COMMUNITY RESPONSE TO HIV and AIDS
EVALUATION RESEARCH HIGHLIGHTS: KENYA

OCTOBER 2011

COUNTRY CONTEXT

Recent surveys estimate Kenya's HIV prevalence rate in the adult population to be between 7.4 percent (Kenya AIDS Indicators Survey (2007)) and 6.3 percent (Kenya Demographic and Health Survey (2008-09)). Both surveys confirmed that women have a higher prevalence compared to men with the sex differential being more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men (NACC 2010).

The estimated number of people living with HIV is 1.3 million to 1.6 million. New infections are estimated at 100,000 in 2009 for adults (15+). The HIV Prevention Response and Modes of Transmission Analysis (2009) found out that the largest new infections (44%) occur among men and women who are in a union or in regular partnerships; men who have sex with men and prisoners contribute about 15% of new infections and injecting drug use accounts for 3.8% (NACC 2010).

For many years, civil society organizations (CSOs) and especially community-based organizations (CBOs) have been at the forefront of the fight against AIDS in Kenya. CSOs and CBOs have been at the forefront of the fight against HIV and AIDS in Kenya. Their involvement was identified as a key component of the national response in the Kenya National AIDS Strategic Plan (KNASP III, 2009/10-2012/13). KNAASP III included community mobilization and community-based programs as one of the four pillars of the national response. It also noted that "knowledge, demand and utilization of services in the formal health system are highly dependent on a strong community-based advocacy and referral system." While the plan seeks to increase the role of CBOs, the effects of their activities have not been rigorously assessed to date.

STUDY FOCUS

This evaluation study aimed to determine the added value of strong CBO activity in conjunction with the government response to the epidemic. Specifically, the evaluation sought to examine the effect of the community-based response through CBO service provision on the following community-level outcome indicators:

- *HIV and AIDS-related results:* knowledge of prevention strategies, perceived HIV risk, sexual risk behaviour, AIDS-related morbidity and mortality
- *Utilization of HIV and AIDS-related services:* use of services from CBOs
- *Social transformation results:* gender attitudes, HIV-related stigma, knowledge of OVC rights, participation in political processes

The evaluation sought to enhance understanding of the contribution of CBOs to HIV and AIDS-related outcomes in order to inform future action by communities and approaches to community engagement in the wider health and development arenas.

KENYA AT A GLANCE

Region	East Africa
Capital	Nairobi
Population (millions)	39.80
Poverty (% population headcount ratio at national poverty line)	45.9 (in 2005)
GDP (US$ billions)	29.38
Life expectancy at birth (total years)	55
Primary completion rate (total %relevant age group)	90 (2005)
Number of people living with HIV	1,500,000 [1,300,000-1,600,000]
Adult prevalence rate (age 15-49)	6.3% [5.8% - 6.5%]
Adults living with HIV (aged 15 and up)	1,300,000 [1,200,000-1,400,000]
Women living with HIV (age 15 and up)	760,000 [650,000-860,000]
Children living with HIV (age 0-14)	180,000 [98,000-260,000]
Deaths due to AIDS	80,000 [61,000-99,000]
Orphans due to AIDS (age 0-17)	1,200,000 [980,000-1,400,000]
National Policy: *Kenya National AIDS Strategic Plan 2009/2010-2012/2013 (KNASP III)*	
National Coordinating Body: *National AIDS Control Council (NACC)*	

Source: UNAIDS 2010 & World Bank 2011

COMMUNITY RESPONSE EVALUATION

Communities

The specific definition of community used in this evaluation is based on the one definition used by the National AIDS/STD Control Program, Ministry of Health: " A collection of household units brought together by common interests, and/or made up of at least 5,000 people (or 100 households) living in the same geographical area. These villages are mainly administered under a Chief based at the location level. A collection of villages form a sub-location, which then collectively form a location. A community would share, therefore, similar culture social practices, beliefs and value systems.

Community Response

Ideally, the strength of a community response would be measured by the scope and intensity of HIV and AIDS-related programs implemented by CBOs. As this data was not available, the strength of a community response was measured by the number of CBOs. Data collected during the survey was used to verify the initial community assignment.

