. As a result, this provided triangulation and the researcher was in a better position to answer the research questions of this study. The researcher engaged the services of two research assistants. The researcher orientated the two on what was expected of them before sending them to the field to assist in the distribution and collection of the questionnaires.

3.5.1 Piloting the instruments

The researcher conducted a pilot study in Kibera slums with the help of the research assistants. The pilot study was essential to help improve face validity and content of the instruments. The

questionnaires were given to 32 persons arrived at from 10% of the sample size of 323. Two NGOs were interviewed using the interview guide to help improve on the instrument.

3.5.2 Validity of Research Instruments

According to Mugenda and Mugenda (1999) validity is a measure of the degree to which result obtained from data represents the phenomena under study. A valid instrument should therefore contain questions that are relevant to the study. The researcher used existing instruments, in the form of questionnaires and interview guides that had substantial evidence of validity in a variety of populations. The researcher then used the instruments to conduct the pilot study in Kibera slums with the help of the research assistants. In addition, the researcher sought assistance from three experts in order to help improve content validity of the instrument.

3.5.3 Reliability of Research Instruments

Mugenda and Mugenda (1999) defines reliability as a measure of the degree to which a research instrument yields consistent results or data after repeated tests when administered a number of times. To enhance the reliability of the instrument, a split-half reliability method was conducted on 32 respondents in Kibera slums. This involved 16 respondents being interviewed and scored from Lindi ward and another group of 16 respondents interviewed and scored from Silanga Ward. The results of the scores were compared to one to ensure the instrument measured the same thing. Using the Rulon's Split-half Method, the split were tested into two halves and created half-test scores. The difference between half-test scores was then computed. The variances of the total scores were determined to obtain the reliability estimate.

3.6 Data Collection Procedures

Mugenda and Mugenda (2003) argue that there are two data collection techniques: primary and secondary data collection techniques. For this study, the researcher used both primary and secondary data collection techniques. Primary data collection technique is whereby data is used for the purposes it was originally collected for (Sapsford & Jupp, 2006). There are various data collection techniques that can be used in the collection of primary data. The study however employed the following data collection techniques: (1) questionnaires; (2) interviews.

The researcher trained 2 research assistants on the research instruments. Due to the sensitivity of the research topic, the researchers were identified through the Community Health Workers (CHWs) who had served the community members on HIV/AIDS interventions. The researcher anticipated that with the assistance of the CHWs, identifying the respondents and obtaining their responses in a timely manner would be feasible. For the NGOs, the interview guide was used to obtain their responses and information obtained from them used for triangulation during data analysis.

Secondary data is described as data which is used for other purposes than the one it was originally collected for (Kothari, 2008). The study sourced secondary data from accredited journal articles that were in line with the objectives of this study which were then correlated with the findings of this study. By so doing, the researcher had the ability to critically analyze and answer the research questions of this study. It also gave the researcher the ability to develop comprehensive and elaborate conclusions.

3.7 Data Analysis Technique

Data collected from the field were checked for completeness, coded and analyzed using Ms Excel and SPSS (Statistical Package for Social Sciences). This implied that the responses from the questionnaires were scored, edited, coded and entered into the computer for analysis. Tabulation was done for each questionnaire depending on the responses elicited by the respondents. Data analyzed was thereby presented in frequency distribution tables.

3.8 Ethical Considerations of the Study

The researcher adhered to the following ethical considerations in the course of the data collection process. First, the respondents participated on their own volition. This implied that in case any of the respondents felt like withdrawing during the data collection process; they would be allowed to do so. Secondly, the researcher sought the permission from the relevant research stakeholders before undertaking the study. Thirdly, the researcher upheld anonymity and thus the respondents were not required to give their names. Fourthly, the researcher was to communicate the findings of the research study to the research stakeholders upon completion.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the study findings which have been discussed in line with the study objective themes and sub-thematic areas as follows: Questionnaires return rate, demographic characteristics (gender, age, marital status and highest level of education), area of service provision, and length/duration of service provision. The chapter discusses themes from objective one to objective four. The quantitative data was analyzed using descriptive statistics where frequencies and percentages guided the researcher to interpret the data. Analysis of the qualitative data from the interview guides was also conducted.

4.2 Questionnaire Return Rate

The target respondents were the people served by NGO's involved in HIV/AIDS control strategies in Laini Saba Ward, Kibera. Out of the 323 questionnaires distributed to the targeted sample, 280 questionnaires were returned. 43 questionnaires were not returned with the targeted respondents citing misplacement of the questionnaires. It is out of the returned questionnaires' responses that the presentation of the general information and data analysis was done. This response rate was good and adequate. According to Babbie (1995), a response rate of 70% and above was satisfactory for data analysis. A return rate of 86.7% was realized as presented in Table 4:1

Table 4.1: Questionnaire Return Rate

Questionnaires	Number of Questionnaires	Percentage
Returned Questionnaires	280	86.7
Questionnaires not returned	43	13.3
Totals	323	100

4.3 Demographic characteristics of respondents

Personal information of the respondents was based on gender of the respondents, age, marital status; highest level of education, number of the years lived in Kibera and the part of Kibera in which the respondents lived in.

4.3.1 Distribution of respondents by gender

This intended to find out how community behaviour and attitudes of male and female persons influenced sustainability of HIV/AIDS control strategies. According to the findings on the gender of the respondents, majority, 188 respondents were females representing (67.1%) while the remaining 92 respondents were males representing (32.9%). This shows that more females participated in HIV/AIDS control strategies in Laini Saba, Kibera as compared to their male counterparts. Table 4.2 shows the distribution of respondents by gender.

Table 4.2: Distribution of respondents by gender

Gender	Frequency	Percentage
Male	92	32.9
Female	188	67.1
Total	280	100.0

4.3.2 Distribution of respondents by age

Distribution of respondents by age was vital to find out how different age groups perceived HIV/AIDS control strategies and how it affected them. According to the findings majority of the respondents (116) were of the age category of 26-35 years representing (41.4%). Those of age category of 19-25 years were 85 representing (30.4%). Those of age category 50 and above were 20 (7.1%) and those who were 18 years and below were only 10 representing (3.6%). Table represents this discussion.

