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USAID KENYA *APHIAplus* WESTERN KENYA PROJECT

An Outcomes Evaluation Report
of
SPLASH! INSIDE OUT (SIO) Interventions

July 2015

USAID KENYA

APHIA*plus* WESTERN KENYA

AN OUTCOMES EVALUATION REPORT OF SPLASH INSIDE-OUT INTERVENTIONS

Award No: AID-623-A-11-00002

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JULY 2015

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ACKNOWLEDGEMENTS

PATH acknowledges the contribution of several individuals and stakeholders who made this report possible. First and foremost we acknowledge the American People and the United States Government, through USAID, for providing the funds and support for the APHIA*plus* Western Kenya project that is implementing the SIO interventions. Second, we appreciate the support provided by the National Government and County Governments of Kisumu and Busia for approving the evaluation and providing on ground support.

We are grateful to the local implementing partners and the health activists who ensured that logistics were in place including contacting the respondents for interviews and focus group discussions. We appreciate and heavily indebted to all the respondents who took time off their schedules to provide much needed information that is the substance of this report.

We would like to express our gratitude to the team of research assistants and supervisors who spent long hours reaching out to and seeking information from the respondents.

And last, but not least; PATH would like to recognize the contribution of the lead consultant, the Principal and Co-Investigators and the APHIA*plus* project staff in ensuring that all the planned activities were implemented as scheduled and this report is finalized.

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ACRONYMS AND ABBREVIATIONS

ADS	Anglican Development Services
AIDS	Acquired immune-deficiency syndrome
APHIA <i>plus</i>	AIDS, Population and Health Integrated Assistance
ARV	Antiretroviral
CHW	Community health workers
EII	Evidence-informed intervention
FF	Fisher folk
FGD	Focus group discussion
FP	Family planning
FSW	Female sex worker
GoK	Government of Kenya
HA	Health activist
HIV	Human immune-deficiency virus
HTC	HIV testing and counseling
IDI	In-depth interviews
IDUs	Injecting drug users
IGA	Income-generating activity
IUD	Intrauterine device
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KASH	Keeping Alive Societies Hope
KII	Key informant interviews
KNBS	Kenya National Bureau of Statistics
KRCS	Kenya Red Cross Society
LIP	Local implementing partner
MARPs	Most-at-risk populations
MFIs	Microfinance institutions
MSM	Men who have sex with men
MSW	Male sex worker
NASCOP	National AIDS & STI Control Programme
NHIF	National Hospital Insurance Fund
OSIEA	Open Society Initiative for Eastern Africa
PATH	Program for Appropriate Technology in Health
PWIDs	People who inject drugs
PMTCT	Prevention of mother-to-child transmission
PWPs	Prevention with Persons with HIV
SIO	Splash! Inside Out
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TB	Tuberculosis
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
YOS	Youth out of school
YTLI	Youth in tertiary learning institutions

EXECUTIVE SUMMARY

Project background: The AIDS, Population, and Health Integrated Assistance (APHIAplus) Western Kenya is a five-year project (January 2011 to December 2015) funded by the United States Agency for International Development (USAID). The project is being implemented by a consortium led by PATH, comprising the Elizabeth Glaser Pediatric AIDS Foundation, Jhpiego, and World Vision.

The project's strategic objective is "improved health outcomes and impact through sustainable country-led programs and partnerships." Within this objective, two main result areas, in particular, contribute to the work and priorities of USAID Kenya. Result 3 focuses on improving and expanding availability of high-impact and high-quality health services at the facility and community levels, increasing demand for those services, as well as improving health-seeking behaviors of the communities. Result 4 addresses social determinants of health. It aims to improve the health and well-being of marginalized, poor, and underserved households, families, and children by enhancing and increasing access to economic security initiatives; food and nutrition security; education, life skills, and literacy; and safe water, sanitation, and hygiene. This will be reinforced by expanding social mobilization for health.

About *Splash Inside Out (SIO) interventions:* SIO is a combination prevention intervention that the AIDS, Population and Health Integrated Assistance (APHIAplus) project is implementing to reach key populations—mainly men who have sex with men (MSM) and female sex workers (FSWs)—and vulnerable groups including men and women in workplaces, fisher folk (FF), youth out of school (YOS), and youth in tertiary learning institutions (YTLI). SIO is an evidence-informed intervention (EII) that utilizes trained health activists (HAs) to reach out to these populations with appropriate prevention messages by recruiting beneficiaries, conducting sessions, and accompanying peers to service delivery points.

Objectives and key questions of the evaluation: The outcomes evaluation was conducted from May to July 2015 to: (i) examine the status of behavioral outcomes among beneficiaries of the interventions; (ii) study the efficacy of Splash! Inside Out (SIO) as a combination prevention intervention; and (iii) make appropriate recommendations. The evaluation was guided by the following key questions:

- Are there behavior changes observed among people who received full benefits of SIO in line with the SIO logic model (expected outcomes)? Were there any unanticipated outcomes?
- Are there any differences among the different key populations targeted?
- What changed among beneficiaries who did not receive full set of SIO intervention?
- Can the changes be attributed to SIO interventions?

Methods: The evaluation was conducted in Busia and Kisumu, two of the ten counties involved in SIO interventions. A mixed methods approach was used to generate the information used for this evaluation: 459 interviewer-based

questionnaires were implemented among the project beneficiaries; 35 key informant interviews (KIIs) among health activities, project coordinators, and program managers; and 12 focus group discussions (FGDs) with groups of HAs, FF, FSWs, and MSM. The data were analyzed using descriptive techniques then tested for differences between respondents with low exposure level (1 to 4 sessions) and those with high exposure level (5+ sessions) using the chi-square test of independence for categorical variables. The analysis focused on measures related to HIV-related knowledge, attitudes, and practices. The qualitative data were analyzed manually based on the evaluation objectives.

Findings: The results are presented in two sections: (i) results on the implementation process and (ii) results on project outcomes. The results on the implementation process indicate that SIO reached 17,459 FF, FSWs, and MSM in 2013 (9,839, 7,081, and 539, respectively) while in 2014 it reached 75,677 (48,717, 23,986, and 2,974, respectively). The two SIO models of sharing information with peers—one-on-one and small group sessions (of 5 to 25 people) worked well for different target groups. Some peers, especially the MSM and FSWs, preferred one-on-one discussions rather than being part of group discussions. The adoption of a HA model was considered more beneficial than the traditional peer education model. Some of the key elements highlighted about SIO were: (i) the open process of selecting HAs; (ii) the training provided to the local implementing partners (LIPs), coordinators, and HAs; (iii) holding regular review meetings that provided opportunities to share progress and challenges and to find solutions to emerging issues; and (iv) access to legal support, health services, and commodities (condoms and water-based lubricants). The key challenges identified by the study participants included: (i) late release of funds by APhiAPlus that caused the suspension or delay in the execution of some activities; (ii) poor record-keeping; (iii) management of expectations; and (iv) ineffectiveness of some partnership arrangements.

In terms of project outcomes, the results indicate that all the respondents had heard of HIV and AIDS and almost all (97%) knew about antiretrovirals (ARVs). The most common means of HIV transmission cited by the respondents was unprotected sex (98.1%). A high proportion of the respondents indicated that they would buy food from a vendor who is HIV positive (93.1%), that they would care for an infected family member (97.9%), and that an infected female teacher should be allowed to continue teaching (94.3%). However, more than half (57%) indicated that they would keep it a secret if a family member were infected with HIV.

Over one-tenth (14%) of the respondents reported, unprompted, that they were HIV positive. In terms of risk perception at a personal level, there were some differences between the target populations, with the FF considering themselves to be at a lower risk of HIV transmission (24.7% medium and 15.2% high), compared to the FSWs (27.7% medium and 20% high) and the MSM (38.6% medium and 15.9% high). During the in-depth interviews (IDIs) and FGDs the MSM were perceived to be at higher risk of HIV infection because of higher levels of stigma and discrimination. A high proportion of the respondents (75.5%) reported to have had an HIV test in the three months preceding the evaluation and 98.2% had received their results. The FSWs reported that they discussed their HIV status among themselves and

supported each other with treatment, whereas this was less apparent among the MSM.

Over two-fifths (42.4%) of the beneficiaries reported that they went for an HIV test (FF-53.1%, FSW-68.3%, and MSM-61.2%) after going through SIO sessions. Another 25.3% made a decision to use condoms all the time (FF-15.4%, FSWs-40.3%, and MSM-25.3%). The HAs reported that they had observed changes in the communities, including better understanding of re-infection and the willingness of women to seek condoms. The rating of SIO activities was generally high, with most activities being rated at good or satisfactory. Risk-taking was, however, still high among the respondents: 23.9% reported to have had sex without protection with someone whose HIV status was unknown (FF-15.8%, FSWs-34.2%, and MSM-32.7%). During an FGD with FSWs it emerged that through SIO they had acquired skills to negotiate for safe sex. Access to legal services through the LIPs had reduced abuse among the male sex workers (MSWs) and FSWs.

Slightly over four-fifths (84.1%) reported that they had shared the information they had gathered with other people. A half (52.6%) of them had talked to friends/peers, siblings (12.3%), and other sexual partners (10.5%). The results show that a higher proportion of the MSM talked to friends/peers (61.2%) compared to the FSWs (48.3%) and FF (44%). The main sources of information about HIV were the radio (71% unprompted and 72.4% prompted), health centers (61.8% unprompted and 74.5% prompted), and peer educator/health activist (45.9% unprompted and 85.9% prompted).

SIO efficacy: The data were analyzed based on the number of SIO sessions attended by the respondents to examine the differences in six key outcomes. Responses were clustered to differentiate those who attended 1 to 4 sessions (less than full exposure) and those who attended 5 sessions or more (full exposure). There was strong evidence of relationship between level of exposure (based on sessions attended) among FSWs in the following key SIO outcome indicators: (i) had HIV test in the 3 months prior to the evaluation ($X^2 = 0.800$, $df = 1$, $p\text{-value} < 0.05$); (ii) talked to sexual partner about HIV and AIDS in the last 3 months ($X^2 = 8.756$, $df = 1$, $p\text{-value} < 0.05$); and (iii) had unprotected sex with any partner whose HIV status was not known to respondent ($X^2 = 10.644$, $df = 1$, $p\text{-value} < 0.05$). In addition, there was marginal evidence of the effectiveness of the intervention on speaking to a sexual partner about HIV and AIDS ($X^2 = 10.76$, $df = 1$, $p\text{-value} = 0.05$). However, no evidence was observed regarding speaking to anyone about HIV and AIDS ($X^2 = 0.023$, $df = 1$, $p\text{-value} > 0.05$).

Conclusion: The results show that, through the health activism and the linkages established with the various service providers, the program was effective in achieving its behavioral and biomedical objectives. The analysis on the effectiveness of SIO shows that, although the evidence is weak, some of the respondents who had attended 5 or more sessions were better able to understand their risks and adopt protective behavior.

Recommendations: These are presented in two subsections: general and SIO specific.

General recommendations

- i. *Address structural determinants:* There is a need to tackle structural determinants of HIV and AIDS as part of prevention, since poverty and socio-cultural factors are key facilitators of sexual vulnerability.
- ii. *More focus on MSM:* Some members have limited access to information and services due to fear and stigma. The recruitment and training of more HAs should be considered while strengthening the snowball approach to reach them.
- iii. *Increase preventive interventions in the general population:* Although it makes epidemiological sense to focus on key and vulnerable populations, it is important not to relent on educating the general population on HIV and AIDS.
- iv. *Address stigma and discrimination:* The levels of stigma are still high, especially among the MSM; thus, there is a need to focus on measures to address HIV and AIDS stigma at the national, county, and community levels.
- v. *Support national and county governments' efforts in implementing the Kenya AIDS Strategic Framework (KASF) 2014/5–2018/9:* The Framework provides suggestions on targeted interventions that could be adopted by counties to address their challenges in HIV and AIDS mitigation.

Recommendations on SIO

- i. *A common understanding on what constitutes a session:* The APHIAPlus team, the LIPs, the HAs, and the peers used the term 'session' variably. It is critical that the terminology is harmonized to provide a basis for follow-up, monitoring, and evaluation of the efficacy of the interventions.
- ii. *Reporting:* APHIAPlus should consider introducing less bulky reporting tools or the adoption of e-reporting tools.
- iii. *Referrals:* The referral booklets should be produced in triplicate to allow the LIPs to keep copies for their records and follow-up.
- iv. *Timely release of funds:* Delayed release of funds interferes with the capacity of LIPs to effectively implement their activities. It also has a negative impact on the commitment of HAs and other program actors.

SECTION 1: INTRODUCTION

1.1 Background

Kenya had approximately 1.6 million people living with HIV in 2012 and about 57,000 were estimated to have died from AIDS-related illnesses (Kenya AIDS Indicator Survey [KAIS] 2012). The country is experiencing a mixed epidemic; both generalized and concentrated. The concentrated epidemic is among female sex workers (FSWs), men who have sex with men (MSM), and people who inject drugs (PWIDs), initially referred to as injecting drug users (IDUs), who collectively contribute about 30% to new HIV infections. In 2012, the Lake Victoria region in Western Kenya had the highest prevalence rates of HIV ranging, from 6.4% in Nyamira to 25.7% in Homa Bay (KASF 2014).

In recognition of the shift in transmission dynamics, the Government of Kenya (GoK) has committed, in the Kenya AIDS Strategic Framework (KASF) 2014/5–2018/9, to focus on key populations and a range of vulnerable populations. The key populations identified for attention are FSWs, MSM, and PWIDs. Vulnerable populations include young girls and women, people in prisons and other closed settings, fishing communities, truck drivers, street children, and people with disabilities.

Efforts toward reducing the prevalence of HIV and mitigating the impacts of AIDS in the country have been going on for over four decades. The United States Agency for International Development (USAID) has been at the forefront of funding various organizations in the country to address the national key strategic actions toward this goal. Under the current USAID-funded AIDS, Population and Health Integrated Assistance (APHIAplus), PATH is responsible for the interventions in Western Kenya (Zone 1), which is a five-year funded program (2011–2015). The project focus is on scale-up of services, integration of health service delivery, strengthening the health systems, fostering community involvement, and building capacity of health workers and the GoK to offer quality health services to the surrounding populations as well as creating innovative methods for effective service delivery initiatives and approaches.

About APHIAplus Western Kenya Project: The AIDS, Population, and Health Integrated Assistance (APHIAplus) Western Kenya is a five-year project (January 2011 to December 2015) funded by the United States Agency for International Development (USAID). The project is being implemented by a consortium led by PATH, comprising the Elizabeth Glaser Pediatric AIDS Foundation, Jhpiego, and World Vision.

The project's strategic objective is "improved health outcomes and impact through sustainable country-led programs and partnerships." Within this objective, two main result areas, in particular, contribute to the work and priorities of USAID Kenya. Result 3 focuses on improving and expanding availability of high-impact and high-quality health services at the facility and community levels, increasing demand for those services, as well as improving health-seeking behaviors of the

communities. Result 4 addresses social determinants of health. It aims to improve the health and well-being of marginalized, poor, and underserved households, families, and children by enhancing and increasing access to economic security initiatives; food and nutrition security; education, life skills, and literacy; and safe water, sanitation, and hygiene. This will be reinforced by expanding social mobilization for health.

