



EVALUATION AND BENCHMARKING

FOR ACCELERATING EMPOWERMENT AMONG
RURAL WOMEN TO IMPROVE QUALITY LIVES,
SURVIVAL AND COPING WITH HIV



WORKING WITH
WOMEN LIVING WITH
HIV AND POPULATIONS
AFFECTED BY HIV



INVESTING IN
SUSTAINABLE SOLUTIONS
FOR RURAL WOMEN
LIVING WITH HIV



STRENGTHENING AND
PROMOTING RURAL
HEALTH SERVICES

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OBONYO GORDON, DR | URBANVIEW CONSULTING



About the Project and the Baseline Assessment

This is the report for baseline study and development of evaluation design for the Project: “Descent Care Program”. The project seeks to ensure that:

1. 200 young women and their children in Koderia, East Gem and East Kabondo in Rangwe Sub-County have improved coping mechanisms for HIV infection and report Positive Test Results
2. 400 young women and their children living with HIV in East gem and East Kabondo locations in Rangwe Sub-county reporting improved quality of life and survival with HIV
3. Institutional capacity and programming is strengthened in selected areas of project monitoring & evaluation, learning and documentation for more effective and efficient delivery of its services to the community
4. Durable solutions decision making processes at County and Sub-County level are informed by knowledge and evidence generated by RUNELD (policies and programing processes)

The study was conducted in three (3) locations in Rangwe Sub-County of Homabay County in Western Kenya. The localities are **Koderia, East Kabondo**, and **East Gem** in Rangwe Sub-County. They represent the main areas most affected within Homa Bay County and are therefore, accordingly, the sites where the Descent Care Program will be implemented, targeting the affected populations.

The Context

The study was conducted in a context of constantly changing clan dynamics and vicious stigmatization of HIV related issues in addition to limited resources for young mothers living with HIV. Women in Kenya face discrimination in terms of access to education, employment and healthcare. As a result, men often dominate sexual relationships, with women not always able to practice safer sex even when they know the risks. For example, in 2014, 35% of adult women (aged 15-49) who were or had been married had experienced spousal violence and 14% had experienced sexual violence. These social conditions continue to put young women living with HIV at risk.

According to Kenya Aids Response Progress Report 2016 Knowledge of HIV prevention among young people is increasing. In the 2008 KHDS, 48% of young women and 55% of young men demonstrated adequate knowledge of HIV prevention, compared to 73% of young women and 82% of young men in 2014. Empirically, it's evident that men tend to have more knowledge on HIV related issues compared to women who are the most affected.

Even with the many efforts that Organizations like RUNELD have tried to implement to reduce infections and increase access to information and services, teaching young people about HIV and sexual health remains controversial. KDHS 2014 found 40% of adults were against educating young people about condoms. Many cited fear of encouraging young people to have sex as a reason. RUNELD intends to change this and seeks to encourage women to test for HIV, adhere to drugs, take nutritional supplements, have access to friendly counseling services and where possible have improved income to boost their financial capacities. The rural communities which the beneficiaries come from present a picture of a mix formal and informal power structures, formal and informal economic activities, and formal and informal local authorities, creating challenges to formal politics and access to friendly health services.

Study Approach

A mixed-methods approach integrating both participatory qualitative and quantitative techniques was adopted for this baseline study. The methods included literature review, key informant interviews, Focus Group Discussions and a Household sample survey. While quantitative tools were useful in establishing baseline numerical values for the various outcomes and outputs as indicated in the program's logical framework, qualitative feedback from key stakeholders was critical in deepening the understanding of the operational space and clarifying essential causal relationships in aspects of the program. Qualitative approaches were equally used to triangulate findings that evidently required additional information.

The Household sample survey was a key element of the methodology, and it provided the primary means of collecting quantitative information on the key indicators in the population of interest. In order to elicit sufficient responses, the survey questions were carefully crafted drawing from the outline of Program outcomes, and outputs and their causal linkages. A total of 80 households participated in the survey.

The study area included three (3) localities in Rangwe Sub-County. The localities are **Kodera, East Kabondo** and East **Gem** in Homa Bay County. These are localities where the Descent Care Program will be implemented targeting young women living with HIV.



1.1. Population and Socio-economic Situation

Over the years, stigmatization, low levels of education and inadequate access to accurate HIV related information, service delivery and social support systems has had an impact on young women living with HIV in Homa Bay. A large segment of the population is without access to basic quality and timely health (due to delays in health provision, distance and inadequate drugs within the accessible health facilities), education services and other social services with complete absence of some higher-level services in many rural areas.

Access to basic services such as water and sanitation, healthcare, education and shelter though available are sometimes restricted in Rangwe based on the level of income and ability to pay for services. Access to quality healthcare for women living with HIV is extremely limited with the majority of services being provided by selected higher level facilities supported by NGOs which in most cases are not close to the targeted end user.