Table 4.3 Distribution of respondents by age

Respondents / Age Bracket	Frequency	Percentage
18 years and below	10	3.6
19 – 25 years	85	30.4
26 – 35 years	116	41.4
36 – 49 years	49	17.5
50 years and above	20	7.1
Total	280	100.0

From Table 4.3 It can be concluded that people of age brackets 26-35 were more receptive to HIV/AIDS control strategies as compared to others of other age brackets in Laini Saba Kibera slums. However, a slight majority of the respondents of age bracket 19-25 also indicated that the youth in Kibera were generally conscious of their HIV/AIDS status and thus had a positive attitude towards HIV/AIDS control strategies. Of importance to note is also the fact that there were a number of teenagers too who accessed these control strategies.

4.3.3 Marital status of respondents

Due to concerns of high HIV prevalence among the married people (NASCO, 2006) the researcher intended to find out the attitudes of the respondents by marital status on HIV/AIDS control strategies. When asked on their marital status, the study established that majority of the respondents (157) were married representing (56.1%), 107 respondents were single representing 38.2%, 16 respondents were widowed. No respondent was separated or divorced. Table 4.4 shows this discussion.

Table 4.4: Marital status of respondents

Marital status	Frequency	Percentage
Married	157	56.1
Single	107	38.2
Divorced / separated	00	00.00
Widowed	16	5.7
Total	280	100.0

From Table 4.4, it can be argued that due to the marital status of married people that is directly related to sexual activities, HIV/AIDS control strategies are more practical to them. In this case they are more likely to be tested, more likely to use condoms and spearhead the campaigns on HIV/AIDS. However single persons and the widowed also need sensitization on HIV/AIDS since they are also affected by dangers related to this scourge.

4.3.4 Highest level of education

This highest level of education attained by respondents is important since the levels of literacy in a given location directly influence the people's attitudes, behaviours and their awareness about HIV/AIDS control strategies. To analyze their highest levels of education, the respondents were asked to tick their level of education provided in the questionnaires. The levels provided were; primary, secondary and tertiary. When asked of their levels of education, majority of the respondents (176) had attained secondary education representing 62.9%, followed by those who had attained tertiary education comprising of 23.9% (67 respondents). Those who had attained primary education were 37 comprising of 13.2%. Table 4.5. illustrates this finding.

Table 4.5: Highest level of education

Education level	Frequency	Percentage (%)
Primary	37	13.2
Secondary	176	62.9
Tertiary	67	23.9
Total	280	100.0

From the given data in Table 4.5 it is worth stating that education levels influence how HIV/AIDS control strategies can be sustained. This is because education and people's attitudes and behavior are inter-related. According to Table 4.5 however, more education initiatives still needs to be undertaken since a slight majority had attained tertiary education. It is also important to note that the implementation of HIV/AIDS control strategies highly depend on the literacy levels of a given population. Laini Saba Ward in Kibera therefore requires more tertiary education if these strategies are be successful.

4.3.5 Duration lived in Kibera

The respondents were further asked of the number of years they had lived in Kibera. This was relevant in assessing the effectiveness of HIV/AIDS control strategies since the implementation of these strategies require a substantial amount of time. When asked the number of years they had lived in Kibera, majority (119 respondents) had lived in Kibera for more than 5 years comprising of 42.5%. Those who had lived in Kibera between 3-5 years were 88 representing 31.4% while those of between 0-3 years were 73 comprising of 26.1%. Table 4.6 shows the duration lived in Kibera.

Table 4.6: Duration lived in Kibera

Duration	Frequency	Percentage
0 – 3 years	73	26.1
3 – 5 years	88	31.4
More than 5 years	119	42.5
Total	280	100.0

From the data given in Table 4.6, it is noted that the respondents had stayed in Kibera for long enough to assess the factors influencing the sustainability of HIV/AIDS control strategies. This is because the implementation of these strategies requires sufficient time. Moreover it is only when the respondents have experienced the services offered by the targeted NGO's that they can comprehensively comment on the effectiveness of the strategies.

4.3.6 Respondents residence in Kibera

The researcher intended to confirm whether all the respondents come or lived in Laini Saba Ward in Kibera. To achieve this, the respondents were asked which part of Kibera they came from. This was by either indicating Laini Saba or other parts of Kibera. When asked this question, all the respondents (280 respondents) were living in Laini Saba representing 100%.

The fact that all the respondents came from Laini Saba Ward aided the research study since they were well familiar with the Non-governmental organizations in the ward and the services that they offered. The accuracy of the responses was also accurate since none of the respondent was living outside Laini Saba Ward.

4.4 NGO's provision of HIV/AIDS control strategies

To determine whether HIV/AIDS control services were being offered, the researcher asked the respondents if NGO's in Laini Saba Ward provided the services. In this case the respondents were to answer by either indicating yes not sure or no/ according to the findings, majority of the respondents (171 respondents) indicated "yes" representing 61.1%, 86 respondents indicated "not sure," comprising of 30.7% while 23 indicated "No" representing 8.2%. Table 4.7 shows this discussion.

Table 4.7: NGO's provision of HIV/AIDS control strategies

NGO's provision of control services	Frequency	Percentage
Yes	171	61.1
Not sure	86	30.7
No	23	8.2
Total	280	100.0

Table 4.7 indicate that majority of the respondents agreed that the NGO's in Laini Saba Slum in Kibera provided the ward with HIV/AIDS control strategies. However a significant number (30.65%) were not sure whether these control initiatives were available. This indicated that there was a need for more advocacy initiatives on the services available to the residents by the NGOs.

Furthermore, the few respondents whose response stated that there were no services offered by the NGO'S indicated that the attitudes of some people in the ward towards HIV/AIDS control strategies was negative thus the need for change of attitude.

4.4.1 HIV/AIDS control strategies adopted by NGO's

This intended to find out the form of HIV/AIDS control strategies that the NGO's had adopted. The respondents were given the strategies which included; condom distribution, prevention of mother to child transmission, behaviour change campaign, testing and counseling services. According to the findings majority of the respondents (92) stated that condom distribution was the major control strategies adopted by NGO's in Laini Saba Ward, comprising 32.9%, a slight majority (81 respondents) indicated that the NGO's adopted testing and counseling services comprising of 28.9%, 53 respondents (18.9%) stated that all these strategies had been adopted by the NGO's with 36 respondents representing 12.9% stating prevention of mother to child transmission as a control strategy adopted. On the other hand only 18 respondents comprising of 6.4% cited behavioral change campaigns as a strategy adopted by the NGO's. Table 4.8 illustrated this discussion.