APHIAplus builds on the experiences of the APHIA II Western project. The project operates in ten counties in the Nyanza and Western regions of Kenya. These are: Kisumu, Nyamira, Homa Bay, Kisii, Migori, and Siaya in Nyanza; and Busia, Kakamega, Bungoma, and Vihiga in Western region. The project's objectives are to:

- i. Expand integrated facility-based services through mentorship, supportive supervision, and innovative high-impact programming.
- ii. Activate synergies for whole market planning and implementation through sub-county level Annual Work Plans (AWP) mechanisms.
- iii. Foster dynamic integration and enhanced linkages between households and health and social services through community health workers (CHWs), referrals, and community structures.
- iv. Strengthen community capacity for members to advocate for their rights; monitor and evaluate services in their community; and own, lead, and participate in education and programs tailored to their needs.

1.2 About Splash! Inside Out

PATH Kenya developed Splash! Inside Out (SIO) in 2012, as a redesign of the original SPLASH! peer education HIV prevention intervention developed in 2000 under the USAID-funded Kenya IMPACT project and subsequently implemented in the AMKENI and APHIA II Western Kenya projects. SIO is a combination prevention intervention that the APHIAplus project is implementing to reach key populations, mainly MSM and FSW and vulnerable groups including men and women in workplaces, FF, youth out of school (YOS), and youth in tertiary learning institutions (YTLI). SIO is an evidence-informed intervention (EII) that utilizes trained health activists (HAs). The HAs reach these populations with appropriate prevention messages through recruiting beneficiaries, conducting sessions, and accompanying peers to service delivery points. The sessions can be one-on-one or small group discussions of between 5 and 25 participants. A training guide containing five modules is used to provide the HAs with the requisite skills to support their peers. They are also supplied with information packages on the key issues of concern including HIV and AIDS, TB, family planning, relationships, voluntary medical male circumcision (VMMC), sexually transmitted infections (STIs), and gender issues (generally referred to as Health Information Reference Pack or File). The HAs also promote the uptake of services and act as distributors of prevention tools such as condoms and water-based lubricants for MSM and FSWs. Theoretically, SIO is based on increasing health literacy above the cognitive level to the point where the HA is empowered to advocate for access to treatment and commodities as well as champion against the traditions and cultures that increase risk.

The topics for discussion during a SIO session are generated by the peers and what the HA does is to facilitate the discussion based on the knowledge gained through training by the SIO project team. SIO has been implemented since 2012 and as the APHIAplus project funding comes to an end, it was considered necessary to conduct an evaluation to assess the outcomes of the approach.

The outcome evaluation was conducted to assess the uptake of self-reported HIV testing and counseling (HTC) and effective referrals to other services including HIV care and treatment and VMMC; perceptions of respondents toward risk of HIV infection; knowledge on HIV prevention strategies including partner reduction and male circumcision; and communication or dialogue about health issues at the community level. In addition to assessing the outcomes of SIO, the evaluation also examined how the intervention was implemented in order to understand the level of exposure the target population received. This was done through a review of program data and discussions with implementing partners.

1.3 SIO evaluation hypothesis and objectives

Hypothesis: The hypothesis for the evaluation was that members of key and vulnerable populations who are exposed to 5 or more sessions of SIO will be better able to accept or seek referral for HIV counseling and testing services and other health services and practice safer sex (reduce number of sexual partners and increase use of condoms and water-based lubricants), compared to those who are exposed to fewer than 5 sessions.

Objectives: The intervention evaluation sought to address the following objectives:

- i. Examine the status of behavioral outcomes among beneficiaries of the interventions.
- ii. Evaluate the efficacy of SIO as a combination prevention intervention.
- iii. Make appropriate recommendations.

Questions: The evaluation was guided by the following key questions:

- i. Are there behavior changes observed among people who received full benefits of SIO in line with the SIO logic model (expected outcomes)? Were there any unanticipated outcomes?
- ii. Are there any differences among the different key populations targeted?
- iii. What changed among beneficiaries who did not receive full set of SIO intervention?
- iv. Can the changes be attributed to SIO interventions?

The evaluation was conducted in two of the ten counties involved in APHIAPlus, namely Busia and Kisumu, which fall within the category of counties categorized as HIV and AIDS Prevention, Care, and Treatment 'Saturation Counties' whose HIV prevalence is between 10% and 28% (NACC and NASCOP 2014). In addition, the two counties had the three categories of target population for the evaluation: the fisher folk (FF), FSWs, and MSM. Specific characteristics of the county are briefly described below.

- Busia County has an estimated population of 536,000 people with about 16,970 on antiretrovirals (ARVs). Mother-to-child transmission of HIV is estimated at 5.3%. The malaria positivity rate is 47.2% and tuberculosis (TB) prevalence is 329/100,000 (Health Policy Project 2012).
- Kisumu County has an estimated population of 1 million people with about 40,000 people on ARVs. Mother-to-child transmission of HIV is estimated at 9.3% and TB prevalence is 379/100,000 (which is way above the national average of 223/100,000). Malaria positivity is estimated at 36.6% (Health Policy Project 2012).

SECTION 2: METHODS

This evaluation was implemented among the FF, MSM, and FSW aged 18 to 49 years in Kisumu and Busia Counties. The main criterion for inclusion was peers who had participated in at least one session between January 2013 and December 2014. The data collection process also involved interviewing the HAs, coordinators, and leaders of local implementing partner (LIP) organizations.

2.1 Sampling frame and sample selection

A mixed method approach that includes both quantitative (interviewer-based questionnaire) and qualitative (focus-group discussions [FGDs] and key informant interviews [KIIs]) was used to assess SIO outcomes among the target population. The selection of the respondents to the quantitative survey entailed several stages:

- i. Selecting two LIPs per county: Keeping Alive Societies Hope (KASH) and Kenya Red Cross Society (KRCS) in Kisumu; and Anglican Development Services, Western (ADS) and Busia Survivors in Busia.
- ii. For each of the LIPs, a list of the trained and active HAs was drawn and 31 were randomly selected based on the total number of peers reached by the LIPs: ADS Western – 9; Busia Survivors – 10; KRCS – 7; and KASH - 5.
- iii. For each of the selected HAs, a list of all the peers they had interacted with, over the period January 2013 to December 2014, was drawn and a random sample of 15 to 16 names selected. A replacement name was also selected in case the individual selected was not available for the interview.

2.2 Training of the research team

Training was held in Kisumu over a three-day period (from May 25 to 28, 2015). In total 22 participants attended the training: 12 research assistants, 6 supervisors, and 4 data entry clerks. Four APHIAPlus staff and a consultant facilitated the training. The first two days of training entailed introducing the participants to APHIAPlus and SIO, taking them through the evaluation protocol, research ethics, and data collection techniques and tools. The process also involved translating the tools into Kiswahili and Dholuo.¹ Role-plays were used to help the research team to understand the sequence of questions and the skip pattern.

The third day was used for pre-testing the tools. The KRCS facilitated the pre-test at a beach that was not involved in the main data collection exercise. Each research team member interviewed one person using the questionnaire, and each supervisor conducted one KII. The process was followed by a debriefing session that involved reviewing the process and time spent and refining the data collection tools.

2.3 Data collection

The process of document review was initiated on May 18, 2015, while primary data

¹During the pre-test in Kisumu it emerged that some of the respondents, especially the fisher folk, did not understand Kiswahili—hence the need to translate the tool into Dholou for a standardized approach to the interviews.

were collected from May 28 to June 06, 2015, in the two counties. The approach used to gather data is summarized below (a summary of the tools used is presented in Table 1; see also Annex 1).

- i. Program data review was conducted to determine the number of people reached through SIO and the referrals made to access services, as well as to analyze any changes in access to key services. These data and records were obtained from the HAs, LIPs, and APHIAplus project.
- ii. A review of the implementation process was done with implementing partners to get an understanding of the process. The data were generated by use of a KII guide.
- iii. Quantitative data: a questionnaire was administered to peers who had participated in SIO sessions to establish the level of exposure to the intervention and also their knowledge, attitude, and practice. It should be noted that in Kisumu the achievement in terms of interviews planned and conducted was 94% while for Busia it was 88%.
- iv. Qualitative: FGDs and KIIs were used to gather qualitative data. KIIs were conducted to obtain important details about behavior and practice. FGDs were held with beneficiaries to capture the changes that have occurred as a result of their participation in SIO sessions.

Table 1: A summary of the tools used to generate data for the evaluation				
Tool	Kisumu		Busia	
	Planned	Achieved	Planned	Achieved
Questionnaire				
FF	123	117 (95%)	144	138 (96%)
FSW	44	41 (93%)	131	120 (92%)
MSM	32	29 (91%)	32	13 (41%)
Total	199	187 (94%)	307	271 (88%)
Key informant interviews				
FF	7	7	9	9
FSW	3	3	8	6
MSM	2	2	2	3
Coordinator	2	2	2	2
LIP manager/ director	1	1	1	0
Total	15	15	22	20
Focus group discussions				
FF	2	2	2	2
FSW	1	1	1	1
MSM	1	1	1	0
Health activists	2	2	2	5
Total	6	6	6	5

Abbreviations: FF, fisher folk; FSW, female sex worker; LIP, local implementing partner; MSM, men who have sex with men.

2.4 Data analysis

Analysis of quantitative data: The data were analyzed using descriptive techniques, then tested for differences between respondents with low exposure level (1 to 4 sessions) and those with high exposure level (5+ sessions) using the chi-square test of independence for categorical variables. The analysis focused on measures related

to HIV-related knowledge, attitude, and practice.

Analysis of qualitative data: The qualitative data were analyzed manually based on the evaluation objectives. All the transcripts were typed and read through by the consultant. Quotes have been used in this report to give the participants a voice and triangulate the quantitative results.

2.5 Ethical approvals and consenting

The ethical approvals for the evaluation were obtained from the National Commission for Science, Technology and Innovation (NACOSTI) and Maseno University Ethical Review Committee. An approval for non-research determination was also obtained from PATH's research and ethical committee. During the training, the research team was oriented on the consenting process. For each of the data collection tools, the participants were expected to consent and these consent forms are in the custody of APHIAplus. All the participants were assured of confidentiality and anonymity.

2.6 Key challenges

Although the LIPs made great effort to ensure that the HAs were aware of the evaluation and that they were available to support the team, there were several challenges encountered, especially in Busia:

- i. *Refusals:* in Busia, some of the MSM declined to participate in the evaluation, demanding payment for transport, which had not been factored in the evaluation budget. This explains the shortfall in number of questionnaires conducted in Busia among this group.
- ii. *Working hours:* there were some difficulties getting the FSWs and MSM during the day. To mitigate this challenge, the research team worked during evening hours in Busia town because that was the only time they could reach the respondents.
- iii. *Poor record-keeping:* part of the questionnaire (Section Zero) was to be completed based on the records kept by the HAs. However, during the assessment it became apparent that some of the HAs' records were poorly kept with missing or incomplete information. The process was also laborious and some of the sections of the questionnaire had to be completed later (in Kisumu, for instance).

SECTION 3: RESULTS ON THE IMPLEMENTATION PROCESS

The results presented in this section are based on program data review and the discussions held with LIP coordinators, managers, and the HAs. The main focus is to present the number of people reached, the implementation process and the lessons learned, the key challenges faced by the LIPs, and the sustainability of the gains made through the SIO intervention.

3.1 The initiation of SIO

It is notable that the SIO project intervention was designed based on the lessons learned by PATH through the implementation of peer-education activities since 2000. The planning and training process took close to two years and it involved developing documents, selecting LIPs, recruiting HAs, and conducting training as summarized in Table 2.

No.	Dates	Key activities
1.	Jan–Dec 2011	Use of APHIA II Western Project Community Health Volunteers' Manual to reach most-at-risk populations (MARPs)
2.	Jan–Apr 2012	SIO concept is adopted by APHIAplus to respond to the needs of the MARPS
3.	May–Aug 2012	SIO is developed, reviewed, and released as Draft Health Activist Trainers Guide; also, Draft Health Activist Manual: How to Engage in Health Activism is released
4.	Sep 2012	Preparations to conduct SIO training of trainers (TOT) gets underway
5.	Oct–Nov 2012	SIO TOT is conducted for representatives of local implementing partners (LIPs)
6.	Dec 2012	LIPs begin the identification and recruitment of those to be trained as health activists
7.	Jan–Apr 2013	LIPs conduct SIO health activists training
8.	Jan–Jun 2013	SIO rollout gets underway as the draft data collection tools are completed, printed, and distributed to LIPs

3.2 Program reach

Twelve (12) of the original 17 APHIAplus-contracted LIPs have been implementing SIO for FSWs, MSM, and FF in the various counties of the Western Region of Kenya. Data available to the evaluation team indicate that in 2013 and 2014 the project had reached 17,459 and 75,677 beneficiaries among FSWs, MSM, and FF as shown in Table 3.

Key Population	Year	
	2013	2014
Female sex workers (FSWs)	9,839	48,717
Fisher folk (FF)	7,081	23,986
Men who have sex with men (MSM)	539	2,974
Total	17,459	75,677

Although the project was initiated in 2011, the rollout of activities was evident from 2012 with the recruitment of HAs among the MSM.

3.3 SIO implementation process and lessons learned

The four organizations involved in this evaluation (KASH, ADS, Busia Survivors, and KRCS) have been involved in HIV and AIDS interventions for at least 10 years. Each of the organizations was, at the time of the evaluation, in addition to SIO, implementing other interventions funded by other organizations but targeting the same population. For instance, KASH was at the time of the evaluation implementing a governance project funded by USAID and a human rights project funded by the Open Society Initiative for Eastern Africa (OSIEA) with a focus on FSW and MSM. Busia Survivors was also receiving financial support from OSIEA. ADS in Busia was implementing a human rights component funded by Diaconia Sweden. This project deals with justice, economic empowerment, and access to sexual and reproductive health (SRH) services.

The two SIO models of sharing information (one-on-one and small group discussions) worked well for different target groups and for the varied topics. It was noted that many FSWs in Busia were reported to prefer talking about HIV and AIDS during one-on-one discussions rather than during group sessions. This was connected to the fear of others knowing one's HIV status.

In discussions with the coordinators and project teams, they were in agreement that the adoption of a HA model was different from the traditional peer-education approach. Several elements of the implementation of SIO highlighted by the HA coordinators and LIP managers are summarized below.

