

**FACTORS INFLUENCING IMPLEMENTATION OF EFFECTIVE HIV PREVENTION  
PROGRAMMES; A CASE OF SEECTED PUBLIC AND PRIVATE KENYAN  
UNIVERSITIES**

**BY**

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For The Requirements OF The Award Of The Degree Of Master Of  
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Nairobi.**

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## **DECLARATION**

This research project report is my original work and has not been presented for examination in any university or any other institution of higher learning.

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**L50/76788/2009**

I declare that this research project report has been submitted for examination with my approval as the university supervisor.

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## **DEDICATION**

This research project report is dedicated my parents Fredrick and Mary Barasa for their inspiration, moral support and encouragement during the study. I dedicate this research project to my family members, colleagues and friends for their support and understanding during this time of conducting this study.

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## ABBREVIATIONS

<b>AAU</b>	Association of African Universities
<b>ACU</b>	Aids Control Unit
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CDC</b>	Centers for disease Control and prevention
<b>CSO</b>	Civil Society Organizations
<b>CUE</b>	Commission for University Education
<b>DASCO</b>	District Aids and STI Control Programme
<b>HCT</b>	HIV Counseling and Testing
<b>HIV</b>	Human Immune Deficiency Virus
<b>KAIS</b>	Kenya Aids Indicator Survey
<b>KDHS</b>	Kenya Demographic Health and Survey
<b>KNASP</b>	Kenya National AIDS Strategic Plan
<b>LVCT</b>	Liverpool VCT
<b>MSM</b>	Men who have Sex with Men
<b>NAC</b>	National Aids Council
<b>NACC</b>	National Aids Control Council
<b>NASCOP</b>	National Aids and STI Control Programme
<b>NGO</b>	Non Governmental Organization
<b>NOPE</b>	National Organization of Peer Educators
<b>OCA</b>	Organizational Capacity Assessment
<b>OVC</b>	Orphans and Vulnerable Children
<b>PEPFAR</b>	Presidential Emergency Program Funds for Aids Relief
<b>QMS</b>	Quality Management System
<b>SADC</b>	Southern Africa Development Conference
<b>SIDA</b>	Swedish International Development Authority
<b>SOPs</b>	Standard Operating Procedures
<b>STI</b>	Sexually Transmission Infections
<b>UNAIDS</b>	Joint United Nations Program on HIV and Aids
<b>UNGASS</b>	United Nation General Assembly Special Session on HIV and AIDS



**USAID** United States Aid for International Development  
**VCT** Voluntary Counseling and Testing

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## ABSTRACT

HIV and Aids is a global disease which UNAIDS estimates that there were 33.3 people living with HIV at the end of 2009 compared with 26.2 million. In sub Saharan Africa, 22.5 million people are living with HIV while about 1.3 million people died from AIDS related complications in 2010 (UNAIDS, 2010). Kenya Demographic and Health Survey (KDHS 2008-09) estimated prevalence for the same population at 6.3 percent. The Kenya Aids Indicator Survey (KAIS 2007) estimated that the prevalence for HIV in Kenya was at 7.4% in 2007. The findings show that Kenya's epidemic has stabilized in the past few years. Kenyan Universities responded by establishing an Aids Control Unit at the Commission for University Education. The universities' ACUs are coordinated through the Commission for University Education's ACU. The ACUs are mandated to develop programmes geared towards addressing HIV and Aids prevention, care and support. The ACUs have received a lot of financial and technical support to implement HIV and Aids programmes. However, Baseline Sero-behavioural study conducted in Six Universities in Kenya (2010) established that there is a limited human and infrastructural capacity to provide student-friendly programs, shortage of VCT counselors, weak referral systems and lack of confidentiality. It is as a result of this that the research project sought to establish factors influencing implementation of HIV programmes in Kenyan Universities. The objectives of the study were: To determine the influence of leadership capacity of Kenyan Universities ACU staff on offering HIV prevention programme among selected private and public Kenyan Universities; to assess the quality of service delivery of Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities; to establish the influence of level of supplies management of Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities; to assess use of data for decision making in Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities and ; to determine the influence of human resource capacity among selected private and public Kenyan Universities. This sample size for this research was 362 drawn from selected 15 universities (7 from public universities, 8 from private universities). Primary data was collected using questionnaires, observation, and interviews and secondary data was collected from reports, books, journals and newspapers. The data collected was analysed using descriptive statistics and data was presented using frequency tables and percentages. On the positive note, the research revealed that there is clear leadership, a good supplies management, trusted HIV prevention data that is used for decision making. On the flip side, ACUs lack of enough and competent staff, inadequate finances and staff lacking some project management skills, especially monitoring and evaluation skills. Major study recommendations include development of capacity improvement plans, increased financial support for ACUs and finally allocate more skilled and experienced human resource with monitoring and evaluation background.

## **CHAPTER ONE INTRODUCTION**

### **1.1 Background to the Study**

HIV and Aids is a global disease which UNAIDS estimates that there were 33.3 million [31.4 million–35.3 million] people living with HIV at the end of 2009 compared with 26.2 million. In sub Saharan Africa, 22.5 million people are living with HIV while about 1.3 million people died from AIDS related complications in 2010 ( UNAIDS, 2010).

#### **1.1.1 Global and regional perspective in trends of HIV and Aids**

In 2009, there were an estimated 2.6 million [2.3 million–2.8 million] people who became newly infected with HIV (UNAIDS 2010). This is nearly one fifth (19%) fewer than the 3.1 million [2.9 million–3.4 million] people newly infected in 1999, and more than one fifth (21%) fewer than the estimated 3.2 million [3.0 million–3.5 million] in 1997, the year in which annual new infections peaked . In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009. 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million [1.6 million–2.0 million] people became infected in 2009; considerably lower than the estimated 2.2 million [1.9 million–2.4 million] people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics (UNAIDS 2010).

#### **1.1.2 Kenyan Situation in HIV and Aids trends**

In Kenya, the Kenya AIDS Indicators Survey (2012) estimated the average HIV prevalence among the general population aged 15-49 at 5.6 percent while the Kenya Demographic and Health Survey (KDHS 2008-09) estimated prevalence for the same population at 6.3 percent. The difference between the HIV prevalence estimates of the two surveys is not statistically significant given the overlap of confidence intervals. The findings show that Kenya’s epidemic has stabilized in the past few years (UNGASS 2010)

The surveys confirmed that women still have a higher prevalence compared to men: women 6.9 percent against 4.4 percent for men (KAIS 2012) and women 8 percent compared to 4.3 percent for

men (KDHS 2008-09). Sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men - 5.6 percent against 1.4 percent respectively (KAIS 2007) and 4.5 percent and 1.1 percent respectively (KDHS 2008-09).

HIV prevalence in Kenya has been declining in the last two decades. National estimates show that in 1997-98 the prevalence among adults (15-49 years) was 10 percent (Sentinel Surveillance) declining to 6.7 percent (KDHS 2003), 7.1 percent (KAIS 2007), 6.3 percent (KDHS 2008-09) and 5.6 percent (KAIS 2012). Recent spectrum modelling estimates for 2009 gave a HIV prevalence of 6.2%. The recent surveys (KAIS 2007, KAIS 2012 and KDHS 2008-09) show that the prevalence has stabilized and this was confirmed by the Mode of Transmission Study (2008).

### **1.1.3 Universities ACUs Response to HIV prevention**

The ACUs have been in the forefront of conducting education and provision of services to the university community. This has been done through partnerships with external organizations like I Choose Life-Africa, Pathfinder International, FHI 360, Walter Reed Project, PATH, Nav Partners, among others. I Choose Life-Africa is a National NGO that has had a lot of working relationship with the universities since 2002 (ICL 2006). The organization has conducted research on several HIV and sexual activities among students of Kenyatta University, University of Nairobi, Maseno University, Egerton University and Pan African Christian College. Additionally, the organization has worked with 12 universities, 3 university colleges and several other tertiary institutions as well as high schools and out of school communities in areas of HIV prevention.

### **1.2 Statement of the Problem**

According to the Commission for University Education Report (2010), Kenyan Universities are at the forefront in implementing HIV prevention programmes. Some of the achievements made include twelve (12) universities have workplace HIV and AIDS policies; trainers for sub-ACUs have been trained on HIV mainstreaming and development of workplace policy; fora have been organized for universities and constituent colleges to share best practice; some universities offer HIV and AIDS as common or core course and as part of orientation programme for new students; VCT is available in a number of universities and their colleges and; Information, Education and Communication (IEC) activities have been widely undertaken. In the same report, the CUE highlights challenges that universities face in implementing effective HIV prevention programmes. Some of the challenges cited

include weak sub - ACUs in universities; low response to HIV and AIDS by universities in terms of implementation of comprehensive HIV programmes, operations research and capacity development; inadequate capacity to implement HIV and AIDS programmes; inadequate commitment and support by top management of universities for the university sector HIV programmes (financial, human, and infrastructural) and inadequate and low level staffing of sub-ACUs; It is against this background that the study seeks to establish the factors influencing the technical capacity challenges of Kenyan Universities Aids Control Units to implement effective HIV prevention programmes.

### **1.3 Purpose of the study**

The purpose of this study was to establish the factors influencing implementation of effective HIV prevention programmes among selected private and public Kenyan Universities

### **1.4 Objectives of the study**

The objectives of the study were as follows;

- i) To determine the influence of leadership capacity of Kenyan Universities ACU staff on offering HIV prevention programme among selected private and public Kenyan Universities
- ii) To assess the quality of service delivery of Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities
- iii) To establish the influence of level of supplies management of Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities
- iv) To assess use of data for decision making in Kenyan Universities ACU on effective HIV prevention programme among selected private and public Kenyan Universities
- v) To determine the influence of human resource capacity among selected private and public Kenyan Universities

### **1.5 Research questions**

The research questions were as follows;

- i) What is the influence of leadership capacity of Kenyan Universities ACU staff on delivering HIV prevention programme?



- ii) What is the level of quality of service delivery of Kenyan Universities ACU in delivering HIV prevention programme?
- iii) To what extent is the influence of supplies management of Kenyan Universities ACU in delivering HIV prevention programme
- iv) To what extent is data used for decision making in Kenyan Universities ACU in delivering HIV prevention programme?
- v) What is the human resource capacity of Kenyan Universities ACU in delivering HIV prevention programme?

### **1.6 Significance of the Study**

The study intended to establish the capacity of Kenyan Universities' ACUs in carrying out HIV prevention programmes. The findings of the study will help the universities ACU identify gaps in their capacity to implement effective HIV prevention programmes. A capacity development plan will then be developed to address their gaps.

The findings of the study may benefit to the Commission for University Education (CUE) since it is mandated to coordinate Kenyan Universities ACUs programmes. The CUE will then mobilize resources with a view to improving ACUs programmes in the Universities. The other beneficiary of the findings may be individual universities. The universities may use their internal mechanisms to improve the capacity of the ACUs with a view to improving their capacity in implementing cost effective and sustainable HIV prevention programmes. Last but not least, the National Aids Control Council (NAC) and NASCOP might also benefit by being informed on where the universities ACU capacity gaps are. The net effect for this will be for NAC and NASCOP to support the universities ACUs to strengthen their capacity to implement their HIV prevention programmes. The final lot of beneficiaries will be the external partners and funding agencies. These external players might be in a position to address the real capacity gap in the universities ACUs. This will go a long way in improving the quality of service delivery among university ACUs. By doing so, the universities will be playing a major role in combating HIV in the country. Additionally, the universities may take a proactive measure by assessing and capacity building other organizations with a view to implementing cost effective, sustainable and efficient HIV prevention programmes.

### **1.7 Delimitation of the Study**

This study involved selected Kenyan Public and private Universities ACUs. The study was also restricted to Kenyan Universities that I Choose Life-Africa is either implementing HIV prevention activities or the ones that have ever benefited from I Choose Life-Africa's interventions for at least one year. The public universities and their year of establishment were: University of Nairobi (1970), Moi University (1984) Kenyatta University (1985), Egerton University (1987), Jomo Kenyatta University of science and technology (1994), Maeno University (2001) and Masinde Muliro University of science and Technology (2007). The Private universities that participated in the study were: The University of Eastern Africa, Baraton (1991), Catholic University of East Africa (1992), Daystar University (1994), Scott Christian University (1997), United States International University (1999), Africa Nazarene University (2002), Kenya Methodist University (2006) and St. Paul's University (2007). The sample included heads of ACUs in these universities. Furthermore, the study focused only on staff working in ACUs and students who have gone through some form of HIV and Aids training.

### **1.8 Limitations of the Study**

Two major challenges were encountered in the study. First, the respondents took a long time to fill the questionnaire, with one particular university taking 5 weeks to complete the questionnaire. To mitigate against this, the research assistants kept on pursuing the respondents until the questionnaire was finally filled.

The second challenge was be the cost of collecting data. The universities ACUs that participated in the study were situated in at different geographical distances that were over 400 KMs apart.. The cost was supported by I Choose Life-Africa which provided logistical support like transport and accommodation to the sites that were out of Nairobi.

### **1.9 Assumptions of the Study**

The major assumption was that the respondents would answer questions correctly and truthfully. The other assumption was that respondents would be in sessions as well as the participants exuded willingness to participate in the research.

## 1.10 Definitions of Significant Terms

In this study, **public universities** refer to the universities that were created by an act of parliament. The public universities that participated in this study are the ones that were established before 2007. **Private universities** identified in this study are those that are chartered by the Commission for University Education. Private universities that participated in this study are the ones that were established before 2007.

**Capacity** in this research refers to the ability of the university to implement HIV prevention activities in five different areas: leadership; quality of service; supplies management; data use and; human resource. Capacity therefore looks at five different areas (leadership, supplies management, service delivery, data use for decision making and human resource).

**Leadership** refers to the figurehead in charge of managing HIV prevention programmes in Kenyan universities. Furthermore, leadership capacity will also establish if the head of a particular ACU has experience in managing HIV prevention programmes; leadership experience in designing guidelines to implement HIV prevention programmes; active involvement in running HIV prevention programme and; engagement of the leadership in training other programmes.

**Service delivery** refers to six broad areas in programme strategy; program specific protocols, guidelines/ standard operating procedures/ approach; physical space availability and usage; service demand generation; community involvement and; referral system.

**Supplies management** refers to the procurement policies and procedures in place as well as well as commodity utilization (storage and utilization). **Data use in the capacity assessment** refers to the ability of the ACUs to collect data, compile data, analyse data, evaluate programme activities, use data for decision making and have a feedback system for data. Finally, **human resource capacity** refers to the programme staffing needs and training and skills development of the ACU staff.

**Effective HIV Prevention** refers to having good leadership, better service delivery mechanisms, better supplies management, consistent use of data for decision making and adequate human resource capacity.

### **1.11 Organization of the study**

The research project is organized in five chapters with a reference and appendix section. Chapter one starts with background of the study that gives the general information HIV situation globally, regionally and in the country with specific reference to Kenyan Universities. It gives us a glimpse of what has been done in Kenyan Universities. The purpose of the study, research objectives and research questions are also given. These are followed by significance of the study, limitations and delimitations of the study. Chapter one concludes by giving assumptions of the study and definition of significant terms.

Chapter two summarizes literature related to this study. The literature review is done in line with the variables highlighted in the objectives and conceptual framework. Chapter three describes the research design and methodology adopted in this study. The target population and the sampling procedure are identified. Then methods of data collection, validity and reliability follow. Finally we have operational definition of variables and methods of data analysis.

Chapter four contains data presentation, analysis and interpretation and chapter five gives the discussion of the findings, summary, conclusions of the factors influencing the technical capacity of implementing effective HIV and Aids Prevention Programmes in Kenya and further on gives the researcher's recommendations. The final section has the references and appendix.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter describes the global and regional trends of HIV and Aids infections. It then looks at Kenyan trends in HIV and Aids infections. Thereafter the chapter looks at the definition of the technical capacity and the response that universities have had in HIV and Aids prevention efforts. The chapter finally looks at the theoretical and conceptual framework of the study. Under conceptual framework, different variables (independent, dependent, moderating, intervening and extraneous) are defined.

#### **2.2 Situation in HIV and Aids trends**

In 2009, there were an estimated 2.6 million [2.3 million–2.8 million] people who became newly infected with HIV (UNAIDS 2010). This is nearly one fifth (19%) fewer than the 3.1 million [2.9 million–3.4 million] people newly infected in 1999, and more than one fifth (21%) fewer than the estimated 3.2 million [3.0 million–3.5 million] in 1997, the year in which annual new infections peaked . In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009. 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million [1.6 million–2.0 million] people became infected in 2009; considerably lower than the estimated 2.2 million [1.9 million–2.4 million] people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics (UNAIDS 2010).

In Kenya, about 1.3 million to 1.6 million people are living with HIV. Furthermore, new infections are estimated at 100,000 in 2009 for adults (15 years and above). The HIV Prevention Response and Modes of Transmission Analysis (2009) found out that the largest new infections (44 percent) occur among men and women who are in a union or in regular partnerships, men who have sex with men

(MSM), and prisoners contribute about 15 percent of new infections and injecting drug use accounts for 3.8 percent (UNGASS, 2010)

Kenya Demographic and Health Survey (KDHS 2008-09) estimated prevalence for the same population at 6.3 percent. The Kenya Aids Indicator Survey (KAIS 2012) estimated that the prevalence for HIV in Kenya is at 5.6% in 2012. The findings show that Kenya's epidemic has stabilized in the past few years. The surveys confirmed that women still have a higher prevalence compared to men: women 6.9 % against 4.4 % for men (KAIS 2012) and women 8% compared to 4.3 % for men (KDHS 2008-09). Sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men - 5.6 percent against 1.4 percent respectively (KAIS 2007) and 4.5 percent and 1.1 percent respectively (KDHS 2008-09).

Different efforts by civil societies, non-governmental organizations, faith based organizations and different corporate and institutions have responded towards HIV prevention activities. Since AIDS was declared a national disaster by retired president Moi in 1999 (Aids in Kenya, 2<sup>nd</sup> Edition, 2005), there have been efforts lead by the universities to help in research and modeling interventions to help address the HIV prevention and treatment programmes.

As a result of AIDS being a national disaster, the National Aids Control Council (NAC) was established as a corporate body under the State Corporations Act by a Presidential Order in Legal Notice No. 170 of 26<sup>th</sup> September 1999 to provide policy and strategic framework for mobilizing and coordinating resources for prevention of HIV transmission and provision of care and support to the infected and the affected in Kenya (NAC 2010).

The Association of African Universities (AAU) through the Working Group on Higher Education (WGHE) commissioned a study "Challenging the challenger, expanding the Response of Universities in Africa to HIV/AIDS" (Kelly, 2002). The purpose was to generate understanding of the way the disease is affecting African universities and to identify responses and coping mechanisms that might profitably be shared with sister institutions in similar circumstances.