Widespread stigma and discrimination against people living with HIV can adversely affect people's willingness to be tested and their adherence to antiretroviral therapy (KDHS, 2014). The survey revealed that 26% of women and 46% of men in the age group 15-49 expressed accepting attitudes towards people living with HIV. Whereas the percentages are comparable to the national averages, there is still need for more anti-stigma messages in the county in order to encourage more people to know their HIV status and improve adherence to treatment among HIV-infected persons¹

¹Kenya HIV County Profiles 2016

1.2. Purpose of the DCP Evaluation Design and Baseline Study

This study covered the geographical areas of Koderera, East Kabondo, and East Gem of Homa Bay County. It had two core components of the Evaluation Design and the Baseline Study and focused on generating information on key thematic aspects some of which include; *Gender integration, Community and civil society engagement, Representation and transparency, community driven approaches, Use of Nutritional Supplements for People living with HIV, Strengthening of referral mechanisms, Coping mechanisms, Disaggregated Program impact, Psychosocial support, Durable solutions framework, Measurable results and changes, Research Monitoring Evaluation and learning, Stakeholder Management, Impact Sustainability, Health Services provision, and Inclusivity (involvement of men).*

In particular, the study had three distinct objectives;

- **To prepare an evaluation design for the project incorporating a baseline, mid-term and impact evaluation.**
- **To assess measurability and suitability of project indicators within the context of the intervention areas and provide recommendations;**
- **To establish baseline values for the project indicators (outcome) level and recommend any adjustments based on the findings of the baseline study.**

1.3. Limitations of Study

Attribution of Impact: The design of this baseline study did not consider the need to gather information from a control group, which then means that the best chance for RUNELD-KENYA to establish attribution of impact would be through a longitudinal study. The reality within the DCP's environment is that there are other players with competing or complementing interventions and whose contribution to changes to the target households over time may or may not be significant. **A longitudinal Study will require the establishment of a case management module that identifies and tracks specific attributes of study respondents/beneficiaries over the entire period of the program.**

Outcome vs Output Level Base Values: The study design gave prominence to outcome indicators due to the need to focus on changes in the households of the targeted population, and the improvements of support systems. Output indicators are predominantly activity oriented and are used to measure process related elements (read implementation level results), rather than to capture changes in practice, or improvements in livelihood for target households (read population level results). It is therefore inferred that Outcome level baseline values have been given prominence over output level baseline values – in accordance with industry practice for baseline surveys on population-based programs. Nonetheless, **the study has provided baseline values for both Outcome and Output Indicators, but detailed descriptive narratives have only been presented for the respective Outcome Areas.** That said, for indicators for which numeric values were challenging to obtain, the study has considered the use of qualitative/descriptive measurements.

Terrain and poor communication network: The area targeted with the study had poor mobile communication network and some selected areas for the study had challenges with GPS data collection. Additionally, the terrain and poor road network in the rural villages of the targeted population delayed the start of data collection since the study team had to travel and sometimes walk to some specific households. The low level of funding for the study might have influenced the results. In some communities like Koderu where the households are more than 5km apart the respondents had to be invited to a central point since the cost of transport could have been higher. This could have influenced the results of the survey. Other factors that posed challenges to coordination include concerns over incidences of target groups having meetings during the time of data collection that may have influenced results, although this cannot be verified.



3.

THE BASELINE

1. Should be role Model
2. Must be faithful
3. Should Love everyone.
4. Must be Patient.
5. Must keep time
6. Must keep secret