Table 4.8: HIV/AIDS Control Strategies Adopted by NGO's

HIV/AIDs control strategy	Frequency	Percentage
Condom Distribution	92	32.9
Prevention of mother-to child transmission	36	12.9
Behaviour change campaigns	18	6.4
Testing and counseling services	81	28.9
All of the above	53	18.9
Total	280	100.0

From the data in Table 4.8, it is noted that condom distribution was the major control strategy that NGO's in Laini Saba Ward in Kibera used to curb HIV/AIDS. However there is need to implement more strategies on behaviour change campaigns since the residents did not consider it as a major control strategy. In addition, the fact that some respondents cited that all these

strategies were adopted by the NGO's was an indication that there were tremendous efforts being made to control the spread of HIV/AIDS.

The Organizations were interviewed to find out which approach they emphasized in relation to HIV/AIDS control strategies. The responses included emphasis on use of a condom, being faithful to one trusted partner or abstinence for those not sexually active, stigma reduction, testing and counseling and a combination of all the first three (abstinence, being faithful and condom use). The reasons for choosing one aspect of the control strategy to emphasize also varied a lot and could generally be categorized into these groups: Religious afflictions, Organizations policies and culture as well as community convictions. 18 of the 19 organizations interviewed had all three aspects of abstinence, being faithful and condom use in their campaigns. One organization, known as a Drop in Center, dealt with testing and counseling and provision of condoms services mainly to the most at risk populations such as truck drivers and commercial sex workers.

In one of the organizations, the Project Officer stated: *"...We actually emphasize on being faithful. We tell those who are married to be faithful to each other and also the youths who are already dating. For those who are not already sexually active we emphasize abstinence."*(KICOSHEP).

The reason why they emphasize on being faithful to one person is as she explains:

".....we decided to emphasize on something that could help people who were already sexually active...They say `how can you just put food on the table and look at it...you must eat it`. We tell them however to get tested and also use condoms..."

"...a majority of our members are Christians and we want to uphold the Christian faith.....but the new members who are not Christians we try to bring them closer to God first" (Ghetto light youth group, a youth group affiliated to the local church).

Having heard from the organization which aspects of the control strategies they emphasized, the research also wanted to find out how they made the decision on which area to emphasize. In

some cases, the community members themselves seemed to have an upper hand on what they wanted for the strategies as was eventually used by some organizations.

“The youths told us that it was impractical to preach abstinences that they would rather be told to be faithful, so we choose that....” Noted the project officer in Rehma Ta Allah

Other organizations also evaluated the approaches other organizations had taken and choose a different approach.

“...we see that other organizations have failed in those areas that they emphasize on so we choose a different approach of staying faithful” adds the project officer Rehma Ta Allah

4.5 Community members attitude on sustainability of HIV/AIDS Control Strategies

This section intended to find out how the attitude of the community of Laini Saba influenced sustainability of HIV/AIDS control strategies. This is because in many communities in Kenya people suffering from HIV/AIDS have often been discriminated upon. Furthermore HIV is an infection that many people have fears, prejudices and negative attitude about (AIDs in Kenya, 1996). In this case, the respondents were asked seven questions related to community attitude on HIV/AIDS. The responses were on a likert scale with strongly agree = 5, agree = 4, Neutral = 3, Disagree = 2 and strongly disagree =1.

The sum total of each individual was scored. The responses were presented under three aspects: agree, disagree and those with moderate attitude. The scores were analysed from the total sum for each individual and presented in a frequency table. From the seven statements, the index score varied between 7 indicating strongly disagreed (therefore: $7 \times 1=7$), and 35 (7×5) indicating strongly agreed responses. The average index score was 21 (7×3) indicating average level of accepting attitudes. In this case, the higher the score, the higher the level of accepting attitudes towards HIV/AIDS control strategies and vice versa.

Table 4.9 Scale of Frequency on findings on community attitude

Scale	Responses	Frequency	Percentage
7-16	Disagree	78	28.0
17-26	Moderate	108	39.0
27-35	Agree	94	33.0
Total		280	100.0

Table 4.9 indicates that the majority (39.0%) of the sampled respondents had moderate accepting attitude towards HIV/AIDS control strategies while 28.0% had negative attitude. On the other hand 33.0% had accepting attitude towards the HIV/AIDS control strategies implemented by the NGOs. This implies that availability and access of the HIV/AIDS control strategies was not a problem. However, much advocacy was still needed since some people had negative attitude towards the NGOs HIV/AIDS control strategies. In addition, the NGO's still had some grass-root work to interact with the community members so as to effectively access the impact of these control strategies. On the issue of HIV modes of transmission awareness, the findings imply that the community was still ignorant and unsure of how HIV/AIDS was transmitted. The community also felt that those with HIV/AIDS were discrimination upon. This was also collaborated by what the NGOs stated as described in the qualitative analysis on poor knowledge of transmission and there being discrimination particularly by family members if they knew ones status.

The organizations were also asked the responses they got from the community about the HIV/AIDS control strategies. It was also important to know if they liked the approaches being taken by the organizations. This was grouped in two broad groups, positive and negative feedback. On the positive feedback the organizations reported that the community liked the approach of putting them in small groups. They especially liked that they could talk one on one with the programme officers and get instant feedback if they had questions. They could also ask personal questions without fear especially in programmes where they explored their present and past behaviors. This approach was taken by AMREF Youth Group. UMANDE Trust confidently reported that they got positive feedback from the community especially that they were consistent with their messages on stigma reduction.

Carolina for Kibera reported that the women with whom they work with also wanted men to be included in their programmes. This was very important as it is two persons who decide to have protected or unprotected sex. The community suggested that the campaigns should focus on being faithful to one trusted partner even for young people. Many admitted they could not abstain for long. In general the organizations reported that the community responded well to their programmes and wanted them to continue with the control strategies.

“They believe HIV is with us and we must fight it!” reports KICOSHEP.

On the negative feedback, the community blamed the NGOs for giving them conflicting information on the control strategies. It is not easy for them when for example three organizations preach three different things. For example one emphasizing on being faithful, the other testing and counseling, another abstinence while one insists they must use condoms and each claiming their chosen approach was the best. In addition, even though there was a constant campaign by the organizations on use of condoms, majority of the community reported that they were not 100% safe. It seemed like an easy approach as condoms can easily be distributed and one can even report that the programme is doing well based on the indicator the number of condoms distributed. It does not make sense to distribute condoms while the recipients have negative attitudes about them laced with contemptible myths and believes.

