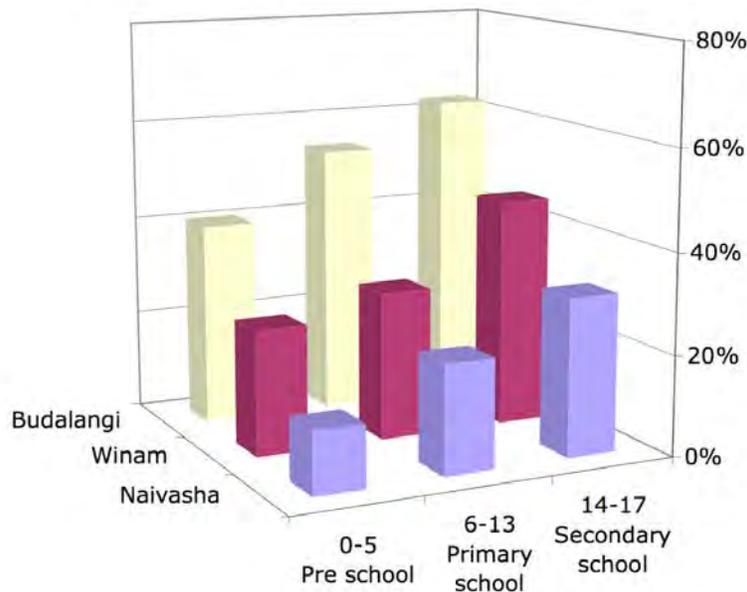


Kenya AIDS, Treatment and Support for Orphans and Vulnerable Children (KATSO)

## KATSO Baseline Assessment Report

March 2005

### Prevalence of Orphans and Vulnerable Children by school age in three KATSO sites



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The views expressed in this report are solely the responsibility of the KATSO Baseline Assessment Team and do not reflect the views of USAID.

## Table of Contents

Executive Summary.....	iv
I. Background.....	1
II. Baseline Assessment Design and Implementation.....	4
III. Performance Monitoring and Evaluation Plan.....	7
A. Overall approach.....	7
B. KATSO Master List of Indicators.....	9
C. Site Reporting System.....	11
D. Conclusions and next steps.....	15
IV. Household Surveys.....	16
A. Specific Objectives.....	16
B. Methodology and implementation.....	16
1. Questionnaire.....	16
2. Sample design.....	18
3. Data collection.....	20
4. Data entry.....	21
5. Data analysis.....	22
C. Results.....	22
1. Organization.....	22
2. Achieved Sample Size.....	23
3. Household Characteristics.....	24
4. Age and Education.....	25
5. Prevalence of Orphans and Vulnerable Children.....	26
6. School attendance, food security and support of OVCs.....	29
7. Chronically Ill Adults.....	30
8. Young Adults/Youths.....	31
9. Voluntary Counselling and Testing.....	36
10. Summary of KATSO Outcome Indicators.....	39
D. Conclusions.....	41
V. Focus Group Discussions.....	45
A. Design and Implementation.....	45
B. Findings.....	46
C. Conclusions.....	51
<b>VI.</b> Overall conclusions and recommendations.....	52
A. KATSO Baseline Assessment Findings.....	52
B. KATSO Design, Monitoring and Evaluation.....	54
APPENDICES.....	56
Appendix 1 Selected reference documents.....	57
Appendix 2 KATSO Strategic Framework.....	58
Appendix 3 Selected characteristics of 10 KATSO sites.....	59
Appendix 4 HIV and Orphan Prevalence in 10 KATSO Sites.....	61
Appendix 5 KATSO Master List of Indicators.....	62
Appendix 6 KATSO Performance Monitoring Reports.....	78
Appendix 7 Training Schedule for HHS enumerators.....	88
Appendix 8 List of HHS enumerators and supervisors.....	89