- i. *The process of selecting HAs:* This was reported to be an open process that entailed people applying and being interviewed. One MSM HA reported that he saw the advertisement, applied, was called for an interview and was offered the position.
- ii. *The training of LIP coordinators:* The coordinators interviewed reported that they had attended various training sessions sponsored by APHIAPlus to equip them with SIO implementation and management skills including reporting.
- iii. *The training provided to the HAs:* Through the project, the HAs were trained for various periods of time on the SIO approach and provided with skills to enable them to transfer the knowledge and skills to their peers (this could imply a lack of uniform training for all HAs). The main challenge expressed during the discussions was the need for refresher courses and training of new HAs to replace those who have left for various reasons.
- iv. *Regular review meetings:* The project holds quarterly review meetings during which SIO implementation issues are deliberated, challenges shared, and resolutions reached.

- v. *Access to legal support:* It was clear during discussions with the FSWs and MSM that having a legal officer in the LIP was of critical importance. One of the MSM key informants commented: 'No police officer can mess with me now—I just tell them that I will call my lawyer.' The HAs and peers had also been taken through human rights training, and some of them were serving as paralegals through other partner funding. The FSWs in Kisumu were categorical that they knew their rights and under KASH they were protected.
- vi. *Facilitation for the LIPs to link up with service providers:* The referral linkages established with health facilities were seen as enablers to behavior change. The FSWs and MSM cited friendly service points in Kisumu and Busia where they sought health care without fear of stigma and discrimination. The establishment of the Drop in Center by KASH in Kisumu and the health clinic by Busia Survivors was considered by the peers as one of the key milestones for the project.
- vii. *Supply of commodities, more specifically condoms and lubricants to the FSWs and MSM:* Access to lubricants was identified as an important intervention for both the FSWs and MSM.
- viii. *Facilitation of the HAs as a motivation for them to continue performing their roles on the project:* The allowances given to the HAs were contingent upon them submitting their monthly reports. The KES 1,500 given to each HA monthly is a considerable investment by APHIAPlus. However, a majority of the HAs complained that the amount of money given was not commensurate with the tasks they were expected to perform. The suggested amount was 'over KES 5,000 per month' and that they should be on contract.

In summary, the evaluation participants cited the following as some of the key achievements of SIO:

- i. Involvement of the police: there are joint activities between the FSWs and the police.
- ii. Sensitizing bar owners, public health officers, and city/county police officers on the needs of the MSM and FSWs.
- iii. The peers were more confident and enthusiastic and the level of their engagement in project activities had increased over time.
- iv. Feedback from the beneficiaries indicated that the HAs were contributing to their communities.
- v. Referrals and access to services were working well. There was, however, a suggestion that the referral forms should be in triplicate so that a copy can be retained by the LIP.
- vi. Through Community PWP there has been a reduction in the number of people who are sick and those not adhering to treatment.
- vii. Reduction of sex workers living in denial of HIV infection.
- viii. Increased family planning (FP) uptake and reduced number of abortions.

- ix. Increased access to psychosocial support: access to continuous counseling on need basis.
- x. Increased access to prevention of mother-to-child transmission (PMTCT) of HIV.
- xi. Access to legal support, which had led to a reduction in the abuse of the rights of FSWs, MSM and FF.
- xii. Opportunities for international representation for some members: one of the FSWs in Kisumu had been to an international conference prior to the assessment and she was very happy with the opportunity accorded to her.

3.4 Key challenges experienced by the LIPs and health activists

During the FGDs and KIIs, the participants shared their challenges in implementing SIO, including those listed below.

- i. *Late remittance of funds by APHIAPlus*: Late fund dispersal led to the cancellation of some activities and resulted in some HAs abandoning their activities. For instance, the ADS lost 14 activists (from 56 to 42). The KASH team reported that the delay had led to the cancellation of the monthly review meetings, yet these were considered important forums for sharing information, assuring quality, and finding solutions to challenges.

Box 1: Some operation challenges

 - Sometimes the peers do not come for the forums such as the group sessions when they are called
 - The peers sometimes talk like the health activists are gaining from the program on their behalf when they are not gaining financially
 - Inadequate and inconsistent access to KY jelly and condoms
 - Limited advocacy meetings that would ensure peers take the sessions seriously

Source: FGD FSWs
- ii. *Reporting*: Poor record-keeping was reported and observed during the evaluation.
- iii. *Managing expectations*: Some of the peers, especially the MSM, expected handouts if they were to be involved in any project activity.
- iv. *Effectiveness of partnership arrangements*: Challenges were reported with respect to partnerships that were agreed upon between the LIP and APHIAPlus. For instance, the arrangement between Busia Survivors and APHIAPlus whereby Jhpiego was expected to provide HTC counselors and conduct HTC as per Jhpiego's APHIAPlus mandate was reported not to have worked well. A key informant stated that:

The arrangement is that Jhpiego provides counselors but this has not worked well. Busia Survivors mobilizes its members and then it is informed that the counselors are not available. (KII, Busia)

In summary, the challenges reported by the evaluation participants are listed below.

- i. The reporting tools were considered too many and bulky. In addition, the bags provided for carrying the tools were termed inappropriate given the size and weight of the six books.

- ii. Capacity-building: the need for refresher courses was reported. In addition, due to the mobility of the target population, there was a constant need to make replacements that required training.
- iii. Regular customers of FSWs abuse the children of FSWs and they have no legal recourse.

3.5 Sustainability of SIO activities

During the qualitative enquiry, it emerged that the SIO beneficiaries had been informed of the pending closure of the APhiAPlus project. The participants were therefore asked their views regarding the closure and what impact it would have on the target population. The key concern for FSWs and MSM was the possible limited access to commodities—condoms and lubricants. They were of the view that they would continue to share the knowledge they had acquired although, without the facilitation from the LIPs, their efforts would be limited. The following were the other activities and opportunities that would be affected with the project's closure:

- i. Sensitization of new entrants into sex work and fishing-related activities.
- ii. Linkage to service providers, which were perceived to work mainly due to the linkages created through the project.
- iii. Networking opportunities that were made possible through APhiAPlus.
- iv. Access to information that was channeled through APhiAPlus to the LIPs and then to the project beneficiaries.

What was, however, clear from the discussions with the HAs was the fact that as long as the LIPs would continue to exist, they would be supported in undertaking some of the activities. One of the project coordinators noted that, although APhiAPlus funding was coming to an end, the limited funds in the organization would be used to support the HAs in undertaking some of the activities that do not require heavy financial inputs.

Apart from the expected support by the LIPs, some of the HAs and peers had formed income-generating groups. Further, some were involved in other ventures that would support them beyond the project. It is probable that the income from the income-generating activities (IGAs) will substitute for the monthly stipend, and that therefore the HAs may continue conducting sessions. For example:

- i. The FSWs under KASH had formed a merry-go-round and table banking where each member was contributing funds on a regular basis and could borrow when in need.
- ii. At Sio Port Beach, members had started contributing to National Hospital Insurance Fund (NHIF) to ensure access to health services. In addition, they had established a savings and credit cooperative (SACCO) through which they would be able to access funds for development and emergencies.
- iii. At Busia Survivors, members were involved in table banking. Additionally, they had enrolled in an Emergency Support Scheme where they contribute Ksh.50 per month and could access funds when in need of treatment.

SECTION 4: RESULTS ON PROJECT OUTCOMES

This section presents the key results of the evaluation in nine subsections based on both the quantitative and qualitative data: (i) socio-demographic characteristics of the respondents; (ii) knowledge on HIV and AIDS, PMTCT, and STIs; (iii) HIV and AIDS accepting attitudes; (iv) HIV and AIDS behavior change and practices; (v) HIV counseling and testing and voluntary medical male circumcision; (vi) exposure to and effects of SIO; (vii) information sharing on HIV and AIDS; (viii) exposure to health promotion messages; and (ix) SIO efficacy analysis. Quotes are used to give voice to the participants who took part in the qualitative aspects of the evaluation.

4.1 Socio-demographic characteristics of the respondents

The questionnaire was implemented among the three target groups: FF, FSWs, and MSM. About two-thirds (67%) of the respondents were female and about two-fifths (41.8%) were married or living with a partner, as summarized in Table 4.

Characteristic	N=439	%
Sex	Male	33.0
	Female	67.0
Education	Never attended school	2.7
	Attended primary school	38.6
	Completed primary school	18.9
	Attended secondary school	20.3
	Completed secondary school	15.5
	University	1.1
	Attended tertiary college	2.3
Marital status	Attended vocational or technical school	0.5
	Never married	21.9
	Currently married/living with a partner	41.8
	Married live separately	1.6
	Divorced/separated	18.3
Employment status	Widowed	16.4
	Employed	16.0
	Not employed	84.0
Location	If not employed, he/she earned income in the last 2 months	87.9
	Kisumu	41.7
Key population	Busia	58.3
	Fisher folk (FF)	54.9
	Female sex workers (FSWs)	33.9
	Men who have sex with men (MSM)	11.2

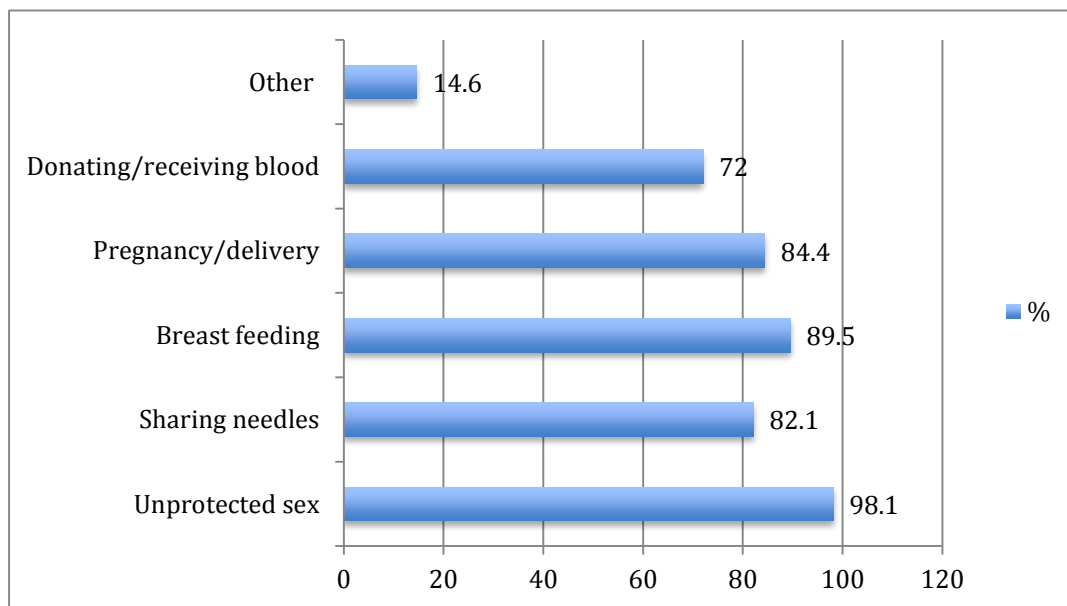
It is notable that although most of the study respondents were not employed they earned income in the last 2 months prior to the evaluation. It was reported that some of the MSM and FSWs in Busia were engaged in other income-generating activities (IGAs) as a way of camouflaging their real source of income. A key informant observed that:

Most of our members are involved in other activities during the day. Some sell second-hand clothes, others are barmaids while others do petty trade. They do this to cover up their sex work. Those who have children try to hide the sex work from them. (KII, Busia)

4.2 Knowledge on HIV and AIDS, PMTCT, and STIs

It is notable that all the respondents had heard about HIV and AIDS and almost all (97%) had heard about ARVs. In terms of citing ways through which HIV is transmitted, the results indicate high levels of knowledge among all the categories of respondents as shown in Figure 1.

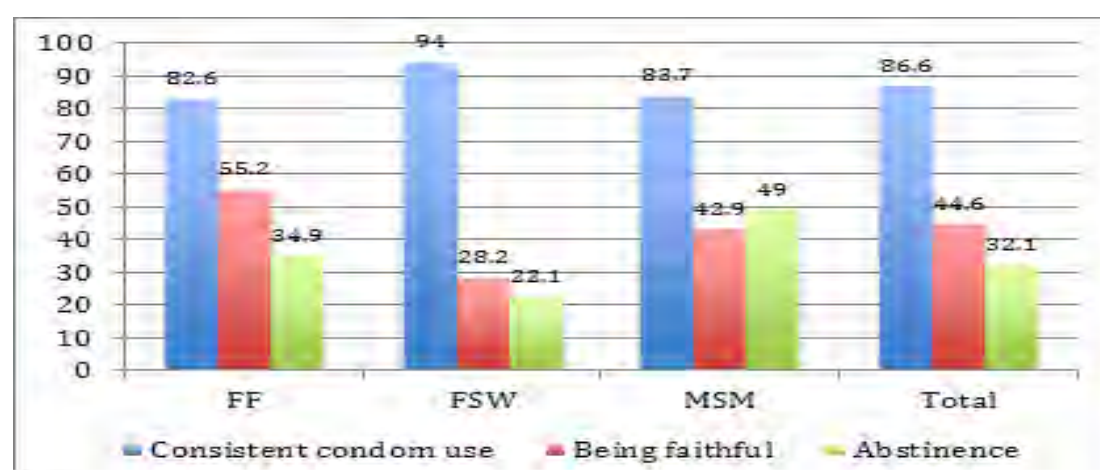
Figure 1: Reported ways through which HIV is transmitted (percentage)



When asked about the most common means of transmitting HIV in Kenya, most of the respondents (98.1%) cited unprotected sex.

The respondents were also asked to name measures someone can take to protect him/herself from contracting HIV. The most common form of prevention cited was consistent use of condoms (86.6%). The results based on the target groups (FF, FSWs, and MSM) differed in terms of the importance placed on the preventive measures, as shown in Figure 2.

Figure 2: HIV prevention strategies reported by target group (percentage)



Abbreviations: FF, fisher folk; FSW, female sex worker; MSM, men who have sex with men.

During the qualitative enquiry, the FSWs were of the view that abstinence was unrealistic since their business was to sell sex. A male FF noted that it was not possible for grown men and women to abstain, thus:

You come from the Lake after several days... It is impossible to abstain. The only thing that can work is to be faithful to your partner or you use condoms. (KII, FF, Busia)

The respondents were asked a range of questions to assess their knowledge levels on HIV and AIDS. The responses summarized in Table 5 indicate a high level of knowledge regarding risky behaviors that can expose one to HIV infection.

No.	Question	% (Yes)			
		FF	FSW	MSM	Total
1.	Can the risk of HIV transmission be reduced by having sex with only one faithful partner?	85.4	78.2	81.6	82.6
2.	Can the risk of HIV transmission be reduced by using condoms?	95.4	98.6	93.9	96.3
3.	Can a healthy-looking person have HIV?	92.1	96.6	98.0	94.3
4.	Can people protect themselves from getting infected with HIV by having no sexual intercourse?	61.8	72.8	55.1	64.8
5.	Is there anything a person infected with HIV can do to be cured?	27.1	29.7	10.2	26.1
6.	Can a healthy-looking person transmit HIV?	89.6	96.6	98.0	92.9
7.	Can a person get HIV from mosquito bites?	28.3	29.7	14.3	27.2
8.	Can people get HIV because of witchcraft or through other supernatural means?	7.5	3.4	8.2	6.2
9.	Can the virus that causes HIV be transmitted to a baby during pregnancy?	57.1	63.5	55.1	59.0
10.	Can the virus that causes HIV be transmitted to a baby during delivery?	92.9	95.3	83.7	92.7
11.	Can the virus that causes HIV be transmitted to a baby through breastfeeding?	87.9	87.2	85.7	87.7

Abbreviations: FF, fisher folk; FSW, female sex worker; MSM, men who have sex with men.