It is as a result of this report that the AAU recommended to Universities to have an Aids Control Unit in each university. Kenyan Universities responded by establishing an Aids Control Unit at the Commission for University Education. The universities' ACUs are coordinated through the Commission for University Education's ACU. The ACUs are mandated to come up with programmes geared towards coming up with programmes to address HIV and Aids prevention, care and support. The universities' ACUs have received a lot of financial and technical support to implement HIV and Aids activities from various organizations both local and international. A lot of funds have come through Commission for University Education, several United States of America's Government Agencies (CDC, USAID and Department of Defense-Walter Reed), SIDA and through fees charged by students among others grants.

These HIV prevention activities in Kenyan Universities have been ongoing since early 2000 to date. With a lot of activities being carried out at the universities, there is no documented data showing the capacity of universities' ACUs to implement cost effective, sustainable HIV and Aids programmes in Kenya. This capacity is in form of leadership, service delivery, supplies management, Data Collection, Data Compilation and Analysis, Decision Making and Feedback Systems and finally human resource capacity.

In Kenya, the Kenya AIDS Indicators Survey (2012) estimated the average HIV prevalence among the general population aged 15-49 at 5.6 percent while the Kenya Demographic and Health Survey (KDHS 2008-09) estimated prevalence for the same population at 6.3 percent. The difference between the HIV prevalence estimates of the two surveys is not statistically significant given the overlap of confidence intervals. The findings show that Kenya's epidemic has stabilized in the past few years (UNGASS 2010)

The surveys confirmed that women still have a higher prevalence compared to men: women 6.9 percent against 4.4 percent for men (KAIS 2012) and women 8 percent compared to 4.3 percent for men (KDHS 2008-09). Sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men - 5.6 percent against 1.4 percent respectively (KAIS 2007) and 4.5 percent and 1.1 percent respectively (KDHS 2008-09).

HIV prevalence in Kenya has been declining in the last two decades. National estimates show that in 1997-98 the prevalence among adults (15-49 years) was 10 percent (Sentinel Surveillance) declining to 6.7 percent (KDHS 2003), 7.1 percent (KAIS 2007), 6.3 percent (KDHS 2008-09) and 5.6 percent (KAIS 2012). Recent spectrum modelling estimates for 2009 gave a HIV prevalence of 6.2%. The recent surveys (KAIS 2007, KAIS 2012 and KDHS 2008-09) show that the prevalence has stabilized and this was confirmed by the Mode of Transmission Study (2008).

### **2.3 Importance of studying Universities**

According to Mary Crewe and Charles Nzioka in their publication on “The higher education response to HIV/AIDS Universities”, they say that universities have an ethical and intellectual onus to openly debate on the issues surrounding HIV and AIDS prevalence while at the same time give creative responses to the epidemic. The universities constitute one of the essential components in developing a united and effective country response to the pandemic for the following reasons: first, universities cater for sexually-active young people, mainly in the 18-30 year old category. Global data shows that more than a third of all people living with HIV are under the age of 25 (UNAIDS, 2010). Second, some social life aspects place members of universities risk of contracting HIV. Enhanced personal freedom coupled with the attractions and pressures of life in tertiary and higher education institutions is a recipe for sexual activity and experimentation. Casual sex and multiple sexual partnerships are common. Instances of offering sex in return for favours like promotions or good grades – which are euphemistically termed as ‘sexually transmitted degrees and diplomas’ – exist in some of these institutions. Commercial sex may not be uncommon as poor students seek to earn money to pay for their fees or for personal upkeep. Third, campuses are places where the safety of all students and staff, especially women must be guaranteed. Nevertheless, some university residences have earned a reputation as being places where rape, sexual violence and harassment of women are commonplace and where unprotected sex is perhaps the norm. Fourth, universities have a responsibility to ensure that all trained graduates have the capacity to deal with HIV and AIDS at their own individual and professional levels. Fifth, these institutions have an obligation to cater for the welfare of their members by creating an environment that reduces the likelihood of HIV transmission. Last but not least, HIV and AIDS can seriously impair and undermine the operation and functioning of tertiary and higher education institutions. Often, it takes particular talents, resources and a lot of time to produce specializations in particular academic disciplines. Subject specialists in tertiary level institutions cannot be interchanged easily, as may be the case in other school levels. Even where skilled manpower



exists, the process of staff recruitment to replace other staff lost to HIV and AIDS is expensive both in terms of time and resources. Finally, Mary Crewe and Charles Nzioka end by noting that universities have a responsibility to promote gender sensitization and awareness of the situation

#### **2.4 Capacity of Kenyan Universities in implementing HIV and Aids prevention programmes**

A baseline study conducted by East African Community/ AMREF Lake Victoria Partnership Programme (2012) in six Kenyan Universities found out that a number of useful lessons were learnt from the baseline survey in six universities in Kenya. These include Problem of contextual factors affecting students; problem of risky behaviors; limited provision of student-friendly services; institutional arrangement and HIV/AIDS policies; lack of student-host community HIV/AIDS planning; lack of integrated HIV and FP services; weak support and referral systems; too much academic and social freedom; lack of Monitoring and Evaluation of programmes.

Several approaches have been used to address such a complex epidemic. Both biomedical and behavioral strategies have an important role to play. And synergies are needed between the approaches to address an ever-changing epidemic. Structural interventions addressing contextual factors contributing to the epidemic including poverty, gender violence, stigma and discrimination may be more effectively addressed by governments or in the occupational setting (Piot & Coll Seck, 2001){De Cock, 2002 10 /id}. The World Health Organization has promoted a strategy to maximize effectiveness of coordinated efforts within countries by encouraging nationally and locally defined goals along the principles of the “Three Ones”. These principles provide a coherent framework responding to the epidemic by promoting a response guided by one national authority, one strategic plan, and one monitoring and evaluation strategy (Piot et al., 2008).

In Kenya, the National AIDS Council is the body responsible for planning and coordinating the country’s AIDS response. The mandate of the National AIDS Control Council is to coordinate the multi-sectoral response to HIV in Kenya. In building upon this role, and seeking to forge a stronger response in the coming years, NAC, in partnership with a wide range of stakeholders, developed the Kenya National AIDS Strategic Plan 2009/10-2012/13 (KNASP III), whose vision is: ‘An HIV-free Society in Kenya’ (Kenya National Aids Strategic Plan 2009/10-2013/14).

As the coordinating body, NAC seeks to encourage implementation of mix of interventions that are synergistic and for which the incremental impact of a specific intervention will be measured with the sum total of the impact of all interventions at the national level. Thus national surveillance results do not decipher the impact of the behavioral, structural, or biomedical aspects of the intervention mix. The NAC also directs the focus of prevention efforts among a hierarchy of subpopulation targets, emphasizing the importance of reaching women and youth.( (Adams 2009).

The response to HIV/and AIDS in Kenya is currently guided by two documents: Vision 2030 and the Medium Term Plan 2008–2012. Vision 2030 outlines the country’s goal to become a globally competitive and prosperous nation with a high quality of life by 2030. The Medium Term Plan 2008–2012 outlines national indicators and targets for HIV. In addition, the Kenya National HIV and AIDS National Strategic Plan for 2009/10–2012/13 (KNSP III) provides guidance on how to implement the national response and reach agreed-upon targets. KNSP III is organized around four primary strategies: health sector HIV service delivery; sectoral mainstreaming of HIV; community-based HIV programs; and governance and strategic information. Programs under KNSP III emphasize community-based approaches, achievement of universal access, coordination among stakeholders to maximize the impact of HIV and AIDS programs, cost-effective approaches, and a rights-based approach.

Universities are regarded as a community by KNAPS III. Universities have also positively responded towards the HIV prevention efforts. According to William Saint (2004) in his findings on Crafting Institutional responses to HIV/AIDS: Guidelines and Resources for Tertiary Institutions in Sub-Saharan Africa, he states that there are four key elements that lead to successful HIV prevention efforts among tertiary institutions

#### **2.4.1: leadership**

Leadership is the most important single factor. According to William Saint (2004) in his publication on Crafting Institutional Responses to HIV/AIDS he states that “Where vice-chancellors, have made AIDS an institutional priority, the effect on their institutions has been immediate and visible decision-making and program management structures have been established. Networks have been created, resources have been found, and the climate of silence and denial that surrounds AIDS has begun to be broken down (Chetty 2000). Apart from serving as an advocate for attention to AIDS within their

institutions, managers are likely to find that the following four actions can be highly effective: undertake an assessment of the impact of AIDS on their institution; train key staff (Dean of Students office, health services, library, union leaders) in AIDS awareness, counseling and confidentiality; personally challenge instances of shame, stigma, and discrimination; and promote respect for women staff and students, particularly through anti-sexual harassment policies (Otaala, 2003)".

Evidence shows that an effective response to HIV and AIDS requires a strong and visionary leadership. Strong and committed leadership can inspire action, mobilize resources, establish policies and set up responsive organizational structures (see also Kelly and Bain, 2005). In instances where institutional leaders have made HIV and AIDS a priority, the response has been immediate, effective and visible.

According to UNESCO 2006, in their "The higher education response to HIV and AIDS" publication, leadership in the response to HIV and AIDS should not, however, be limited to only the top levels of institutional management. In tertiary institutions, leadership could also come from deans, heads of departments and professors. Leadership could also come from student anti-AIDS clubs, professional student associations, peer-group networks and possibly from people living with HIV (UNESCO, 2006). The University of Nairobi has a very strong association known as Medical Students Against AIDS, which serves not only university students but also offers peer counselling to secondary school students and other forms of assistance to many urban communities in Nairobi. Similar organizations can also be found in other public universities in Kenya, such as in Kenyatta University (Ochanda, Njima and Schneegans, 2006).

In universities, leadership that comes from vice chancellors or a designated senior manager sends a strong message within the institution and to the wider community that HIV and AIDS management is a priority. A recent study on the response of teacher training colleges to HIV and AIDS demonstrated that when institutional heads provide leadership in HIV and AIDS, college communities are likely to take such activities more seriously (Nzioka, 2006).

One example is the University of Durban, now known as the University of KwaZulu-Natal, where strong response began in the late 1990s under the leadership of the Vice-Chancellor. One outcome was the establishment of what is now the internationally renowned Health Economics and AIDS Research Division (HEARD) under the leadership of Professor Alan Whiteside. In institutions like this,

decision-making and programme management structures have been established, networks have been created, resources have been found and the climate of silence and denial about AIDS has been broken.

The creation of the position of Chair in HIV and AIDS Education at the University of the West Indies, Barbados, in October 2004 is yet another good example of how tertiary institutions can develop institutional leadership in response to HIV and AIDS. This Chair was created by the Commonwealth Secretariat, in partnership with the United Nations Educational Scientific and Cultural Organization (UNESCO) with the aim of providing institutional leadership on HIV and AIDS through education in the Caribbean. This was the first time an internationally supported Chair in the area of HIV/AIDS and Education was created in a higher education institution to highlight the critical role that higher education institutions can play in the response to HIV and AIDS (Morrissey, 2005).

According to the report on HIV/AIDS and Tertiary Education in Sub-Saharan Africa , Strong and focused leadership is necessary to break the highly observable culture of silence on HIV and AIDS and to help to acknowledge the threat to institutional functions and operations. Effective responses to HIV and AIDS by top institutional leadership in tertiary institutions should: take cognizant to the fact that HIV and AIDS may have an impact on the institutions' functions and operations; appreciate that HIV and AIDS could undermine the quality and quantity of the training and educational services offered; prioritize a careful and well co-ordinate response to HIV and AIDS; integrate HIV and AIDS into the institutional mission, while ensuring that HIV-and AIDS- related stigma and discrimination is addressed; target all members of the institutional community including students, teachers/lecturers and non-teaching staff and ;establish interventions that are both inward-looking (protecting the institution's own functioning) and serving the needs of the wider community.

#### **2.4.2 Quality of service**

According as defined by Agency for Health Research and Quality, refers to the degree to which a health or social service meets or exceeds established professional standards and user expectations. In order to continuously improve systems of care for individuals and populations, evaluation of the quality of care should consider the quality of inputs, quality of the service delivery process and quality of outcomes. Kenyan universities have quality assurance departments to check on the quality of service delivery. According the Commission of University Head of ACU, each university ACU be it private or public has a quality check on their service delivery. This is done through standards and

check lists. Standards for HIV prevention programmes are developed by National Aids and STI Control Programme (NASCOP) and all implementers, including universities adhere to these. Other standards are the Peer Education Training Standards and standards on provision of HIV Testing and Counseling.

Quality of service usually involves Continuous Quality Improvement and quality assurance. Continuous quality improvement is an ongoing process that involves service providers in ongoing activities to continuously improve service delivery. Activities include monitoring and evaluating inputs, processes, outputs, and outcomes. In contrast to quality assurance, which focuses on identifying and solving problems, CQI seeks to prevent problems and to maximize the quality of care. Steps in the CQI process include the following: Plan – Identify problems (including their components—not just the big picture) and then plan strategies/tests that might result in improvements; Do – Use strategies/tests that are designed to address problems; Study – Collect and analyze data to see if strategies have resulted in improvements and Act – If the strategies are effective, make them an ongoing activity. If they are not effective, return to the Plan stage. Use collected data to identify new ways to address problems. Quality Assurance on the other hand involves identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

### **2.4.3 Supplies management**

Commodity supplies management is a set of activities and procedures that ensure that health commodities are available, accessible and of high quality (AMREF, 2004). Allan and Nesta Ferguson Trust (2004) in their publication on Commodity Management For HIV/AIDS, they state that most of the basic health commodities used in providing Comprehensive HIV treatment and care are already present at every health facility, for example, supplies such as cotton wool and disinfectants. However there are key HIV/AIDS health commodities such as: AntiRetroviral (ARV) drugs (for ART, PMTCT and PEP) , drugs for prophylaxis and treatment of STIs and Opportunistic Infections (OIs), HIV Test kits, condoms and laboratory reagents and supplies. The proper management of HIV/AIDS-related commodities ensures that they are available and accessible to all the staff serving the patients at a health facility. Thus all staff have an important role to play in ensuring good commodity management

even if they do not directly handle the commodities. Supplies management in HIV/AIDS programmes is important for the following reasons: availability of supplies, such as HIV test kits, increases the demand for HIV testing among university community thus leading to likelihood of scaling up treatment. Therefore, if the commodities are not continuously available and accessible, then a health facility is not able to offer the care and treatment required; presence of supplies increases staff motivation to provide services. When commodities are not available, then staff feel discouraged since they are not able to offer good patient care; HIV and AIDS supplies are costly to procure and to manage. Managing the supplies ensures that they are stored and distributed efficiently to prevent wastage; continuous availability of the supplies such as Post Exposure Prophylaxis drugs is required at the health facility where clients can access drugs that will prevent HIV infection and; ensuring continuous supplies. Many HIV/AIDS supplies have a short shelf-life, usually less than 2 years by the time they reach a health facility. Hence there is need for careful supplies management to minimize expiries.

In their publication on Commodity Management for HIV/AIDS, AMREF (2004) proposes that for proper tracking of supplies, Logistical Management Information System (LMIS) is proposed to be in place. LMIS ensures movement of the required quantity of commodities from one place to another in the least possible time and at the least possible cost. LMIS collects, organizes and reports on data regarding the movement of the commodities. The purpose of LMIS is to improve quality of commodity management decisions since it provides a means of tracking commodities as they enter and leave the supply pipeline. An effective LMIS for HIV/AIDS commodities will thus prevent stock-outs and stock imbalances of commodities at health facilities

#### **2.3.4 Data use in decision making**

The Kenyan universities have implemented nonacademic HIV prevention programs through the Aids Control Units. The main mandate for ACUs is to Combat HIV/AIDS through promotion of behavior change, education, information dissemination, support from workplace to empower communities to participate fully in Social Cultural and economic development. (The Presidency and Cabinet Affairs Office AIDS Control Unit (2009)). Accurate data on HIV prevalence levels among staff and students may be lacking in some higher and tertiary education institutions, but there is anecdotal evidence that HIV- and AIDS-related illnesses and deaths among both staff and students in these institutions are on

the increase. Student absences and deaths are, however, less conspicuous owing to rapid growth in student populations in these institutions and also due to the fact that many students with HIV- and AIDS-related illnesses withdraw from their studies and subsequently there is little way of tracking where they go and what.

According to AMREF (2004) data in any health facility is critical. Data on consumption of the commodities, inventory / stock records, supplier lead times (that is, the time taken for suppliers to deliver the drugs once the order has been given to them) and cost of supplies helps in planning and ensuring that there is no stock out. AMREF further suggests that essential data items are taken from the following records and reports: Stock-keeping Records record, Stock on hand, receipts, issues, losses & adjustments, Bin cards, Inventory Control cards; Consumption / Dispensing Records store consumption data; transaction records record stock movements and commodity status at a health facility at a particular time period. Other forms and records that may be used to record client data in are: appointments dairy, prescriptions, medical records, etc.

Therefore, data for decision making is an important element in effective management of HIV and AIDS prevention programmes. Policy makers and managers usually make decisions on the direction of HIV prevention programmes based on the available data. After all is said and done, activities will come and go but data will always withstand the taste of time. Finally, with the changing phase for HIV prevention programmes, from generalized intervention programmes (1999-2007) to targeted interventions (2008-2012) and finally to HIV concentrated population, (2012-2014), proper use of data will ensure that the universities and other institutions are in tandem with what is happening, therefore, proper use of data for decision making will accelerate the possibility of elimination of new HIV cases in universities.

#### **2.4.5 Human resource capacity**

Institutions that establish AIDS Coordination Units have better organized programs. New initiatives do not happen by themselves. Sustainability and accountability for results cannot depend entirely on voluntary workers. A visible focal point – an office with two or three competent staff – is necessary to provide day to day attention, encouragement to other units, strategic reflection, and a means of disseminating new knowledge and ideas in the AIDS arena (University of Natal, 2000). Another

aspect of human resource in universities is the availability of student peer educators. Prevention activities planned and executed with student involvement are far more effective. Peer education programs are but one example of such effectiveness. Students generally have an understanding of their social milieu that older adults often lack peer educators. Therefore, HIV prevention is important, but insufficient by itself. An institutional response strategy to HIV must be based on a continuum of prevention, treatment, care, and support. All campuses contain persons living with HIV. They deserve understanding, encouragement, respect, and occasional accommodation. A large number of staff and students are required to deal with the psychological stress and trauma associated with the knowledge that a family member or close friend is battling AIDS. Students in particular require support, counseling, and timely intervention to help them to remain in school under these circumstances.