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STUDY METHODS

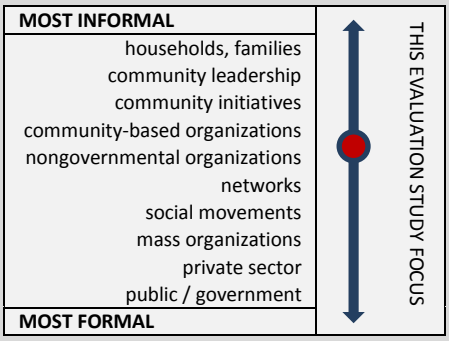
The mixed-method evaluation used a quasi-experimental design which consisted of three components: a household survey carried out in 14 communities (7 study and 7 comparison), qualitative data collected from CSOs and key informants, and analysis of the allocation of funds data by CBOs. The evaluation was conducted in two Western provinces, which have high HIV prevalence rates.

Communities demonstrating a stronger community response to HIV and AIDS were compared to communities with similar characteristics, but showing a weaker response to HIV and AIDS. Communities demonstrating a *stronger* community response were assigned to the study group; those with a *weaker* community response were assigned to the comparison group. Data from the household survey and qualitative interviews were used to verify the initial study/comparison assignment and communities where re-assigned during the data analysis phase, where needed. Data collection consisted of:

1. a household survey
2. in-depth interviews with CBO staff about their activities
3. in-depth interviews with key informants about CBO activity in the community and about social transformation
4. funding allocation data from CBOs in 6 study communities were collected to determine: the total funds received; the unit costs; how these funds are allocated to the continuum of prevention, treatment, care, support, and mitigation; and what type of activities in the community were supported (data on perceived funding gaps and barriers was also collected in in-depth interviews with CBOs.)

The evaluation was conducted in Nyanza Province (HIV prevalence of 13.9%) and Western Province (HIV prevalence of 5.4%) – both showing a high level of community engagement and AIDS-engaged CBOs. A total of 14 communities (10 in Nyanza; 4 in Western) were included in the study.

This evaluation is focused on: AIDS-engaged community-based organizations (CBOs) in Kenya



Significant associations between the strength of CBO engagement and outcomes (dichotomous)

Variable	Odds Ratio (OR)	95% Confidence Interval (CI)
People reduce HIV chances having one uninfected sex partner	9.26	3.09-27.76
People reduce chances of getting HIV by using a condom	14.67	7.73-27.85
Know of drugs to reduce mother-to-child transmission	3.85	1.92-7.70
Used condom consistently (with all sex partners) in the last 12 months	4.09	2.30-7.27
Know of institutions that protect children's rights	3.48	1.62-7.46
Persons in household sick with an unspecified long-term illness	0.169	0.037-0.773

STUDY FINDINGS

***CBO activity**:* CBOs across study and comparison communities focused mainly on prevention, socio-economic impact alleviation, and support for orphans and vulnerable children (OVC) and PLHIV. The funding study showed that prevention is one of the largest spending categories of CBOs. To affect knowledge and behavior, CBOs carried out communication campaigns, for example through community theatres and drama groups, bazars or holiday celebrations. Other CBOs targeted specific groups, mostly PLHIV and OVC.

Do community members in communities with a stronger community-based response demonstrate better HIV and AIDS-related results?

***Knowledge of HIV-prevention strategies**:* Study communities had better knowledge of prevention measures, including having one uninfected partner (9 times better knowledge), using condoms (15 times better knowledge), and drugs to prevent mother-to-child transmission (4 times better knowledge). Virtually all CBOs indicated increasing AIDS-related knowledge and awareness among community members as their main achievements, and key informants also credited CBOs for these.

***Perceived risk**:* Study communities had a higher perception of risk of HIV

infection.

Sexual risk behavior: Study communities were 4 times more likely to use condoms consistently (all sex partners during the past 12 months).

AIDS-related morbidity and mortality: High CBO engagement was associated with lower morbidity of unspecified illnesses, but there were no differences in illnesses related to HIV, tuberculosis and sexually transmitted infections. In addition, there were no differences between study and comparison communities in reports of mortality among household members.

Do community members in communities with a stronger community-based response demonstrate better use of HIV-related services?

Use of HIV testing and counseling, and treatment and care services: There were no significant differences between the communities.

Use of OVC-related services: There were no statistically significant differences between communities with respect to use of OVC services (material support, psychological support services and schooling support).

Do community members in communities with a stronger community-based response demonstrate better social indicators?

Gender attitudes: Key informants (KIs) attributed increased awareness of women's rights, improvement in gender norms, decreases in violence against women and increases in education for women to national policies rather than the impact of CBO activities. This is corroborated by the household survey data which showed no significant association between the strength of CBO engagement and indicators of gender norms.