“Some community members say condoms have small holes through which the virus can pass through, hence they cannot use them as it gives them false security. They would rather just have sex without condom and know they are at a risk than believe they are safe while they are not...”
Reports one organization.

It is therefore noted that more advocacy initiatives and education awareness campaigns are needed in order to change the community’s attitude towards embracing the sustainability of HIV/AIDs control strategies. This is with regards to grass root implementation of the strategies. Furthermore according to the findings, community members seemed not to be aware of HIV/AIDs modes of transmission very well leading to stigmatization and discrimination, an

issue that the NGO's need to address if they are to achieve successful implementation of these strategies. For instance this can be achieved through sensitization campaigns.

4.6 Community behaviour on Sustainability of HIV/AIDS Control Strategies

This section intended to find out how community behavior influenced the sustainability of HIV/AIDS control strategies. This is because sexual behavior is directly related to transmission of HIV/AIDS. To achieve this, the researcher asked seven questions related to sexual behavior. The responses were on a likert scale with strongly agree = 5, agree = 4, Neutral = 3, Disagree = 2 and strongly disagree =1. Table 4.10 shows the summary of the findings on community behavior towards HIV/AIDS control strategies followed by the implications of these findings.

The sum total of each individual was scored. The responses were presented under three aspects: agree, disagree and those with moderate behaviour. The scores were analyzed from the total sum for each individual and presented in a frequency table. From the seven statements, the index score varied between 7 indicating strongly disagreed (therefore: 7 X 1=7), and 35 (7 x 5) indicating strongly agreed responses. The average index score was 21 (7 x 3) indicating average level of behavioral influence on the HIV/AIDS control strategies. Table 4.10 shows the scale of frequency on findings on community behaviour.

Table 4.10 Scale of Frequency on findings on Community behaviour

Scale	Responses	Frequency	Percentage
7-16	Disagree	22	8.0
17-26	Moderate	115	41.0
27-35	Agree	143	51.0
Total		280	100.0

From Table 4.10, majority of the respondents (143) representing 51.0% demonstrated behavior influences sustainability of HIV/AIDS based on the seven statements. 115 representing 41.0% indicated average level of behavioural influence while only 22 respondents representing 8.0% demonstrated that behaviour does not influence sustainability of the HIV/AIDS control strategies. It can therefore be concluded that NGO's in Laini Saba Ward had done tremendous work in ensuring positive behavioral change with regards to HIV/AIDS. This is noted by the

number of people who had been tested and the fact that majority of the people were willing to commit to one partner. However, there was still much to be done since condom use with more one partner was still depicted by some respondents as not a 100% guarantee of not acquiring the disease. This was further collaborated by the NGOs from interviews conducted.

Some organizations reported incidences of stigmatization and discrimination on those who accessed their services for example at UZIMA Foundation Africa. However, it is important to note that most of them said that discrimination was experienced from family members of the victims since those members are the ones who knew well their HIV status. Nevertheless, the community was not very harsh on them. This was attributed to the fact that the families feared that they would infect other family members with the virus.

“We still have more work to do with regard the modes of transmission of HIV/AIDS since most people still believe that just coming to contact with a HIV/AIDS patient say even through greeting will lead to transmission or infection. Our patients often complain of being discriminated upon especially by their relatives due to fear that they will infect their loved ones. Some even associated them with adulterous people who brought shame to their families. There are also some who fear even accompanying them to our premises due to fear of other relatives also accusing them of contracting the virus. As an organization we are doing what we can to curb these stereotypes” Noted the project officer at Uzima Foundation Africa.

This is an indication that more advocacy and grassroots initiatives were needed by the NGOs targeting especially the families that had a member as a victim of HIV/AIDS so as to educate them on the events in which the virus can be transmitted. Much education was also needed to help them care for those members with the virus.

4.7 Funding on sustainability of HIV/AIDS control strategies

The researcher further sought to find out how funding influences the sustainability of HIV/AIDS control strategies. To achieve this, questions on the influence of funding on HIV/AIDS control strategies were asked. This was vital since the successful implementation of these strategies highly depend on the availability of funds. According to Kenya HIV and AIDs monitoring and

evaluation annual report (2006), sustainable financing for HIV/AIDS is one of the emerging challenges of the response to the epidemic.

To this end, the respondents were asked three questions to gauge how funding influenced sustainability of HIV/AIDS control strategies. These were whether the NGO's always implemented the control strategies, whether there were challenges in obtaining condoms from the NGO's and whether the funding received by the NGO's was adequate for HIV/AIDS control. The responses were on a likert scale with strongly agree = 5, agree = 4, Neutral = 3, Disagree = 2 and strongly disagree =1.

The sum total of each individual was scored. The responses were presented under three aspects: agree, disagree and those with moderate responses on funding. The scores were analysed from the total sum for each individual and presented in a frequency table. The index score varied between 3 indicating strongly disagreed (therefore: $3 \times 1 = 3$), and $(3 \times 5 = 15)$ indicating strongly agreed responses. The average index score was $(3 \times 3 = 9)$ indicating average level of funding. Table 4.11 shows the scale of frequency on findings on funding.

Table 4.11 Scale of frequency on findings on adequacy of Funding

Scale	Responses	Frequency	Percentage
3-7	Disagree	163	58.0
8-12	Moderate	93	33.0
13-17	Agree	24	9.0
Total		280	100.0

From Table 4.11, majority of the respondents 163 (58.0%) felt that NGOs funding was inadequate for the sustainability of HIV/AIDS control strategies. On the other hand 93 respondents denoted that funding was moderately adequate representing 33.0% while 24 respondents, representing (9.0%) felt that NGOs funding was sufficient for the sustainability of HIV/AIDS control strategies. This implied that funding directly affected provision of these services and thus inadequate funding was likely to hamper the progress of HIV/AIDS control. Nevertheless, the finding by the researcher on whether there were challenges experienced in obtaining condoms from the NGO's showed that NGO's were very successful in ensuring that there was a sufficient fund for distribution of condoms to the community.

From the interviews conducted with the organizations, it was noted the INGOs were well funded mainly by the donors from the West. The NGOs too in many cases were well funded but occasionally lacking in funds to expand on their activities and programmes. They also relied heavily on the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the start of their activities relied on when such funds would be released. On the other hand CBOs were not so well funded and many of them were seasonal and could only be operational when there were funds.

All in all it is worth stating that limited funding still poses a potential threat towards achieving sustainable provision of HIV/AIDS control strategies. NGOs ought to therefore expand their financial base to be able to achieve this.