3.1. STUDY DESIGN

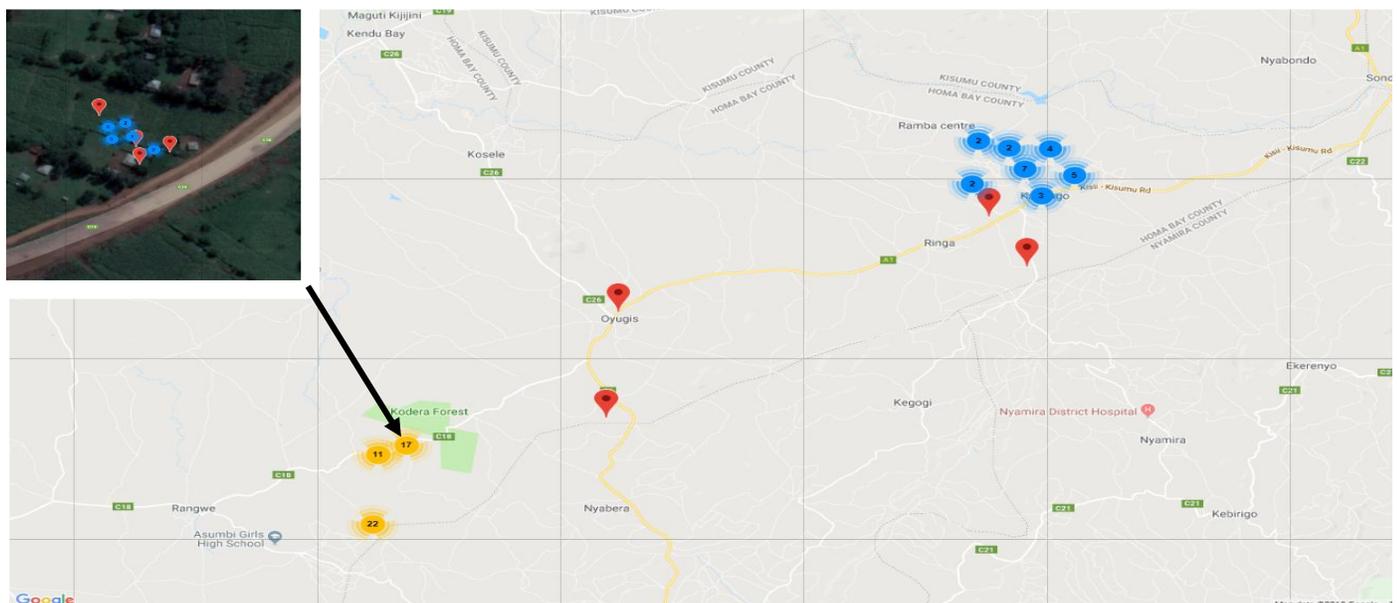
3.1.1. Approach

A mixed-methods approach integrating both participatory qualitative and quantitative techniques was adopted for this baseline study. While quantitative tools were useful in establishing baseline numerical values for the various outcomes and outputs as indicated in the program's logical framework, qualitative feedback from key stakeholders was critical in deepening the understanding of the operational space and clarifying essential causal relationships in aspects of the program. Qualitative approaches were equally used to triangulate findings that evidently required additional information.

The design adopted both 'project theory modelling' and contextual analysis to interrogate DCP's underlying logic, the processes through which it intended to produce changes, how the changes would be measured and anticipated contextual/systemic factors that may lead to variations in outcomes, and which should be considered as risk or catalytic factors.

3.1.2. Study Sites

The study area included three (3) localities in Rangwe. The localities are **East Kabondo**, **Kodera**, and **East Gem**. The maps in the sections below show the exact locations of the settlements covered by the study. The geographical impression has been generated by GIS codes of the respondent households as picked up by data collection devices. One will notice a few outlier households, which is explained by the fact that there were select instances of delays in uploading of location data - due to unreliability of internet connectivity. As is evident, these incidences were nominal and had little bearing on the quality of data gathered from the households, nor that of the overall data collection process.



3.1.3. Data Collection and Stakeholder Participation

The study applied the following data collection methods and tools;

- a) **Detailed Documents and Literature Review:** In appreciation of the large relevant body of evidence that already exists, the consultant identified key documents for review. These documents were identified based on their usefulness in helping the study to understand; the demographic trends, behavioral tendencies of the intended target population, the operational environment/systemic gaps and opportunities, the strategic pathway and the institutional arrangements for implementation.

These documents included (but were not limited to); program proposals, monitoring frameworks, select survey reports, periodic operations report, workshop and training reports, strategic emails that give program direction, and monitoring and evaluation documents. The documents were reviewed in relation to the three outcome areas of the DCP to ensure consistency and appropriateness of DCP indicators and their measurements.