Appendix 9	Household Survey Questionnaire.....	91
Appendix 10	Household Surveys Sampling Frames .....	115
Appendix 11	Results from household surveys .....	119
Appendix 12	Prevalence of OVCs in three KATSO sites.....	131
Appendix 13	Sexual behavior of youths.....	132
Appendix 14	KATSO Outcome Indicators.....	133
Appendix 15	Focus Group Discussions Guidelines .....	134
Appendix 16	Focus Group Discussions Results.....	143

## List of Tables

Table 1	KATSO involvement in USAID/PEPFAR Program Areas in Kenya.....	2
Table 2	Schedule of the KATSO Baseline Assessment.....	2
Table 3	Location and Characteristics of the KATSO Baseline Assessment Sites.....	6
Table 4	Contents of the KBA Household and Individual Questionnaires.....	17
Table 5	Expected individuals in a sample of 440 households.....	19
Table 6	Achieved sample sizes .....	24
Table 7	Households composition and food security.....	25
Table 8	Age distribution and education of household members.....	26
Table 9	Individual and household level indicators of OVCs.....	28
Table 10	School attendance, food security and support of OVCs.....	30
Table 11	Prevalence and Support of Adults Chronically Ill.....	31
Table 12	School attendance and marital status of youths.....	32
Table 13	Knowledge of HIV/AIDS among youths.....	33
Table 14	Sexual activity of youths 15-24 .....	35
Table 15	Voluntary Counselling and Testing.....	36
Table 16	Stigma and discrimination.....	37
Table 17	Signs of depression.....	38
Table 18	KATSO Outcome Indicators.....	40
Table 19	FGD Respondents profile and number of participants.....	46

## List of Figures

Figure 1	How to set up a monitoring system.....	8
Figure 2	KATSO Routine Information Flow and Reporting Processes.....	13

## Acronyms and Abbreviations

ART	Anti-Retro viral Therapy/Treatment
ARV	Anti-Retro Viral (drugs)
CBO	Community-Based Organization
CCC	Community Care Coalition
CDM	Community Development Motivators
FGD	Focus Group Discussion
GOK	Government of Kenya
GIK	Gift-In-Kind
HBC	Home Based Care
HBOC	Home-Based OVC Care givers
HHS	Household Survey
KATSO	Kenya AIDS Treatment and Support for Orphans and Vulnerable Children
OGAC	Office of the US Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
VCT	Voluntary Counselling and Testing
USAID	United States Agency for International Development
WV	World Vision
WVK	World Vision Kenya
WVUS	World Vision United States

## Executive Summary

The Kenya AIDS Treatment and Support for Orphans and Vulnerable Children (KATSO) project is jointly funded by the US government under the USAID Presidential Emergency Plan for AIDS Relief (PEPFAR) program and World Vision US, and is implemented by World Vision Kenya (WVK). The project was initially approved for a period of two years starting on October 29, 2004, with a possible extension to five years.

KATSO is implemented in 10 districts of 6 provinces in Kenya, namely, Nairobi, Maragua, Nakuru, Busia, Teso, Bungoma, Kisumu, Suba, Migori, and Kilifi. In most KATSO sites, the activities are managed at the level of one WVK Area Development Program (ADP), where WVK otherwise implements a long-term community development program. In each District, the target area usually is one Division, starting with the ADP; in 3 sites, the target area consists of 2 Divisions.

KATSO focuses on home-based care and support for Orphans and Vulnerable Children (OVCs) and for People Living with HIV/AIDS. The project also supports and promotes Voluntary Counselling and Testing services, behaviour change activities for youths, and antiretroviral therapy services in one site.

The KATSO baseline assessment (KBA) was designed and implemented by an assessment team, hereafter called the KBA Team, composed of the KATSO Clinical Care Technical Specialist, the KATSO Monitoring and Evaluation Officer, the KATSO Project Officer from WVUS, and an external consultant. The schedule of work of the KBA Team is outlined below.

Jan 31 – Feb 7	Overall design and tools development
Feb 8 – 22	Data collection
Feb 23 – March 19	Household survey data entry
March 14 – 18	Preliminary analyses

After reviewing KATSO monitoring and evaluation needs, and the time and human resources available for the assessment, the KBA Team decided to focus on:

- The development of the overall KATSO Performance Monitoring and Evaluation Plan;
- Three Household Surveys (HHS) in 3 KATSO sites;
- Three series of Focus Group Discussions (FGD) to complement the HHS.