## **2.5 Status of HIV programmes in Kenyan Universities**

Through the Association of African Universities, the university ACUs ten years ago (since 2002), virtually nothing was known about the status of HIV and AIDS on African tertiary campuses. In his ground-breaking exploration of this area, Prof. Michael Kelly of the University of Zambia found that “a conspiracy of silence” was associated with the subject. He observed that “The most striking feature of the university response to HIV and AIDS is what could only be described as the awe-inspiring silence that surrounds the disease at institutional, academic, and personal levels. Notwithstanding some qualifications, for all practical purposes both individuals and institutions conduct themselves as if the disease did not exist.” (Kelly, 2001).

Since this assessment, significant progress has been registered. At least ten cases studies of HIV/AIDS within different institutions of higher learning have been undertaken. The Association of African Universities incorporated an AIDS component within its core services program for 2000 – 2005. The Association of Commonwealth Universities produced guidelines for institutional response (ACU 2002). In October 2003, the university vice-chancellors from thirteen countries of the Southern Africa Development Conference (SADC) agreed to take a series of actions intended to establish essential services, promote policies and management practices, and create institutional capacities for easing the impact of HIV/AIDS on their campuses. As a result of these experiences, tertiary education policymakers, leaders, staff and students gained an understanding of what was needed as well as what worked in the battle against HIV and AIDS.



In spite of these accomplishments, the challenge posed to tertiary institutions by HIV/AIDS remains formidable. By way of illustration, a modeling exercise conducted among the tertiary institutions of South Africa concluded that the university undergraduate HIV infection rate was estimated at 22%, rising to 33% in 2005; and that the infection rate among post-graduate students was estimated at 11%, rising to 21% in 2005 (Kinghorn 2000).

To support the development of institutional responses to HIV and AIDS within the African context, the Association of African Universities produced an HIV/AIDS “toolkit” for tertiary institutions (Chetty 2003). Intended specifically for use by institutional managers within the campus community, the toolkit is a package of reference materials designed to support the development and management of comprehensive institutional responses to AIDS. It includes resource materials, advocacy strategies, and practical guidelines. (William 2004)

The toolkit seeks to help an institution define a response that makes sense within the context of tertiary education. Among the distinguishing characteristics of this context are: sexually active young adults, risky social behavior, social experimentation, and a sense of personal independence and invulnerability. Circumstances of poverty increase the potential for transactional sex on campus. Financial constraints make it difficult for institutions to address AIDS as a priority. Managers are besieged by more vocal demands for attention, and may lack the training necessary to act with confidence. And surrounding the campus community may be a culture of silence in which HIV/AIDS is cast as an individual, personal matter where institutional involvement is inappropriate (Chetty 2003). The toolkit poses four specific tasks for institutional leadership. First, to break the silence surrounding HIV and AIDS and legitimize its discussion on campus. Second, to recognize publicly the concrete threat that AIDS presents to the institution. Third, to support whatever work is already being done on AIDS within the institution and use this as a platform to build upon. Finally, to make a response to HIV/AIDS an integral part of the institution’s mission and strategic plan. (William 2004)

## 2.6 Theoretical Framework

The main theoretical underpinning in this report is the Theory of Change. A Theory of change is a coherent set of ideas that describe: what the change should be, how a change process occurs, what makes it happen, what has to happen for the intended result to be reached, who needs to be involved, whose interests are at stake, and what the result of a change process should be. According to Doug Reeler (2006), he states that when thinking about intentional change of institutions we enter into the planning paradigms and the instruments that are being used by development organisations and donors in planning or change and the management of change. In many organizations, the so-called logical framework approach is the preferred or the required approach used. This theory assumes that project interventions themselves introduce the change stimulus and processes that matter and are the vehicles that can actually deliver development. participatory processes in the planning phase can get all stakeholders onboard, paving the way for ownership and sustainability

## 2.7 Conceptual Framework of the study

The conceptual framework consists of independent, moderating, extraneous and dependent variables. A variable may be described as any property that can change in quantity or quality. It is also defined as a characteristic of interest in research which contains the information of interest. It is this characteristic which is manipulated to get the relevant information on a phenomenon.

An **independent variable** is a variable that causes a change in the dependent variable. In this study, the independent variables are leadership capacity, quality of service delivery, supplies management, data use for decision making and human resource capacity. The first variable is the level of leadership capacity of Kenyan Universities ACU staff. In this variable, issues investigated include having an identified leader, the ACU having a board, leadership experience in HIV programmes, availability of guidelines for implementing HIV programme, active involvement in HIV programming and leadership engagement in other programmes. The second independent variable is the quality of service delivery of Kenyan Universities ACUs. This variable examined program strategy, programme specific guidelines, physical space availability and usage, service demand generation strategies, community involvement and referral system. The third variable on supplies management of Kenyan Universities ACUs seeks to find out Procurement policies and procedures availability, availability of written

procurement plan, inventory management and commodity storage. The fourth variable looked at data use for decision making in Kenyan Universities. This included data collection, data compilation and analysis, data for decision making, evaluation of HIV prevention activities and having a feedback system in place. The last independent variable in this research project was the human resource capacity of Kenyan Universities ACUs. This variable examined staff availability, staffing capacity in terms of education and experience, staffing organogram and training and skills development

A **dependent variable** is a variable whose outcome depends on the manipulation of the independent variable (Gakuu, 2009). In the conceptual framework, effective HIV prevention programme is the dependent variable. The outcome of this variable relies on the independent variables.

The other variable was the intervening variable. An **intervening variable** is a variable that might affect the relationship of the dependent and independent variables but it is difficult to measure or to see the nature of their influence. In this study, the intervening variables referred to the location of the university. The location of university referred to whether the university was situated in an urban setting or rural and peri-urban environment.

A **moderating variable** behaves like the independent variable in that it has a significant contributory effect or contingent effect on the relationship between the independent and dependent variable (Gakuu, 2009). In the conceptual framework, the moderating variables are availability of financial resource, university administrative support, workload of the head of Aids Control Unit, students involvement in planning and executing activities.

The last variable was the **extraneous variable**. An extraneous variable are those variable (both independent and independent) which have the capacity to affect a given relationship. In a research study, such variables are assumed or ignored; however, it is prudent for a researcher to note them. But such variables are assumed not to be very significant in predicting dependent variable. Two types of extraneous variables that were studied were the personality of the head of ACU and type of university (public or privately university).

The following is the conceptual framework used for this research study.

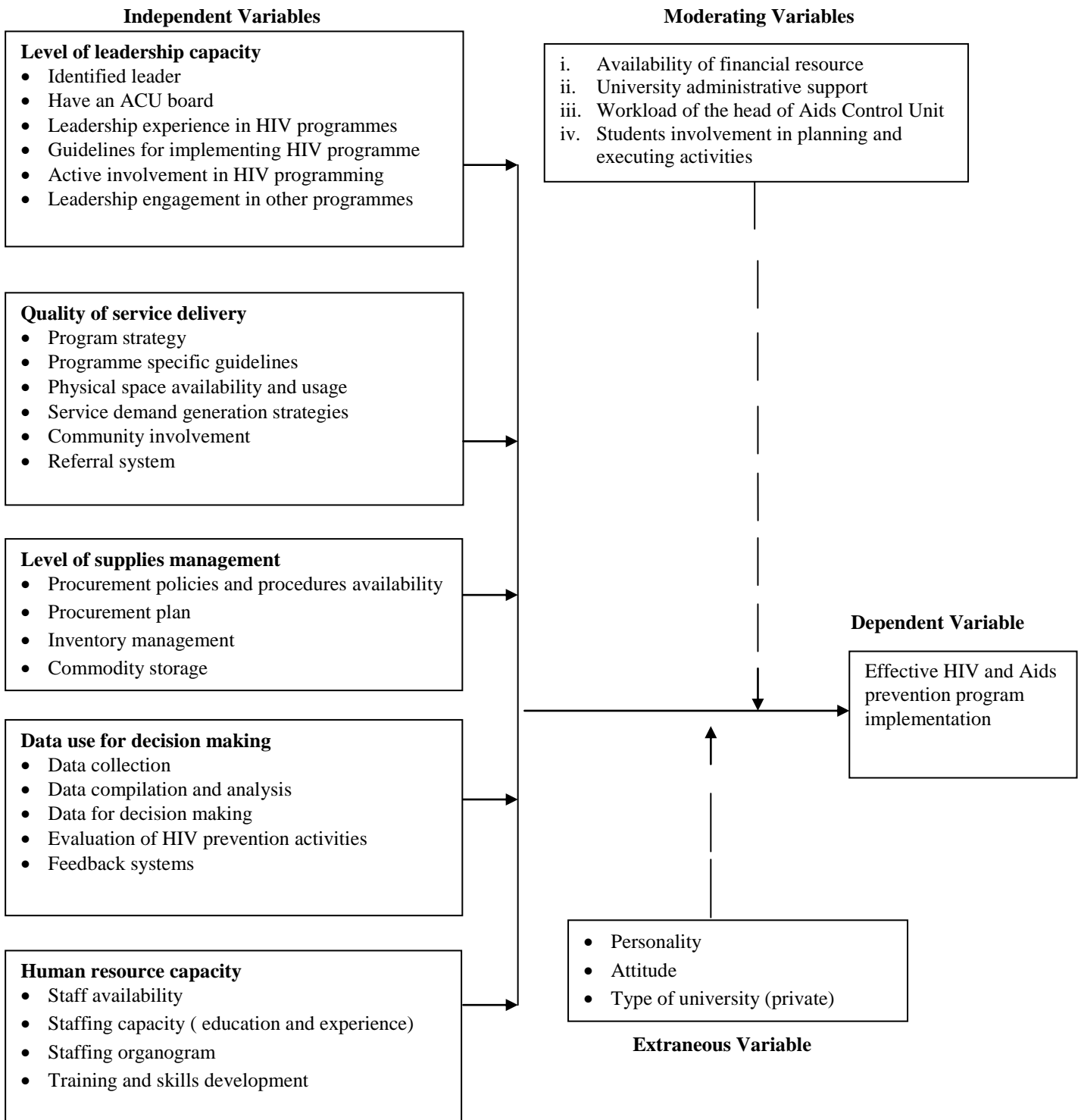


Figure 1: Conceptual Framework

## **2.7 Summary of literature review**

The literature review looked at the global, regional, Kenyan and university contexts of HIV situation. The chapter discussed factors that influence capacity of universities in delivering effective HIV prevention programmes. These factors include; leadership, service delivery, supplies management, data use and human resource capacity. The chapter further discusses the variables used in the study. A conceptual framework is presented to show the interrelationships between the variables.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter describes the research methodology that was used. Specifically, the chapter contains research design, target population, sampling procedure, methods of data collection, validity and reliability, operational definition of variables and methods of data analysis.

#### **3.2 Research design**

This was as descriptive research adopted to collect data from the selected Kenyan Public and Private Universities that were in existence by 2007. The respondents in this study comprised of Heads of Aids Control Units, Staff working in the Aids Control Unit, peer educators, university students, the Head of ACU at the Commission for University Education. This involved systematic gathering of quantitative and qualitative information from the respondents with a purpose of generalization. The findings were used to make generalization on the factors influencing effective HIV implementation in Kenyan Universities. The descriptive statistic allowed the description of formation contained in many scores with a few indices such as the mean, median and mode.

#### **3.3 Target Population and sample size**

The target population was students and staff of ACUs from the 15 universities that participated in the study. The target population was drawn from Kenyan Public and Private Universities that were in existence before 2007. These universities were selected because they have a more developed mechanism of addressing HIV prevention programmes. The universities have staff who are in charge of developing and implementing the HIV prevention programmes. Moreover, their students were involved in designing and or implementing the HIV intervention programmes. These universities received a lot of financial and technical support from the government, NGOs and development partners, thus making them a good study. A total of 15 universities fell in this category; 7 public universities and 8 private universities. The public universities and their year of establishment were: University of Nairobi (1970), Moi University (1984) Kenyatta University (1985), Egerton University (1987), Jomo Kenyatta University of science and technology (1994), Maeno University (2001) and

Masinde Muliro University of science and Technology (2007). The Private universities that participated in the study were: The University of Eastern Africa, Baraton (1991), Catholic University of East Africa (1992), Daystar University (1994), Scott Christian University (1997), United States International University (1999), Africa Nazarene University (2002), Kenya Methodist University (2006) and St. Paul's University (2007).

### 3.4. Sampling procedure

The 15 universities had a total of 3,618 population of eligible respondents who went through HIV and Aids prevention training on. However, a sample size of 362 respondents was arrived at based on a sample determination formula by Israel (1992) that is;

$$n = \frac{N}{1 + N(e)^2}$$

Where

n - The desired sample size,

N - The whole population of study, in this case the number of the church members

e - Level of precision (sampling error), the range in which the true value of the population is estimated. In this study this range is + 5% i.e. 0.05

In this case therefore, substituting the values to the equation,

$$n = \frac{3,618}{1 + 3,618 (0.05)^2}$$

The sample size (n) becomes 362.

The matrix below shows how the sample size was distributed per university

University	Year of establishment	Students trained in HIV prevention	Sample size	
			staff	Students
University of Nairobi	1970	902	2	48
Moi University	1984	53	2	2
Kenyatta University	1985	679	2	68
Egerton University	1987	203	2	18
Jomo Kenyatta University of Agriculture and Technology	1994	151	2	24
Maseno University	2001	305	2	52
Masinde Muliro University of Science and Technology	2007	302	2	28
University of Eastern Africa, Baraton	1991	153	2	14
Catholic University of Eastern Africa	1992	103	2	9
Daystar University	1994	165	2	13
Scott Christian University	1997	15	2	2
United States International University	1999	196	2	19
Africa Nazarene University	2002	81	2	17
Kenya Methodist University	2006	154	2	4
St. Paul's University	2007	156	2	14
<b>Total</b>		<b>3618</b>	<b>24</b>	<b>332</b>
<b>Total Sample size</b>			<b>362</b>	

### 3.5 Methods of Data Collection

Primary and secondary data was collected using different data collection methods which were used in order to generate quantitative and qualitative data as shown below:



### **3.5.1. Primary data**

This is firsthand data collected through structured interviews, questionnaires, and interviews from identified resource persons and institutions. Two focused group discussions and Key informant Interviews were also employed to get more insights into the key qualitative issues.

### **3.5.2 Administration of Questionnaires**

These were forms sent to respondents by the researcher with the aim of gathering some specific information on a particular issue or issues. This involved the use of predetermined structured questions to collect data from respondents. The questionnaires were administered to the staff and students of the 15 universities that participated in the study. To help in questionnaire distribution and administration, 5 research assistants were recruited and oriented on questionnaire administration. ACU staff were sent hard copy questionnaires by the research assistants and a follow up was done a week later to collect the questionnaire. As for students, questionnaires were administered during their meetings.

### **3.5.3. Key Informant Interviews**

Key Informants identified are termed as persons who may be the most knowledgeable or experts in the field of HIV prevention. This included head of ACU at the Commission for Higher Education, Head of National Aids Council (formerly National Aids Control Council) and Head of Youth Programmes at National Aids and STI Control Programme. This was done through face to face interviews and use of questionnaires.

### **3.5.4 Focus Group Discussions**

Focus groups are a form of semi-structured interview with a selected group of people who discuss predetermined topics in an open and participatory manner, guided by a facilitator. The study identified two focused group discussions each comprising of ten. The two focused group discussions one was drawn from public university and the other from private university. The focused group discussions provided more clarification of the issues and also more qualitative information that would not be obtained through other methods.

### **3.5.5 Secondary data**

This is the recorded information obtained from the existing literature relevant to the areas of study. It involved reading of journals and reports on HIV prevention programmes.

### **3.6 Validity of the Research Instruments**

Validity is the degree to which results obtained using the data actually represents the phenomenon under study. Validity is concerned with the idea that the research design fully addresses the research questions and objectives the researcher is trying to answer and achieve. Validity ensures that the instruments used if administered again do not give any difference in results (Mugenda and Mugenda, 2000). Pre-testing of the instruments was piloted at Kisii University and words were clarified in order to enhance understanding. Based on the pre-test results the corrections and adjustments on the research instruments were made.

### **3.7 Reliability of the Research Instruments**

Reliability refers to the consistency of scores or answers obtained from one administration of an instrument to another, and from one set of items to another. Reliability is about consistency in the research and whether another researcher would use the same design and obtain similar findings. Reliability was ensured by use of the same instruments throughout to ensure consistency; use of valid instruments which included questionnaires, and in depth interview guides that were validated through pre-test that was done with ICL staff who are heading Tertiary Institutions interventions. Triangulation method was used to test reliability. The five trained research assistants were maintained to ensure consistency throughout the data collection process.

### **3.8 Data Analysis Techniques**

Data analysis refers to the computation of certain measures along with searching for patterns of relationship that exists among data-groups. In the process of analysis, relationships or differences supporting or conflicting with original or new hypothesis should be subjected to statistical tests of significance to determine with what validity data can be said to indicate any conclusions (Cass notes on Research Methods page 157, 2010). Direct field quotations were used to back-up qualitative information that was collected through the focused group discussion and key informant interviews. For qualitative data, only responses from questionnaires that were returned were used.

The methods used in data analysis involved use of descriptive statistics by summarizing data and describing the sample by use of frequency distribution tables and percentages.

### 3.9 Operational Definition of Variables

The matrix below shows how the variables will be measured in order to operationalize research.

*Table 3.1. Operational definition of variables*

Objective	Variable	Measurement Indicator	Analysis Tools	Type of Analysis
	<b>Independent</b>			
To determine the level of leadership capacity of Kenyan Universities ACU staff in delivering HIV prevention programme	Level of leadership capacity	<ul style="list-style-type: none"> <li>• Identified leader</li> <li>• Have an ACU board</li> <li>• Leadership experience in HIV programmes</li> <li>• Guidelines for implementing HIV programme</li> <li>• Active involvement in HIV programming</li> <li>• Leadership engagement in other programmes</li> </ul>	Frequency and percentages	Descriptive analysis: Tabular
	Quality of service delivery	<ul style="list-style-type: none"> <li>• Program strategy</li> <li>• Programme specific guidelines</li> <li>• Physical space availability and usage</li> <li>• Service demand generation strategies</li> <li>• Community involvement Referral system</li> </ul>	Frequency and percentages	Descriptive analysis: Tabular
	Supplies management	<ul style="list-style-type: none"> <li>• Procurement policies and procedures availability</li> <li>• Procurement plan</li> <li>• Inventory management</li> <li>• Commodity storage</li> </ul>	Frequency and percentages	Descriptive analysis: Tabular
	Data use for decision making	<ul style="list-style-type: none"> <li>• Data collection</li> <li>• Data compilation and analysis</li> <li>• Data for decision making</li> <li>• Evaluation of HIV</li> </ul>	Frequency and percentages	Descriptive analysis: Tabular

<b>Objective</b>	<b>Variable</b>	<b>Measurement Indicator</b>	<b>Analysis Tools</b>	<b>Type of Analysis</b>
		prevention activities • Feedback systems		
	Human resource capacity	• Staff availability • Staffing capacity (education and experience) • Staffing organogram • Training and skills development	Frequency and percentages	Descriptive analysis: Tabular
	<b>DEPENDENT</b>			
To assess how effective HIV and Prevention programs have been affected by the state of technical capacities.	Effective HIV and Aids prevention program	• Supportive and involved leadership • Good quality of programme implementation • Seamless supplies availability and distribution as per the procurement guidelines • Evidence of use of data for decision making • Adequate, knowledgeable and experienced staff to implement the programme	Frequency and percentages	Descriptive analysis: Tabular

### **3.10 Ethical considerations**

To protect the respondents, a research permit was applied and granted. The respondents were explained for on the importance of accurately filling the questionnaire and they were given an opt out option should they need to do so. Last but not least, the respondents were not required to write their names on the questionnaire. Finally, all respondents were more than 18 years.