4.8 Monitoring and Evaluation on Sustainability of HIV/AIDS Control Strategies

This section sought to find out how monitoring and evaluation influences sustainability of HIV/AIDS control strategies. This is because measuring how the implementation of these strategies was progressing was key to their sustainability. This also helps the project managers to calculate how much resources need to be supplemented since they are able to identify the gaps. To achieve this, the researcher asked four questions related to monitoring and evaluation.

The questions posed were; whether NGO's conducted monitoring visits in their home areas, whether they ensured their participation in the monitoring meetings, whether they had participated in any monitoring surveys conducted by the NGO's and whether there was information sharing through the NGO's. The responses were on a likert scale with strongly agree = 5, agree = 4, Neutral = 3, Disagree = 2 and strongly disagree =1. Table 4.13 shows the summary of the findings on monitoring and evaluation followed by the implications of these findings. The sum total of each individual was scored. The scores were analysed from the total sum for each individual and presented in a frequency table. The responses were presented under three aspects: agree, disagree and those with moderate responses on adequacy of monitoring and evaluation. The index score varied between 4 indicating strongly disagreed responses (therefore: $4 \times 1=4$), and 20 ($4 \times 5=20$) indicating strongly agreed responses. The average index score was 12 (4×3) indicating average level of monitoring and evaluation. Table 4.12 shows the scale of frequency on findings on community behaviour.

Table 4.12 Scale of Frequency on findings on Monitoring and Evaluation

Scale	Responses	Frequency	Percentage
5-10	Disagreed	146	52.2
11-15	Moderate	88	31.4
16-20	Agreed	46	16.4
Total		280	100.0

From Table 4.12, majority of the respondents (146) representing 52.2% had a negative response on the levels of monitoring and evaluation efforts by the NGOs. On the other hand, 31.4% were moderately satisfied with their efforts. Only 16.4% were satisfied with their monitoring and evaluation efforts. This implied that the community members input on monitoring and evaluation was not sufficient. In other words the NGO's did not fully engage the people of Laini Saba in evaluating the progress of the HIV/AIDS strategies. This was collaborated from the qualitative analysis where we noted the NGOs stated they were unable to hold supervisory visits to the homes of the community members to monitor on the HIV/AIDS control strategies.

From Table 4.12, it can be depicted that NGO's in Laini Saba Ward need to monitor the progress of the HIV/AIDS strategies. According to the findings, the community felt left out in assessing the progress of these strategies yet they were the direct beneficiaries of the strategies.

During the interview with the organizations, some organizations admitted that they found it difficult to monitor the activities of the Community members beyond their offices and premises. One would not follow them to find out if they were actually using condoms and attending testing and counseling sessions. However, they stated despite this challenge, the Community Health Workers, did their best to monitor those who were infected to ensure they attended a clinic for their antiretroviral therapy (ART).

Firmly founded organizations were more likely to evaluate their activities to find out if they were achieving their objectives. The indicators for success were also spelt out for the staff to know if they were within the objectives. Individual run programmes were more flexible as they are not accountable to any one and could change their objectives to suit the moment. Some of such organizations were also seasonal and could only exist if there is an activity and funds for the

same. They could be classified as “brief case NGOs” as they had neither specific offices nor address where they could be traced to.

The more adequately trained the staff were on Monitoring and Evaluation, the more efficient they would be. While INGOs and NGOs employed professionals and well trained staff to their respective specialization areas, the CBOs gambled with lack of adequate staff while those available double up as project manager, project directors, Monitoring and Evaluation officers, accountant, office assistant and also driver’s in-cases where they have vehicles for the organization. Individual organizations were run by the founder and in many occasions it did not matter whether they were professionals or not. They could get a few people, friends or family who could help in the daily running of the organization.

It was noted information sharing by the NGO’s to the members of the community was vital since it is only through this that they would obtain trust by which they would be open to them to get accurate feedback. All in all the NGO’s ought to develop sustainable means of measuring progress in terms of process, outcomes and the impact since monitoring and evaluation need not only to see and record the indicators of process and outcomes of the implementation of the strategies, but also to access the impact.

CHAPTER FIVE
SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND
RECOMMENDATIONS OF THE STUDY

5.1 Introduction

This chapter presents the summary of findings, discussions, conclusions, recommendations as well as suggestions for further research.

5.2 Summary of findings

The summary of findings highlights briefly the demographic findings of the study and the influence of attitude, behavior, funding and monitoring and evaluation on sustainability of HIV/AIDS control strategies.

5.2.1 Demographic Characteristics of Respondents

From the findings majority of the respondents were female (188 respondents) representing 67.1% as compared to their male counterparts who were 92 respondents representing 32.9%. Majority of the respondents were of the age category of 26-35 years representing 41.4%. On the marital status of the respondents it was established that majority of the respondents (157) were married representing 56.1%, 107 respondents were single representing 38.2%, 16 respondents (5.7%) were widowed while there were no respondents who were separated or divorced. When asked on their highest level of education, majority of the respondents, 176 (62.9%) had attained secondary education, 67(23.9%) tertiary education while only 37(13.2%) had attained primary education.

When asked on the duration that they had lived in Kibera, majority of them, 119 (42.5%) had lived in Kibera for more than 5 years. Those who had lived in Kibera for between 3-5 years were 88 (31.4%) while those who had lived there for between 0-3 years were only 73 representing 26.1%. When the researcher sought to find out the respondents' residence in Kibera by providing an option of either Laini Saba Ward or other wards in Kibera, all the respondents 280 (100%) stated that they lived in Laini Saba Ward. These demographic findings were important since they enabled the researcher to understand the background of the respondents and to establish whether these backgrounds in any way influenced HIV/AIDS sustainability.

5.2.2 Community's attitude on sustainability of HIV/AIDS Control Strategies

The researcher assessed the level of accepting or non-accepting attitudes by community members using aspects of attitude that included NGO's involvement in HIV/AIDS control strategies, awareness of HIV/AIDS modes of transmission, awareness of HIV prevention methods, sustainability of communication and education by NGO's and whether the community stigmatized those who accessed these control strategies. The statements were on interaction with NGOs on HIV/AIDS control strategies and that community discriminates those who access HIV/AIDS services. Majority (39.0%) of the sampled respondents had moderate accepting attitude towards HIV/AIDS control strategies while 28.0% had negative attitude. On the other hand 33.0% had accepting positive attitude towards the HIV/AIDS control strategies implemented by the NGOs. However the fact that 33.0% were not positive indicate despite availability of control strategies, more advocacies was still needed to be done. Furthermore according to the findings majority of respondents agreed that they were aware of the NGOs involved in HIV/AIDS strategies. The community also felt that those with HIV/AIDS were discrimination upon. This was also collaborated by what the NGOs stated as described in the qualitative analysis on poor knowledge of transmission and there being discrimination particularly by family members if they knew ones status.