The HHSs were designed to provide baseline data to be compared with follow-on assessments after a few years of project implementation. The decision to focus on 3 sites was made as the best compromise between:

- The programming need for locally relevant data in all KATSO sites;
- The overall KATSO management and reporting need for data representing the entire project area; and
- The feasibility and logistics of implementing the household surveys within the available timeframe and resources.

The HHSs and FGDs were conducted in Naivasha (Nakuru District), Winam (Kisumu District) and Budalangi (Busia District), three sites selected as representing areas of lower, intermediate and higher burden of HIV/AIDS, respectively.

## **KATSO Baseline Assessments Findings**

Overall, the results of the three surveys showed consistent variations across the three KBA sites with respect to several indicators of the burden of HIV (prevalence of OVCs and of chronically ill adults) or of potentially related factors (age of sexual debut and related high-risk behaviour among youths). These findings call for the design of care and support strategies that vary across the KATSO sites.

The baseline findings from the household surveys and focus group discussions with respect to the main KATSO outcome indicators are summarized below according to the KATSO Strategic Objective that they measure.

### *SO1: Strengthened Community-Led Response*

- Some organized psychosocial support already exists for chronically ill adults, but not much so for OVCs
- Most youths have heard of AIDS and know at least one way to protect themselves against HIV infection. However, less than two thirds of youths are able to correctly identify the three main ways of preventing sexual transmission of HIV and reject three major misconceptions about HIV transmission.
- The majority of youths are sexually active at a rather low age, and most frequently before marriage. Marriage is more frequent and occurs earlier for females.
- Most never married youths who never had sex declares that they intend to be abstinent until marriage, and very few sexually active youths declared that they had more than one partners in the last 12 months. However, very few unmarried and sexually active youths declare having used a condom the first time.
- Although food security remains an issue in all KBA sites, only in the site with relatively higher food security (Naivasha) are OVCs at higher risk than non-OVCs. In the two other sites, OVCs and non-OVCs have the same risk.

### *SO2: Enabling Environment*

- Very few OVCs currently receive organized medical, psychosocial, or material support, although various types of support exist in the three KBA sites. Support for schooling is more frequent than the other types of support in the three sites.
- About three quarters of the adult population express accepting attitudes towards PLWHAs.

### *SO3: Prevention, Care and Support*

- Very few adults were ever tested for HIV; most of those were tested within 12 months before the surveys.
- The coverage of adequate organized support for chronically ill adults is very low. CCC member and caregivers recognize this situation, which they attribute to the large number of

persons in need of such services and to the lack of resources in the community to organize such services.

## **KATSO Performance Monitoring and Evaluation Plan**

The KBA Team made significant progress defining the KATSO Performance Monitoring and Evaluation Plan. As KATSO management and field staff become familiar with the project, they now have the opportunity to:

- Refine the KATSO strategies outlined in the Program Description;
- Define technical standards for the main activities;
- Adopt the list of monitoring indicators, annual targets, forms and guidelines for the Management and the sites' levels of the project;
- Conduct a pilot test of the Performance Monitoring System, and an external review after one first quarter;
- Integrate the Performance Monitoring System into the planning system;
- Conduct annual performance reviews, including periodic (2-3 years) external reviews or evaluations;
- Conduct periodic special studies and assessments allowing for process and outcome evaluations. Potential designs for such studies include the same household surveys as for the KBA surveys; simpler, lighter versions of the KBA surveys in other KATSO sites; and Lot Quality Assurance Sampling (LQAS) surveys;
- Maintain site-specific and general reference data relevant to KATSO management;
- Identify and address the training needs of KATSO Management and sites' staff in monitoring and evaluation of HIV/AIDS care and support projects;
- Conduct secondary analyses of the KBA survey data, including the sexual behaviour of youths; the socioeconomic determinants of the main KATSO indicators; and the schooling, sexual behaviour and other differentials between OVCs and non-OVCs; and the number of the various types of OVCs in each site and ADP;
- Conduct a systematic review of the methods and tools used for the KBA surveys (sample design, questionnaires, questions, indicators) to draw lessons for follow-on KATSO assessments and broader applications than KATSO.