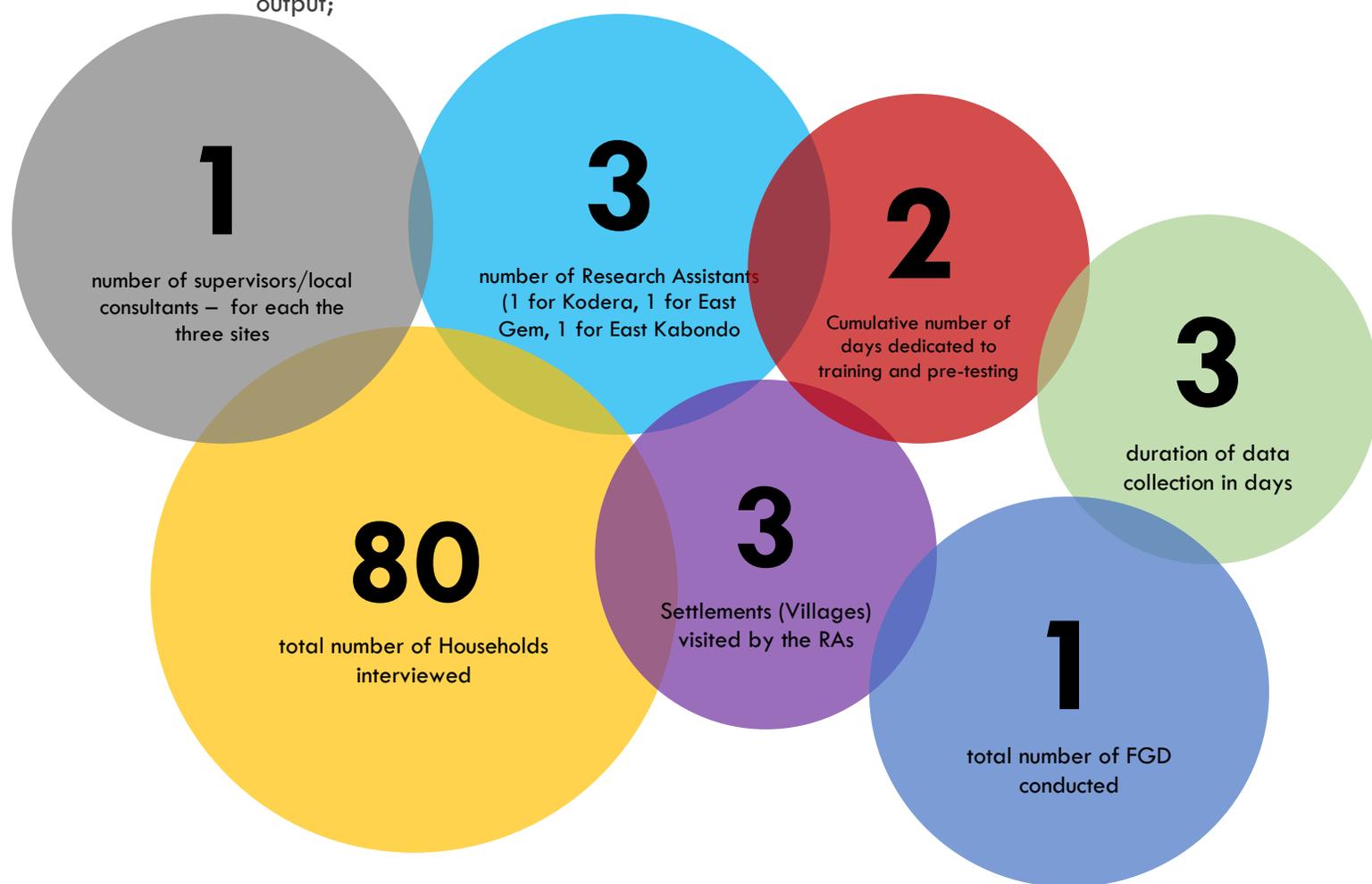
In addition, the desk review extended to include a wide range of technical documents like KAIS, KDHS and KACP. It was critical that the intervention be appropriately contextualized to establish relevance, intended scope and focus, scale, and interests.

- b) **Focused Group Discussions:** FGDs were conducted with beneficiaries in the various targeted population and were mostly women living with HIV. The issues of discussion were drawn from the outcome areas framed using the 3 indicators. Only one FGD was conducted in the that consisted of women living with HIV from East Kabondo and Kodera.

The FGD was conducted by the local consultant in order to capture nuanced inferences and reduce the burden of transcription. Given the constraints of time, technical resources and generative nature of women living with HIV small group dynamics study set up FGD of 8 persons, and standard FGD practice procedures were used during the discussions. The FGD was based on geographical considerations and age-groups.

Household Survey: Household interviews were a major method of collecting quantitative data as they provided the primary means of collecting quantitative information on the key indicators at the population level. In order to elicit sufficient responses, the survey questions were carefully crafted drawing from the outline of Program outcomes, and outputs and their causal linkages. A total of 72 households participated in the survey – distributed as indicated in the section below.

The Venn diagram below is an illustration of key study figures as factors of baseline output;