4.3 HIV and AIDS accepting attitudes and stigma

The respondents were asked a range of questions regarding how they would relate to people infected with HIV to which they answered in the affirmative or not as presented in Table 6.

No.	Perception	%
1.	Would you buy fresh vegetables from a vendor with HIV or AIDS?	93.1
2.	Would you keep it a secret if a member of your family is infected with HIV?	57.0
3.	Would you care for a member of your family infected with HIV?	97.9
4.	Should a female teacher infected with HIV be allowed to teach?	94.3

The respondents were also asked to agree or disagree on two statements: *Do you agree or disagree that PLHIV [people living with HIV] should be ashamed of themselves? Do you agree or disagree that PLHIV should be blamed for bringing HIV to the community?* Most of the respondents (94.5%) disagreed with the statement that PLHIV should be ashamed of themselves and 92.5% disagreed with the statement that PLHIV should be blamed for bringing HIV into the community.

In terms of stigma, the qualitative results indicated that it was still prevalent. A program coordinator noted that:

The level of stigma among the MSM is very high. They are also very mobile. They have challenges in finding places to do their business in this town. It is difficult for them to get guesthouses locally to do their business. (KII, Busia)

4.4 HIV and AIDS behavior change and practice

4.4.1 Sexual experience

Almost all the respondents reported to ever have had sex (98.8%) reported that they had had sex in the 12 months preceding the evaluation. Of all the respondents who reported to have had sex in the last 12 months, 51.9% reported to have had sex with more than one sexual partner. The highest proportion of those who reported to have had sex with multiple partners in the preceding 12 months was among the FSWs (81.2%), followed by the MSM (78.7%), and lastly the FF (27.3%). There were no gender differences reported in sex with multiple partners.

4.4.2 Alcohol and drug use

In terms of use of alcohol and drugs, about one-third (62.4%) of the respondents reported that they had never taken any substances and 18.7% reported that they took alcohol at least once a week, as shown in Table 7.

No.	Frequency	%
1.	Every day	7.5
2.	At least once a week	19.9
3.	Less than once a week	5.6
4.	Never	66.5
5.	No response	0.4

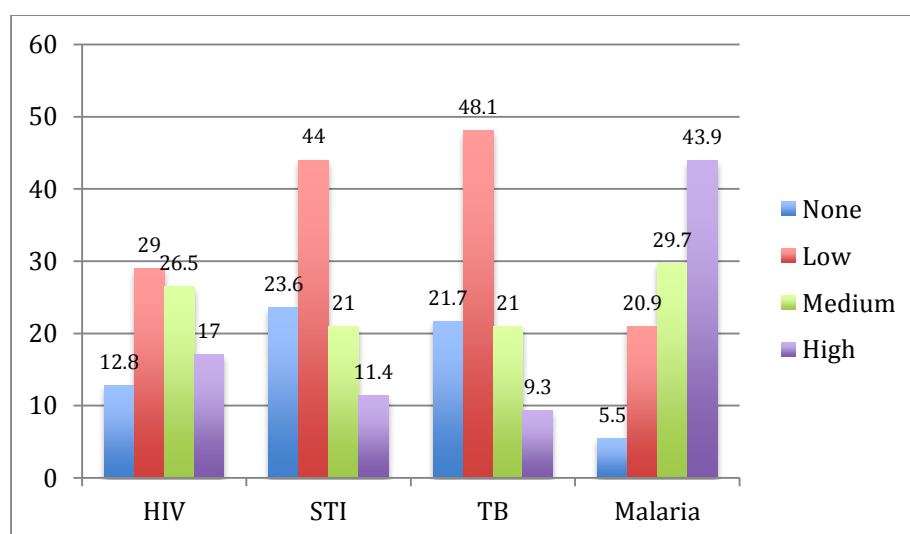
Those who take alcohol/drugs were asked if they had had sex in the 3 months prior to the evaluation while under the influence of alcohol/drugs. The results indicate that about 35.9% were under the influence as presented in Table 8.

No.	Sex under the influence of alcohol/drugs	%
1.	None of us was	51.5
2.	I was	8.8
3.	My partner was	16.3
4.	Both us were	10.8
5.	Not applicable	11.1
6.	Don't know	1.0
7.	No response	0.5

4.4.3 HIV risk perception including risk of TB and malaria

The respondents were also asked to rate the risk of getting infected with a range of diseases. It is notable that 14% of them reported, unprompted, to be infected with HIV at the time of data collection. The risk of contracting malaria was perceived as high as illustrated in Figure 3.

Figure 3: Perceived risk of contracting HIV, a sexually transmitted infection (STI), tuberculosis (TB), and malaria (percentage)



There were some differences observed in perceived risk among the three target populations as illustrated in Table 9.

No.	Risk	Perceived risk	FF	FSW	MSM
1.	HIV infection	No risk	18.8	5.7	4.5
		Low risk	33.2	23.6	25.0
		Medium risk	24.7	27.7	38.6
		High risk	15.2	20.0	15.9
2.	STI	No risk	31.1	17.5	6.1
		Low risk	45.2	39.9	51.0
		Medium risk	16.2	24.5	32.7
		High risk	7.5	18.2	10.2
3.	TB	No risk	22.9	22.2	14.3
		Low risk	48.5	42.4	63.3
		Medium risk	21.1	22.2	16.3
		High risk	7.5	13.2	6.1
4.	Malaria	No risk	5.3	4.9	8.2
		Low risk	22.4	14.6	32.7
		Medium risk	30.3	28.5	30.6
		High risk	42.1	52.1	28.6

Abbreviations: FF, fisher folk; FSW, female sex worker; HIV, human immune-deficiency virus, MSM, men who have sex with men; STI, sexually transmitted infection; TB, tuberculosis.

Exposure to TB was considered a key challenge among the FF due to their nature of work as observed by a group of HAs:

TB is another problem and it is a challenge especially along the beaches where people are crowded and the disease can easily spread to people since TB is spread through the air. We encourage people to get TB screening and treatment. Some of those people I have referred are under medication while some have already completed treatment. (KII, FF, Busia)

There was however a perception among the HAs and coordinators that more effort and investment was required to see behavior change among the MSM, since most of them were still in the closet. For instance, a coordinator noted that:

The MSM share sexual partners and they tend to want to get into long-term relationships with their clients. In addition, they possess clients and spread infections amongst themselves. Recruitment of school boys is a key area of concern for us with some of the young boys who want to experiment posing as clients. Condom use is also low among the MSM and some of them are not ready to come from their closets because some of their clients are pastors and priests who would want to remain anonymous. (KII, MSM)

4.4.4 Family planning

In terms of knowledge of FP, almost all the respondents knew of ways through which pregnancy can be prevented (99.3%). The most commonly cited methods of pregnancy prevention were the injectable (72.4%), pills (67.4%), and male condom (62.2%) as presented in Table 10.

No.	Contraceptive method	%
1.	Injectable	72.4
2.	Pills	67.4
3.	Male condom	62.2
4.	Implants	54.9
5.	Intrauterine device (IUD)	34.4
6.	Female condom	29.2
7.	None	11.2
8.	Female sterilization	10.7
9.	Rhythm	9.3
10.	Male sterilization	8.2
11.	Withdrawal	3.0
12.	Lactational amenorrhea method (LAM)	2.7
13.	Emergency contraceptive	2.3
14.	Other	3.6

In addition, the respondents were asked if they had ever used any FP method. The results indicate that the most commonly used forms of contraception were male condoms (36%) and injectables (31.7%) as summarized in the Table 11.

No.	Contraceptive method	%
1.	Male condom	36.0
2.	Injectable	31.7
3.	Implants	18.7
4.	Pills	13.7
5.	None	11.2
6.	Female condom	6.2
7.	IUD	4.1
8.	Female sterilization	1.6
9.	Rhythm	1.8
10.	Withdrawal	0.7
11.	Male sterilization	0.5
12.	Emergency contraceptive	0.7
13.	Other	1.1

4.5 HIV counseling and testing and voluntary medical male circumcision

Almost all the respondents (99.5%) reported that they knew where someone who needed to test for HIV could get the test done. About three-quarters of the respondents (75.5%) reported that they had been tested in the three months preceding the evaluation and 98.2% had received their results, as shown in Table 12.

No.	HIV testing	%
1.	In the last 3 months have you been tested to see if you are infected with HIV?	75.5
2.	Did you find the result of your test?	98.2
3.	Tested for HIV in the last 3 months – FF (fisher folk)	74.4
4.	Tested for HIV in the last 3 months – FSWs (female sex workers)	73.5
5.	Tested for HIV in the last 3 months – MSM (men who have sex with men)	85.7
6.	Tested for HIV in the last 3 months – Kisumu	82.0
7.	Tested for HIV in the last 4 months – Busia	70.9

Through the FGDs and KIIs among the FSWs and MSM, it was apparent that they approached HIV testing differently. On one hand, the FSWs reported that they talked to each other about their results and they knew each other's status and who among them was on treatment. Indeed, they tended to provide information on their HIV status unprompted. The MSM, on the other hand, reported that HIV status was a personal issue and individuals could choose to share the results or not.

All male respondents (n=146) were asked if they were circumcised, and the majority (73.3%, n=107) responded in the affirmative. A site breakdown showed that 57.3% of male respondents in Kisumu County were circumcised compared to 90.1% in Busia County.

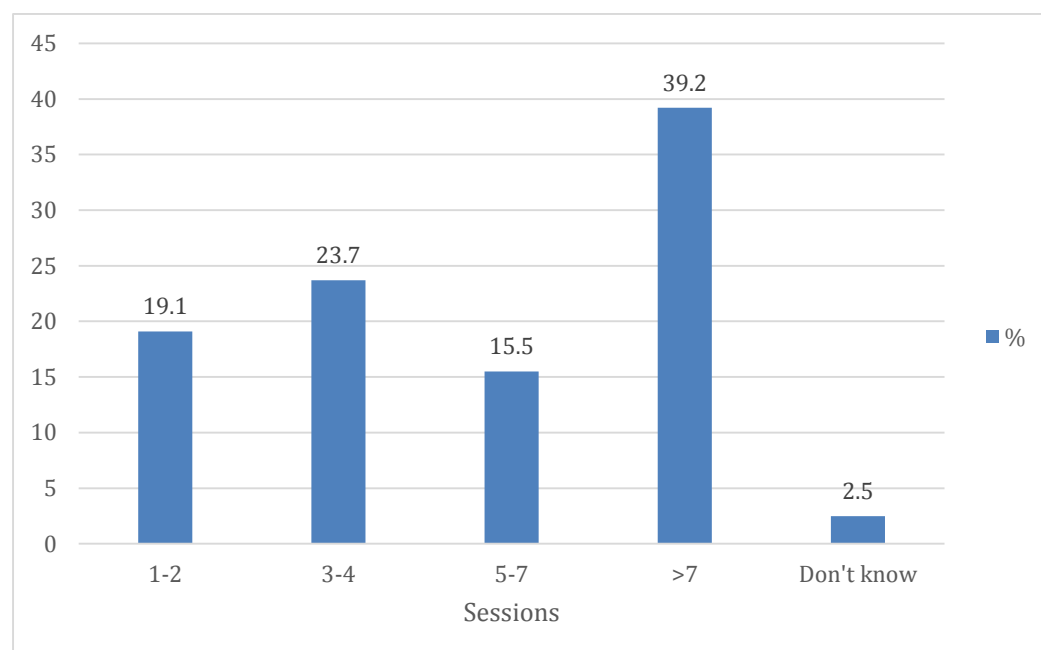
4.6 Exposure to and effects of SIO

The respondents were asked a range of questions regarding their exposure to the SIO project and the impact of the intervention on their behavior. The questions examined the sessions attended, services sought, and services accorded to them.

4.6.1 Number of sessions attended

When asked about the number of sessions the beneficiaries had attended between January 2013 and December 2014, about two-fifths (39.2%) had attended more than 7 sessions as illustrated in Figure 4.

Figure 4: Reported number of Splash! Inside Out (SIO) sessions attended (percentage)



In terms of the issues discussed during the sessions, the most cited was HIV and AIDS, as summarized in Table 13.

No.	Topic	%
1.	HIV and AIDS	87.8
2.	Family planning	39.2
3.	Sexually transmitted infection (STI)	34.4
4.	Care and support of people living with HIV (PLHIV)	28.7
5.	Sexuality and relationships	22.5
6.	Alcohol and drug abuse	21.5
7.	Tuberculosis (TB)	21.3
8.	Malaria	19.1
9.	Prevention of mother-to-child transmission (PMTCT) of HIV	15.6
10.	Maternal health	11.0
11.	Gender	7.2
12.	Other	20.0

4.6.2 Effects of SIO

The respondents were also asked to name the effects of the intervention on them including what actions they had taken since getting involved in the project. The responses, summarized in Table 14, indicate that a higher proportion of FSWs than other target groups went for an HIV test (68.3%).

No.	Action taken	%			
		FF	FSW	MSM	Total
1.	Went for an HIV test	53.1	68.3	61.2	42.4
2.	Made a decision to use condoms all the time	15.4	40.3	28.6	25.3
3.	Spoke to someone else about behavior change	25.3	21.5	28.6	24.4
4.	I reduced sexual partners	13.3	17.4	18.4	15.3
5.	My attitude toward people living with HIV (PLHIV) changed	9.5	21.5	20.4	14.8
6.	I realized I was at risk of HIV	12.4	14.1	12.2	13.0
7.	Went for voluntary medical male circumcision (VMMC)	5.0	0.0	6.1	3.4
8.	Other	20.7	14.1	16.3	18.0

Abbreviations: FF, fisher folk; FSW, female sex worker; MSM, men who have sex with men.

The 'Other' category included actions such as willingness to take ARVs, used FP, and changed behavior at a personal level.

During the KIIs, the HAs were asked about what changes they had seen among their peers as a result of the SIO intervention. All of them were of the view that knowledge levels had increased and some of the peers had adopted risk-reduction behavior. One key informant cited four changes he had observed among the FF, thus:

People are changing slowly. People know protective sex and about re-infections. They have access to FP information. They hold monthly meetings during which they give and receive feedback. Many children being born are HIV free and many of the youth are HIV free because of protective sex. (KII, HA)

A group of FSWs in Kisumu observed that, due to the project, their peers had a good understanding of the risks including the risk of re-infection. They also understood the need to be on treatment:

Due to the sessions with the health activists, the peers now know that those who are HIV positive have to live positively and hence they take their drugs without missing even when they take alcohol.