## **CHAPTER FOUR**

### **DATA ANALYSIS, PRESENTATION, AND INTERPRETATION**

#### **4.1. Introduction**

This chapter covers data presentation, analysis and interpretation. Data was analyzed, summarized in line with the objectives of the study and presented in the form of frequency tables, percentages, and narratives. The data was collected from staffs of ACUs and students who participate in HIV prevention activities in the universities. Qualitative data was collected from head of ACU at the Commission for University Education, Head of National Aids council and Head of youth HIV prevention activities from National Aids and STI Control Programme. This chapter therefore explores the socio-demographic characteristics of the respondents, then their technical capacities in the five identified themes.

#### **4.2. Questionnaire Response Rate**

The response rate was 311 questionnaires out of the 362 distributed. This represents 86% rate of return of the questionnaires. According to Mugenda and Mugenda (2000), a return rate of over 70% is very good and thus this response return rate is acceptable for the study.

#### **4.3. Socio-Demographic Characteristics of respondents**

The social demographic characteristics of the respondents were assessed, looking at the type of University, religious affiliation of the university, total number of students in the university, when the University was ACU established, staffing for ACUs, population university serves, type of HIV prevention services offered, funds allocation to run the ACUs, number of trained peer educators, participation in National Technical Working Groups, partners the ACUs work with and their roles.

The characteristics are given in the table 4.1

*Table 4.1: Type of University*

<b>Characteristic</b>	<b>Frequency</b>	<b>Percent</b>
<b>Type of University</b>		
<b>Public</b>	7	47
<b>Private</b>	8	53
<b>Total Students Population</b>		
<b>Less than 3000</b>	1	7
<b>3000 -9000</b>	8	53
<b>9000 and above</b>	6	40
<b>Population served</b>		
<b>Student</b>	15	100
<b>Non-teaching staff</b>	15	100
<b>Teaching staff</b>	15	100
<b>Community</b>	15	100
<b>PHLIV</b>	7	47
<b>Most at risk population</b>	3	20
<b>HIV Services offered</b>		
<b>Comprehensive Prevention</b>	13	87
<b>Counselling and testing HCT</b>	12	80
<b>Preventing parent to child transmission</b>	7	47
<b>OVC type of prevention</b>	3	20

#### **4.4 Type of University**

From the Table 7(4.1, 47%) of institutions that participated in the study were public universities, while 8 (53%) were private universities. In terms of population of students served, majority of the universities 8 (53%) serve a population of between 3,000 to 9,000 students while 40% of universities serve a population of at least 9,000 students and 7% serves a population of less than 3,000 students. All universities (100%) responded to be having HIV prevention activities for students, teaching and non-teaching staff and the surrounding community. As for the HIV prevention services offered by the universities ACUs, 7(47%) of the universities ACUs provided comprehensive HIV prevention while 80% provided HIV Counselling and Testing services while 7( 47%) offered HIV Prevention of Mother to Child Transmission services while another 20% offered OVC type of prevention.

#### **4.5 Resource allocation**

Two types of resources were identified; financial resources and human resources.

#### 4.5.1 Finance Resource Allocation by Universities ACUs

From the respondents, 73% of the universities ACUs have a budget for running HIV and Aids prevention services. The remaining 37% cited not having a budget for ACU activities as shown in table 4.2.

*Table 4.2: Finance Resource Allocation by Universities ACUs*

<b>Statement</b>	<b>Yes (%)</b>	<b>No (%)</b>
<b>Does your university have a budget for HIV prevention activities?</b>	73	37

#### 4.5.2 Human Resource Allocation

A total of 8 universities (53%) conducted HIV training for their peer educators between 2009-2011. During this period, a total of 881 peer educators to help in HIV prevention were trained as shown in table 4.3. All (100%) universities that participated in this study have at least one dedicated staff that focuses on designing and implementing HIV prevention activities.

*Table 4.3: Number of PE trained*

<b>Year</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>Total</b>
<b>Total Peer Educators trained</b>	372	229	280	881

#### 4.6 ACU participation in National Technical Working Groups in HIV Prevention

Only 3 universities (20%) participate in National Level Technical Working groups meetings conducted by National Aids Control Council, National Anti-Drugs Campaign Development Authority and National Aids and STI Control Programme as shown in table 4.4.

*Table 4.4: ACUs participation in National Technical Working Groups for HIV Prevention*

<b>ACUs participating in National Technical Working Group</b>	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	3	20
<b>No</b>	12	80
<b>Total</b>	15	100

## 4.7 Partnerships and linkages

The following table summarizes the partners that the universities ACUs have and their roles in the universities

*Table 4.5: ACU partnerships formed and their roles*

<b>Partners</b>	<b>Roles</b>
<ul style="list-style-type: none"> <li>• Association of African Universities</li> <li>• Aphia plus Western</li> <li>• Beacon of Hope</li> <li>• Catholic Medical Mission</li> <li>• Commission for University Education</li> <li>• Clinix Healthcare</li> <li>• District Aids and STI Control Programme</li> <li>• I Choose Life-Africa</li> <li>• Impact Research and Development</li> <li>• LVCT</li> <li>• Ministry of health</li> <li>• National Aids Council</li> <li>• National Organization of Peer educators</li> <li>• Population Services International</li> </ul>	<ul style="list-style-type: none"> <li>• Financing of HIV related activities</li> <li>• Train Peer Educators</li> <li>• Conduct peer education</li> <li>• Provision of condoms</li> <li>• provision of HIV test kits</li> <li>• Technical advice on HIV Prevention</li> <li>• Conduct VCT outreach services</li> <li>• Provide Voluntary Male Medical Circumcision Services</li> <li>• Empowerment services</li> </ul>

From table 4.5, universities have relied on various local and international partners including the government through the Commission for University Education, NASCOP, NAC and DASCO to deliver HIV prevention services. From the analysis, most of the funding of the HIV prevention activities is generated from partners. As seen in table 4.2 on Finance Resource Allocation by Universities, 37% of universities do not have a specific budget for HIV prevention. The question then is what will happen to universities if these partners pull out?

## 4.8 Capacity of Universities ACUs to Implement Effective HIV Prevention Programmes

### 4.8.1: Level of leadership capacity and implementation of HIV Prevention Programmes

To ascertain the existence and type of leader, five statements on leadership were formulated. These were: identified leader, experience of the leader, guidelines on HIV prevention, management of HIV prevention programmes and training of other institutions. Table 4.6 summarizes the response of ACU Leadership.



*Table 4.6: ACU Leadership*

<b>Statement</b>	<b>Yes (%)</b>	<b>No (%)</b>
<b>Is there an identified leader at the ACU who is responsible for the management of HIV and AIDS prevention activities?</b>	91	9
<b>Does the identified leader have experience managing HIV Prevention programs?</b>	91	9
<b>Does ACU need assistance designing and/ or setting up, and/or finalizing guidelines to implement the HIV prevention program?</b>	73	27
<b>Is the identified leader or leadership team actively involved in establishing or running HIV prevention programs?</b>	64	36
<b>Is the leader (ship) able and engaged in training for satellites or other institutions/campuses?</b>	27	23

From the table 4.6, a total of 283 respondents out of 311, representing (91%) cited that universities ACUs have an identified leader who is experienced in managing HIV prevention programmes while 86% of respondents reported that their university ACU heads have at least 3 years' experience in managing HIV programmes. A total of 73% of the ACUs need assistance in designing or finalizing guidelines in running of HIV prevention programmes. Additionally, 64% of the ACU leaders are actively participating in the running of the HIV prevention programmes therefore it seems as if some of the ACU heads are there as figure heads but not actively involved in giving directions and participating in the affairs of the ACUs. From the responses, there is a lot of inward looking within universities given the fact that only 27% of the universities ACUs conduct trainings for other institutions/campuses.

To assess the assistance needed by ACUs, questions on type of assistance needed were asked. Table 4.7 shows the type of assistance needed by ACUs.

Table 4.7: Type of assistance needed by ACUs

Type of Assistance	% of Universities
Designing HIV prevention program	55%
Setting up HIV prevention programme	45%
Finalizing guidelines in setting up HIV prevention programme	45%
Other assistance	27%

## 4.8.2 Quality of Service Delivery and implementation of HIV Prevention Programmes

This section looks at the service delivery of the ACUs and the models used in service delivery. First, it begins by looking at the program strategy as shown in the table 4.8

### 4.8.2.1 Program Strategy

Table 4.8 Program strategy

Statement	Yes (%)	No (%)
Is there an identified potential model or actual BCC strategy being used	64	36
Is the strategy a response to evidence based need and has national priority/ policy been considered in selecting the model of response?	54	46

As shown in table 4.8, only 64% of ACUs have an identified model for Behaviour Change Strategy. Moreover, only 54% of what is implemented is based on a response that has a national priority. The results clearly show that around half of the ACU leadership is unaware of why they are implementing HIV activities. They are implementing activities without basing the activities on any implementation model like theory of change model, health belief model, or information-motivation-behavioural model. Worse of, being in a higher learning institution, it is widely expected that the leadership of ACU will be actively engaged in implementing HIV prevention activities that are as a result of evidence. Evidence from Kenya Aids Indicator Survey (KAIS) shows that; 66% females and 59% Males aged 15-24 have had sex; men and women who completed any secondary education had a higher rate of HIV infection than those who reported no primary education; HIV prevalence was higher among women at all education levels compared to men; highest rate of HIV infection among those who

completed at least some secondary education was 7.1% while the lowest rate of infection was among those women with no primary education (4%) and; men who completed primary school had twice the rate of HIV infection compared those who had not attended school (4.8% compared to 2.4%) (KAIS 2012). Therefore, universities should seek to have university specific data so as to mold the HIV and Aids specific prevention activities based on their data.

#### 4.8.2.2 Standard operating procedures

For effective delivery of services, there needs to be Standard Operating Procedures (SOPs). International standard Organisation (ISO) Certification like ISO 9001:2000 on Quality Management Standards has given a lot of thought to processes and how to maximize quality and efficiency. Once certified for quality, the processes are established and guidelines put in place for anyone to follow. From the respondents, 27% of universities do not have approved HIV SOPs in place. In addition, 45% of universities are not even aware if there is need for SOPs. The data shows that only 27% of universities have both finalized and approved SOPs. The situation at the universities need urgent attention, especially if the universities' ACUs are to achieve quality implementation of HIV prevention that will yield maximum and impact. Table 4.9 shows the level at which universities ACUs are at when it pertain SOPs.

*Table 4.9 ACUs strategy used for HIV and Aids prevention interventions*

<b>Is there an identified potential model or actual BCC strategy being used?</b>	<b>Frequency</b>	<b>Percent</b>
Some prevention SOPS exist but details lack	28	9.0
Some operating procedures around HIV prevention services to be provided	57	18.2
SOP are both finalized and approved	85	27.3
Missing	142	45.5
Total	311	100

The study sought to identify ACUs as service delivery. Findings show that there is no ACU that met the threshold of having a detailed model or BCC strategy and operating procedures both formalized and approved. Majority of ACUs have chosen model or adapted a BCC strategy but lacks details while at the same time they need modifications based on current or expanding needs as shown in table 4.10

Table 4.10 Service delivery Strategy

<b>Reflects service delivery strategy at the ACU (N=169)</b>	<b>Frequency</b>	<b>Percent</b>
<b>The ACU has developed/identified a potential model or BCC strategy models</b>	28	9.1
<b>Has chosen a model or adapted a BCC strategy and the strategy is a response to an evidence-based determination of need and audience identification</b>	28	9.1
<b>Has chosen model or adapted a BCC strategy but lacks details. The ACU needs assistance in adapting or implementing to reflect realities of current communities/ sites.</b>	57	18.2
<b>A detailed model or BCC strategy exists and has been adapted to the local context. It needs modifications based on current or expanding needs.</b>	57	18.2
Total	169	54.5
Missing	142	45.5
Total	311	100

#### **4.8.2.3 Program Specific Protocols, Guidelines/ Standard Operating Procedures/ Approach**

After identifying the existence and usage of SOPs, the next questions focused on program specific protocols, guidelines/SOPs/approach. As shown in table 4.11, 73% of universities have some form of guidelines/standards. A further 67% of respondents agreed that the guidelines are up to date and harmonized with National Guidelines and they address all client needs while a good majority (87%) of the leadership is able to interpret and disseminate the prevention guidelines to the implementers and stakeholders. However, asked when the prevention program being delivered can be used as a resource for other prevention programs, less than half (45%) of ACUs agreed to the statement as shown in the table below. This therefore means that a majority of ACUs do not want their sites to be used as resource for other prevention programs hence depicting to lack of capacities by ACUs in the area of SOPs.

Table 4.11 ACU Program Specific Protocols, Standard Operating Procedures/ Approach

Statement	Yes (%)	No (%)
<b>Are there any program specific guidelines or standard operating procedures being applied in the prevention program?</b>	73	27
<b>Are the guidelines up to date and harmonized with National Guidelines and they address all client needs?</b>	67	33
<b>Has the leadership been able to interpret and disseminate the prevention guidelines to the implementers and stakeholders?</b>	87	13
<b>Are all the sites (campuses) applying the same prevention guidelines?</b>		
<b>Is the HIV prevention program being delivered standardized to national guidelines and the site can be used as a resource for other prevention programs</b>	45	55

#### 4.8.2.4 Physical Space and implementation of HIV Prevention Programmes

Physical space refers to a specific designated area that aids implementation of HIV interventions. From the respondents, 78% of ACUs have a designated space to conduct HIV prevention services. However, it seems as if from the ACU leadership, the allocated space is not enough. A majority of respondents (63%) stated that the space designated is not sufficient. However, despite lack of enough space, 67% of the ACU leaders have never done an assessment to establish the space needs hence whatever the university allocates is not based on any need. Despite the lack of enough space, it is noteworthy to find out that majority of respondents (80%) stated that the allocated space is sufficient to address the needs of the clients, including confidentiality as shown in table 4.12

Table 4.12 Physical space availability and usage

Statement	Yes (%)	No (%)
<b>Is there a designated space for HIV Prevention services delivery if applicable?</b>	78	22
<b>Is the space sufficient for providing specific HIV Prevention services if</b>	37	63

Statement	Yes (%)	No (%)
<b>applicable?</b>		
<b>Is the available space sufficient to address the confidentiality issues of the clients where required</b>	80	20
<b>Is there a plan to meet client space needs in the university community / mobile service delivery including confidentiality?</b>	75	35
<b>Has an assessment been made to determine the space needs for service delivery as the HIV Prevention program grows?</b>	67	33

#### 4.8.2.5 Demand Generation and implementation of HIV Prevention Programmes

The utilization of HIV services mainly depends on community mobilization and demand generation. Asked whether the ACUs have any strategy on demand generation, 90% of respondents stated that ACUs have a formal and documented campaign to mobilize clients for HIV prevention service uptake and the target population is clearly defined. Additionally, 73% of the HIV prevention campaign covers all areas of HIV prevention including HIV counseling and testing and is it well understood by the staff. However, despite the clearly laid out demand generation activities, 50 % of ACUs were not clear whether more demand was created as a result of demand generation. At the same time, 33% of ACUs noted that the mobilization campaign model is not replicable to other HIV prevention programs, hence posing a challenge of scalability. Table 4.13 shows demand generation and mobilization campaigns by ACUs.

*Table 4.13 Demand generation and mobilization campaign by ACUs*

Statement	Yes (%)	No (%)
Is there any formal and documented campaign to mobilize clients for HIV prevention service uptake?	90	10
Is there an ongoing campaign to mobilize clients with targets that involves the university? Are the target beneficiaries been clearly defined?	90	10
Is the campaign covering all areas of HIV prevention including HIV counseling and testing and is it well understood by the staff?	73	27
Has the community mobilization generated more demand and has an assessment been done to determine the impact of the mobilization activities.	50	50
Is the mobilization campaign model replicable to other HIV prevention	67	33

#### **4.8.2.6 Community Involvement**

Institutions of higher learning can play an important role in the development of community outreach projects for HIV and AIDS prevention, care, and counselling of the infected and affected. These could include impact-mitigation projects for orphans and vulnerable children, and people living with HIV or suffering from AIDS. Students could be encouraged to participate in the development and implementation of awareness campaigns and peer-education activities within the university community as well as the surrounding ones. They could also assist local communities by offering skilled/professional services free of charge, which could also serve as opportunities for the students to gain professional experience. For example, in some countries, university students from different faculties would visit a slum settlement within the vicinity of the university and offer public education and free medical services to the inhabitants. Such outreach programmes were also observed in teacher colleges in Kenya, where teacher trainees visit schools on the weekends to do their teaching practice and educate the local communities on the risks of HIV and AIDS (Nzioka, 2006).

Universities work in and with various communities to address HIV prevention activities. This section sought out to establish whether universities do involve communities in HIV prevention and if they do then to what extent. As shown in the table 4.14, only 50% of universities ACUs meet with the community to set priorities for intervention. Furthermore, 57% of respondents agree that there is a linkage between the ACU's Behaviour Change Communication (BCC) strategy and the community for the benefit of the target audience. On the other hand, since all universities cite students as the key beneficiaries of the HIV prevention activities, it is encouraging to see that 87% of the universities ACUs involve students in designing HIV prevention activities while only 64% of ACUs have a framework for the HIV prevention program to receive input from the students. This clearly shows that while there is an attempt by universities to involve students in designing of HIV prevention activities, once the final decision is made (by ACU board/committee/senate), then students are not given an opportunity to give input on the final activities that ACU will roll out hence this might lead to misunderstanding between the students and ACU leadership.

*Table 4.14 Community involvement in design of HIV and Aids prevention activities*

Statement	Yes (%)	No (%)
Are there forums where the ACU meets with the community to set priorities for intervention?	50	50
Are the students involved in designing HIV prevention activities?	87	13
Is there a framework for the HIV prevention program to receive input from the students?	64	36
Is there a linkage between the ACU's Behaviour Change Communication (BCC) strategy and the community for the benefit of the target audience?	57	43

Asked about community participation in HIV and Aids prevention activities, about half of the ACUs (45%) partially involve the community in HIV prevention activities. Only 9% of ACUs meet the desired threshold of ensuring that the community participates in most prevention activities. Having grass root support for HIV prevention services as well as effective and well documented referral of clients to and from the community services is what all ACUs should aspire to be. Table 4.15 gives an overview of community involvement in HIV and Aids prevention activities.