5.2.3 Community behaviour on sustainability of HIV/AIDS Control Strategies

The researcher sought to find out; whether the respondents had been tested for HIV/AIDS, whether knowing one's HIV status led to behaviour change, whether the respondents used condom all the time with a new sexual partner, whether they had more than one sexual partner, whether they were aware of NGO's campaign on change of behaviour, whether changed behaviour as a result of the campaigns was sustainable and whether the community behaviour had changed as a result of the control strategies. The index score varied between 7 indicating strongly disagreed (therefore: $7 \times 1=7$), and 35 (7×5) indicating strongly agreed responses. The average index score was 21 (7×3) indicating average level of behavioral influence on the HIV/AIDS control strategies.

From the findings, majority of the respondents (143) representing 51.0% stated behavior influences sustainability of HIV/AIDS based on the seven statements. 115 representing 41.0%

indicated average level of behavioural influence while only 22 respondents representing 8.0% demonstrated that behaviour does not influence sustainability of the HIV/AIDS control strategies.

5.2.4 Funding on sustainability of HIV/AIDS control Strategies

To determine the sustainability of funding, the respondents were asked whether the NGO's always implemented the control strategies, whether there were challenges in obtaining condoms from the NGO's and whether the funding received by the NGO's was adequate for HIV/AIDS control. The index score varied between 3 indicating strongly disagreed (therefore: $3 \times 1 = 3$), and $(3 \times 5 = 15)$ indicating strongly agreed responses. The average index score was $(3 \times 3 = 9)$ indicating average level of funding. To this end, majority of the respondents 163 (58.0%) felt that NGOs funding was inadequate for the sustainability of HIV/AIDS control strategies. On the other hand 93 respondents denoted that funding was moderately adequate representing 33.0% while 24 respondents, representing (9.0%) felt that NGOs funding was sufficient for the sustainability of HIV/AIDS control strategies.

5.2.5 Monitoring and Evaluation on Sustainability of HIV/AIDS Control Strategies

To analyze how monitoring and evaluation influences sustainability of HIV/AIDS control strategies, the researcher asked; whether NGO's conducted monitoring visits in their home areas, whether they ensured their participation in the monitoring meetings, whether they had participated in any monitoring surveys conducted by the NGO's and whether there was information sharing through the NGO's. The index score varied between 4 indicating strongly disagreed (therefore: $4 \times 1 = 4$), and 20 ($4 \times 5 = 20$) indicating strongly agreed responses. The average index score was 12 (4×3) indicating average level of monitoring and evaluation. From the findings, majority of the respondents (146) representing 52.2% had a negative response on the levels of monitoring and evaluation efforts by the NGOs. On the other hand, 31.4% were moderately satisfied with their efforts. Only 16.4% were satisfied with their monitoring and evaluation efforts. This implied that the community members input on monitoring and evaluation was not sufficient. In other words the NGO's did not fully engage the people of Laini Saba in evaluating the progress of the HIV/AIDS strategies. This was collaborated from the qualitative

analysis where we noted the NGOs stated they were unable to hold supervisory visits to the homes of the community members to monitor on the HIV/AIDS control strategies.

5.3 Discussion of findings

Based on the findings of the study, majority of the respondents (41.4%) were of the age group 26-35 years, an age category by which majority of the respondents were married. According to NASCOP (2006), HIV/AIDS prevalence was substantially high among the married people. Nevertheless the fact that the majority of respondents (51%) stated that they sought HIV/AIDS control strategies services from the NGOs is an indication that they were taking the control strategies seriously. In addition these also gave an indication that this could be attributed to the effort by the NGOs in Laini Saba.

Community members' attitude on sustainability of HIV/AIDS control strategies were generally positive despite a few community members being stigmatized. In addition, most community members felt they were not discriminated upon in the ward. However, from the qualitative analysis we noted that discrimination was mainly by the family members that they lived with. According to Pebody (2012), stigma results in people with HIV feeling insulted, rejected, gossiped about and excluded from social activities. It is therefore worth noting that HIV/AIDS education was needed to educate the community members on the need to care for HIV/AIDS victims and not to stigmatize them. NASCOP (2006) depicts that stigmatizing attitudes among the health care workers was dangerous to HIV patients thus the need to have proper knowledge on these control strategies and HIV/AIDS as a subject.

Community behavior was depicted to influence the sustainability of these control strategies. According to the findings of this study, majority with a mean score of 3.6 the respondents having agreed to have been tested for HIV/AIDS is a strong indication that they were conscious of their status, which explains how positive change of human behavior lowers the prevalence of this scourge, (Preventing and Mitigating Aids in Sub-Saharan Africa, 1996). Furthermore the fact that majority of the respondents stated that they were committed to one sexual partner indicates that positive behavioral change was having an impact on HIV/AIDS eradication. According to Sakala (1996), monogamy is seen as a powerful tool of curbing the spread of this scourge. In

addition, regarding the use of condoms, majority of the respondents (mean score 3.3) stated that they used condoms all the time with a new partner an indication that condom use was one of the most effective control strategies. Oballa (2007) noted that condom use was perceived as a way of preventing HIV among the married people but was seen as less effective among the youth. Moreover, community behavior had changed as a result of the campaigns that were made by the NGO's according to the findings of this study. This contradicts Oballa's argument that NGO's were the last resort of source of information on HIV/AIDS among the youth.

Funding plays an important role on the sustainability of these HIV control strategies. According to the Kenya HIV and AIDS Annual Evaluation Report (2006), the changing phases of HIV pandemic explain why the scourge needs sustainable funding. To this end, the study found out that there was limited funding of HIV projects in Laini Saba ward (according to majority of the respondents) and this made access of these control strategies difficult. Nevertheless, the NGO's made sure there was sufficient funding to cater for condom distribution. This shows that HIV/AIDS control strategies suffered insufficient funding. There was therefore need to supplement the funding if at all sustainability of the control strategies would be realized.