It was reported that the FSW peers reminded each other when it was time to take their ARVs because being healthy was seen as one way of keeping customers coming back. They also noted that once a customer agreed to use condoms he would be protected and he will be alive to come back for more services.

The discussions and interviews indicated increased access to services. The FF accessed health services from nearby health facilities, whereas the FSWs and MSM sought services from facilities that were considered friendly. The HAs have referral forms that they use to refer their members, which are respected by the health facilities. A key informant opined thus:

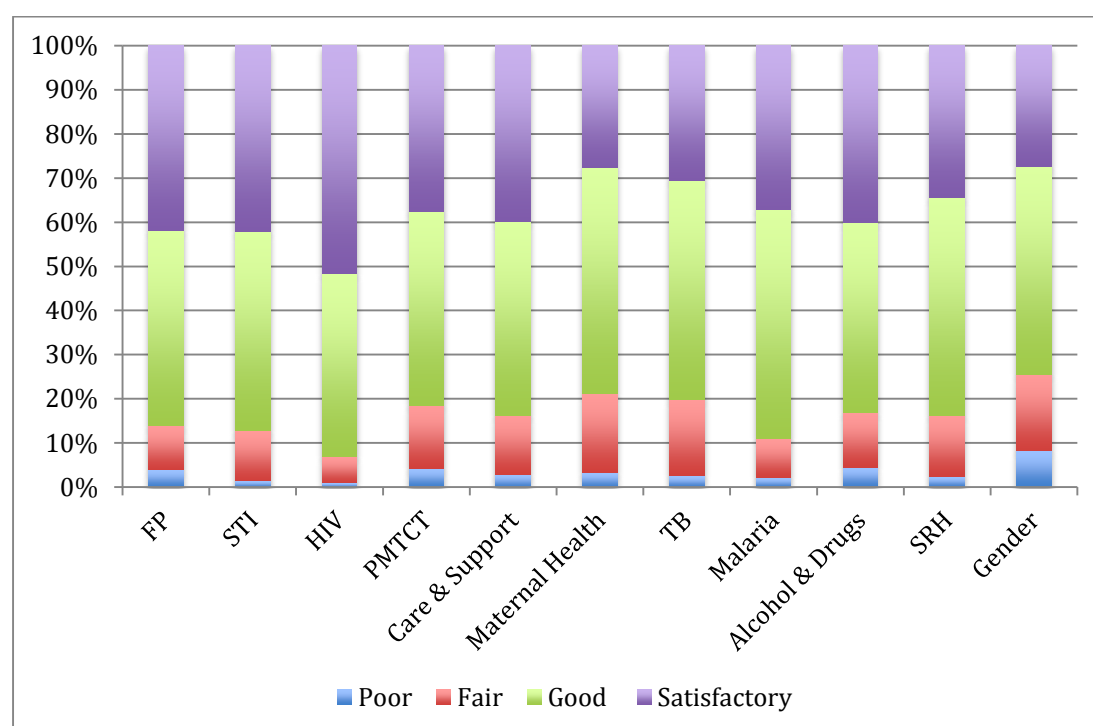
We refer the peers to Busembe for testing and for ARVs. But if the condition is serious, we refer them to Sio Port. We have referral forms that we use for this purpose. However, there are some of our members who do not take up the referrals or when they go they do not find the provider. (KII, HA, Busia)

It emerged that, for the collaborating health facilities, there were point persons for care but when these individuals were out of the duty station, the referred patients would often not get the services required.

4.6.3 Rating of SIO services

The respondents were asked to rate the services they had received through the SIO project. It is notable that over 60% rated all the services as good or satisfactory as illustrated in Figure 5.

Figure 5: Rating of Splash! Inside Out (SIO) services by respondents



Abbreviations: FP, family planning; HIV, human immune-deficiency virus; PMTCT, prevention of mother-to-child transmission; SRH, sexual and reproductive health; TB, tuberculosis.

About half of the respondents (47.4%) reported to have been exposed to messages from other groups/organizations apart from SIO. These messages were mainly on HIV and AIDS from other service delivery nongovernmental organizations (NGOs) including the African Medical and Research Foundation (AMREF), Academic Model Providing Access to Healthcare (AMPATH), and National AIDS & STI Control Programme (NASCOPI).

4.6.4 Risk reduction

To assess the beneficiaries' behavior in terms of risk reduction, the respondents were asked specific questions on their sexual behavior in the 3 months preceding the evaluation. The results on sexual behavior were subjected to further analysis, and it is clear that the FSWs and MSM still practice high-risk behaviors as shown in Table 15.

No.	Behavior	%			
		FF	FSW	MSM	Total
1.	Had unprotected penetrative sex with a partner whose HIV status is not known to you	15.8	34.2	32.7	23.9
2.	Had unprotected penetrative sex with a partner whose HIV status is known to you	41.1	29.5	34.7	36.5
3.	Had sex with someone with whom you have had no previous intimate relationship	6.2	26.0	16.3	14.0
4.	Performed oral sex or had oral sex performed on you	5.0	17.2	26.5	11.5
5.	Had sex in exchange for gifts	2.1	59.6	42.9	25.9

Abbreviations: FF, fisher folk; FSW, female sex worker; MSM, men who have sex with men.

The proportion of respondents who reported to have had sex in exchange for money was higher among women (32.3%) than men (13.1%). Table 16 presents the results on other sex-related behavior among the target populations. Abuse appears to be common among the respondents.

No.	Behavior	%
1.	Been treated disrespectfully (denied household money, insulted) by your partner, a friend, employer, or colleague	27.1
2.	Took alcoholic drinks until you forgot to do important things	14.6
3.	Been physically assaulted by a family member	14.1
4.	Suffered from a persistent cough	12.5
5.	Shared a razor blade	11.2
6.	Drank alcohol until you blacked out	8.1
7.	Been forced, coerced, or fooled (including drugged) into having sexual intercourse	7.7
8.	Shared a needle	5.3
9.	Sought treatment for a sexually transmitted infection (STI) from a non-qualified health provider	3.4
10.	Shared any drug paraphernalia with friends	3.2
11.	Sought treatment for STI from a traditional healer	2.3

During a FGD with a group of HAs, one of the participants alluded to the gender transformation that had occurred as result of exposure to SIO, thus:

Ladies take condoms and I am impressed by that since in the past generation, before the SIO project, ladies were not carrying condoms but nowadays after awareness they request for condoms because they now understand that some men may take advantage of them. (KII, FF, Busia)

A group of FSWs in Busia cited the advantages of SIO and how they had gained in terms of prevention. They observed:

M: What about prevention?

R6: We have always taught them to negotiate for condom use before going to the room and the lady should correctly put the condom on an erect penis as we were taught during the splash sessions.

R4: Again, they should check the expiry date of the condoms and how they are worn. If possible they should have sex when lights are on. *[Giggles and laughter]*

R3: Since we know when you drink you may forget to use condoms, we were taught to encourage our peers to drink less, some of us do not drink when we are on duty. *[Laughter]*

R5: In fact, when a client buys you alcohol you keep some and sell it later, because when you are drunk you are not able to negotiate well.

Box 2: Madam E (female sex worker)

She has been a health activist since 2012. She has mobilized her peers to go for sexually transmitted infection (STI) screening and knows that all her peers know their HIV status. In addition, all her peers know their rights and they know that sex work is a job like any other. The peers have been linked to other groups and they now have table banking, although they are not yet registered as a group. The peers are healthy now. For example, STIs have been reduced. Those on treatment are supported by group members and are reminded to take their medicines. Consequently, they have customers now because they look healthy since *'no one wants to have sex with someone who is coughing all the time.'* In addition, the peers have stopped stealing from their customers.

Source: FSW health activist, Kisumu

A program coordinator noted that there were more apparent changes in behavior among the FSWs compared to the MSM. This was opined to be due to the fact that FSW activities were initiated several years earlier (for KASH in 2003 and for Busia Survivors in 2005) and the practice was more acceptable, while the MSM activities were added later (2008 and 2012, respectively) in a context of high levels of stigma. A respondent from one of the organizations observed that:

The FSW activities were initiated in 2003 while MSM interventions were introduced in 2008. The FSW component is therefore stronger than the MSM. However, the main challenge is that MSM still has a lot of stigma. (KII, Busia)

A group of FSWs noted that new entrants into the trade, who tend to be young girls and/or single mothers, face higher risks to HIV infection due to the fact that they do not have a good understanding of the trade. They stated thus:

R6: Most of the new sex workers come from poor backgrounds or they are single mothers who badly need money for rent, food or fees so they will rush in for such an offer [of sex without condoms] without thinking of the risks of getting HIV and unwanted pregnancies

R5: At a lounge in town men offer KES 2000 for one 'shot' without protection. For a new people they would consider this to be a lot of money and maybe at that time they are drunk and they have no capacity to say no.

Among the FF, SIO was reported to have led to a reduction in 'fish for sex,' which was recognized as a challenge in the past. Several strategies had been designed to support the women to gain access to additional funds to support their IGAs. A key informant in one of the beaches in Busia observed:

Fish for sex was a major problem in the past but this has gone down. We have encouraged the women to form groups—K-Rep Bank (formerly a Micro-finance institute) visits them monthly. However, Ugandan men come and take our girls to the other side yet they do not know about SIO. (KII, Busembe Beach, Busia)

It was however reported that once trained, the MSM seem to want to move on and create their own projects as opposed to the FSWs. A LIP director observed that:

MSM are more aggressive. Two of those trained have established organizations that are currently running. However, we have trained many FSWs who have not progressed as much. (KII, LIP, Kisumu)

It emerged during discussions that MSWs were at a high risk of HIV infection and other STIs due to the nature of their interaction and high levels of stigma. A group of MSM noted that although their members were sex workers in Busia, it was difficult for them to find rooms to do their business. This had implications on their mobility—they move constantly between towns (for instance, four of the MSM interviewed in Busia came in from Bungoma). It also emerged that despite having passed through SIO sessions, they still encountered abuse and risk, thus:

R1: Some men who have sex with men still have stigma.

M: *So how does this put them at risk?*

R7: They fear going for testing or treatment.

R1: If I may add, they have sex with people whose HIV status they do not know. The people can force them to have unprotected sex because they know some MSM do not want to blow their cover, therefore they cannot report them anywhere.

R3: Some male sex workers do not have lubricants or cannot afford to buy, so they use vaseline or saliva, which exposes them to further risk. [*Continuous laughter*] (FGD, FSWs, Busia)

4.7 Information sharing on HIV and AIDS

A large part of the SIO intervention was on providing information to peers who would in turn share it with other people. When the respondents were asked if they had shared the information they had gathered with other people in the 3 months prior to the survey, slightly over four-fifths (84.1%) responded in the affirmative. A higher proportion of them had talked to friends/peers (52.6%), siblings (12.3%), and other sexual partners (10.5%). A lower proportion had talked to boyfriend/girlfriend (8%), health worker (7.5%), and parents (3.2%). The results show that a higher proportion of the MSM talked to friends/peers (61.2%) compared to the FSWs (48.3%) and FF (44%). When asked if they had talked to their sexual partners about HIV, 74% responded in the affirmative.

This aspect of information sharing was also captured during the KIIs with the HAs. They noted that unlike peer education, which was akin to giving lectures, SIO provided them with skills that allowed them to speak out and support others. They described SIO as enabling them to *"speak out yourself to make others like you to speak out"* and *"accepting yourself and splashing it out to others."* Further, the HAs for FF reported that *"the communities now trust us and we have become change agents."* In fact, an activist in Busia noted that:

I always carry condoms with me because my clients request for condoms anywhere they meet me and if I do not have them they blame me. So to avoid blame, I have to carry condoms at all times. (FGD, HA, Busia)

4.8 Exposure to health promotion messages

The main modes of exposure to health promotion messages cited by the respondents, unprompted, were radio (71.0%), followed by health center (61.8%) and peer educator (45.9%). When respondents were prompted, peer educator (85.9%) ranked highest followed by community health workers (77.0%) and health center (74.5%) as shown in Table 17.

No.	Media	Unprompted	Prompted
1.	Radio spots/shows	71.0	72.4
2.	Health center	61.8	74.5
3.	Peer educator/health activist	45.9	85.9
4.	Television	46.1	57.2
5.	Community health worker/volunteer	35.1	77.0
6.	Dialogue group	35.4	68.3
7.	Health outreach	29.0	63.7
8.	Newspapers/magazine	25.8	53.4
9.	Community event (baraza)	23.3	56.1
10.	Nongovernmental, community-based, or faith-based organization (NGO/CBO/FBO)	23.2	73.3
11.	Posters/stickers	23.8	66.6
12.	T-shirt	16.3	79.6
13.	Billboard	11.5	62.7
14.	Brochure/newsletters	10.2	51.4
15.	Theatre performance	7.6	49.1
16.	Sporting event	7.5	42.6
17.	Magnet theatre performance	3.8	34.9

It was evident during the interviews that some of the respondents and interviewees were oblivious of billboards on HIV and AIDS that were next to where some of the interviews and discussions were being held. When prompted, the respondents would be surprised that they had not mentioned a billboard while it had been there for a long period.

4.9 SIO efficacy analysis

In evaluating the efficacy of SIO, the participants were asked about the number of SIO sessions they had attended during the period covered by the study. This was aimed at identifying the level of exposure to SIO. HAs' records were also obtained to verify the participation of respondents in SIO. The data on sessions attended were then analyzed to examine the differences in six key outcomes shown in Table 18. Responses were clustered to differentiate those who had attended 1 to 4 sessions (less than full exposure) and those who had attended 5 sessions² or more (full exposure). A Pearson's chi-square test (goodness of fit test) was used to determine if the outcomes were independent of the level of exposure.

Overall, the results show no evidence of relationship between the numbers of sessions attended by the study respondents in most of the key outcome indicators

²According to the SIO guide, participants are considered to have full benefit of the intervention if they have attended 5 or more sessions.

assessed in the evaluation. However strong evidence of relationship was noted in two indicators (marked with * in Table 18).

No.	Key outcome variable	Measure	Exposure level		Chi-square (X ²)	P-value
			1-4 sessions	5 or more sessions		
1.	Knowledge of HIV risk-reduction methods	Knowledge of all three risk-reduction methods (condom use, abstinence, and being faithful to an infected partner)	12.8%	9.6%	1.13	0.287
2.	Perception of risk	High perception of risk of HIV infection	51.5%	50.7%	0.019	0.89
3.	HIV counseling and testing	Tested in the 3 months prior to the evaluation	71.1%	78.8%	3.41	0.065
4.	Information sharing on HIV and AIDS	Talked to anyone about HIV and AIDS in the last 3 months	84.4%	83.9%	0.023	0.88
		Talked to sexual partner about HIV and AIDS in the last 3 months	71.5%	76.0%	10.76	0.05*
6.	Sexual behavior	Have you had sex with more than one partner in the last 12 months?	41.6%	59.2%		0.001*
		In the last 3 months have you had unprotected sex with any partner whose HIV status was not known to you?	35.8%	36.9%		0.81
		Consistent use of condoms	86.7%	86.5%	0.006	0.940

*Shows strong evidence of the relationship between exposure to SIO and the intended outcome.