*Table 4.15 Community participation in implementation of HIV prevention activities*

Statement	Frequency	Percent
There is no interface with the community. The community does not participate in identifying the audiences for HIV prevention services	57	18.2
The community is partially involved in HIV prevention activities. There is minimum community input in HIV prevention activities	142	45.5
The community is fully involved in planning prevention activities and interventions.	28	9.1
The community participates in program review and there are village/grass root structures formed to support the HIV prevention services		
The community participates in planning and scheduling HIV prevention activities.	28	9.1
The community receives feedback on mobilization, uptake of HIV prevention services and referral mechanisms		
The community participates in most prevention activities. There is grass root support for HIV prevention services. There is effective and well documented referral of clients to and from the community services	28	9.1



Total	280	90.9
Missing	31	9.1
Total	311	100

#### 4.8.2.7 Referral systems

University ACUs are mandated to conduct HIV prevention activities within their catchment population. However, there are situations where students and staff need to be referred for specialized attention. These situations range from psychosocial counseling to treatment, care and support for HIV infected and/or affected. Asked whether there are any referrals being made, 90% of respondents agreed that ACUs are making referrals at the moment. However, despite the referrals made, 38% of respondents stated that ACUs do not have a database for the referrals being made while at the same time only 54% of universities ACU's referral networks are able to provide a complete HIV prevention/Care package according to national or donor guidelines. As shown in table 4.14, 63% of the universities ACUs agree that their referral documentation need to be improved while only 18% of ACUs have formal referral arrangement with the other providers. This clearly shows that despite 90% of universities ACUs conducting referrals, there is a weakness in documentation of referrals and weak referral networking system in place, hence the ACU leadership not being able to track the effectiveness of the referral system in place.

*Table 4.16 Clients referral, documentation and network*

Statement	Yes (%)	No (%)
Are there any referrals being done at the moment?	90	10
Is there a database for all the ACUs providing HCT and related services in the area?	62	38
Are the other service providers aware of the HIV prevention services you provide and have they referred to you?	83	17
Have referrals been made to providers of HCT services	64	36
Is there documentation on the clients referred for HCT and means of verification of services received?	86	14
Is the referral network able to provide a complete HIV prevention/Care package according to National or donor guidelines	54	64

*Table 4.17 ACUs capacity in client referral system*

Statement	Frequency	Percent
No referrals made for HIV prevention/other services. other providers not aware of ACU	28	9.1
referral documentation needs to be improved so that the ACU can determined if referrals were acted upon	198	63.6
client are referred for services and there is formal referral arrangement with the other providers	57	18.2
Total	283	90.9
Missing	28	9.1
Total	311	100

#### **4.8.3 Level of Supplies Management and implementation of HIV Prevention Programmes**

This section deals with procurement planning and commodity storage and utilization. It stipulates the presence of procurement to meet the planned HIV prevention program needs. From the respondents, only 56% of ACUs have a procurement plan to meet the planned HIV prevention program needs while 36% of ACUs do not have a reliable system for procurement and management of HIV prevention supplies and it does conform to government and other standard guidelines. Furthermore, only 57% of ACUs have quality assurance process for product availability and certification while only 60% of ACUs have inventory management procedures sufficient to serve as a resource center. On a more positive note, majority of ACUs (71%) have a supply chain system in place that accommodates the specific requirements of an HIV prevention program like communication materials.

##### **4.8.3.1 Procurement Planning**

Procurement planning is essential for provision of HIV prevention activities. Be it human resource, supplies and equipment, proper planning ensures smooth flow of interventions. Asked about procurement planning; 56% of respondents stated that ACUs have a procurement plan while only 64% of ACUs have a reliable system for procurement and management of HIV prevention supplies.

As for quality assurance process for product availability and certification, only 57% of respondents agreed that ACUs have this in place while 71 % and 60% of ACUs have supply chain system in place that accommodates the specific requirements of an HIV prevention program and inventory management procedures sufficient to serve as a resource center/training site respectively. The findings are summarized in table 4.18.

*Table 4.18 ACUs procurement planning*

Statement	Yes (%)	No (%)
Does the program have a procurement plan to meet the planned HIV prevention program needs?	56	44
Does the site have a reliable system for procurement and management of HIV prevention supplies and does it conform to government and other standard guidelines?	64	36
Does the site have a quality assurance process for product availability and certification?	57	43
Does the site have a supply chain system in place that accommodates the specific requirements of an HIV prevention program (Eg IEC materials)?	71	29
Does the site have inventory management procedures sufficient to serve as a resource site?	60	40

#### **4.4.2 Procurement planning standards**

Each university ACU should aim at having an inventory and supply chain management system that is compressive for continued services with no stock out. This will ensure that there is a good forecast on what is needed when and by whom. Proper forecast also leads to efficient utilization of resources as well as proper funds allocation. From table 4.19, only 9% of ACUs are closer to the procurement planning of having inventory and supply chain management system that is compressive for continued services with no stock out. The rest of ACUs need support in procurement planning.

Table 4.19 Procurement planning standards

Statement	Frequency	Percent
procurement plan & the items to be procured or ordered from central stores are planned effectively	85	27.3
procurement plan relates to the planning activities and conforms to national and funder guidelines	113	36.4
inventory and supply chain management system is compressive for continued services with no stock out	28	9.1
Total	226	72.7
Missing	85	27.3
Total	311	100

#### 4.8.3.2 Commodity utilization (Storage and Utilization)

Commodity storage and utilization of HIV prevention items like dispensers, test kits among others is critical towards provision of behavioural and biomedical services for HIV prevention. This makes storage and utilization of commodities very core. Asked whether the ACUs have supplies storage areas, only 56% of respondents stated that ACUs do have a designated area for storing supplies. Of those who have some form of storage, a majority of them (55%) reported that the storage area is not appropriate and does not meet safety standards for the storage of HIV prevention supplies. On the other hand, 80% of ACUs reported that there is a framework for proper storage and management of the prevention supplies while 83% reported that their programs have the ability to serve as a resource/training sites. The results show that the ACUs have proper storage mechanism while at the same time they want to serve as a resource/ training centre. However, majority of the ACUs do not have designated supplies storage areas and do not meet the storage standards. As shown in table 4.20, it is clear that the inability of most ACUs to conduct an assessment on storage needs is hampering space for HIV prevention activities and that of supplies storage.

Table 4.20 Commodity storage and utilization

Statement	Yes (%)	No (%)
Does the program have a designated supplies storage area?	56	44
Is the storage area appropriate and meets safety standards for the storage of HIV prevention supplies?	45	55
Is there a framework for proper storage and management of the prevention supplies?	80	20
<b>Does the program</b> have the ability to serve as a resource/training site?	83	17

#### 4.8.4 Data use for decision making

This section examines how the ACUs collect data, compile and analyse it, use the data to make key strategic decisions and the feedback mechanisms in place. Data for decision use affects and informs how well the strategies are working. It also guides the intervention activities on where to increase effort and where not to.

##### 4.8.4.1 Data Collection and implementation of HIV Prevention Programmes

Asked about data collection, 67% of respondents stated that ACUs have a documented procedure to guide data collection at various levels including Unique Client identification while only 64% of ACUs have tools for collecting data at the various levels in line with management and donor indicators. Half of the respondents (50%) stated that ACUs have an operational data collection system that contributes to program implementation and review that may be utilized as a resource for other programs while 71% and 83% of ACUs have standardized data collection mechanism and documented data collection procedures respectively as shown in table 4.21. From this analysis, it seems as if HIV prevention data is collected but not in a harmonized and deliberate manner from half of the universities' ACUs.

*Table 4.21 ACUs data collection system*

Statement	Yes (%)	No (%)
Does the ACU have a documented procedure to guide data collection at various levels including Unique Client identification	67	33
Does the ACU have tools for collecting data at the various levels in line with management and donor indicators?	64	36
Has the ACU standardized Data collection tools at various levels including Anti Aids Clubs if applicable?	71	29
Does the ACU have documented procedures for data transmission (Data flow Plan) to and from various levels?	83	17
Does the ACU have an operational data collection system that contributes to program implementation and review that may be utilized as a resource for other programs	50	50

#### **4.8.4.2 Data collection capacity of ACUs**

Table 4.22 gives a summary of ACUs capacities in data collection is concerned. From the findings, none of the universities reached the data collection threshold of having a data collection system that contributes to program implementation and review that may be utilized as a resource for other programs. Only 9% of ACUs have a documented procedure for data while the rest are at various levels as shown in table 4.22.

*Table 4.22 ACUs Data collection capacity*

Statement	Frequency	Percent
Has documented data collection procedures at all levels and procedures that ensure unique client identification, if relevant.	57	18.2
There are data collection tools at the various levels within the ACU for service delivery points. Tools have been reviewed to include necessary management, national and donor indicators	113	36.4

Statement	Frequency	Percent
Data collection tools have been standardized to collect management, national and donor data across sub-partners and service delivery points. This oversight clearly documented in MoUs with sub-partners. The staff and community involved in data collection have been adequately trained and supervised in the use of the tools.	28	9.1
There is a documented procedure for data transmission (data flow plan).	28	9.1
Total	226	72.7
Missing	85	27.3
Total	311	100

#### 4.8.4.3 Data Quality Assurance and Improvement

When it comes to data quality assurance and improvement, about half (56%) of the respondents stated that ACUs have identified data requirements for decision making while another half (50%) of ACUs have identified gaps in current data collected. A majority of respondents stated that 60% of ACUs do not have the capacity for data management tasks while at the same time only 50% of the ACUs have an identified feedback mechanism (including all stakeholders) and a system to routinely assess quality in critical areas of service delivery. Finally, the greatest weakness of ACUs is that they don't have an operational data quality management system that actively engages stakeholders and can be used as a resource for other programs. This, as shown in table 4.23, shows that none of the ACUs (0%) have data quality management system in place hence a glaring gap in effective HIV prevention activities in Kenyan Universities.

*Table 4.23: Data Quality Assurance and Improvement*

Statement	Yes (%)	No (%)
Has the ACU identified data requirements for decision making?	56	44
Has the ACU identified gaps in current data collected?	50	50
Does the ACU have the capacity for data management tasks?	40	60
Has the ACU identified a feedback mechanism (including all stakeholders) and a system to routinely assess quality in critical areas of service delivery?	50	50

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Does the ACU have an operational data quality management system that actively engages stakeholders and can be used as a resource for other programs?	0	100
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#### 4.8.4.4 Data for Decision Making

Effective decision making is part of leadership management. Good decision making has to be empirical. In order for one to arrive at an objective decision, there is need for quality data. Asked whether ACUs have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation, only 67% of respondents agreed that ACUs have baseline information. However, only 50% of ACUs have a process to compare current information to expectations or past status 55% of ACUs do not have staff who regularly evaluate their performance and the ACU's achievements using data and only 60% of ACUs have sufficiently strong data interpretation and application systems that other stakeholders rely upon it as shown in table 4.24. This clearly shows that majority of ACUs (55%) do not have staff who have skills to evaluate ACUs performance using data hence a clear and objective way of assessing the performance of ACUs is not there.

*Table 4.24 Data for decision making*

Statement	Yes (%)	No (%)
Does the ACU have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation?	67	33
Does the ACU have a process to compare current information to expectations or past status?	50	50
Does the ACU have staff who regularly evaluate their performance and the ACU's achievements using data?	45	55
Does the ACU have sufficiently strong data interpretation and application systems that other stakeholders rely upon it?	60	40

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#### 4.8.5.5 Feedback and Sharing data

After data has been analyzed, the natural flow is to provide feedback and share the data to various stakeholders. Despite having challenges in collecting and analyzing data, 82% of ACU have reports from data collection that are provided to external parties and 78% of ACU staff state that data is used



to inform the wider implementation.. When data is shared with external parties, 73% of implementation partners utilize the information from the ACU to guide and improve their comprehensive care programmes and 87% of ACUs data is recognized as reliable and a source of planning and strategic information for HIV/AIDS and best practices as shown in the table 4.25. It is evident from this sub-section that external partners and implementers have high regard to ACU data as they use the data to make strategic implementation decisions. These decisions do affect the choice for HIV prevention model. Hence, ACUs are encouraged to horn the skills of staff in data collection and analysis.

*Table 4.25 Feedback and sharing data*

Statement	Yes (%)	No (%)
Does the ACU have reports from data collection that are provided to external parties?	82	18
Does the system use data to inform the wider implementation team (not only to correct the collection of data)?	78	22
Does the ACU provide performance reports to all stakeholders within and external to the ACU including the university community?	73	27
Do implementation partners utilize the information from the ACU to guide and improve their comprehensive care programmes?	73	27
Is the ACU's data recognized as reliable and a source of planning and strategic information for HIV/AIDS and best practices?	87	13

#### **4.8.5.6 Evaluation**

Systems must be created for tertiary and higher education institutions to monitor and evaluate their policies and programmes. Monitoring involves tracking the inputs, processes, outputs and quality of a programme over time. It also involves assessing whether the ways in which a programme is being implemented is consistent with its initial design and implementation plan. Institutions of higher learning can develop both quantitative and qualitative monitoring indicators. Evaluation entails assessing programme outcomes, what such outcomes mean and whether such outcomes make a difference. Sustained monitoring and evaluation is an essential activity of any HIV and AIDS

programme, and the findings need to be relayed to the staff and students who are involved in the programme.

Any project or programme success can only be founded on comparing the baseline and endline evaluation. The baseline studies help to establish the situation and these findings are used to design the project/programme. After designing the project/programme, implementation, monitoring and control follows. After the implementation, the project/programme is evaluated to assess its effectiveness/impact. When asked about whether ACUs have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation, three quarter (75%) of respondents agreed. While majority of ACUs have plans, only 43% of respondents stated that ACUs have baseline values available for all indicators with date of collection and data source and 50% of respondents stated that ACU staffs are skilled in data triangulation, analysis and sampling methodology. A paltry 33% of ACU have a budget line for evaluation while only 67% of ACUs have good outcome and impact indicators with same data source to measure at baseline and follow up. Table 4.26 gives a summary on evaluation status for ACUs. It is clear that ACUs have not taken evaluations seriously. This is manifested by the number of ACUs that have a dedicated budget line to conduct evaluations. Earlier on, it was established that only 73% of universities have a dedicated budget line for HIV prevention activities. Moreover, it seems as if some universities despite allocating monies have not taken evaluation of interventions with the seriousness it deserves.

*Table 4.26 Evaluation status of ACUs*

Statement	Yes (%)	No (%)
Does the ACU have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation?	75	25
Does the ACU have baseline values available for all indicators with date of collection and data source	43	57
Does the ACU have staffs skilled in data triangulation, analysis and sampling methodology?	50	50
Does the ACU have a budget line for Evaluation?	33	67
Does the ACU have SMART outcome and impact indicators with same data source to measure at baseline and follow up?	67	33

#### 4.8.6 Human Resource Capacity and implementation of HIV Prevention Programmes

This section looks at the human resource capacity in terms of staffing needs, and training and skills development.

##### 4.8.6.1 Staffing Needs

Human resource drives the design, implementation and evaluation of HIV prevention. The most important resource in any organization is the human resource. When asked about the staffing requirements, 55% of staff responded by stating that ACUs have identified program staff requirements but have no capacity to fill them. On the contrary, 80% of ACU staff stated that ACUs have the capacity to maintain staff needs for those who are on board. As the programme grows, only 75% of ACU staff stated that ACUs have the capacity to maintain staffing needs as shown in table 4.27. Staffing needs include office space, office utilities, transport facilitation and resources to partner and conduct external learning forums.

*Table 4.27 Staffing needs for ACUs*

Statement	Yes (%)	No (%)
The ACU has identified program staff requirements but has no capacity to fill them	55	45
Does the ACU have the capacity to maintain staff needs?	80	20
Does the ACU have the capacity to cater for the staffing needs as the program grows?	75	25

##### 4.8.6.2 ACUs Staffing needs capacity

Asked which statement reflected the staffing needs capacity at ACU, none of the ACU had the required standard of having manpower staffed according to program requirements and able to cater for staff needs as the program grows and the staffing model can be used as a resource for other programs. It is evident that ACUs are at different staffing levels ranging from having staff with no manpower forecast (18%), having staff with written manpower forecasting plan (18%), having positions filled

with qualified staff who have the correct training and experience (27%) to having qualified staff with correct training, experience & have written and defined manpower forecast plan (18%). Table 4.28 summarizes the staffing needs capacity for the ACUs.

*Table 4.28 ACUs staffing capacity*

Statement	Frequency	Percent
ACU has the skills, experience and training to maintain the program but has no written manpower forecasting plan	57	18.2
ACU has the skills, experience and training to maintain the program and has written manpower forecasting plan	57	18.2
Vacancies have been filled with qualified staff who have the correct training and experience	85	27.3
Qualified staff with correct training, experience & have written and defined manpower forecast plan	57	18.2
Total	254	81.8
Missing	57	18.2
Total	11	100

#### **4.8.6.3 Training and Skills Development**

The last section of human capacity for the ACUs is the staff training and skills development. Asked whether ACU trained its implementation staff in the selected Standard Operating Procedure (SOP) and related data and management processes, a majority (56%) of ACUs staff stated that ACUs have not trained their staff in selected SOPs while a significant majority (86%) have their staff trained on program specific services linked to the selected SOP (eg demand generation, referrals, community). However, despite the training, only 57% of program staff been evaluated for the non-SOP and related skills that they require and been provided with appropriate training and use it while only 33% of ACUs have staff training and skills development that can be used a resource for other ACUs. With all the trainings and experience, only 60% of ACU program staff are able to train, coach and mentor other

implementers and stakeholders to meet growing program needs while a mere 33% of ACU have staff training and skills development that can be used a resource for other ACUs. These training needs and experiences show that ACUs on average are not as adequately prepared to implement HIV prevention programs within their jurisdiction. It is no wonder that only 60% are able to transfer their skills to other implementers, meaning that the ACU staff need to allocate more financial resources, technical skills and time towards human resource development. In conclusion, there seems to be no ACU that has reached the desired level of being recognized as a mentoring site for other practitioners to second staff for training and on the job experience. Table 4.29 summarizes ACU staff training and skills development.