3.1.4. Sampling and Coverage

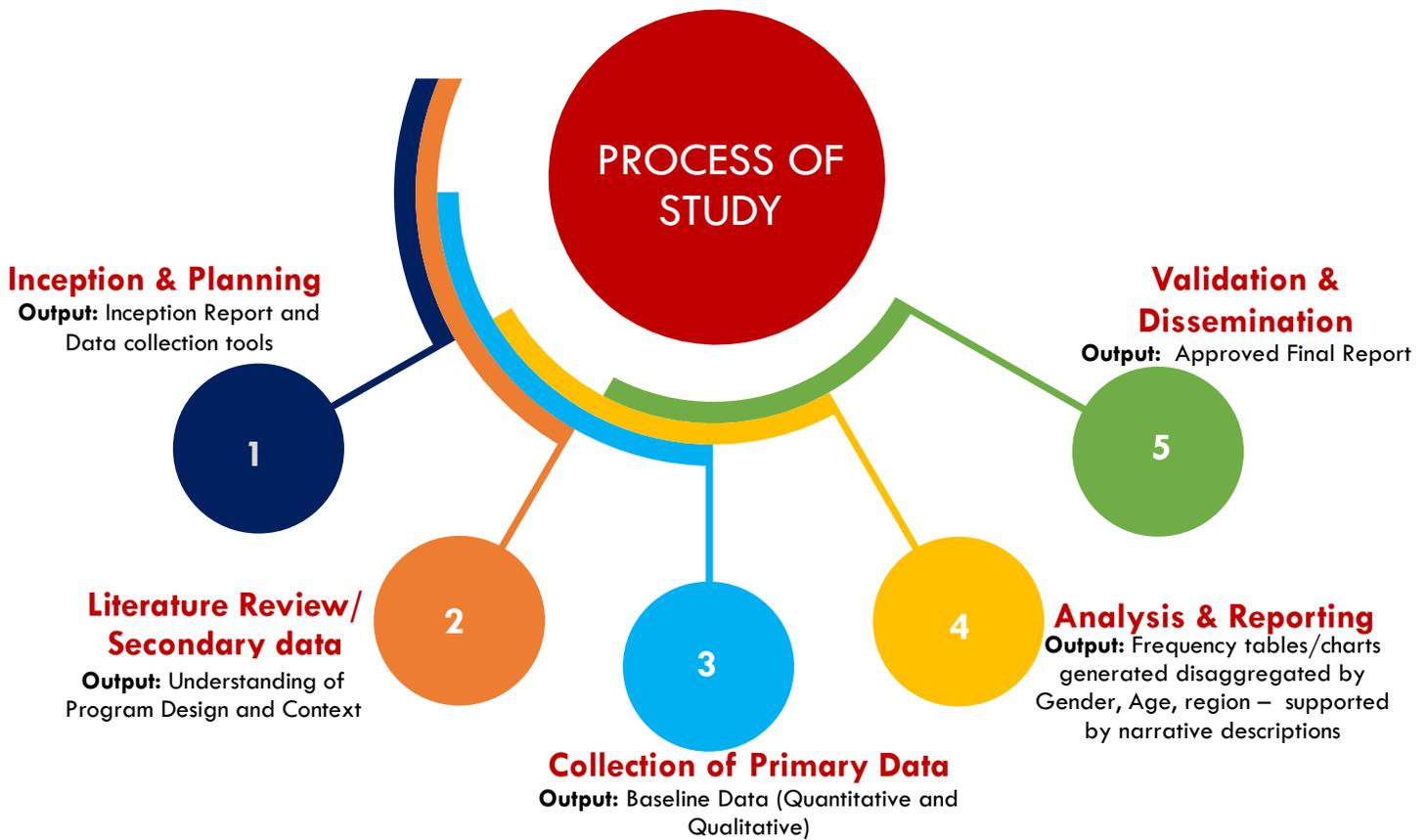
The DCP has factored a targeting scope that covers young women living with HIV and Care givers of children living with HIV. The baseline survey sampling distribution was therefore informed by this and the intended accessible population in the three targeted locations.

The study covered proportionately the targeted households in Koderia, East Kabondo and East Gem in Homa Bay County. Using the household as a primary sampling unit, a stratified random sampling technique was used to select targeted beneficiary households for interviews. The beneficiaries were randomly sampled from all the project sites using a pre-developed list. Considering a target of 90 households, a confidence level of 90%, a confidence interval of 5%, the sample size was calculated as (using an online sample size calculator - www.macorr.com). An additional 10% insurance factor was considered bringing the total questionnaires to **73+ 10% IF = 80 Households.**

This number was proportionately distributed to the 3 locations. A list of beneficiary Households was then used to randomize the required number of households. A household questionnaire transcribed into an Android based software (Survey CTO) was used to gather data from the sampled households. The evaluation utilized GIS technology to locate project beneficiaries for the purpose of capturing demographic and behavioral trends. - A copy of questionnaire is included in ***Annex I (Household Survey Tool)***.

3.1.5. Summary of Process

The baseline study process is best presented by the diagram indicated below - details of which have been discussed in various sections above.



3.2. STUDY FINDINGS

3.2.1. Quality of Program Design

- a) **Background checks and Feasibility tests:-** It was evident that a rigorous context and needs analysis was conducted and factored in the design of the proposed program activities. This baseline study considers the proper use of contextual information as good practice that should be sustained within RUNELD-KENYA. It must however be noted that in the absence of a project feasibility study, the organization relied on lessons drawn from the previous phases implemented in the same locations, and the depth of their understanding of the operational context and were properly guided by well-established frameworks provided by the Ministry of Health (MoH) and National Aids Control Council (NACC). **Put together, this understanding of the contextual challenges facing populations living with HIV, and the guidelines provided by the Frameworks, informed the choice of outcomes, activities and performance indicators.**

The design thus relied on tested and proven solutions to address issues affecting young women and children living with HIV and consolidated gains from past/on-going similar actions to propose a set of interventions that will contribute to improved livelihood options for the target populations. **Commendably, this baseline study is yet another deliberate effort/opportunity to quantify critical indicators that will be used to measure the exact changes at both population and systemic levels.**It generates additional knowledge on the indicators and outcome areas, with the purpose being to strengthen the delivery of DCP interventions. In this way, **the baseline study adds to the quality and fluidity of program design.**

However, considering the rapidly changing environment in implementation of HIV programs across the world, **precautions must be taken to ensure that monitoring data is gathered with absolute fidelity and that such data is continuously analysed and utilised to inform project management** – including the need for a review (should that be a necessary response to an emerging scenario).