Knowledge of risk-reduction methods: *No evidence of relationship* ($X^2 = 1.13$, $df = 1$, $p\text{-value} > 0.05$).

The analysis indicates that the respondents who attended 5 or more SIO sessions were not statistically more knowledgeable about HIV risk-reduction methods compared to those who had attended 1 to 4 sessions.

HIV risk perception: *No evidence of relationship* ($X^2 = 0.19$, $df = 1$, $p\text{-value} > 0.05$).

Likewise, the analysis indicates that the respondents who had attended 5 or more SIO sessions were not statistically different from those who had attended 1 to 4 sessions in their HIV risk perception.

HIV counseling and testing: *No evidence of relationship* ($X^2 = 3.41$, $df = 1$, $p\text{-value} > 0.05$).

The analysis indicates that respondents who attended 5 or more SIO sessions were not different in taking HIV testing during the preceding 3 months compared to those who had attended 1 to 4 sessions.

Sharing information about HIV and AIDS with others outside the peer network:

Marginal evidence was observed on the relationship between exposure to 5 or more sessions and speaking to a sexual partner about HIV and AIDS ($X^2 =$

10.76, $df = 1$, p -value = 0.05). However, no evidence was observed regarding speaking to anyone about HIV and AIDS ($X^2 = 0.023$, $df = 1$, p -value > 0.05).

Having sex with more than one partner in the last 12 months: *Strong evidence of relationship* ($X^2 = 110$, $df = 1$, p -value < 0.05).

There is strong evidence of the relationship between exposure to more than 5 SIO sessions compared to having attended 1 to 4 sessions.

Had unprotected sex with a partner whose HIV status was not known to the respondent in the last 3 months: *No evidence of relationship* ($X^2 = 0.005$, $df = 1$, p -value > 0.05).

There was no evidence of a relationship between having unprotected sex with a partner whose HIV status was unknown to the respondents during the 3 months preceding the assessment and the number of SIO sessions attended.

Consistent use of condoms: *No evidence of relationship* ($X^2 = 0.006$, $df = 1$, p -value > 0.05).

There is no evidence of a relationship between consistent use of condoms and the number of SIO sessions attended.

4.9.1 SIO efficacy among the target population

The results were analyzed based on the target population to assess if there was evidence of a relationship between the outcomes and sessions attended (as shown in Table 19). Strong evidence of a relationship between level of exposure (based on sessions attended) and desired outcomes was observed among FSWs in the following key SIO outcome indicators:

- Had HIV test in the 3 months prior to the evaluation ($X^2 = 0.800$, $df = 1$, p -value < 0.05).
- Talked to sexual partner about HIV and AIDS in the last 3 months ($X^2 = 8.756$, $df = 1$, p -value < 0.05).
- Had unprotected sex with any partner whose HIV status was not known to respondent ($X^2 = 10.644$, $df = 1$, p -value < 0.05).

Table 19: Splash! Inside Out (SIO) efficacy analysis, by target population

Measure	Key populations	Exposure level		Chi-square (X ²)	P-value
		1-4 sessions	5 or more sessions		
Knowledge of all 3 risk-reduction methods (condom use, abstinence, and being faithful to an infected partner)	FF	11.0%	12.3%	0.092	0.761
	FSW	9.5%	6.5%	0.392	0.531
	MSM	31.6%	10.0%	3.613	0.57
High perception of risk of HIV infection	FF	46.5%	40.6%	0.725	0.395
	FSW	61.9%	60.7%	0.010	0.920
	MSM	68.8%	61.9%	0.187	0.666
Tested in the 3 months prior to the evaluation	FF	74.0%	75.4%	0.064	0.800
	FSW	56.1%	80.2%	0.800	0.003*
	MSM	84.2%	86.7%	8.803	0.811
Talked to anyone about HIV and AIDS in the last 3 months	FF	81.9%	81.6%	0.004	0.950
	FSW	90.2%	84.6%	0.783	0.376
	MSM	88.9%	90.0%	0.015	0.903
Talked to sexual partner about HIV and AIDS in the last 3 months	FF	72.4%	76.3%	3.981	0.137
	FSW	64.9%	72.7%	8.756	0.013*
	MSM	81.3%	85.2%	0.114	0.735
Have you had sex with more than one partner in the last 12 months?	FF	27.5%	27.0%	0.007	0.932
	FSW	69.7%	85.0%	3.807	0.051
	MSM	73.7%	82.1%	0.484	0.487
In the last 3 months have you had unprotected sex with any partner whose HIV status was not known to you?	FF	55.9%	62.3%	1.009	0.315
	FSW	90.2%	62.9%	10.644	0.001*
	MSM	63.2%	66.7%	0.063 ^e	0.801
Consistent use of condoms	FF	83.5%	81.6%	0.148	0.700
	FSW	95.2%	93.5%	0.168	0.682
	MSM	89.5%	80.0%	0.764	0.382

*Shows strong evidence of the relationship between exposure to SIO and the intended outcome.

Abbreviations: FF, fisher folk; FSW, female sex worker; MSM, men who have sex with men.

SECTION 5: DISCUSSION

There is a general assumption that development programs that combine evidence-based strategies tailored to diverse populations while aiming for high coverage can have a measurable reduction in population-level HIV transmission (Ramzi et al 2013). Key components of a comprehensive package of services for HIV interventions include empowering peer-led outreach (such as targeted behavior and social norm change approaches); community-based services in safe spaces (such as drop-in centers); interventions to address gender-based violence; provision of condoms and lubricants; STI testing and treatment; HIV testing and counseling; clinical care and antiretroviral treatment; and community-based care and support for resilience.³

The initiation of SIO was informed by the experience of PATH from 2000 in implementing peer-based interventions and a review of literature on programs addressing HIV and AIDS. The evidence showed that effective peer-based combination prevention interventions among key and vulnerable populations were inadequate. Such interventions need to be augmented to support demand creation for essential health services, to enhance skills for healthy behavior, and to influence social norms around health-seeking behavior in the long-term. The inadequacy in the past approaches of reaching key and vulnerable populations is recognized in the KASF (2014/5–2018/9). The Framework proposes several approaches that address the needs of the general population and those of key and vulnerable populations who are sometimes not reached with untargeted interventions. Indeed, one of the objectives of the KASF is to *'reduce HIV-related stigma and discrimination by 50%.'* The third section of the Framework is on *'using a human rights approach to facilitate access to services for PLHIV, key populations and other priority groups in all sectors.'* The four objectives in this section of the KASF have direct relevance to the approaches adopted by SIO: (i) remove barriers to access of HIV, SRH, and rights information and services in public and private entities; (ii) improve national and county legal and policy environment for protection of priority and key populations and PLHIV; (iii) improve access to legal and social justice and protection from stigma and discrimination in the public and private sector; and (iv) use a human rights approach to assist programs to pursue zero tolerance to stigma and discrimination.

The SIO project was designed to target populations that have long been inadequately reached while some (FSWs and MSM) continue to encounter stigma and discrimination that negatively impact their ability to access information and services. The approach used, of working through HAs, was aimed at going beyond peer education to empower the project beneficiaries to become actors and proactively seek information and services to better manage their risk-reduction strategies and their health.

³<http://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/key-populations-targeted-approaches-toward>.

The outcome evaluation was aimed at: (i) assessing the status of the behavioral outcomes among beneficiaries of the interventions; (ii) assessing the efficacy of SIO as a combination prevention intervention; and (iii) making appropriate recommendations (presented in section 6 of this report).

(i) The status of behavioral outcomes among SIO beneficiaries: The assessment indicates that the beneficiaries experienced personal changes in terms of perception of risk and also in taking measures toward risk reduction (HIV testing, use of condoms, and remaining faithful to one partner—mainly for the FF). It is notable that the knowledge levels on prevention measures were slightly higher among the SIO participants than the general population. For instance, citing of HIV prevention by use of condoms was 86.6% among the SIO participants while for the general population it was 84% based on the KDHS (2014) preliminary report. In addition, the proportion of people who got tested and received their results was higher among the SIO group at 75.5% compared to the general population, where 53% of women and 45% of men were tested for HIV and received the results. The levels of testing among the SIO target group were much higher than those reported nationally.

The discussions with the target population highlighted a high level of confidence among the FSWs regarding their HIV status and their work, which is an indication that they have attained a level of self-identity that allows them to speak out (they are able to 'splash it out'), seek, and demand services. Indeed, in their interactions with the judicial and justice system, through the support of legal officers attached to the LIPs, there were reports that harassment had been reduced and that they felt more protected. Furthermore, each of the LIPs has made connections with friendly health providers, while two had established operational health facilities that allowed the FSWs and MSM to access services in friendly environments.

The perceptions of the beneficiaries toward the program were generally positive with HIV and AIDS interventions being lauded as having been successful. It is however notable that the FSWs and FF appeared to be more open and accessible than the MSM, especially those in Busia. This could be related to the fact that stigma is still high among the MSM and disclosure could be accompanied by harassment from the community. Disclosure of sexual orientation continues to be a key challenge in Kenya, where negative public pronouncements on homosexuality are commonplace (KASF 2014). The use of HAs is however one key measure of ensuring that MSM can access commodities and services and that they have peers they can consult and hold discussions with in confidence.

Risk reduction was a key element of the SIO interventions. The results indicate that following exposure to SIO, some beneficiaries made conscious decisions to go for HIV testing, to use condoms consistently, and to be faithful to their sexual partners. Although being faithful was considered difficult by the FSWs, the FF cited it as a viable risk-reduction measure. Given the target population, abstinence did not rank highly among the HIV preventive measures.

A key outcome of the SIO intervention was the accepting attitude of the beneficiaries toward people infected with HIV. Most (over 90%) indicated that they

would buy fresh vegetables from an infected person, that they would care for an infected family member, and that an infected female teacher should be allowed to continue teaching. The results on 'keeping it a secret if a family member is infected' (57%) indicate that there is still stigma at the community level that should be addressed.

The key areas of behavior change that were expected from the combination prevention approach were attained by SIO. Most of the respondents knew their HIV status and understood the risk of re-infection, and those needing treatment were on treatment. The consistency in protective behavior among the FSWs and MSM (especially the MSWs) was, however, limited—perhaps due to poverty and the need for money. The fact that some men were willing to pay more for sex without condoms may have made it difficult for women and men in need of money to insist on condom use. Further, the fear of abuse was seen to limit their ability to insist on preventive behavior.

The various successes experienced by SIO could also be related to the LIPs who used resources from other programs to augment the activities funded by APhiAPlus. It was noted that SIO was strong on behavioral and biomedical interventions but weak on the structural elements. The human rights component of the FF, FSW, and MSM interventions were largely funded through other donor funds. The establishment of table banking and connections to microfinance institutions (MFIs) were also facilitated through alternative funding mechanisms. In terms of sustainability of the gains made through SIO and related interventions, the facts that some of the FF in Busia were enrolled on NHIF and some members of the Busia Survivors group were contributing to an emergency fund were considered structures that would provide an income to the HAs, and therefore they would be in a position to continue supporting their peers.

It is clear from the results that the ideal of health activism going beyond peer education to change agency was achieved under SIO. The HAs considered themselves and were seen by their peers as assets in terms of facilitating access to information and services. They felt compelled to help their peers beyond providing information. For instance, they moved around with condoms, accompanied the peers to access several services, and provided ongoing support for those with personal problems. The HAs had become agents of change for themselves and for their peers. Asked what would happen when the APhiAPlus funding ends, the HAs indicated that since they had the knowledge, they would continue to share this with their peers. The only challenge identified going forth was access to commodities such as condoms and lubricants.

(ii) The efficacy of SIO as a combination prevention intervention: Participation in SIO sessions was considered complete once a peer had completed a set of subsessions within a particular session/topic area. For instance, the session on STIs covered an introductory component, risk factors, types of STIs, signs and symptoms, management, and prevention. Consequently, a peer was considered to have completed the session on STI if he or she participated in all the subsessions, which were held at the convenience of the peers. The analysis shows that the

intervention was effective in passing critical knowledge to the participants on HIV and AIDS and the necessary preventive measures.

Although knowledge levels among the target population are closely aligned to those of the general population (KDHS 2014), it should be noted that by and large the FSWs and MSM have for long been isolated, with constrained access to information and services due to the criminalization of their activities, work schedules, and pervasive stigma and discrimination (mainly faced by the MSM).

Going for HTC and being on treatment were highlighted in the qualitative discussions as key outcomes of the intervention. Indeed, the FSWs were open in their discussions and would, unprompted, talk about their status and their experience with treatment. The MSM, on the other hand, still face high levels of stigma, especially those in Busia. Thus, more investment is required to support them to 'self-identify' after which it will become easier for them to acknowledge their risks and take the necessary preventive actions. It is notable that the FSWs and FF respondents felt that risk-taking was higher among the MSM. Because disclosure of HIV status within the MSM groups was not as open, compared to the FSWs, there were concerns that they could be infecting each other unknowingly.

It should however be noted that the definition of 'sessions' differed among the respondents. Some may have counted each encounter with the HA as a session while others may have considered a completed session as one session. To counter this challenge, the assessment team clustered participation into two categories (1–4 sessions and 5 or above), but there is a possibility of double counting and miscounting. The analysis on SIO efficacy should therefore be interpreted cautiously.

SECTION 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The outcomes evaluation set out to assess the impact of the SIO intervention among key and vulnerable populations in the Western Region of Kenya. The adoption of a health activism approach was informed by the need to implement a highly effective intervention within an environment that enforces the uptake of risk-reduction strategies adopted by individuals. The program had three areas of focus: behavioral; biomedical; and structural. It is evident that through the health activism and the linkages established with the various service providers, the program was effective in achieving the behavioral and biomedical imperatives. Structural aspects were not effectively addressed mainly due to the fact that such interventions are dependent on actors that operated beyond the remit of the project. The LIPs, however, used other resources and linkages to connect their members to MFIs and to support the formation of table banking groups and the contribution to NHIF, among other forms of safeguards. It is critical in future for similar interventions to consider the structural components given the socio-cultural and economic environments that continue to determine the behavior of key and vulnerable populations in the country.

The assessment sought to test the hypothesis that members of key and vulnerable populations who are exposed to 5 or more sessions of SIO will be better able to accept or seek referral for HIV counseling and testing services and other health services and practice safer sex (reduce number of sexual partners and increase use of condoms and water-based lubricants), compared to those who are exposed to fewer than 5 sessions. The analysis illustrates that those respondents who had attended 5 or more sessions were better able to understand their risks and adopt protective behavior on some limited variables. This result could be a factor of the interpretation of what a 'session' was or due to the fact that the exposure, however limited, had a positive influence on the target population.