*Table 4.29 ACU staff training and skills development*

Statement	Yes (%)	No (%)
Has the ACU trained its implementation staff in the selected Standard Operating Procedure (SOP) and related data and management processes?	44	56
Have staff received program specific training on related services that is linked to the selected SOP (eg demand generation, referrals, community)?	86	14
Have program staff been evaluated for the non-SOP and related skills that they require and been provided with appropriate training; and use it?	57	43
Are program staff able to train, coach and mentor other implementers and stakeholders to meet growing program needs?	60	40
Does the ACU have staff training and skills development that can be used a resource for other ACUs?	33	67

## CHAPTER FIVE

### SUMMARY OF FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter presents the summary of findings and discussion on the factors influencing the technical capacity of implementing effective HIV and Aids prevention programmes in Kenya citing a case of Kenyan Universities as per the responses of the respondents. The summary of findings, discussions and conclusions are based on the objectives of the study.

#### 5.2 Summary of Findings

This research sought to look into the technical capacity of the ACUs of Kenyan Universities. Table 5.1 below presents a summary of the findings of the research based on the objectives of the study.

*Table 5.1 Summary of Findings and Remarks*

<b>Objective</b>	<b>Summary of Findings and Remarks</b>
To determine the level of leadership capacity of Kenyan Universities ACU staff in delivering HIV prevention programme	<p>The research established that the ACUs have identified leadership with a clear head of ACUs in the universities. The leaders have experience in managing HIV prevention programmes and the leaders are actively involved in establishing or running HIV prevention programs.</p> <p>However, the ACU leadership needs assistance in designing and/or setting up, and/or finalizing guidelines to implement the HIV prevention program. The specific help needed is designing and setting up of HIV prevention and finalization of guidelines in setting up HIV prevention programme programmes. The ACU leadership is not able and not engaged in training for satellites or other institutions/campuses thus not building capacity or transferring skills to satellite campuses. From the research, there is no ACU that cited reaching the epitome of the desired leadership,</p>

Objective	Summary of Findings and Remarks
	<p>which is, having committed leadership with good experience and vision in providing HIV prevention services and is engaged in establishing new HIV prevention delivery activities/centers. It is evident that with the current system where the Vice-Chancellors appoint a figure head to run departments (including ACUs), there is only a figure head as the heads of ACUs. Nearly all ACUs have the leadership and experience but often not enough technical skills required at this level. The lack of adequate technical skills is evident from the kind of technical skills the heads of ACUs are requesting (designing and setting up ACUs and finalization of HIV prevention guidelines).</p>
<p>To assess the quality of service delivery of Kenyan Universities ACU in delivering HIV prevention programme</p>	<p>A majority of ACUs have an identified HIV prevention behaviour change communication strategy in use. The ACUs also have some program specific guidelines or standard operating procedures being applied in the HIV prevention programme and the guidelines have been disseminated to stakeholders and implementers. Additionally, the ACUs have designated space for HIV Prevention services and the space is sufficient to address the confidentiality issues of the clients. ACUs also have a formal and documented campaign to mobilize clients for HIV prevention service uptake with clearly defined target population. The students being the main beneficiaries for HIV prevention activities are involved in designing HIV prevention activities. The ACUs have referrals being done at the moment and these referrals are documented.</p> <p>Despite these positive trends in quality of services, the ACUs have a number of challenges faced. These include: HIV prevention not aligned to evidence based response ; the ACU prevention program being delivered is not standardized to national guidelines and the ACUs cannot be used as a resource for other prevention programs;</p>

Objective	Summary of Findings and Remarks
	<p>despite having allocated space for HIV prevention services, the space is not sufficient; there is no evidence that shows that the community mobilization generated more demand; in spite of ACUs working in communities, forums where the ACU meets with the community to set priorities for intervention are not taking place as often as they should be and; referral documentation needs to be improved so that the ACU can determine if referrals were effectively acted upon.</p>
<p>To establish the level of supplies management of Kenyan Universities ACU in delivering HIV prevention programme</p>	<p>ACUs have a supply chain system in place that accommodates the specific requirements of an HIV prevention program and they have a framework for proper storage and management of the prevention supplies while the ACUs have the ability to serve as a resource/training site.</p> <p>However, ACUs do not have sufficient quality assurance process for product availability and certification. At the same time, the storage area appropriate and meets safety standards for the storage of HIV prevention supplies is not sufficient. From these observations, the ACUs have a fairly strong supplies management. The major assistance needed is to help ACUs assess the physical space needed to store their supplies. By doing so, safety standards will be established and enforced.</p>
<p>To assess the extent to which data is used for decision making in Kenyan Universities ACU in delivering HIV prevention programme</p>	<p>ACUs have a documented procedure to guide data collection, have standardized data collection tools and have documented procedures for data transmission to and from various levels. It is encouraging to note that a majority of ACUs have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation. ACUs are very strong in sharing their data with external partners and their data is used to design HIV prevention programmes. The ACU data is recognized as reliable and a source of planning and strategic information for</p>



Objective	Summary of Findings and Remarks
	<p>HIV/AIDS and best practices.</p> <p>Despite ACUs having documented procedures and great at sharing of data, there are a series of challenges that ACUs face. These include; ACUs not having a process to compare current information to expectations or past status; not having staff who regularly evaluate their performance and the ACU's achievements using data; not having sufficiently strong data interpretation and application systems; not having baseline values available for all indicators with date of collection and data source; not having staffs skilled in data triangulation, analysis and sampling methodology and finally; not having a budget line for evaluation.</p> <p>The fact that the ACUs do not deliberately allocate funds to conduct evaluation studies and by extension strengthen their research abilities, then the ACUs will continue to struggle; hence data generated for decision making will not yield to quality decisions. The inability of ACUs to invest in evaluations has a direct impact on the type and quality of HIV prevention being implemented. More so, since ACUs are not using the national data to design their programmes, they are implementing without having a vision. The results of these actions are depicted in KAIS (2012) where for the first time, the HIV prevalence among the school population is higher (5.8%) than the national prevalence (5.6%)</p>
<p>To determine the human resource capacity of Kenyan Universities ACU in delivering HIV prevention programme</p>	<p>The ACUs have identified leaders. They also have the capacity to maintain current staff needs and even maintain staff needs as the programme grows. In terms of replacing staff, the staff vacancies have been filled with qualified staff who have the correct training and experience.</p> <p>On the flip side, ACUs do know their staffing requirement. However, due to insufficient funds, the ACUs have no capacity to fill them. The staff at ACUs are partially trained in selected</p>

Objective	Summary of Findings and Remarks
	Standard Operating Procedure (SOP) and related data and management processes. Of great concern, with limited staffing capacities, ACUs do not have staff training and skills development that can be used a resource for other ACUs, hence showing that the ACUs cannot easily transfer skills nor can they be a learning center for other organizations.

### 5.3 Discussion

This section discusses the findings obtained with regard factors influencing technical capacity challenge in implementation of effective HIV prevention programmes in Kenya presented below.

#### 5.3.1. Socio-Demographic and Economic Characteristics

A total of 362 participants from 15 universities in Kenya were sampled out for the study. Of these, 7 were public universities while 8 were private universities. As for students' population, 40% of universities have a student population of over 9,000 while, 53% of universities have between 3,000 and 9,000 students and 7% of universities have a population of less than 7%. All (100%) universities cited serving student, non-teaching, teaching staff population and the surrounding community. In terms of services offered, 82% of universities offer comprehensive HIV prevention while 72% of universities offer HIV Testing and Counselling and 9% offer parent to child transmission and OVC type intervention. Resources are critical to any project implementation. It was established that only 73% of universities have allocated financial resources towards HIV prevention activities. In terms of human resource, a total of 1,131 peer educators had been trained for 3 years (2009-2011). The total full time staff in all the universities is 40, with an average of 3 staff per ACU office. Majority of the universities (64%) recorded less than 1,000 individuals tested for HIV while the rest (36%) had between 1,000 to 3,000 individuals tested for HIV. HIV is still a national disaster. It is expected that universities should play a critical role in shaping the policy and designs of HIV prevention activities. Surprisingly, only 18% of ACUs participate in any form of National Technical Working Group. The rest, 82%, are inward looking and do not contribute towards national efforts of HIV prevention policy and design development. To achieve maximum results, ACUs have partnered with different

government institutions, local and international organizations to provide financial and technical resources. The ways in which HIV and AIDS will affect the finances of the institution are many and varied. Campus health services will face considerable financial strain if they have to provide HIV testing, counselling, treatment for opportunistic infections and sexually transmitted infections and anti-retroviral treatment (when this is not provided by the state). A further direct cost for the health services of an institution will be increased expenditures on disposable materials such as gloves and other equipment to protect health workers and researchers.

Funeral benefits need to be considered, as well as replacement costs of staff who leave or who die and skills training for new members of staff. Other costs would include temporary replacement of staff. The benefit packages for staff members can also be affected as the demand for payout of these packages can occur sooner than expected.

Some of the indirect costs include staff absenteeism due to illness or family responsibilities, caring for others and attending funerals.

The HIV epidemic is also threatening the funding sources of tertiary and higher education institutions. Money previously budgeted for other services may have to be channeled towards HIV- and AIDS-related expenditures implying the need to raise more money. HIV- and AIDS-related costs may also mean less money available for bursaries and scholarships and may affect the ability of students to pay for their tuition and books and other requirements.

Universities recorded several successes and challenges. Key achievements made by the universities ACUs include: distribution of IEC materials; having a behaviour change education day; condom distribution; collaborating and working with more partners; comprehensive HIV/AIDS education; high school mentorship on academics & career; HIV testing and counseling; mainstreaming HIV/AIDS in university curriculum and; training of peer educators.

Some of the challenges that universities encountered include: absence of head of ACU; attitude to condom use demonstration; complacent attitude among academic staff; drug alcohol abuse; few staff; inadequate funding; lack of institutionalization; lack of permanent VCT facilities; lack of regular peer

counselor; limited condom supplies; limited testing kits; little knowledge of ACU within institution; no youth friendly center; staff/personnel are not trained in HIV and working with partner who end project once their goals are met.

### **5.3.2 Factors influencing technical capacity of implementing Effective HIV and Aids Programmes**

From the research project, several factors influence the technical capacity of implementing effective HIV prevention programmes. These factors are in various magnitudes as established in the research findings.

#### **5.3.2.1 Level of leadership capacity of Kenyan Universities ACU staff**

The Kenyan Universities ACUs have an identified leader. Majority of the leaders (86%) have at least 3 years' experience in managing HIV prevention programmes. This was supported by the Head of ACU at the Commission for University Education said “ *one of the greatest strength of universities, be it public or private, is that they have clear leadership. Whenever the Commission wants to discuss on matters of ACUs in universities, it is very easy to contact the leaders through the Vice- chancellors*” She further stated that “*there is consistency across board to have one person who has been at the help of ACUs for at least 3 years. This makes continuity of university interventions very easy*” these statements echo the findings of the study. However, the experience has not translated to better design and finalization of policies and guidelines as expressed by 73% of the ACU leaders. ACU are only providing leadership within their universities. Only 18% of ACU leaders participate in National Technical Working Groups (TWGs). It is through the TWGs that national policies and programme designs are developed. Their absence has had a direct impact on how the universities ACUs are implemented. Additionally, there seems to be no inter-university ACU exchange programmes or ACUs conducting trainings for others. As reported, only 27% of the universities ACUs conduct trainings for other institutions/campuses. Lack of exchange programmes and training of other institutions confines the ACUs in their own cocoon, hence no cross learning or sharing of best practices thus depicting ineffective leadership at top level.

#### **5.3.2.2. Quality of service delivery of Kenyan Universities ACU**

Around two-thirds (64%) of ACUs have an identified model for Behaviour Change Strategy. However, around half of ACUs (54%) are implementing activities that are evidence based. The other 46% are having activities without any scientific model. As depicted in KAIS (2012), the haphazard implementation has had an effect of the HIV prevalence among institutions of learning. Evidence from KAIS (2012) shows that; 66% females and 59% Males aged 15-24 have had sex. The report further reveals that HIV prevalence was higher among women at all education levels compared to men; highest rate of HIV infection among those who completed at least some secondary education was 7.1% while the lowest rate of infection was among those women with no primary education (4%) and; men who completed primary school had twice the rate of HIV infection compared those who had not attended school (4.8% compared to 2.4%).

With such evidence, universities should mold the activities to address the challenges. It is undesirable to find that a majority of universities either do not have standard operating procedures or are unaware of their existence. The lack of the standard operating procedures is compromising the quality of delivery of comprehensive HIV prevention. On a more positive note, majority of universities have a physical space. The space is sufficient to address the needs of the clients, including confidentiality to conduct HIV prevention services. The only challenge faced by the ACUs is that majority of them have never conducted an assessment to establish the space needs. As for community mobilization, majority of ACUs have strategy on demand generation. The area of weakness is the inability of the universities to establish the correlation between demand generation and service uptake. University-community linkage is very weak. Only half of the universities do involve communities in setting of HIV prevention activities.

The picture is completely different when it comes to students. Nearly all universities involve students in designing HIV prevention activities. Beneficiary engagement leads to ownership and involvement in implementing activities. The major weakness in the community engagement is creating a database for referral. Universities have cited challenges in referral tracking and documentation of referrals. This was supported by who said that “ *whenever am invited to officiate a University HIV function, I am always thrilled by the level of organization and vigour that universities do. If only they could extend this to their surrounding communities, then we will be seeing a community that appreciates university existence*” This was further supported during the FGD session where students agreed that they like

doing community service and it would be good when all students have a community service unit so that they can interact more with the community as they study.

### **5.3.2.3 Supplies management of Kenyan Universities**

Effective supplies management is geared to ensure that clients are able to access their requirements in a timely manner and with enough supplies to manage their needs. A majority of universities have a supply chain system in place that accommodates the specific requirements of an HIV prevention program (Eg IEC materials). Majority of the universities (80%) reported that they have have framework for proper storage and management of the prevention supplies while 83% reported that their programs have the ability to serve as a resource/training sites. During the FGD session, the university students agreed that there is effort by universities to have enough supplies. However, one of the participant said that “ *in 2012,at our campus in Kikuyu,there was a condom stock out. This lead to students rioting demanding re-stocking of condoms*” This ascertain by this participant highlights the extent to which having proper supplies management system in place, hence the need for all universities to monitor the movement of supplies and re-stock as per their guidelines.

### **5.3.2.4 Data use for decision making in Kenyan Universities**

Data for decision making is the greatest challenge that the ACUs of Kenyan Universities are facing. Half of the ACUs (50%) have an operational data collection system that contributes to program implementation and review that may be utilized as a resource for other programs. Despite data being collected, there is lack of harmonized ways of data collection. None of the universities has a data collection system that contributes to program implementation and review that may be utilized as a resource for other programs. When it comes to data quality assurance and improvement, about half of ACUs have identified data requirements for decision making while again half of ACUs have identified gaps in current data collected. The technical human resource capacity for data management is still an area for improvement in half of the universities. It was also evident that none of the ACUs have data quality management system in place. Finally, majority ACUs are also struggling to generate their data for effective decision making and activities implementation. As reported, only 43% have conducted any form of baseline in their universities. This is no surprise as only 33% of universities have a budget line for baseline in their departments. The lack of baseline means that there is no empirical data that

aide in implementation. At the same time, it seems as if a majority of ACUs are shooting in the dark. No wonder, as most of the populations recorded a reduction in HIV prevalence, the institutions of learning recorded an increase in the prevalence (KAIS 2012). Perhaps this explains the reason why there is little representation of universities at the national Technical Working Groups on HIV prevention. During the key informant interview, the Head of Youth Prevention at Nascop stated that *“we hardly see universities participating in our Technical Working Groups. We at times rely on external researchers to help design interventions yet we have qualified and experienced university staff. The moment we will have universities embrace working with us then we will accelerate faster in designing evidence based interventions for the country”* During the FGD session, all participants agreed that the universities do not do a great job in coming up with university specific information. The interventions are generalized with a hope of reaching all. When asked about the data on universities HIV prevalence, a Director at the National Aids Council said that *“the prevalence of HIV among universities is less than 1%. Therefore there is need to do a lot of preventive interventions without forgetting to involve those who are infected”* FGD participants thought otherwise. They were strongly pointed stating that there is rampant sex in the campus hence chances of high HIV prevalence in the campus. When further probed, they agreed that there is no data to support their arguments. This just highlights the gap that universities should be addressing.

#### **5.3.2.5 Human resource capacity of Kenyan Universities ACU**

Nearly all ACUs (91%) reported having a clear leader and leadership. ACUs also have an average of 4 staff. However, not all these staff are technical staff. Most ACUs have one administrator who helps in execution of HIV prevention activities. Other office staff are deployed to do office work (cleaning, secretarial and running errands). Slightly over half (55%) of ACUs know their staffing needs. However, they are unable to fill in the positions because of lack of funds. From the research findings, human resource still remains a challenge. The filling of positions, as reported, does not necessarily meet the ACUs needs. Only 45% of ACUs have positions filled with qualified staff who have the correct training and experience. When it comes to trainings, a majority of ACUs do not invest in staff training on various elements of comprehensive HIV training. Only 33% of ACUs have staff training and skills development that can be used a resource for other ACUs. Skills transfer is not a norm in some of the universities. Only 60% of staff are able to transfer their skills to other implementers. One of the FGD participant, who is a university staff put it bluntly. She said that *“I was employed as an*

*administrator, just like any other administrator. However, when I was posted at the ACU, I never knew that I needed to have many skills like proposal writing, monitoring and evaluation and event management and most importantly facilitation and communication skills. I cannot stand in front of students and train them on anything. I will die if one day I will be told to do so”* This summarizes the need to invest in the ACU staff training programmes so that the caliber of staff can meaningfully address issues of HIV prevention within and outside the university.

#### **5.4 Conclusions**

Tertiary and higher education institutions have a crucial role to play in developing responses that will ensure that all staff and students have access to education, prevention and care in an environment in which their rights are protected. Tertiary institutions are uniquely placed to develop innovative and effective responses to HIV and AIDS. This is because as institutions of higher education, they are concerned with the generation and development of new ideas and their key role is to push the boundaries of knowledge and to give intellectual leadership and vision. At the same time, tertiary or higher education institutions are more vulnerable to HIV and AIDS than other formal institutions of learning because they cater mainly for students who fall within the ages of 18-25 – an age group with a high HIV prevalence, which is largely as a result of unprotected sexual relations. Understanding this dichotomy can help higher education institutions.

The study showed that all the five factors affect the technical capacity of implementing effective HIV and Aids programmes in various dimensions. The Kenyan universities need to examine if the current HIV and Aids prevention efforts are yielding results. As shown in the KAIS (2012) report, there is a lot of work that the universities need to do in order for them to turn off the tap of infections.

There is a clear leadership structure and leaders for HIV prevention in Kenyan Universities. These leaders have at least 3 years experience in managing HIV prevention programmes. This is the greatest strength that the universities have. They should take advantage of this opportunity so as to grow their programmes, thus contributing to reduction or even elimination of HIV. Another major strength that was drawn from the findings was that the public and other external stakeholders trust the data generated by universities. As such, universities should play a pivotal role in shaping the HIV prevention dialogue and implementation in the country. Sadly, only 18% of universities participate in any form of National Level Technical working Groups on HIV prevention.