HIV-related stigma: There was no significant evidence that CBOs affect the level of stigma at the community level. KIs attributed changes over the past 5 years to shifts in awareness of AIDS rather than to CBO activities. Most of the CBOs did not report activities specifically targeting stigma in the general population, nor did they consider stigma-reduction to be part of their achievements.

Knowledge of OVC rights: Study communities showed greater awareness of institutions that protect children's rights. However, KIs did not credit local CBOs with raising awareness. There were no significant differences between the study and comparison communities with respect to attitudes toward protection of the rights of children.

Participation in political processes: Study communities showed higher numbers of household members voting in national and local elections and participating in electoral campaigns.

How are CBOs spending their resources?

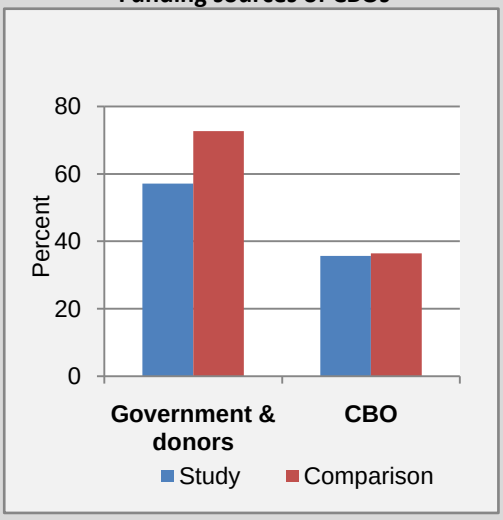
Annual funding reported by the 25 CBOs surveyed was low. Funding averaged US$21,356 in the communities with high CBO engagement and US$7,506 in communities with low CBO engagement. Part of the differences between these two communities is due to one large CBO that received 42% of all funds in the study communities. In total, 31% of CBO funding came from bilateral and multilateral agencies.

However, CBOs are able to mobilize support from a variety of sources, accessing funding from the central and local government as well as private foundations and charities. CBOs in both communities also relied heavily on volunteer (in-kind) support for service provision. As a result, CBOs may be

Significant associations between the strength of CBO engagement and outcomes (ordinal and continuous)

Variable	Coefficient	95% CI
Perceived risk of HIV infection	0.686	0.071-1.301
Voted in local election	2.998	1.265-4.731
Voted in general election	3.472	0.483-6.461
Participated in electoral campaign	1.355	0.698-2.012

Funding sources of CBOs



increasing the total pool of funds available for the fight against AIDS in Kenya rather than taking funding away from the central government.

CONCLUSIONS

The findings suggest that CBOs provide added value in addressing the AIDS epidemic in specific ways that are closely tied to the services they provide. Thus, increasing CBO engagement can be an effective means for scaling up prevention efforts. At the same time, the evaluation findings suggest that these targeted prevention activities do not necessarily have a measurable impact on the larger social transformation indicators, such as HIV-related stigma and gender norms.

Utilization of treatment and care services as well as HIV counseling and testing did not seem to be affected by the level of CBO engagement. This may be due to the fact that CBOs are mostly not engaged in providing these services at present.

CBOs play an important role in mobilizing community resources, and especially mobilizing volunteer care givers

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EVALUATION OF THE COMMUNITY RESPONSE TO HIV AND AIDS

The World Bank in collaboration with DFID and the UK Consortium on AIDS and International Development launched an evaluation exercise in 2009 to assess the results achieved by community responses to HIV and AIDS. The primary objective of this effort is to build a more robust pool of evidence on the impact and added value of community-based activities and actions. This brief is part of a series summarizing the findings from studies conducted in Burkina Faso, India, Kenya, Lesotho, Nigeria, Senegal, South Africa and Zimbabwe.

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EVALUATION PARTNERS IN KENYA

This brief is based on a more detailed paper entitled “Effects of the Community Response to HIV and AIDS in Kenya: Final Report, March 2011” prepared by ICF Macro and National Coordinating Agency for Population and Development (NCAPD)

This evaluation in Kenya is the result of a joint collaboration between the World Bank Africa Region, the World Bank’s Development Impact Initiative (DIME) and the AIDS Team in the Human development Network with Field research was conducted by ICF Macro and the Kenya National Coordinating Agency for Population and Development. The study was supported by the UK Department for International Development (DFID) and the World Bank.