- b) **Quality of Intervention Logic (the Theory of Change)**—there is need for internal logic for DCP with the goal, expected outcomes, and outputs having very clear causal linkages. **The**

potential for selected activities to create the changes envisaged should be evident in outcomes - to the extent that internal mechanisms of implementation should remain efficient, and external factors do not change rapidly over the life of the program. Based on opinions of community level stakeholders interviewed (through FGD) during the baseline, the proposed actions of the project should reflect contextual realities and should be in line with the needs of the target populations.

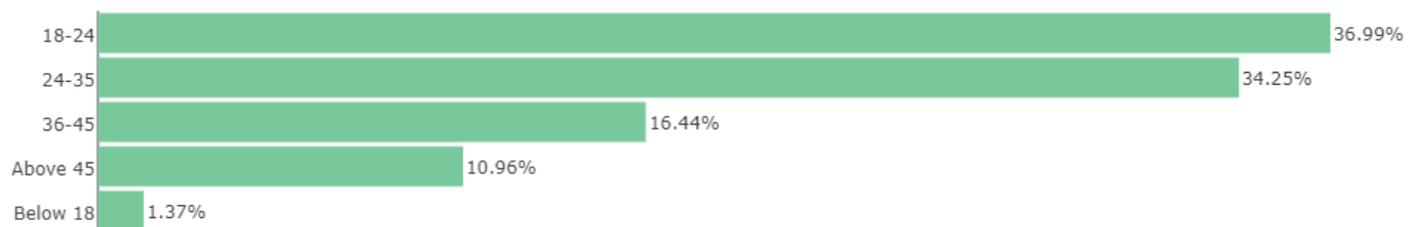
That said, there is an opportunity to develop the ToC to improve the realignment of indicators for avoidance of double reporting and for better output-outcome association. For example; Livelihood related output indicators could easily be placed under a single outcome for which they best realign, rather than have them captured under numerous outcome areas. **In theory and in practice, indicators (at whatever level) should be unidimensional, which means they should measure only a single variable at a time. However, there are instances in the DCP log frame where indicators measure multiple variables. This may create challenges in setting performance targets and has potential to reduce the prominence of certain outputs.**For example; *“% of target population who are able to achieve an adequate standard of living and survival in relation to access to reliable source of income, psychosocial support services and nutrition”*. In this instance, it would be advisable to have distinct indicators that separately describe the direction of change for income, for psychosocial support, and for nutrition – of course at the risk of having too many indicators, but with the guarantee of gathering evidence effectively.

- c) **Monitoring, Evaluation and Coordination**— RUNELD has sufficient capacity for management level monitoring and evaluation, and the project indicators are sufficient (save for a few realignments as recommended in 2.2.1(b) above. Activity-based monitoring is recommended as it is less prone to inconsistencies considering progress data would be summarized quarterly to capture changes in project indicators. **This study recommends the development of a Performance Monitoring Plan a practical tool to guide and provide detailed descriptions to field teams on the nature of data to be collected, the frequency with which such data should be collected, how it is to be collected (tools), and how it is to be analysed and utilised.**

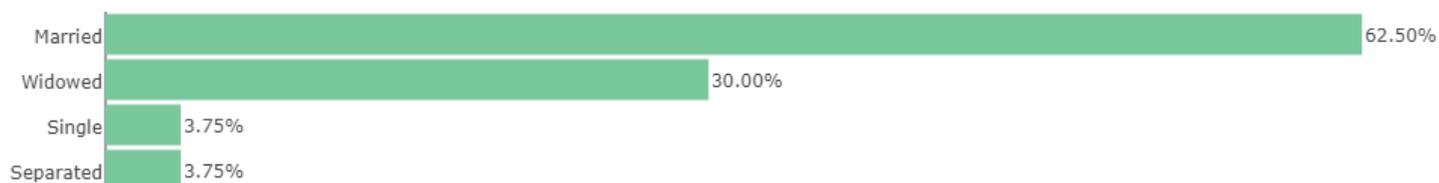
- d) **Sustainability and Exit Strategy:** The DCP proposal suggests various mechanisms for sustainability. Going forward the program will need to proactively strengthen mechanisms ensure that community activities continue beyond closeout as some of the activities suggested may require strong post implementation support. **Transfer of Knowledge, inclusivity, community organizing, and community asset management are just a few ideas that could easily be incorporated into the design as a means of ensuring the intended achievements of the program are sustained beyond the implementation period.**
- e) **Risk Management**– The project design satisfactorily identifies risk factors and purposes to track and report such factors. However, the design could benefit from succinct description of risk scenarios and suggest appropriate response/coping mechanisms. For instance, risks associated with political interference, change in policies related to HIV programs implementations, or the resistance by government authorities to some activities like rights-based issues, should be anticipated and mitigations suggested.

3.2.2. Demographic Characteristics of the respondents

- a) **Age of the respondents:** of the respondents interviewed 71.24% were youth between the age of 18-35 years. This is the group that is mostly affected by the HIV pandemic in the region. However, it was noticeable that within the selected respondents 1.37% accounted for the adolescents below 18 years who are living positively and only 10% of the adults interviewed were above 45 years as depicted by the graph below.