6.2 General recommendations

- (i) **Address structural determinants:** There is a need to tackle structural determinants of HIV and AIDS as part of prevention interventions, since poverty and socio-cultural factors are key facilitators of sexual vulnerability. Prevention programs must therefore include capacity-building to address poverty through economic strengthening and deal with issues around gender relations and the socio-cultural environment in which people live. Cultural practices and traditions that put people at risk, more so women, must be re-examined by the key and vulnerable populations in order to create social and cultural contexts that support low-risk behavior. In terms of increasing the capacity for income generation, the efforts could include financial literacy, seed funds for small group activities, membership in medical schemes, etc.

- (ii) **More focus on MSM:** Although the project has had some impact on MSM, it is notable that some are still in the closet, which limits their access to information and services. The recruitment and training of additional HAs should be considered and the current mode of using the snowball approach to reach MSM should be enhanced. In some situations, one-on-one sessions could be promoted until the individuals feel comfortable to participate in group sessions.
- (iii) **Increase preventive interventions in the general population:** Although it makes epidemiological sense to focus on key and vulnerable populations, it is important not to relent on educating the general population on HIV and AIDS. The experiences of the FSWs and MSWs indicate that some people insist on not using condoms despite not knowing the status of the sex workers. There is thus a need for continued information-sharing and capacity-building with the general population, especially on prevention, as a means of safeguarding the knowledge and skills acquired by members of key and vulnerable populations.
- (iv) **Address stigma and discrimination:** The levels of stigma are still high, especially on the MSM. There is thus a need to focus on measures to address HIV and AIDS stigma at national, county, and community levels. Engagement of representatives of key and vulnerable populations in decision-making bodies at the three levels could be one way of addressing this.
- (v) **Support national and county governments' efforts in implementing the Kenya AIDS Strategic Framework (KASF) 2014/5–2018/9:** The Framework provides suggestions on targeted interventions that could be adopted by counties to address their challenges in HIV and AIDS mitigation. It is necessary that APHIAPlus and other partners support counties in identifying their needs, prioritizing key actions, and ensuring follow-through of adopted interventions while keeping an eye on the needs of key and vulnerable populations.

6.3 Recommendations on SIO

SIO is an intervention that could be implemented within the context of APHIA or as a stand-alone HIV and AIDS intervention. Hence, there are areas in which the intervention could be improved based on the outcomes of the evaluation.

- (i) **Generate a common understanding of what constitutes a session:** During the evaluation it was clear that the term 'session' was used variably by the APHIAPlus team, the LIPs, the HAs, and the peers. It is critical that the terminology is harmonized to provide a basis for follow-up, assessment, and analysis.
- (ii) **Reporting:** Several peers and coordinators complained that the reporting booklets were too bulky. It is recommended that SIO considers the introduction of less bulky reporting tools or the adoption of e-reporting tools.

- (iii) **Referrals:** The LIPs noted that they do not retain copies of the referrals they make for their members and that it would help if the booklets were produced in triplicate to allow them to keep copies for their records and follow-up.
- (iv) **Timely release of funds:** Planning and implementation of activities is dictated by the flow of funds. Delayed release of funds interferes with the capacity of LIPs to effectively implement their activities. It also has a negative impact on the commitment of HAs and other program actors.

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ANNEX 1: EVALUATION TOOLS

CONSENT FORM FOR KEY INFORMANT INTERVIEWS

Splash Inside Out Outcome evaluation

Consent Form – Knowledge, Attitudes & Practices

Principal investigator: Kirogo Mwangi

Co-Principal Investigator: Tom Omurwa

Address: P. O. Box 76634-00508, Nairobi

We are asking you to be in a research study

A research study is a way to test new ideas or to learn about how or why certain things happen. Researchers from PATH are leading this study. The research team wants to talk to Most at Risk Population (MARPS) i.e. Men who have sex with Men (MSM), Female Sex Workers (FSW), Men and Women in Workplace, Fisher folk, in this area about behavior Change based on the Splash Inside Out interventions that have been implemented by the APHIAPlus western project.

This form will help me explain what this study is about and what will happen if you choose to be in it. After I explain the study, I will answer any questions you have. Then you can decide if you want to be in the study or not.

What we are trying to learn in this study?

We are doing this study to learn if there are any behavioral changes that have taken place among the targeted population where the Splash Inside Out interventions have been taking place. We would also like to know if there are any differences among the different key populations targeted, what changes occurred among the SIO intervention beneficiaries who did not receive full set of Splash Inside Out and can the changes experienced be attributed to the Splash Inside Out intervention

Splash Inside Out is an intervention that APHIAplus western Kenya project has implemented with considerable level of success. It has been using Behavior Change communication in several parts of western Kenya for a period of 4 years. The key population targeted with Splash Inside Out include men who have sex with men, Female sex workers, Men and Fisher folk.

Will this study help you or others?

Being in this research study will not help you personally. But we hope it will help us understand the experiences of the MARPS in regards to behavior change. The findings of this study will be used for programmatic use, providing evidence on the implementation and change among the people targeted with Splash Inside Out.

What we are asking you to do

For this study, we are asking you to participate in an interview which will be conducted by a member of our team. The person interviewing you will ask questions about the following among others:

- Some information about people who you know (friends and other people who are like yourself) who live here

CONSENT FORM FOR FOCUS GROUP DISCUSSIONS

Splash Inside Out Outcome evaluation

Consent Form – Knowledge, Attitudes & Practices

Principal investigator: Kirogo Mwangi

Co-Principal Investigator: Tom Omurwa

Address: P. O. Box 76634-00508, Nairobi

We are asking you to be in a research study

A research study is a way to test new ideas or to learn about how or why certain things happen. Researchers from PATH are leading this study. The research team wants to talk to Most at Risk Population (MARPS) i.e. Men who have sex with Men (MSM), Female Sex Workers (FSW), Men and Women in Workplace, Fisher folk, in this area about behavior Change based on the Splash Inside Out interventions that have been implemented by the APHIAPlus western project.

This form will help me explain what this study is about and what will happen if you choose to be in it. After I explain the study, I will answer any questions you have. Then you can decide if you want to be in the study or not.

What we are trying to learn in this study?

We are doing this study to learn if there are any behavioral changes that have taken place among the targeted population where the Splash Inside Out interventions have been taking place. We would also like to know if there are any differences among the different key populations targeted, what changes occurred among the SIO intervention beneficiaries who did not receive full set of Splash Inside Out and can the changes experienced be attributed to the Splash Inside Out intervention

Splash Inside Out is an intervention that APHIAplus western Kenya project has implemented with considerable level of success. It has been using Behavior Change communication in several parts of western Kenya for a period of 4 years. The key population targeted with Splash Inside Out include men who have sex with men, Female sex workers, Men and Fisher folk,.

Will this study help you or others?

Being in this research study will not help you personally. But we hope it will help us understand the experiences of the MARPS in regards to behavior change. The findings of this study will be used for programmatic use, providing evidence on the implementation and change among the people targeted with Splash Inside Out.

What we are asking you to do

For this study, we are asking you to participate in a discussion to provide us with information on this matter/subject.. A member of our research team will lead the discussion and the discussion will last about 45 minutes.

The interviewer will ask questions about the following among others:

- Some information about people who you know (friends and other people who are like yourself) who live here

SPLASH! INSIDE OUT Outcomes Evaluation

Evaluation Protocols

November 11, 2014

MAILING ADDRESS
PO Box 900922
Seattle, WA 98109
USA

ADDRESS
2201 Westlake Avenue
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Seattle, WA, USA

TEL: 206.285.3500
FAX: 206.285.6619

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FOCUS GROUP DISCUSSION GUIDE

SPLASH INSIDE-OUT Evaluation Focus Group Discussion Guide

(Age 18 – 24; 25-49)

Introduction

Thank you so much for your willingness to take part in this group discussion. Our names are **[Names]**. We work with the APHIAplus and we are talking to you and some other study participants like you because we are interested in your opinions about your experience with the SPLASH INSIDE-OUT (SIO) program. You have been selected for participation as you have been involved with the program, and the evaluation team feels you might have some valuable feedback on SIO programs and your experiences with the services offered.

The discussions are very informal; you can talk about anything you think is important for us to know. We also want to remind you that everything we talk about today is confidential. No one will access the records of the discussion apart from the evaluation team. Your name will not be used or associated with your views. Furthermore whenever we write a report, we will not use any reference in the report that one can use to identify you directly. If there are any questions you'd rather not answer, just let me know – that's fine.

- ✓ Explain the role of note-takers
- ✓ Give a few minutes for answering any questions regarding the discussion
- ✓ Provide ground rules for the discussion (respecting opinions of others, no interruptions, etc.)

Finally, we would like to say that we know it can sometimes be difficult to discuss some of these issues openly. But everyone here is familiar with the issues we will be discussing. They are nothing to be embarrassed about. Your frank responses and discussion will help us really understand the issues better. Remember, your answers to our questions will not be considered "right" or "wrong." They are merely information you will provide based on your experiences, observations, or feelings. Also, please let's respect each other's confidentiality after this discussion is over:

- Can we all agree to not talk about what others say to people outside this discussion? This is very important. (If all agree, then continue).

Before we begin, let's go round the room and introduce ourselves. You could just tell everyone your first name.

Discussion Guide:

- A. General questions about participation in SIO (elicit first impressions of SIO without asking specific questions)
 - o You have all participated in SIO. What did you think of the approach used in reaching people with SIO?
 - o How has participating in SIO helped you to focus on health issues?
- B. Risk Reduction (elicits the understanding of health risk and how SIO has helped their understanding of risk)
 - o
- C. HIV Testing and Services (Comparison group participants only)
 - o Do you think people need to be tested for HIV? Please elaborate.

KEY INFORMANT INTERVIEW DISCUSSION GUIDE

SPLASH INSIDE-OUT Evaluation KII Discussion Guide

(Persons who are knowledgeable about SIO and the targeted key populations; including health program managers within organizations working with the target population)

Introduction

Thank you so much for your willingness to take part in this discussion. My name is [Name] and I am working with APHIAplus. I will be talking to you because we are interested in understanding how SIO has helped people who participated in the discussions to increase their knowledge of HIV prevention and access to other health services. You have been selected for this interview as you have a lot of information on the issues we want to discuss with you and also based on your knowledge of the target group and experience with the SPLASH INSIDE-OUT.

The discussions are very informal; you can talk about anything you think is important for us to know. We also want to remind you that everything we talk about today is confidential. Your name will not be used or associated with your views. Furthermore whenever we write a report, we will not use any reference in the report that one can use to identify you directly. If there are any questions you'd rather not answer, just let me know – that's fine.

Are you willing to participate?

Discussion Guide:

- A. **General questions about the target groups (obtain information on key at-risk populations)**
 - o What are the key at-risk populations in this area? Probe for fisher folk, men who have sex with men and female sex workers
 - o Why do you consider them at –risk/ what are some of the behaviours that put them at risk of HIV infections or infecting others? Please explain.
- B. **Risk Reduction (obtain information on how people among at-risk population who participate in SIO view the risk of HIV infection)**
 - o Do you think people among at-risk populations who have gone through SIO understand the risk
 - o Do you think they begin to reduce risk of being infected with HIV or infection others. Please explain
 - o Do they ask for condoms and use them to prevent the risk
 - o Do they go for HIV testing
 - o Do the men go for voluntary male circumcision? Are there some who do not and why?
- C. **Access to health services (obtain information on health seeking behavior on general health issues)**

Do think there is an improvement in the way people go for health services after going through SIO? What information can you provide how SIO participants are accessing services you were referred for by the peer educator? Do you know if some of the SIO participants might not have gone for the services they were referred for? Probe for:

 - o Screening for sexually transmitted diseases
 - o Voluntary Male Circumcision
 - o Tuberculosis screening
 - o Cervical screening
 - o Emergency Contraception/Family Planning
 - o Rape care, PEP, post rape counseling, etc.

SPLASH! INSIDE OUT QUESTIONNAIRE

Interview ID: __

Respondent ID: __ / __

SPLASH INSIDE-OUT Questionnaire

District: _____

Local Implementing Partner: _____

Community/ Location: _____

Interviewer Name: _____

Introduction:

GREETINGS. MY NAME IS _____, AND I AM WORKING FOR APHIAPLUS. WE ARE CURRENTLY INTERVIEWING PEOPLE ABOUT SOME OF THE WORK DONE BY THE PROJECT ON HIV AND AIDS PREVENTION. I AM HERE TO INTERVIEW YOU ABOUT YOUR INVOLVEMENT WITH THE PROJECT SO THAT WE CAN BETTER UNDERSTAND HOW TO PROVIDE PREVENTION SERVICES BETTER.

Confidentiality and consent:

Although we would like to learn more about HIV and AIDS in your community, we will not be asking anything about your HIV or AIDS status. I'm going to ask you some very personal questions that some people find difficult to answer. However, your answers are very important to help us understand the needs of people in your community. Your answers are completely confidential. Your name will not be written down and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us to better understand what people think and do regarding certain behaviors, and provide us with a better understanding of how we can improve our program. We would greatly appreciate your help in responding to this survey. The survey will take about _____ minutes to complete.

Would you be willing to participate?

Do you want to ask me anything about the survey?

THANK YOU

Signature of Interviewer: _____

Date: _____

(Certifies informed consent has been given verbally by the respondent)

ANNEX 2: SPLASH! INSIDE OUT SITES AND IMPLEMENTERS

Nyanza Province

National Organization of Peer Educators (NOPE) LIP	Prevention – at workplaces/worksites*
YWCA Kisii LIP	Prevention – key populations
I Choose Life - Africa (ICL)	Prevention – key populations
Migori District New	Prevention – key populations
Borabu District New	Prevention – key populations
Family Health Options Kenya (FHOK) – Nyanza	Prevention – at workplaces/worksites*
Keeping Alive Societies Hope (KASH)	Prevention – key populations (FSWs, MSM)
Kenya Red Cross Society (KRCS)	Prevention – key populations (fisher folk)
Support for Additions Prevention and Treatment in Africa (SAPTA) – Kisumu	Prevention – key populations (MSM)
Anglican Development Services (ADS) – Nyanza	Prevention – key populations (fisher folk)
CSA – Nyanza	Prevention – general population
SAIPE – Nyanza	Prevention – general population
Nyamira District New	Prevention – general population
Rachuonyo District New	Prevention – general population
Siaya District New	Prevention – general population
Kisumu East District New	Gender
Masaba District New	Gender
Kuria District New	Gender
Rongo District New	Gender

Western Province

Anglican Development Services – Western (formerly WRCCS)	Prevention – key populations (fisher folk)
Busia Survivors Group	Prevention – key populations (FSWs, MSM)
ACE Africa – Western	Prevention – key populations (FSWs)
Family Health Options Kenya (FHOK) – Western	Prevention – at workplaces/worksites*
KANCO – Western	Prevention – key populations (FSWs)

Abbreviations: FSW, female sex workers; LIP, local implementing partner, MSM, men who have sex with men.