The greatest weakness that ACUs face is in the area of data use for decision making. As evidenced in the study, none of the universities have a data collection system that contributes to program implementation and review that may be utilized as a resource for other programs. To aggravate the situation none of the ACUs have data quality management system in place. As far as staffing is concerned, majority of ACUs do not have staff who have skills to evaluate ACUs performance using data.

From the research, much as there are ACU leaders, most of the universities do not have enough financial resources allocated to ACUs. As reported, only 45% of universities have allocated funds for HIV prevention. Even those that have allocated the funds, the amount located is way below what can run an effective HIV prevention programme.

Another major factor influencing the technical capacity of implementing effective HIV and Aids program is human resource. The study reveals that there is great understaffing in Kenyan universities ACUs. The staff who support are administrators who often have limited technical capacities to support implementation of HIV and Aids programmes. The study revealed that only 45% of the staff in ACUs are qualified to implement HIV and Aids prevention interventions. Sadly, skills transfer is still lacking in Kenyan Universities ACUs. This is depicted by only 33% of ACU staff having training and skills development that can be used a resource for other ACUs.

Some of areas that ACUs have done well as shown in the study include having clear leadership. This, when well utilized brings about focus and results. Another area that ACUs have done well include supplies management and demand generation for service uptake.

## **5.5 Recommendations**

The following are the recommendations based on the findings of the study:

1. The Kenyan Universities ACUs should allocate sufficient financial and sufficient technical human resources in their ACUs
2. The Kenyan Universities ACUs should immediately establish a research, monitoring and evaluation unit in their ACUs. The unit is key to generating important data that will be used for decision making.

3. The current ACU staff should be trained on data for decision making as a matter of urgency
4. The ACU staff should join National Technical Working Groups so as to learn more on policy and programmes design
5. In order for ACUs to have a real picture on HIV and Aids within their institutions, the ACUs should conduct a study to establish the knowledge, attitudes and practices in HIV prevention for the university community.
6. A clear capacity improvement plan based on these findings be developed and implemented.

### **5.6 Areas of Further Study**

The following are areas identified for further study

1. The role of universities in capacity building local organizations to effectively implement health programmes
2. The role of universities in preventing HIV and Aids in learning institutions in Kenya
3. ACU Leadership and management. Does it matter who heads ACU?

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## APPENDICES

### Appendix 1: Questionnaire

This questionnaire has two parts. Part A to be filled by ACU staff. Part B to be filled by all respondents

#### Part A: Background Information

1. Name of University\_\_\_\_\_
2. Type of University: Public\_\_\_\_\_Private\_\_\_\_\_ (Please tick one)
3. Religious affiliation: Christian\_\_\_\_\_Secular\_\_\_\_\_ ( Please tick one)
4. What is the total number of students in the university?\_\_\_\_\_
5. When was ACU established?\_\_\_\_\_
6. How many staff do you have in ACU? List?

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7. What population do you serve? List? (e.g., students, non teaching staff, etc)

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8. What is the estimated population you serve?

E.g Students                      8,000 (approx 4,000male and 4,000 female)

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9. Please list the type of HIV prevention services the ACU offers

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Do you have an annual ACU budget? If yes, how much is it (in kshs.)\_\_\_\_\_

11. What is the source of your budget?

E.g. Commission for University Education approx. Ksh. 450,000

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. How many trained Peer Educators/ Peer Counsellors has ACU trained in the past three years?

- i. 2009.....
- ii. 2010.....
- iii. 2011.....

13. How many individuals have been tested for HIV in the past one year?\_\_\_\_\_

14. Have you conducted any study to find out if there are any MARPS in the institution?

(MARPS- Most at Risk Population)

15. Is the University ACU participating in any National Technical Working Group? If yes, please list the one(s) the ACU is participating in.

16. List any partners you work with and what are their roles?

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17. How do you intend to sustain the ACU activities beyond external support?

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18. What are the key successes that you have achieved in the past one year?

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19. What challenges do you face in implementing HIV prevention services?

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**Part B: Technical Capacity**

<b>DOMAIN 1: LEADERSHIP</b>					
<b>Area 1</b>					
<b>1.1 Leadership</b>	<b>Has identified leadership or committed members at site or in community.</b>	<b>Has leadership with knowledge on HIV prevention issues and is running prevention activities.</b>	<b>Has committed leadership with good experience and vision in providing HIV prevention services. Needs assistance to set up and lead good systems for HIV prevention service delivery.</b>	<b>Has committed leadership with good experience and vision in providing HIV prevention services and is engaged in establishing new HIV prevention delivery activities/centers.</b>	<b>Has strong leadership with full understanding of current HIV prevention issues, has a team and is able to train other teams to expand HIV prevention activities.</b>
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9</b>
	<b>2</b>	<b>4</b>	<b>6</b>	<b>8</b>	<b>10</b>

**1. Is there an identified leader at the ACU who is responsible for the management of HIV and AIDS prevention activities?**

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 2.1 Program Model or approach* - [Domain 1. Area 1 - Score 1-2]

**2. Does the identified leader(s) have experience managing HIV Prevention programs?**

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 2.1 Program Model or approach* - [Domain 1. Area 1 - Score 3-4]

**3. Does ACU need assistance designing and/ or setting up, and/or finalizing guidelines to implement the HIV prevention program?**

[1] Yes → *Proceed to Area 2.1 Program Model or approach* - [Domain 1. Area 1 - Score 5-6]

[2] No, no assistance is required → *Proceed to Question 4*

**4. Is the identified leader or leadership team actively involved in establishing or running HIV prevention programs?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 2.1 Program Model or approach* - [Domain 1. Area 1 – Score 7-8]

**5. Is the leader (ship) able and engaged in training for satellites or other institutions/campuses?**

[1] Yes → *Proceed to section 2.1 Program Model or approach* - [Domain 1. Area 1 - Score 10]

[2] No → *Precede to Area 2.1 Program Model or approach* - [Domain 1. Area 1 - Score 9]

**Domain 1.1 Score:** \_\_\_\_\_

Total leadership points

Leadership: Domain score (Total leadership score) \_\_\_\_\_

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

**Area 1**

<b>2.1 Program Strategy</b>	The ACU has developed/identified a potential model or BCC strategy models.	Has chosen a model or adapted a BCC strategy and the strategy is a response to an evidence-based determination of need and audience identification.	Has chosen model or adapted a BCC strategy but lacks details. The ACU needs assistance in adapting or implementing to reflect realities of current communities/ sites.	A detailed model or BCC strategy exists and has been adapted to the local context. It needs modifications based on current or expanding needs.	Detailed model or BCC strategy exists and operating procedures both formalized and approved; has been able to be adapted to expanding demands; can serve as a model for other sites.
	1 2	3 4	5 6	7 8	9 10

**1. Is there an identified potential model or actual BCC strategy being used?** *[A spectrum of messages, target population, mode of service delivery protocols for each program area, SOPs for the HIV prevention areas that will be addressed]*

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 2.2 Program Approach [Domain 2. Area 1 - Score 1-2]*

**2. Is the strategy a response to evidence based need and has national priority/ policy been considered in selecting the model of response?**

[1] Yes → *Proceed to Area 2.2 Program Approach [Domain 2. Area 1 - Score 3-4]*

[2] No, no assistance is required → *Proceed to Question 3*

**3. Please select the option that best reflects the site's Standard Operating Procedures (SOPs) condition:**

[1] Details lacking for most or all SOPs or task assignments in practice or in writing → *[Domain 2. Area 1 - Score 5]*

[2] Some prevention SOPs exist in practice but details lacking for most or all, OR most have not been drafted → *[Domain 2. Area 1 - Score 6]*

**[4] Some operating procedures around HIV prevention services to be provided are still being drafted or finalized → [Domain 2. Area 1 - Score 7-8]**

**[5] Standard Operating Procedures are both formalized and approved; can serve as a model for other sites [Domain 2. Area 1 - Score 9-10]**

**Domain 2.1 Score: \_\_\_\_\_**

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

<b>Area 2</b>					
<b>2.2 Program Specific Protocols, Guidelines/ Standard Operating Procedures/ Approach</b>	<b>There are HIV prevention operational guidelines / protocols in place.</b>	<b>Guidelines and protocols are up to date and standardized with National/PEPFAR guidelines.</b>	<b>The harmonized guidelines/ protocols have been interpreted and disseminated to the implementers and stakeholders.</b>	<b>The implementers are appropriately applying the guidelines in service delivery.</b>	<b>The service being delivered is standardized across all service delivery points and the model can be used as a resource by other programs</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
			<b>6</b>	<b>7</b>	<b>8</b>
					<b>9</b>
					<b>10</b>

**1. Are there any program specific guidelines or standard operating procedures being applied in the prevention program?**  
*[Reference to National HIV prevention guidelines or any form of guideline acceptable to PEPFAR and other stakeholders]*

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3 - Score 1-2]

**2. Are the guidelines up to date and harmonized with National Guidelines and they address all client needs?**

*[Check if any trainings or orientations circulations have been done]*

[1] Yes → Proceed to Question 3

[2] No → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3- Score 3- 4]

**3. Has the leadership been able to interpret and disseminate the prevention guidelines to the implementers and stakeholders?**

[1] Yes → Proceed to Question 4

[2] No → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3- Score 5-6]

**4. Are all the implementers applying the same guidelines at all centers offering prevention services?**

[1] Yes → Proceed to Question 5

[2] No → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3- Score 7-8]

**5. Is the HIV prevention program being delivered standardized to national/PEPFAR guidelines and the site can be used as a resource for other prevention programs?**

[1] Yes → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3- Score 10]

[2] No → Proceed to Area 2.4 Physical Space - [Domain 2. Area 3- Score 9]

**Domain 2.3 Score \_\_\_\_\_**

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

**Area 3**

<p><b>2.3 Physical Space</b></p>	<p>There is a specific place for carrying out prevention activities.</p>	<p>There is a designated place for delivering a full package of HIV prevention for the anticipated number of program recipients.</p>	<p>The space is appropriate for the activities. Available space caters for the confidentiality issues of the clients, if relevant.</p>	<p>The space requirements in the next one year are known and planned.</p>	<p>There is a documented defined and adequate space for HIV prevention services delivery. Plans are in place to cater for prevention space needs as program continues to expand.</p>
<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	<p>5</p>	<p>6</p>

[Physical Space relates to planning and training with less emphasis on off-site Prevention activities]



**1. Is there a designated space for HIV Prevention services delivery if applicable?**

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 2.5 Demand Generation - [Domain 2. Area 4 - Score 1-2]*

**2. Is the space sufficient for providing specific HIV Prevention services if applicable?**

1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 2. 5 Demand Generation - [Domain 2. Area 4 - Score 3-4]*

**3. Is the available space sufficient to address the confidentiality issues of the clients where required? [*Consider for Visual and Audio Confidentiality*]**

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 2. 5 Demand Generation - [Domain 2. Area 4 - Score 5-6]*

**4. Is there a plan to meet client space needs in community / mobile service delivery including confidentiality?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 2. 5 Demand Generation - [Domain 2. Area 4 - Score 7-8]*

**5. Has an assessment been made to determine the space needs for service delivery as the HIV Prevention program grows?**

1] Yes → *Proceed to Question 2.5 Demand Generation - [Domain 2. Area 3 - Score 10]*

[2] No → *Proceed to Area 2. 5 Demand Generation - [Domain 2. Area 4 - Score 9]*

Domain 2.4. Score: \_\_\_\_\_

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

**Area 4**

<p><b>2.4 Demand Generation</b></p>	<p>The methods used by the ACU to encourage use of the HIV prevention services have specific actions related to the strategy/ approach for HIV</p>	<p>The audience has been stratified in line with the model and approach and a distinguishable demand generation methodology is in use for each strata. The timing and location is determined with community involvement.</p>	<p>The mobilization strategy and target population are well defined. The mobilization campaign covers all HIV prevention services covered by the site/ program.</p>	<p>There has been assessment(s) carried out to find out the best approaches in client mobilization.</p>	<p>There is a clear client mobilization strategy in place which addresses the target population needs. Strategy has been assessed for effectiveness and has generated the expected demand. This is well appreciated by the community and can be replicated in other programs.</p>
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	prevention.				
1	2	3	4	5	6
				7	8
					9
					10

**1. Is there any formal campaign to mobilize clients?**

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 2.6 Community Involvement - [Domain 2. Area 5 - Score 1-2]*

**2. Is there an ongoing campaign to mobilize clients with targets that involves the community? Are the target beneficiaries been clearly defined?**

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 2.3 Physical space - [Domain 2. Area 2 - Score 3-4]*

**3. Is the campaign covering all areas of HIV prevention including HIV counseling and testing and is it well understood by the staff?**

[1] Yes → *Proceed to Question 4*

[2] No → Proceed to Area 2.6 Community Involvement - [Domain 2. Area 5 - Score 5- 6]

**4. Has the community mobilization generated more demand and has an assessment been done to determine the impact of the mobilization activities.**

[1] Yes → Proceed to Question 5

[2] No → Proceed to Area 2.6 Community Involvement - [Domain 2. Area 5 - Score 7-8]

**5. Is the mobilization campaign model replicable to other HIV prevention programs?**

[1] Yes → Proceed to Question 2.3 [Domain 2. Area 2 - Score 10]

[2] No → Proceed to Area 2.6 Community Involvement - [Domain 2. Area 5 -Score 9]

Domain 2.5. Score: \_\_\_\_\_

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

**Area 5**

<b>2.5 Community Involvement</b>	<b>There is no interface with the community. The community does not participate in identifying the audiences for HIV prevention services</b>	<b>The community is partially involved in HIV prevention activities. There is minimum community input in HIV prevention activities.</b>	<b>The community is fully involved in planning prevention activities and interventions. The community participates in program review and there are village/grass root structures formed to support the HIV prevention services.</b>	<b>The community participates in planning and scheduling HIV prevention activities. The community receives feedback on mobilization, uptake of HIV prevention services and referral mechanisms.</b>	<b>The community participates in most prevention activities. There is grass root support for HIV prevention services. There is effective and well documented referral of clients to and from the community services.</b>
	<b>1 2</b>	<b>3 4</b>	<b>5 6</b>	<b>7 8</b>	<b>9 10</b>

**1. Are there forums where the ACU meets with the community to set priorities for intervention?**

*[Meetings with the community can be confirmed by looking at minutes or any documented evidence of meetings]*

[1] Yes → Proceed to Question 2

[2] No → *Proceed to Area 2.6 Referral Systems* - [Domain 2. Area 6 - Score 1-2]

**2. Is the community involved in designing HIV prevention activities?**

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 2. 6 Referral Systems* - [Domain 2. Area 6 - Score 3- 4]

**3. Is there a framework for the HIV prevention program to receive input from the community?**

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 2. 6 Referral Systems* - [Domain 2. Area 6 - Score 5-6]

**4. Is there a linkage between the ACU's BCC strategy and the community for the benefit of the target audience?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 2. 6 Referral Systems* - [Domain 2. Area 6 - Score 7-8]

**5. Is there a community linkage that is in support the HIV prevention interventions that can be used as a resource for other programs?**

[1] Yes → *Proceed to Question 2.5* [Domain 2. Area 6 - Score 10]

[2] No → *Proceed to Area 2.6 Referral systems* - [Domain 2. Area 6 - Score 9]

**Domain 2.6. Score: \_\_\_\_\_**

**DOMAIN 2: SERVICE DELIVERY AND QUALITY MANAGEMENT**

**Area 6**

<p><b>2.6 Referral systems</b></p>	<p><b>There are no referrals made for HIV prevention and other services not offered by the ACU and no list of other providers is available. Other providers not aware of services offered by the ACU.</b></p>	<p><b>There is a list of ACUs providing HIV prevention services but clients are not referred for services. There is no formal arrangement with the ACUs to refer clients.</b></p>	<p><b>Clients are referred for services and there is a formal referral arrangement with the referral ACUs.</b></p> <p><b>Referral documentation needs to be improved so that the ACU can determine if referrals were acted upon.</b></p>	<p><b>Clients are referred for services and there is a formal referral arrangement with the other providers.</b></p> <p><b>Referral documentation is available and able to capture all the referred clients and whether they accessed the services. Even with referrals, the ACU is still not able to cover all the HIV prevention components.</b></p>	<p><b>Clients are referred for other services and there is a formal referral arrangement with other providers. Referral documentation is available and able to capture all the referred clients and whether they accessed the services.</b></p>
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	1	2	3	4	5	6	7	8	9	10
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**1. Are there any referrals being done at the moment? Is there a database for all the ACUs providing HCT and related services in the area?**

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 3.1 Procurement Planning - [Domain 2. Area 7 - Score 1-2]*

**2. Are the other service providers aware of the HIV prevention services you provide and have they referred to you?**

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 3.1 Procurement Planning - [Domain 2. Area 7 - Score 3- 4]*

**3. Have referrals been made to providers of HCT services.** *[Look for referral notes, client return forms, list of other providers etc that show existence of a referral relationship]*

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 3.1 Procurement Planning - [Domain 2. Area 7 - Score 5- 6]*

**4. Is there documentation on the clients referred for HCT and means of verification of services received?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 3.1 Procurement Planning - [Domain 2. Area 7 - Score 7-8]*

**5. Is the referral network able to provide a complete HIV prevention/Care package according to National or PEPFAR guidelines**



[1] Yes → *Proceed to Question 3.1* [Domain 2. Area 5 - Score 10]

[2] No → *Proceed to Area 3.1 Procurement Planning* - [Domain 2. Area 6 - Score 9 ]

**Domain 2.7. Score:** \_\_\_\_\_

**Total Service delivery/ Management Services Points:** \_\_\_\_\_

**Domain Score (Total Service delivery/ Management Services Points / 7) :** \_\_\_\_\_



*[This should detail what, when, how the items to be procured during the work plan period so as to meet client and project needs]*

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 3.2: Commodity Management - [Domain 3. Area 1 – Score 1-2]

**2. Does the site have a reliable system for procurement and management of HIV prevention supplies and does it conform to US government and other standard guidelines?** *[Are they aware of the USG procedures? The Generally acceptable accounting practice should be the minimum]*

[1] Yes → Proceed to Question 3

[2] No → Proceed to Area 3.2: Commodity Management - [Domain 3. Area 1 – Score 3-4]

**3. Does the site have a quality assurance process for product availability and certification?**

[1] Yes → Proceed to Question 4

[2] No → Proceed to Area 3.2: Commodity Management - [Domain 3. Area 1 – Score 5-6]

**4. Does the site have a supply chain system in place that accommodates the specific requirements of an HIV prevention program?**