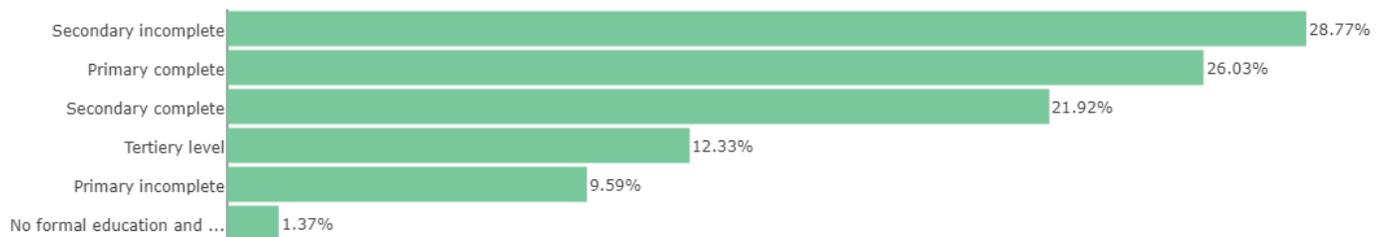


- b) **Marital Status:** Most respondents (62.5%) were married and living with their spouses while 3.75% were separated/divorced, and a further 30% widowed. Only 3.75% of respondents were single/never been married. There were no significant differences in the



regions/locations that would be worth noting.

- c) **Levels of Education:** The level of education is a critical factor in the uptake of essential services including HIV services. There is indeed a large body of evidence that points to the fact that more educated populations reported better health seeking behaviours, have a better understanding of their rights and responsibilities, have better capacity to sustain decent livelihoods, and contribute more meaningfully to development processes. From the findings of this baseline it can be concluded that the target population predominantly had formal education – a similar trend was exhibited across the location as indicated in the graph further below. That said, only 1.37% had no formal schooling. Further details available from the graph and table below.



- d) **Household Sizes:** From the data presented, the average household size across the locations is 6.6. This should be considered by the program as a factor of planning especially for activities whose purpose would be to improve livelihood options for target families. 56.25% of the respondents interviewed had between four (4) and Six (6) children as depicted in the graph below



e) Level of income and % of targeted population with diversified non-remittance sources of income:

The ability of the targeted population (Men and Women living with HIV) to run functional businesses is certainly a factor of diverse enabling factors. Some of these factors include but may not be limited to access to; financial services, business development skills, infrastructure and market systems.

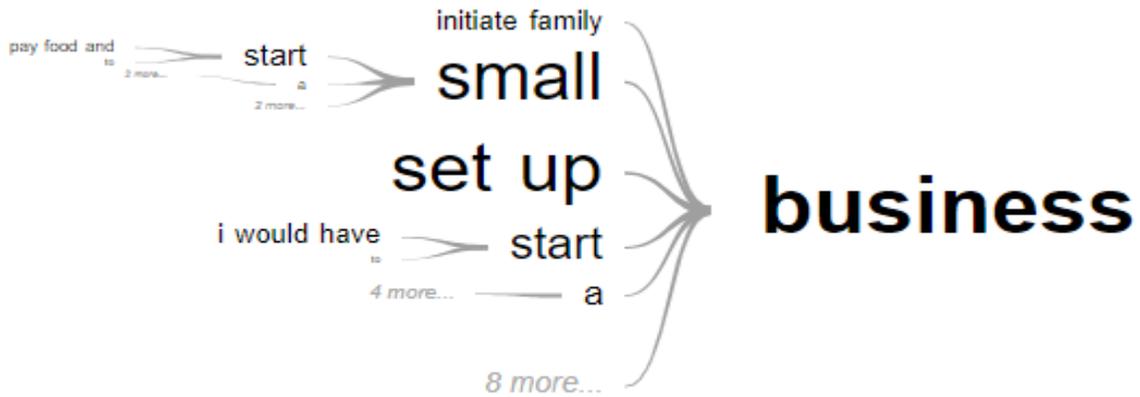
In essence, the diversification of income sources is a key function of resilience initiatives for people living with HIV and sustainability. These initiatives often seek to increase levels household incomes through a combination of activities that may include skills building, investment in productive value chains, improving access to financing and the strengthening of market systems.

This study measured the situation of barriers and catalytic factors in order to better inform DCP activities, and to establish baseline values against which changes will be measured. The graphs below summarize findings on the level of income.

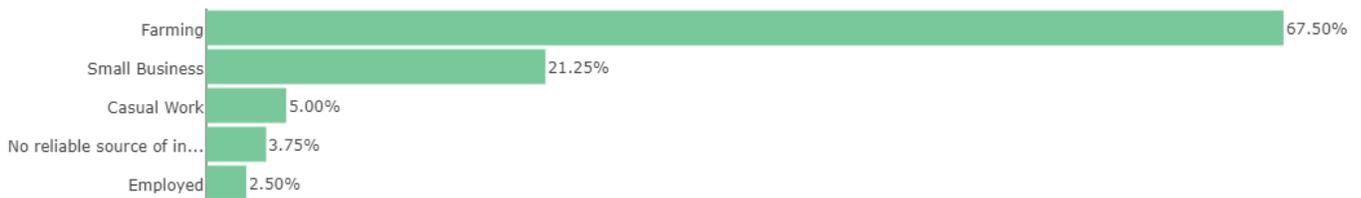


From the above graph its empirically evident that the targeted households need to improve their household incomes considering an average household size of 6.6 against the 70% of the households only earning up to KES 3000.