ANNEX 3: ETHICS COMMITTEE APPROVALS

Maseno University Ethics Review Committee



MASENO UNIVERSITY ETHICS REVIEW COMMITTEE

Tel: +254 057 351 522 Ext: 3060
Fax: +254 057 351 221

Private Bag - 40105, Maseno, Kenya
Email: muero-secretariate@maseno.ac.ke

FROM: Secretary - MUERC

DATE: 3rd March, 2015

TO: Mr. Kirogo Mwangi
Program for Appropriate Technology in Health (PATH)
ACS Plaza, 4th Floor, Lenana Road,
P. O. Box 76634 – 00508 Nairobi, Kenya

REF: MSU/DRPI/MUERC/00121/14

RE: **Splash Inside-Out Outcomes Evaluation Proposal Reference No.: MSU/DRPI/MUERC/00121/14**

This is to inform you that the Maseno University Ethics Review Committee (MUERC) determined that the ethics issues raised at the initial review were adequately addressed in the revised proposal. Consequently, the study is granted approval for implementation effective this 3rd day of March, 2015 for a period of one (1) year.

Please note that authorization to conduct this study will automatically expire on 2nd March, 2016. If you plan to continue with the study beyond this date, please submit an application for continuation approval to MUERC Secretariat by 1st February, 2016.

Approval for continuation of the study will be subject to successful submission of an annual progress report that is to reach MUERC Secretariat by 1st February, 2016.

Please note that any unanticipated problems resulting from the conduct of this study must be reported to MUERC. You are required to submit any proposed changes to this study to MUERC for review and approval prior to initiation. Please advise MUERC when the study is completed or discontinued.

Thank you.

Yours faithfully,

Dr. Eonuke Anyona,
Secretary,
Maseno University Ethics Review Committee.

Cc: Chairman,
Maseno University Ethics Review Committee.

MASENO UNIVERSITY IS ISO 9001:2008 CERTIFIED



PATH Research Determination Committee Review

Research Determination Committee Review Request

RDC #0780
(for RDC use only)

Purpose: The Research Determination Committee (RDC) has been established to decide whether or not data collection activities involving human participants meet the US government's definition of research: "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge." 45 CFR 46.

Practice: Whenever PATH staff or agents are involved in the systematic collection, recording, and analysis of data through intervention or interaction with individuals, or use identifiable private information about individuals, they should either apply to the RDC for a determination that their data collection activity is not research, or submit their protocol directly to the Research Ethics Committee (REC) for review.

Instructions: To receive a review and determination from the RDC, please complete and submit the following form to RDC@path.org, with a copy to your strategic program or country leader. You should receive a response (either a determination or a request for additional information) from the RDC within two working days. If additional information is required, this will extend the time required for review. Thus, it is to your advantage to provide complete information about the activity.

Guidance: Additional information about PATH's policy is available [here](#). Categories of data collection that are exempt from this process can be found [here](#).

Please be sure you are using the most current version of this application, found [here](#).

1. Identification

- 1.1 Activity title: Outcome evaluation of SPLASH INSIDE OUT (SIO)
- 1.2 Submitted by: Kirogo Mwangi
- 1.3 Name of Strategic program or country program: Kenya Country Program (APHIAplus Project)
- 1.4 Source of funding: USAID
- 1.5 Name(s) of partner/collaborating entities and a short description of their role:

2. Logistics

Where will the activity occur? The study will occur in A+ project sites in Western Kenya where the intervention was implemented.

- 2.1 **Why was this site chosen?** These sites were chosen because they are covered by the A+ project. The intervention was used for behavior change communication with key populations who are considered to be at increased risk (according to Kenya AIDS Indicators Survey 2012) of HIV infections, including workplace, fisher folks, men who have sex with men, female sex workers and youth. The study will be conducted among members of the target groups who are aged 18 to 49 years.
- 2.2 **Will this activity be replicated in other locations?** The activity will not be replicated in other areas. The purpose of the study is purely for internal monitoring and evaluation use. The results will be used as feedback on the performance of the SIO.
 - 2.2.1 **If "yes", please state where:** Not applicable

Version 6.4 Updated 9/02/13

ANNEX 4: EVALUATION WORK PLAN

A+ Evaluations SPLASH! Inside Out (SIO) and local implementing partner (LIP) interventions		Start date	End date	Responsible	Accountable	Consulted	Informed
Planning for data collection	<u>Preparatory activities</u>						
	Define the evaluation questions and scope – these includes determining how the SIO - OE and the LIPs evaluation can be integrated to achieve synergy	22/9/2014	1/10/2014	Oby, Juma, Hellen	Oby, Juma, Hellen	Kirogo, Tom, Steve	A+ SMT
	Agree on the study methods (the study design and sampling methods) – including data analysis plans	22/9/2014	1/10/2014	Kirogo	Tom & Steve	Oby, Juma, Hellen	A+ SMT; Jeff Oby, Juma, Hellen
	Obtain RDC approval from MUREC		3/2/2015	Kirogo	Reninah	Steve	Hellen
	Hire data collectors	9/2/2015	11/2/2015	Juma, Hellen	Steve; HR	Kirogo, Tom,	A+ SMT
	<u>Finalize data collection tools</u>						
	Make any necessary final changes to the data collection tools (questionnaires, discussion guides, change story outline, and informed consent forms)	5/2/2015	6/2/2015	Kirogo, Tom, Steve	Kirogo	Oby, Juma, Hellen	A+ SMT; Jeff
	Translate data collection tools	10/2/2015	10/2/2015	Kirogo	Steve	Tom, Juma, Hellen, Oby	
	Pre-test tools	12/2/2015	13/2/2015	Kirogo	Steve	Tom	Juma, Hellen, Oby
	<u>Training of data collectors</u>						
Develop training plan	13/10/2014	17/10/2014	Kirogo	Steve	Tom, Juma, Hellen, Oby		

Data collection	Conduct training of data collectors on quantitative and qualitative methods - including Most Significant Change (MSC) techniques	16/2/2015	18/2/2015	Tom, Steve, Kirogo	Kirogo	Tom, Juma, Hellen, Oby	
	Training on MSC technique for staff who will collect change stories	19/2/2015	20/2/2015	Kirogo	Kirogo	Steve, Juma, Hellen, Oby	A+ SMT
	<u>Data management</u>						
	Develop database/data management system	3/2/2015	16/2/2015	Kirogo	Steve, Tom	Dominic, Sadik	
	Determine data collection processes (data flow: when/where is data uploaded or saved)	4/2/2015	5/2/2015	Kirogo	Steve, Tom	Tom, Juma, Hellen, Oby	
	Plan supervision/data quality checks	4/2/2015	5/2/2015	Kirogo	Steve, Tom	Tom, Juma, Hellen, Oby	
	<u>Data analysis and dissemination</u>						
	Develop data cleaning plan	9/2/2015	13/2/2015	Kirogo	Steve, Tom	Tom, Juma, Hellen, Oby	
	Develop data analysis plan	9/2/2015	13/2/2015	Kirogo	Steve, Tom	Tom, Juma, Hellen, Oby	
	<u>Materials</u>						
Procure materials for data collection (questionnaires, pens, photography etc.)	11/2/2015	13/2/2015	Steve	Steve	Tom, Kirogo		
<u>Data collection</u>							
Collect quantitative data from SIO focus population (fisher folk, sex workers, etc.)	24/2/2015	4/3/2015	Kirogo, Tom	Kirogo		A+ SMT	
Data entry for quantitative data	3/3/2015	6/3/2015	Kirogo, Tom	Kirogo	Steve, Juma, Hellen, Oby		

Analysis and reporting

Conduct focus group discussions (FGDs) with SIO focus population (fisher folk, sex workers, etc.)	24/2/2015	4/3/2015	Kirogo, Tom	Kirogo	Steve, Juma, Hellen, Oby	A+ SMT
Conduct key informant interviews (KII)	24/2/2015	4/3/2015	Kirogo, Tom	Kirogo	Steve, Juma, Hellen, Oby	A+ SMT
Collect MSC stories	23/2/2015	no set end date	Kirogo, Tom	Kirogo	Steve, Juma, Hellen, Oby	A+ SMT

Data analysis

Clean quantitative data	9/3/2015	9/3/2015	Kirogo	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT
Analyze FGD data	9/3/2015	13/3/2015	Kirogo, Allison, Tom	Kirogo	Steve, Juma, Hellen, Oby	
Selection and verification of MSC stories (level 1, 2, 3)	16/3/2015	20/3/2015	Steve, Tom, Kirogo	Kirogo	Juma, Hellen, Oby	A+ SMT

Data reporting

Develop outline of report	9/2/2015	13/2/2015	Kirogo, Allison, Tom	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT
Draft report	23/3/2015	27/3/2015	Kirogo, Allison, Tom	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT
Circulate draft report		30/3/2015	Kirogo, Allison, Tom	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT
Receive feedback		3/4/2015	Kirogo, Allison, Tom	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT
Incorporate feedback	6/4/2015	10/4/2015	Kirogo, Allison, Tom	Kirogo	Tom, Juma, Hellen, Oby	A+ SMT

Finalize report	13/4/2015	Kirogo, Allison, Tom	Steve, Tom	Tom, Juma, Hellen, Oby	A+ SMT
Share report with stakeholders	16/4/2015	Steve	Dr. Mukabi		

ANNEX 5: SCOPES OF WORK FOR TEAM AND CONSULTANT

Scope of Work for Research Team for Splash! Inside Out Evaluation

Scope of Work for Research Team for Splash Inside Out Outcomes Evaluation

Job summary

APHIAplus Western Kenya (Zone 1) will conduct an outcome evaluation of the Splash Inside Out in selected project sites where the intervention is being implemented to assess the uptake of self-reported HIV Testing and Counselling (HTC) and referral to other services including care and treatment and voluntary male medical circumcision (VMMC), perception of respondents towards risk of HIV infection, knowledge of HIV prevention strategies including partner reduction and male circumcision and communication or dialogue about health issues at the community level.

The survey will involve collection of quantitative data from a sample of 500 which is deemed to be representative of different population targeted by APHIAplus with SIO. After consenting (using consent forms) to participate in the study, participants will be interviewed by trained data collection staff using a standard KAP survey tool.

Quantitative information will be collected from key informants such as community leaders, while FGD's will be conducted with member if the target key population. Significant change stories will be collected among members of the targeted key population to identify the most significant change in selected domains of change. The project therefore invites applications from persons interested in working as research assistants (field coordinator, field supervisors, interviewers and data entry clerks) during this survey. Specifically each Research team member will be expected to:

1. Field Coordinator

The temporary staff will be expected to work with the Lead Consultant, project monitoring and evaluation (M&E) team, the program technical teams and the Principal Investigator to coordinate fieldwork activities including

Duties and responsibilities:-

- Composing data collection teams from among the RAs and Supervisors
- Ensuring that the data collection teams have and adhere to the schedule
- Working with the supervisors in each team to ensure safety of completed data collection tools
- Participate in the training of research assistants & supervisors
- Ensure that data entry and transcription of FGD data commence and proceed as planned
- Provide a report on field work activities, and 7] Coordinate the collection and review of change stories.

Scope of Work for Consultant for Splash! Inside Out Evaluation



CONSULTANT SCOPE OF WORK

Technical Support: Implementation of Splash Inside Out Outcomes Evaluation

I. Summary

The objective of the consultancy is to carry out an outcomes evaluation on Splash Inside Out (SIO) intervention in selected project sites where the intervention is being implemented. The consultant will work with the APHIAplus team to finalize the Evaluation protocol, conduct training of research assistants, facilitate data collection, write the report and disseminate the findings to the project team and stakeholders as detailed in the deliverables.

II. Background

APHIA Plus Western Kenya (Zone 1) (AphiaPlus) is a five year United States Agency for International Development (USAID) funded project that focuses on scaling up services, integration of health services, strengthening health systems, fostering community involvement, and building capacity of health workers and the Government of Kenya to offer quality health services to the surrounding population as well as creating innovative methods of effective service delivery initiatives and approaches. APHIAPlus builds on what was established during the APHIA II Western project.

APHIAPlus project objectives are:

- To expand integrated facility-based services through mentorship, support supervision, and innovative, high impact programming.
- To activate synergies for whole market planning and implementation through sub-County level Annual Work Plans (AWP) mechanisms.
- To foster dynamic integration and enhanced linkages between households and health and social services through community health workers, referrals, and community structures.
- To strengthen community capacity to advocate for their rights, monitor and evaluate services in their community and own, lead and participate in education and programs tailored to their needs.

The project operates in ten Counties in Nyanza and Western regions of Kenya. The Counties include; Kisumu, Nyamira, Homa Bay, Kisii, Migori and Siaya in Nyanza; and Busia, Kakamega, Bungoma and Vihiga in Western region.

The project plans to conduct the Splash Inside Out outcome evaluation in selected project sites where the intervention is being implemented to assess the uptake of self-reported HTC and referrals to other services including care and treatment and VMMC; perception of respondents towards risk of HIV infection, knowledge of HIV prevention strategies including

ANNEX 6: LEAD CONSULTANT CV

Amuyunzu-Nyamongo CV (2015)

CURRICULUM VITAE

A. Personal Information

Name: Mary Kigasia Amuyunzu-Nyamongo
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B. Academic Qualifications

1. **PhD (Social Anthropology)**, University of Cambridge (UK), 1994.
2. **BA (Anthropology)**, First Class (Hons), University of Nairobi, 1989.

C. Work Experience

1. **Executive Director and Founder, African Institute for Health & Development** (June 2004 to date). Responsibilities include developing and managing programmes and staff, liaising with stakeholders, mobilizing resources and networking.
2. **Research Scientist/Qualitative Expert, African Population & Health Research Centre** (April 2002 – April 2004). I was responsible for the management of research projects, dissemination of research findings to diverse and appropriate audiences, provision of guidance on qualitative research, proposal development and provision of technical support to national and multi-lateral agencies.
3. **Programme Officer, Population Council** (January 2001 – March 2002). I was the coordinator of a multi-media reproductive health project. This project resulted in live radio broadcasts and over 25 newspaper articles with the largest media house in Kenya - the *Nation Media Group*.
4. **Senior Social Scientist/Medical Anthropologist, African Medical & Research Foundation** (July 1996 – December 2000). I was the research coordinator for two regional adolescent/youth sexual and reproductive health projects, mainly focusing on HIV and AIDS that were implemented in Kenya, Uganda, Tanzania and Ethiopia.
5. **Research Scientist, Kenya Medical Research Institute** (November 1989 – June 1996). I was mainly involved in studies on neglected tropical diseases (including lymphatic filariasis, soil transmitted helminths, schistosomiasis, among others), quality of life measurements and domestic injuries.

D. Consultancy Services

1. **Food Agricultural Organization** (October – November 2014): Facilitation of a consultative workshop in Cape Town, South Africa on November 24-26, 2014. The meeting will discuss the linkage between social protection and agriculture in the African Region.
2. **African Child Policy Forum** (July – October 2014): Production and presentation of a technical paper on *"The potential for linking formal with traditional and informal social protection mechanisms in Africa."* One of the four background papers for 6th International Policy Conference on the African Child (6th IPC): Social Protection in Africa: Making it work For Children.
3. **UN-Women** (September 2014 – February 2015): Kenya AIDS Strategic Framework (KASF) –