## I. Background

The Kenya AIDS Treatment and Support for Orphans and Vulnerable Children (KATSO) project is jointly funded by the US government through the US Agency for International Development (USAID) and the Presidential Emergency Plan for AIDS Relief (PEPFAR) and by World Vision US; it is implemented by World Vision Kenya. The project was initially approved for a period of two years starting on October 29, 2004, with a possible extension to five years.

The Program Description in the USAID/WVUS Cooperative Agreement is the main reference for the implementation of KATSO and for the design of the baseline assessment. The KATSO Strategic Framework from the Program Description is provided in Appendix 2.

KATSO is implemented in 10 districts of 6 provinces in Kenya. Namely:

<u>Province</u>	<u>Districts</u>
1. Nairobi	Nairobi
2. Central	Maragua
3. Rift Valley	Nakuru
4. Western	Busia, Teso and Bungoma
5. Nyanza	Kisumu, Suba and Migori
6. Coast	Kilifi

In most KATSO sites, the activities are managed at the level of one WVK Area Development Program (ADP).<sup>1</sup> In Teso District, the WVK staff in charge of the USAID-funded Child Survival Project also manages the KATSO activities. In most Districts, the target area for one site is a Division, starting with the ADP area. In 3 District, namely, Suba, Teso and Bungoma, the target area consists of 2 Divisions because the target number of OVCs<sup>2</sup> is not achievable within the Division where the ADP, or the Child Survival Project in Teso, is located. Appendix 3 presents selected characteristics of the 10 KATSO sites, such as the name and the 1999 population estimates of the District, Divisions and ADPs where they are located; the predominant type of residence, ethnicity and economic background of the Districts, and some aspects of the implementation of KATSO. Appendix 3 also presents data on the HIV/AIDS burden of the 10 KATSO Districts that will be further discussed in the KBA methodology section II.

KATSO focuses on care and support for Orphans and Vulnerable Children (OVCs) and People Living with HIV/AIDS (PLWHAs). Specifically, the project supports activities within the following program areas of the PEPFAR 2005 Country Operational Plan in Kenya, in all or in selected sites.

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<sup>1</sup> Area Development Programs constitute the World Vision's long-term (12-15 years) community development programming units based on child-sponsorship, and which typically are complemented with and serve as basis for private and public special projects like KATSO. World Vision Kenya currently supports 41 ADPs.

<sup>2</sup> One of the targets of KATSO is to provide home-based care and support to 4,000 OVCs in each site.

**Table 1 KATSO involvement in USAID/PEPFAR Program Areas in Kenya**

USAID/PEPFAR Program Areas	KATSO Involvement	Sites Involved
Abstinence and behaviour change for youth (ABY) <sup>1</sup>	NO	-
Other prevention (OP)	NO	-
Home and community support services (HCS)	YES	10
Orphans and vulnerable children services (OVC)	YES	10
Counselling and testing (CT)	YES	10
Policy, advocacy and systems strengthening (PAS) <sup>1</sup>	NO	-
Prevention of mother to child transmission (PMTCT)	NO	10
Non-antiretroviral treatment health services (NAHS)	YES	3
Antiretroviral treatment (ART)	YES	2
Tuberculosis/HIV co-infection services (TBHIV)	NO	-
Strategic information / monitoring and evaluation (SI)	YES	10

<sup>1</sup> KATSO is not funded for ABY and PAS activities, but implements related activities under the OVC Program Area.