Further, when asked to share ideas on what they would do in the event they get access to additional finances, most respondents indicated an interest in setting up a small business – as summarized by the word tree below.



Most respondents (67.50%) relied on subsistence farming as their major source of income with only 2.50% having some form of employment. Notably, 5% of the respondents were already involved in various businesses as depicted in the graph below and it's this category of respondents that needed more trainings on entrepreneurship. There is however need to diversify livelihoods for the respondents since a remarkable 58.75% of the respondents said they only relied on one source of livelihood. Of the respondents that said they were involved in small businesses, they mentioned having small kiosks, selling grains and groceries. However, none of them could specify the amount they received as profit from the businesses since they had no clear financial records for the businesses. Moreover, 82.50% of the respondents said they would recommend business skills training

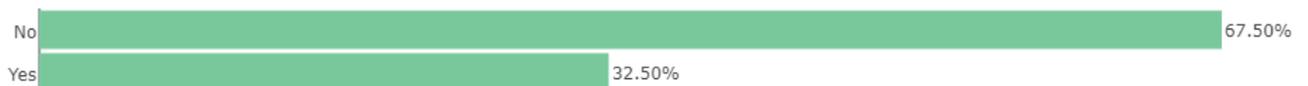


for people living with HIV.

72.50% of the respondents had never had any form of SME training and when asked what form of training they would need, budgeting, entrepreneurship skills and record keeping were some of the areas highlighted as shown in the graph below.

f) Counselling and Psychosocial Support

A significant 21.25% of the respondents said that they had/ were not receiving any



counselling services by the time the baseline was carried out. This clearly highlights the need for access to counselling services, a deeper look at this group highlighted lack of confidentiality and unfriendly services within the government facilities as the reason why they have not access the services. It is however important to note that only 32.50% of the respondents had been trained on counselling or some form of it as depicted in the graph below. The respondents also felt that it is important for people living with HIV to access counselling services at 96.25%

From the study it was empirically evident that the target population do not have a problem in revealing they HIV status with a majority (97.50%) saying that they would be free to reveal their HIV status if asked by anyone.

g) Use of Nutritional Supplements

56.25% of the respondents said that they were using nutritional supplements within their households. It's also important to note that 43.75% were not using nutritional supplements and they said that the reason they did not use the supplements was because they could not access them within the facilities they visited or they were not part of the DCP.



3.3. SUMMARY OF RECOMMENDATIONS

Livelihoods programmes linkages with the Cooperative sub-sector: Some of the targeted population have succeeded in livelihoods start-ups mainly in farming and SMEs. As revealed in the findings during the study, there exists a gap in marketing of produce from the new innovations and financial and book keeping skills. In this regard, it is recommended that linkages be established with Cooperative sub-sector where possible to strengthen marketing for produce from the members involved in farming. To increase income there is need to introduce VSL as a component in improving income levels of households that will improve the living standards through increased income and access to financial services. VSL should target organized groups and even members who were beneficiaries but are not currently

part of the program in order to increase the capital base. This will enhance timely access to micro loans and investment to livelihood options.

Documentation of Good practices: DCP has many achievements worth documenting. Having carried this out for over a two (2) year period, there is great potential in documenting such experience and packaging it into a video documentary, a case study report, or a photo book -the options are limitless. Doing so would provide visibility to RUNELD (and Egmont Trust), and bolster the organizations position as an authority in Working with young women and men living with HIV. There is also an opportunity to extensively document aspects of the project like creating awareness on importance of psychosocial support, or in changing community attitudes towards using herbal remedies.

Involvement of Men Living with HIV: Over time organization have focused on women an opportunity that RUNELD has started to use. It would be recommended to include more men who are living with HIV or have children living with HIV. From the FGD it came out that men are still not being involved although in some cases they are heads of the households or are living with HIV. Stigma is also more felt by men than women within the targeted communities.

3.4 CONCLUSION

RUNELD through DCP has established a good network of community organizations and support groups. There exists a strong link between the level of household income and health status. Emphasis must therefore be put in improvement of household incomes and reducing poverty since such social economic development has dramatic impact on health status especially for people living with HIV and also creates better capacity for raising funds for improved nutrition and quality of health services.

The strengths that RUNELD has and gains that have been made over the past need to be leveraged to increase access to services to people living with HIV in the three targeted locations and beyond. This will require additional human, institutional and financial resources. This will also entail enhanced stakeholder engagement particularly with the devolved structures of County Governments.