Regarding monitoring and evaluation, majority of the respondents (52.2%) respondents disagreed that the NGO's had conducted monitoring and evaluation visits in their homes. In addition a number of the respondents (31.4%) were not sure, an indication that NGO's needed to improve on the monitoring and evaluation strategies. According to Holden (2004), sustainable means of measuring programs in terms of process and impact was needed to enable NGO's realize their full potential as far as delivering HIV/AIDS services are concerned. Community participation in monitoring and evaluation also proved to be a great challenge. Majority of the respondents (31.4%) felt they were not fully involved in the evaluation process. To improve on this there was need to adopt the program monitoring system as an access-based indicator and monitoring database to be used in managing and assessing the impact of these control strategies. All in all the study depicted that much as there were a lot of improvements that NGO's in Laini Saba Ward needed to make, they deserved enough credit for the enormous strides that they had made in fighting the pandemic in Kibera.

5.4 Conclusions of the study

As per the findings of this study, it is noted that HIV/AIDS control strategies play an important role in reducing the prevalence levels of the scourge. The following conclusions can therefore be made;

Women in Laini Saba Ward were more sensitive and conscious of HIV/AIDS control strategies in Kibera as compared to their male counterparts since majority of them (188 women) participated in the study an indication that more emphasis was needed to fully involve men in fighting HIV/AIDS. It can also be concluded that people of age brackets 26-35 were who also formed majority of the married people more sensitive HIV/AIDS control strategies as compared to others of other age brackets in Kibera slums. This is an indication that there was need to further focus on reducing HIV/AIDS prevalence among these groups of people. Nevertheless, the teenagers and the single youths should not be left out since the findings indicated that they too were generally conscious of their HIV/AIDS status and thus had a positive attitude towards HIV/AIDS control strategies.

Regarding the influence of attitude on sustainability of HIV/AIDS control strategies, according to the findings, access to HIV/AIDS control strategies was not a problem. However, much more advocacy was still needed since some people claimed that they were not aware of the operations undertaken by the NGO's. This is an indication that NGO's still had some grass-root work to interact with the community members so as to effectively access the impact of these control strategies. On the other hand HIV/AIDS education forums were required since the community's attitude was still unaware of the modes of transmission of the disease. In addition the fact that stigmatization and discrimination of those who were suffering from HIV/AIDS was still there suggested that more guiding and counseling services targeting these patients were needed. It can also be concluded that many people especially those with living with infected persons need training on how handle and care HIV/AIDS patients.

On the influence of community behavior on sustainability of HIV/AIDS control strategies, it can be concluded that the NGO's in Laini Saba ward had done a tremendous work by advocating for the community members to know their status by having them tested for the disease. This is noted by the fact that majority of them had tested for HIV/AIDS. Nevertheless, it was not clear whether

knowing their status had changed their behavioral trends, implying that more efforts were needed in monitoring and evaluation. In addition, it can also be concluded that more people in the ward were embracing monogamy as a HIV/AIDS control tool by observing one sexual partner. On the other hand, the fact that some people still embraced the use of condoms with new partners contradicted this fact, with some people concluding that condoms promoted infidelity.

Regarding funding on sustainability of HIV/AIDS control strategies, it was noted that more financial support was needed to boost the operations of the NGO's in Laini Saba Ward in Kibera since majority of the respondents concluded that there were no sufficient funds to effectively implement the control strategies. Nevertheless behavioral change was to be concentrated on so as to reduce the financial burden of implementing the control strategies.

To conclude on the influence of monitoring and evaluation as a HIV/AIDS control strategy, more efforts were needed to engage the community when assessing the impact of these control strategies since majority of the respondents felt that they were left out of the monitoring and evaluation process. Furthermore, monitoring and evaluation could only be effective if the target population's contributions were incorporated since these strategies affected them directly.

5.5 Recommendations of the study

This section focuses on the challenges that still remain unresolved and gives recommendations to them even though this study on HIV/AIDS control strategies has been done to completion for policy issues. This was done by focusing on each objective under study.

To strengthen the sustainability of HIV/AIDS control strategies by focusing on the community attitude, the unresolved issues regarding the community members' attitude on HIV victims have to be dealt with. From the study, it is noted that most community members still stigmatize and discriminate on those who were suffering from HIV/AIDS. To eradicate this, more emphasis ought to be put on educating the community members on the need to care for these patients rather than subjecting them the torture of stigmatization. In this case NGO's in collaboration with government health agencies should organize frequent forums such workshops, symposiums and conferences to educate the community members HIV/AIDS, its effects and ways of dealing

with the affected. On the other hand HIV/AIDS patients ought to be counseled and educated on how to handle trauma, prejudice and discrimination on their health state. Furthermore, health workers offering these services also need to be trained on the sociological and ethical aspects and considerations so as to eliminate any form of prejudice directed by health care workers to HIV/AIDS patients. This is important because this form of discrimination leads to fear by the patients thus shying away from accessing or receiving HIV/AIDS services.

In addition, to strengthen the sustainability of these control strategies while focusing on community behaviour the challenges faced by the NGO's regarding the behaviours of the community members ought to be dealt with. In this case sexual behaviors of the members of the community ought to positively relate to reducing the prevalence rate of HIV/AIDS. From the findings of the study, it is noted that the risky sexual behaviors still exist among the members of Laini Saba Ward in Kibera. In this case, cultural behaviours such as wife-inheritance or widow-inheritance ought to be discouraged. To achieve these, community members ought to be sensitized that in deed these practices promote the spread of HIV/AIDS. Grass-root campaigns targeting those who practice these behaviours ought to be capitalized by the NGO's with the help of the government in order to be successful. Moreover, moral standards need to be promoted by the NGO's and local religious institutions with the help of the government. This will help instill positive behaviour such as, abstinence till marriage among the youth and faithfulness among the married couples (commitment to only one sexual partner).

Funding is a vital factor to consider when seeking improvement of the sustainability of HIV/AIDS control strategies also needs to be boosted. According to the findings of this study, lack of sufficient funding has really hampered the progress of implementing these control strategies. To improve on this, the government ought to boost its annual budget on HIV and AIDS. To this end, the government through the county-governments should work hand in hand with local NGO's to share the financial burden that these organizations have regarding this pandemic. In addition more emphasis should be put on positive behavioral change of the community members so as to reduce the financial burden of dealing with HIV/AIDS.