[1] Yes → Proceed to Question 5

[2] No → Proceed to Area 3.2: Commodity Management - [Domain 3. Area 1 – Score 7-8]

**5. Does the site have inventory management procedures sufficient to serve as a resource centre/training site?**

[1] Yes → Proceed to Question 3.2 [Domain 3. Area 1 – Score 10]

[2] No → Proceed to Area 3.2: Pharmacy Management - [Domain 3. Area 1 – Score 9]

**Domain 3.1 Score: \_\_\_\_\_**

**DOMAIN 3: SUPPLIES MANAGEMENT**

**Area 2**

<b>3.2 Commodity utilization (Storage and Utilization)</b>	<b>There is no designated area for storage of procured commodities.</b>	<b>There is a storage area but not sufficient for the commodities procured. The place needs improvement to meet safety standards. Materials are distributed to target audience (eg condoms/ age group).</b>	<b>There is a written quality assurance process and results are followed up.</b>	<b>There is a good inventory and logistics management system in place that takes care of fair forecasting.</b>	<b>The ACU has a comprehensive logistics and commodity management system and best practice of utilizing the system.</b>				
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>

**1. Does the program have a designated supplies storage area?** *[Secure and lockable room where items are kept]*

[1] Yes → *Proceed to Question 2*

[2] No → *Proceed to Area 4.1: HMIS - [Domain 3. Area 2 – Score 1-2]*

**2. Is the storage area appropriate and meets safety standards for the storage of HIV prevention supplies?**

*[The minimum that the place is not damp, well ventilated, free from rodents, well maintained, clean, roof not leaking, firm floor, etc]*

[1] Yes → Proceed to Question 3

[2] No → Proceed to Area 4.1: HMIS - [Domain 3. Area 2 – Score 3-4]

**3. Is there a framework for proper storage and management of the prevention supplies?**

[1] Yes → Proceed to Question 4

[2] No → Proceed to Area 4.1: HMIS - [Domain 3. Area 2 – Score 5-6]

**4. Does the program have inventory management guidelines?**

[1] Yes → Proceed to Question 5

[2] No → Proceed to Area 4.1: HMIS - [Domain 3. Area 2 – Score 7-8]

**5. Does the program have the ability to serve as a resource/training site?**

[1] Yes → Proceed to Area 4.1: HMIS - [Domain 3. Area 2 – Score 10]

[2] No → Proceed to Area 5.2: Pharmacy Management - [Domain 3. Area 2 – Score 9]

Domain 3.2 Score: \_\_\_\_\_

*Total Supplies Management and Quality Assurance Points:* \_\_\_\_\_

Domain Score (Total Supplies Management and Quality Assurance Points / 2): \_\_\_\_\_

**DOMAIN 4: Data Collection , Data Compilation and Analysis, Decision Making and Feedback Systems**

**Area 1**

<b>4.1 Data Collection</b>	<b>Have documented data collection procedures at all levels and procedures that ensure unique client identification, if relevant.</b>	<b>There are data collection tools at the various levels within the ACU for service delivery points. Tools have been reviewed to include necessary management, national and PEPFAR indicators.</b>	<b>Data collection tools have been standardized to collect management, national and PEPFAR data across sub-partners and service delivery points. This oversight clearly documented in MoUs with sub-partners. The staff and community involved in data collection have been adequately trained and supervised in the use of the tools.</b>	<b>There is a documented procedures for data transmission (data flow plan).</b>	<b>Has a data collection system that contributes to program implementation and review that may be utilized as a resource for other programs.</b>
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9</b>

**1. Does the ACU have a documented procedure<sup>1</sup> to guide data collection at various levels including Unique Client identification<sup>2</sup>?**

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 4.2 Data Quality Improvement and assurance - [Domain 4. Area 1 - Score 1-2]

<sup>1</sup> There is a list of operational definitions of what is being counted for each indicator (e.g., what constitutes receiving a service), All groups delivering services use standardized or compatible data-collection forms and there are designated staff responsible for the review and validation prior to submission to the next level

<sup>2</sup> The reporting system avoids double counting (when an individual receiving identical or related services from the same group is improperly counted more than once);

**2. Does the ACU have tools for collecting data at the various levels<sup>3</sup> in line with management and PEPFAR indicators?**

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 4.2 Data Quality Improvement and assurance - [Domain 4. Area 1 - Score 3- 4]*

**3. Has the ACU standardized Data collection tools at various levels including Anti Aids Clubs if applicable?**

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 4. 2 Data Quality Improvement and assurance - [Domain 4. Area 1 - Score 5-6]*

**4. Does the ACU have documented procedures for data transmission (Data flow Plan) to and from various levels?**

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 4.2 Data Quality Improvement and assurance - [Domain 4. Area 1 - Score 7-8]*

**5. Does the ACU have an operational data collection system that contributes to program implementation and review that may be utilized as a resource for other programs?**

[1] Yes → *Proceed to 4.2 Data Quality Improvement and Assurance - [Domain 4. Area 1 Score 10]*

[2] No → *Proceed to Area 4.2 Data Quality Improvement and assurance - [Domain 4. Area 1 - Score 9]*

**Domain 4.1 Score: \_\_\_\_\_**

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<sup>3</sup> Various levels refers to household, community, sub county, district, regional and head office level

**DOMAIN 4: Data Collection, Data Compilation and Analysis, Decision Making and Feedback Systems**

**Area 2**

<p><b>4.2 Data Quality Assurance and Improvement</b></p>	<p>The ACU has identified requirements for having data quality assurance processes in place.</p>	<p>The ACU has identified a strategy to address gaps in data.</p>	<p>The ACU has been able to address gaps in data, and has capacity for data management tasks.</p>	<p>The ACU has identified a feedback mechanism and a system to routinely assess quality of data collected and its relevance to assess service delivery.</p>	<p>The ACU has established a data quality management system and identified quality indicators for routine assessment. Team process to develop interventions and plans for assessment of impact; engages stakeholders as contributors and beneficiaries. Can serve as a resource for other programs.</p>
	<p><b>1</b></p>	<p><b>3</b></p>	<p><b>5</b></p>	<p><b>7</b></p>	<p><b>9</b> <span style="float: right;"><b>10</b></span></p>

**1. Has the ACU identified data requirements for decision making?**

[1] Yes → *Proceed to Question 2*



[2] No → *Proceed to Area 4.3 Evaluation - [Domain 4. Area 2 - Score 1-2]*

**2. Has the ACU identified gaps in current data collected?** [*Gaps refers to inadequate data or the missing link between data and the decisions to be taken e.g. decision to procure consumables*]

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 4.3 Evaluation - [Domain 4. Area 2 - Score 3-4]*

**3. Does the ACU have the capacity for data management tasks?** [*tasks like excel format conversions, data cleaning, data aggregation and analysis*]

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 4.3 Evaluation - [Domain 4. Area 2 - Score 5-6]*

**4. Has the ACU identified a feedback mechanism (including all stakeholders) and a system to routinely assess quality in critical areas of service delivery?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 4.3 Evaluation - [Domain 4. Area 2 - Score 7-8]*

**5. Does the ACU have an operational data quality management system that actively engages stakeholders and can be used as a resource for other programs?**

[1] Yes → *Proceed to Area 4.3 Evaluation [Domain 4. Area 2- Score 10]*

[2] No → *Proceed to Area 4.3 Evaluation - [Domain 4. Area 2 - Score 9]*

Domain 4.2 Score: \_\_\_\_\_

<b>DOMAIN 4: Data collection, Data Compilation and Analysis, Decision Making and Feedback Systems</b>					
<b>Area 3</b>					
<b>4.3 Data for Decision Making</b>	<b>The ACU has historical (or baseline) data against which reports can be compared to help in decision making.</b>	<b>There is a process for comparison of achievements against goals and past progress that results in plans to modify action or approach/ tools.</b>	<b>The management and staff follow a procedure of time-bound corrective action and tracking achievements against plans in all areas of the intervention.</b>	<b>The current approach to implementation or the referral, community or demand generation activities reflect greater effectiveness arising from data used for decision making.</b>	<b>The data collected and analysed within the ACU is provided to stakeholders and partners in providing comprehensive HIV care. Plans of external partners are modified with reference to data collected and reported by this ACU.</b>
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9 10</b>

**1. Does the ACU have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation?**

[1] Yes → *Proceed to Question 2*

[2] No → Proceed to Area 4.4 Feedback and Sharing - [Domain 4. Area 3 - Score 1-2]

**2. Does the ACU have a process to compare current information to expectations or past status? [There should be a mechanism of triangulation of data sources for comparison]**

[1] Yes → *Proceed to Question 3*

[2] No → Proceed to Area 4.4 Feedback and Sharing - [Domain 4. Area 3 - Score 3-4]

**3. Does the ACU have staff who regularly evaluate their performance and the organisation's achievements using data?**

[1] Yes → *Proceed to Question 4*

[2] No → Proceed to Area 4.4 Feedback and Sharing - [Domain 4. Area 3 - Score 5-6]

**4. Does the ACU have records of management and other meetings reflecting that data interpretation affects implementation plans?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 4.4 Feedback and Sharing - [Domain 4. Area 3 - Score 7-8]*

**5. Does the ACU have sufficiently strong data interpretation and application systems that other stakeholders rely upon it?**

[1] Yes → *Proceed to Area 4.4 Feedback and Sharing - [Domain 4. Area 4 - Score 10]*

[2] No → *Proceed to Area 4.4 Feedback and Sharing* - [Domain 4. Area 3 - Score 9]

**Domain 4.3 Score:** \_\_\_\_\_

**DOMAIN 4: Data collection , Data Compilation and Analysis, Decision Making and Feedback Systems**

**Area 4**

<p><b>4.4 Feedback and Sharing</b></p>	<p>The data collected and reports made are not shared outside the ACU.</p>	<p>The data collection and analysis is used to inform non-data members of the implementation team and the community, if relevant.</p>	<p>Feedback on data collected and findings is made to all stakeholders. Summarised and period reports are made to outside parties by way of success stories.</p>	<p>Examples exist of external organisations referring to in reports or changing their plans of implementation due to information shared by the ACU.</p>	<p>The data and findings of the ACU is recognized in national reports and relevant journals. The data is applicable for comparison to national and PEPFAR measures and best practices and lessons are shared with other practitioners.</p>
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9</b>

**1. Does the ACU have reports from data collection that are provided to external parties?**

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 1-2]

**2. Does the system use data to inform the wider implementation team (not only to correct the collection of data)?**

[1] Yes → Proceed to Question 3

[2] No → Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 3-4]

**3. Does the ACU provide performance reports to all stakeholders within and external to the ACU including the community?**

[1] Yes → *Proceed to Question 4*

[2] No → Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 5-6]

**4. Do implementation partners utilize the information from the ACU to guide and improve their comprehensive care programmes?**

[1] Yes → *Proceed to Question 5*

[2] No → Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 7-8]

**5. Is the ACU's data recognized as reliable and a source of planning and strategic information for HIV/AIDS and best practices?**

[1] Yes → *Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 10]*

[2] No → Proceed to Area 5.1: Human Resource Capacity - [Domain 5. Area 4 - Score 9]

Domain 4.4 Score: \_\_\_\_\_ Total Data Collection, Data Compilation and Analysis, Decision Making and Feedback Systems :  
\_\_\_\_\_

Data Collection, Data Compilation and Analysis, Decision Making and Feedback Systems Points / 4) : \_\_\_\_\_

**DOMAIN 4: [Evaluation of Intervention] Post Event**

<b>Area 5</b>					
<b>4.5 Evaluation</b>	<b>The ACU has baseline information for the technical area or baseline values will be available during the first 12 months of the program.</b>	<b>The ACU has baseline values for all indicators OR baseline values will be available for all indicators (with date of collection and data source).</b>	<b>There is a mechanism for triangulation of data sources for comparison. Staff have skills in data triangulation, analysis and sampling methodology (or there is a partnership arrangement with external evaluators).</b>	<b>There is a budget linked to evaluation. The ACU has adequate capacity for evaluation.</b>	<b>The ACU has staff with skills in data triangulation, analysis and sampling methodology or partnership arrangement for external evaluators. There is a budget linked to evaluation. The outcome/impact indicators are SMART. Identical/similar data sources to measure indicators at baseline and follow-up.</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
	<b>7</b>	<b>9</b>	<b>10</b>		

**1. Does the ACU have baseline information or a plan to conduct a baseline for the technical area in the first year of implementation?**

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 5.1 Staffing Needs- [Domain 4. Area 5 - Score 1-2]

**2. Does the ACU have baseline values available for all indicators with date of collection and data source? *[There should be a mechanism of triangulation of data sources for comparison]***

[1] Yes → *Proceed to Question 3*

[2] No → Proceed to Area 5.1 Staffing Needs- [Domain 4. Area 5 - Score 3-4]

**3. Does the ACU have staffs skilled in data triangulation, analysis and sampling methodology?**

[1] Yes → *Proceed to Question 4*

[2] No → Proceed to Area 5.1 Staffing Needs- [Domain 4. Area 5 - Score 5-6]

**4. Does the ACU have a budget line for Evaluation?**

[1] Yes → *Proceed to Question 5*

[2] No → *Proceed to Area 5.1 Staffing Needs-* [Domain 4. Area 5 - Score 7-8]

**5. Does the ACU have SMART outcome and impact indicators with same data source to measure at baseline and follow up?**

[1] Yes → *Proceed to Area 5.1 Staffing Needs-* [Domain 4. Area 5 - Score 10]

[2] No → *Proceed to Area 5.1 Staffing Needs-* [Domain 4. Area 5 - Score 9]

Domain 4.5 Score: \_\_\_\_\_ Evaluation Score determined for USAID funded entities only.



**DOMAIN 5: HUMAN RESOURCE CAPACITY**

<b>Area 1</b>					
<b>5.1 Staffing Needs</b>  [Who is needed, count and grades, is the organogram written and fully staffed?] What about community POLs?	Has identified the program staff requirements and has capacity to fill them.	Vacancies have been filled with suitable staff and the program has the capacity to maintain the staffing but has insufficient resources to meet new staff needs.	Vacancies have been filled with qualified staff who have the correct training and experience to maintain the current program and is able to cater for the staffing needs as the program grows.	Vacancies have been filled with qualified staff who have the skills, experience and training to maintain the current program, is able to cater for the staffing needs as the program grows. Has a written and defined manpower forecast plan.	The site is staffed according to program requirements and is able to cater for staff needs as the program grows and the staffing model can be used as a resource for other programs.
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9</b>

**1. Please select the option that best describes the program staffing situation:**

[1] The ACU has identified program staff requirements but has no capacity to fill them → Proceed to Area 5.2: Training – [Domain 5. Area 1 – Score 1]

[2] The ACU has identified the program staff requirements and has capacity to fill them → *Proceed to Question 2 Area 1 – Score 2*

**2. Does the ACU have the capacity to maintain staff needs?** *[Capacity refers to skills, experience, resources, processes, mechanisms and structures that support the ACU. Needs refer to whether the available staff meet the requirements of the project]*

[1] Yes → *Proceed to Question 3*

[2] No → *Proceed to Area 5.2: Training and Skills Development* – [Domain 5. Area 1 – Score 3-4]

**3. Does the ACU have the capacity to cater for the staffing needs as the program grows?**

[1] Yes → *Proceed to Question 4*

[2] No → *Proceed to Area 5.2: Training and Skills Development* – [Domain 5. Area 1 – Score 5-6]

**4. Please select the option that best describes the ACU’s outline for staffing needs:**

[1] ACU has the skills, experience and training to maintain the program **but** has no written manpower forecasting plan. → *Proceed to Area 5.2: Training* – [Domain 5. Area 1 – Score 7]

[2] ACU has the skills, experience and training to maintain and expand the current program and has a written manpower forecast plan<sup>4</sup> → *Proceed to Question 5* [Domain 5. Area 1 – Score 8]

**5. Can the ACU’s staffing model be used as a resource for other programs** [*At this stage there should be a review of the skills of the ACU against the requirements of introducing new programs so one can establish the gaps and start working on how the gaps maybe closed*]

[1] Yes → *Proceed to Area 5.2: Training and Skills Development* [Domain 5. Area 1 – Score 10]

[2] No → *Proceed to Area 5.2: Training and Skills Development* [Domain 5. Area 1 – Score 9]

**Domain 5.1 Score:** \_\_\_\_\_

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<sup>4</sup> There should be an assessment of what the future needs are at this point so that recruitment is catering for future needs in mind, specifically referring to staff-client ratio and availability of the different types of cadre required.

## DOMAIN 5: HUMAN RESOURCE CAPACITY

### Area 2

<b>5.2 Training and Skills Development</b>	<b>The staff have been trained in accordance with the SOP.</b>	<b>Staff and other implementers have been trained in the SOP and are aware of related implementation and referral issues. There is evidence of the SOP training being implemented.</b>	<b>Staff and implementers have been assessed and where needed have received ‘soft skills’ training including engagement, supervision, planning, community involvement, etc. New skills are assessed for appropriate use/accuracy.</b>	<b>The implementation team are updated and given refreshers on technical and support topics. They are training the wider community with similar skills (eg ToT) and there is evidence of the skills being applied and that they improve the implementation.</b>	<b>The ACU is recognised as a mentoring site for other practitioners to second staff for training and on the job experience.</b>
	<b>1</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>9 10</b>

**1. Has the ACU trained its implementation staff in the selected SOP and related data and management processes?**

[1] Yes → Proceed to Question 2

[2] No → Proceed to Area 6.1: Laboratory Procedures and Capacity - [Domain 5. Area 2 – Score 1- 2]

**2. Have staff received program specific training on related services that is linked to the selected SOP (eg demand generation, referrals, community)?**

[1] Yes → *Proceed to Question 3*

[2] No → Proceed to Area 6.1: Laboratory Procedures and Capacity - [Domain 5. Area 2 – Score 3-4]

**3. Have program staff been evaluated for the non-SOP and related skills that they require and been provided with appropriate training; and use it?**

[1] Yes → Proceed to Question 4

[2] No → Proceed to Area 6.1: Laboratory Procedures and Capacity - [Domain 5. Area 2 – Score 5-6]

**4. Are program staff able to train, coach and mentor other implementers and stakeholders to meet growing program needs?**

[1] Yes → Proceed to Question 5

[2] No → Proceed to Area 6.1: Laboratory Procedures and Capacity - [Domain 5. Area 2 – Score 7-8]

**5. Does the ACU have staff training and skills development that can be used a resource for other ACUs?**

[1] Yes → Proceed to Question 5.3: [Domain 5. Area 2 – Score 10]

[2] No → Proceed to Area 6.1: Laboratory Procedures and Capacity - [Domain 5. Area 2 – Score 9]

**Domain 5.2 Score: \_\_\_\_\_**

**Total Human Resource Points:** \_\_\_\_\_

**Human Resource Domain Score (Total Human Resource Points / 2):** \_\_\_\_\_