The KATSO Program Description in the Cooperative Agreement describes the general Performance Monitoring and Evaluation approaches of the program. For monitoring, the proposed approach is based on site-specific monthly reports on project input, activity and output data, consolidated by the Site Coordinators and submitted to the KATSO Management staff in Nairobi. This site reporting system is to be complemented by periodic mini-surveys to measure quality and coverage of care and support interventions using Lot Quality Assurance Sampling, focus group discussions, direct observations of practices and exit interviews of clients of HBC, VCT, psychosocial support service providers. For evaluation, the proposed approach is to conduct a variety of assessments and project records reviews facilitated by an external consultant, both at baseline and at the end of the project. The baseline assessment is to refine the implementation plan and refine targets as needed.

The KATSO baseline assessment (KBA) was designed and implemented by the KATSO baseline assessment team, hereafter called the KBA Team, composed of the KATSO Clinical Care Technical Specialist, also acting as Project Manager, the KATSO Monitoring and Evaluation Officer (MEO), the KATSO Project Officer from WVUS, and an external consultant. The KBA work was carried out over the time outlined in Table 2.

**Table 2 Schedule of the KATSO Baseline Assessment**

Dates	Activities
Jan 31 – Feb 7	Overall design of KBA; development of data collection tools; planning and logistics – Nairobi
Feb 8 – 11	Training of data collectors – Naivasha and Kisumu
Feb 14 – 22	Data collection -- Three sites: Naivasha, Winam and Budalangi
Feb 23 – 26	Preparation of household survey data entry program; recruitment of data entry clerks – Nairobi
Feb 28 – Mar 13	Household survey data entry – Nairobi
Mar 14 – 19	Household survey data cleaning and preliminary analyses - Nairobi
Mar 21 – Apr 5	Household survey, Focus Group Discussion and Site Reporting System data analyses; preparation and presentation of draft report - Consultant
Apr 6 – mid June	Consolidation of data sets and further analyses; preparation of final report - Consultant

This KATSO Baseline Assessment report is organized in four main sections:

- Section II presents the overall design and implementation of the KBA;
- Section III reviews progress in the development of the KATSO Performance Monitoring and Evaluation Plan, and describes the proposed Site Monitoring System;
- Section IV describes the methodology and main results of household surveys conducted in three KATSO sites;
- Section V describes the methodology and main results of a series of Focus Groups Discussions led by external facilitators in the same KATSO sites.

Section VI summarizes the main findings of the KBA and presents overall recommendations for the performance monitoring and evaluation of KATSO.

The report includes 16 appendices, some of which are self-contained documents and tools for KATSO staff, and, therefore, are essential to this report.

## II. Baseline Assessment Design and Implementation

The primary purpose of the KATSO baseline assessment (KBA) was to provide measurements of selected project indicators that could be compared with similar measurements at later stages of the project. Secondly, the KBA was expected to provide background information to better interpret the baseline values of the KATSO indicators and to inform the design and programming of the project. Thirdly, the KBA Team was to develop tools to monitor activities and collect output data from the 10 KATSO sites. Finally, the KBA was an opportunity for World Vision Kenya and World Vision US to develop and test appropriate tools and skills for conducting situation analyses and baseline assessments of HIV/AIDS projects in ADPs or other contexts.

At the end of the first week of work, the KBA Team had decided to focus on the following three components:

Component 1. The development of the KATSO Performance Monitoring and Evaluation Plan, including the *Site Reporting System* (SRS). Designed and tested for the first time during the KBA, the Site Reporting System will provide information on the 10 KATSO sites, and will be implemented on a continuing basis throughout the duration of the project.

Component 2. The *Household Surveys* (HHS), conducted in three KATSO sites selected as representing areas of lower, intermediate and higher burden of HIV/AIDS. The selection of the three sites is described below.

Component 3. The *Focus Group Discussions* (FGD), conducted by local consultants in the same three sites as the HHS to complement and further explore topics the KBA Team considered not appropriately addressed by the HHS.

Components 2 and 3 of the KBA were implemented in only three KATSO sites as the best compromise between:

1. The need for locally relevant data in each KATSO site;
2. The need for data representing the entire KATSO project area; and
3. The feasibility of implementing the household surveys within the available timeframe and resources.

The KBA Team gathered various data to select the three KBA sites (see Appendix 3),<sup>3</sup> and used the burden of HIV/AIDS and the general socioeconomic context of the epidemic and response as the two main criteria.