Lastly, it's vital that effective monitoring and evaluation tools are in place to aid the sustainability of these strategies. As per the findings of the study, the researcher noted that the local community members were not fully involved in the monitoring and evaluation process. To achieve this, there is need for NGOs ought to prepare monitoring and evaluation instruments with the end users' contributions in mind. Furthermore, assessments programs ought to be in put into place to be able frequently analyze the progress of these control strategies. This assessment may be done monthly to accurately and effectively discover whether these strategies are reducing the prevalence on HIV/AIDS.

5.6 Suggestions for further research

The purpose of this study was to investigate the sustainability of HIV/AIDS control strategies in Kibera. Whereas numerous studies have been done regarding HIV/AIDS and its control, several gaps still remain un-researched. In this areas of further studies in this field ought to be mentioned;

1. While the study has only concentrated on the sustainability of HIV/AIDS control strategies, one could opt to investigate the role of eliminating unfavorable cultural practices in HIV/AIDS prevalence reduction.
2. Further research can be done to find out impact of health devolution on distribution of HIV/AIDS control strategies. This would help find out whether the adoption of county-governance in Kenya has lowered the prevalence rates on this scourge.
3. This also only focused on the control strategies of HIV/AIDS and their sustainability. One can also find out the level of preparedness on health facilities in delivering HIV/AIDS service.

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APPENDICES

Appendix A: R.V. Krejcie and D. W. Morgan (1970) Sample Size Estimation Table

N^*	S^+	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	100000	384

Appendix B: Letter of Transmittal

1 March 2014

Dear Sir/Madam

RE: LETTER OF TRANSMITTAL

Research study on sustainability of HIV/Aids control strategies by Non-Governmental Organizations in Kenya

My name is Roseline N.Muchai, a Master of Arts in Project Planning and Management student at the University of Nairobi. I am currently carrying out my research project and you have been selected to participate in this study that aims to establish the *factors influencing the sustainability of HIV/Aids control strategies by Non-Governmental Organizations in Kenya*. The study will involve carrying out interviews as well as self-administered questionnaires in which your views about the HIV control strategies in Kibera will be highlighted. This will be treated with utmost confidentiality and at no particular time will the information you provide be divulged to anybody without your consent. No reference will be made in both oral and written reports which could link you to any information collected and your name will not appear anywhere. No risks are anticipated as a result of taking part in this exercise.

Thanking you in advance.



Yours faithfully

Roseline Muchai

L50/68180/2011

CONSENT

I have read and understood the above information and all questions pertaining to this project have been answered to my satisfaction. I also understand that by signing and returning this consent form, I have agreed to participate in this study voluntarily, truthfully and completely.

Other

12. Do you conduct monitoring and evaluation of control strategies?

13. How many employees are involved in the monitoring and evaluation of the control strategies?

14. What are your sources of funding?

15. What would you recommend for future success and sustainability of the control strategies?

Appendix D: Questionnaire for the NGOs clients

The questionnaire is designed to gather general information about the factors influencing the sustainability of HIV/Aids control strategies by Non-Governmental Organizations in Kenya. You are assured that your answers will be treated in confidence. Hence do not provide your name. Please indicate the correct option as honestly and as correctly as possible by putting a tick on one of the options. For questions that require your own opinion, please fill blanks (...). You are requested to respond to all items.

Section I: General Information

1. Please indicate your gender:
(a) Male []
(b) Female []

2. What is your age?
a) Below 18 [] b) 19-25[] c) 26-35[] d) 36-49[] e) 50 and above[]

3. What is your marital status?
a) Married [] b) Single [] c) Divorced/widowed/separated []

4. What is your highest level of education?
a) Primary [] b) Secondary[] c) Tertiary[]

5. How many years have you lived at Kibera:
a) 0-3 years [] b) 3-5 years [] c) More than 5 years []

6. Which part of Kibera do you live in?
.....
.....

Section II: Factors influencing sustainability of HIV/AIDS control strategies

You have been provided with statements on the factors influencing sustainability of HIV/AIDS control strategies in Kibera. Please indicate whether you strongly agree, agree, moderately agree,

disagree, or strongly disagree with the given statements: Strongly agree (SA)... 5: Agree (A)... 4 Neutral (N)...3 Disagree (D)... 2 strongly disagree (SD)...1

Influence of attitude on sustainability of HIV/AIDS control strategies by NGO	S A 5	A 4	N 3	D 2	S D 1
7. I am aware of the NGOs involved in HIV/AIDS services					
8. I have interacted with the NGO on HIV/AIDS control strategies					
9. I am aware of HIV Modes of Transmission					
10. he community stigmatizes those who access HIV/AIDS services					
11. he community discriminates those who access HIV/AIDS services					
12. am aware of HIV prevention methods such as PMTCT					
13. he communication and education in place by NGOs are sustainable					

14. Do people's attitudes affect the sustainability of HIV/AIDS control strategies by NGOS?

Yes [] No []. Kindly explain your response:

.....

.....

.....

.....

Influence of behaviour on sustainability of HIV/AIDS control strategies by NGOs	S A 5	A 4	N 3	D 2	S D 1
15. I have been tested for HIV/AIDS					
16. Knowing ones HIV status would lead to behavior change					
17. I use condoms all the time with a new partner					
18. I have more than one sexual partner					
19. I am aware of the NGOs campaign on changed behaviour from casual sex					
20. he changed behaviour campaign by NGOs is sustainable					
21. he community has seen changed behaviour as a result of the HIV/AIDS control strateiges					

22. Do people's behaviour affect the sustainability of HIV/AIDS control strategies by

NGOS? Yes [] No []. Kindly explain your response:

.....

.....

.....

Influence of funding on sustainability of HIV/AIDS control strategies by NGO	SA 5	A 4	N 3	D 2	SD 1
23. NGOs are always able to provide for their control strategies					
24. There are no challenges in obtaining condoms from the NGOs					
25. From my knowledge, the funding that NGOs receive is adequate for the HIV/AIDS control strategies that they implement					

26. Which control strategy do you think the NGO should prioritize on to lower the HIV/AIDS infections?

- Condoms distribution
- Prevention of Mother – To Child Transmission
- Behaviour change campaigns
- Testing and counselling services

Influence of monitoring and evaluation on sustainability of HIV/AIDS control strategies by NGO	S A 5	A 4	N 3	D 2	S D 1
27. The NGOs conduct monitoring visits in my home area					
28. The NGOs have ensured our participation in the monitoring meetings					
29. I have participated in a survey conducted by the NGOs					
30. here is information sharing through the NGOs					

Thank you for your time and responses, these responses will be kept confidential and your identity will not be revealed.