The burden of HIV/AIDS was evaluated based on the available district-level estimates of HIV prevalence and number of OVCs:

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<sup>3</sup> Although the KBA Team consolidated and referenced most of the data in Appendix 3 during the preparation of the final report, they adequately determined the general profile of the KATSO districts during the first week of teamwork.

- *HIV prevalence:* The National AIDS and STDs Control Programme (NASCO) recently completed a special study of the national HIV prevalence based on its Sentinel Surveillance System data from 1990 to 2002. In 2002, this system included 35 antenatal clinics covering most areas of Kenya. For the purpose of the study, the HIV prevalence data from the most closely related site was associated to each urban and each rural area of all the districts in Kenya. The HIV prevalence data used in Appendix 3 are those associated in this study with the areas where the respective KATSO sites are located (rural in most cases except Embakasi/Nairobi and Winam/Kisumu). These 2002 prevalence estimates vary from between 4% and 6% in five sites and more than 25% in two sites.
- *Number of orphans:* The Government of Kenya provides estimates of the number of orphans aged 0-17 years by District for year 2003.<sup>4</sup> These estimates for the 10 KATSO districts are included in Appendix 3 with the percentage of children aged 0-17 who are orphans (hereafter called "orphan prevalence") calculated by dividing the GOK number of orphans by half the 1999 district population projected to 2003. These calculations give orphan prevalence rates between 7% (Kilifi) and 49% (Suba).

Appendix 4 presents two graphs of the HIV and orphan prevalence data for the 10 KATSO sites. The first graph shows the levels of these two indicators for each site, and the second demonstrates the positive relationship that exists between them. The data point for Nyatike, in Migori District, appears as an outlier on this last graph; this is probably because of an underestimated HIV prevalence, since the population in that District is similar to that in Kisumu and Suba, where the HIV prevalence is much higher.

In addition to the burden of HIV data above, the KBA Team gathered data on the general context of the epidemic and response in the 10 KATSO sites: type of residence (urban, semi-urban or rural), ethnicity, main occupation, and access to general health services. They used these data to select sites with different socioeconomic profiles.

The KBA Team selected Naivasha, Winam and Budalangi as the three sites for the baseline household surveys. The main characteristics of these three sites are summarized in Table 3. Naivasha, Winam and Budalangi represent areas with lower, intermediate, and higher burden of HIV/AIDS, respectively. Naivasha is a semi urban area characterized by a predominantly Kikuyu population, and by the presence of export-oriented flower plantations employing a large proportion of the population, which often migrates from other regions of the country. Winam and Budalangi are located in the Victoria Lake region and are characterized by a large proportion of the population relying on fishing and related trade, and a mobile male population. The majority of the population is Luo in Kisumu, an urban area with a more access to health services than the two other sites. In Budalangi, the majority of the population is Luyha living in rather isolated areas, with poor communication. Fishing is the only source of livelihood for most of the population in Budalangi, two thirds of which live below the poverty line.<sup>5</sup> Budalangi is probably one of the most deprived areas in Kenya, and has been under continuing relief and food aid for years. The ADPs started in 1997 in Budalangi, in 2000 in Winam, and in 2004 in Naivasha.

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<sup>4</sup> Data available at the WVK office.

<sup>5</sup> Geographic Dimensions of Well-Being in Kenya.

**Table 3 Location and Characteristics of the KATSO Baseline Assessment Sites**

Characteristics	KATSO Baseline Assessment Sites		
Province	Rift Valley	Nyanza	Western
District	Nakuru	Kisumu	Busia
<b>Division</b>	<b>Naivasha</b>	<b>Winam</b>	<b>Budalangi</b>
Population, 2005*	178,657	371,500	60,074
Residence	Semi Urban	Urban	Rural
Ethnicity	Kikuyus	Luos	Luyhas
Main Occupation	Agriculture	Fishing	Fishing
Health Services Availability	++	+++	+
HIV Prevalence**	6%	26%	11%
Orphan prevalence***	12%	27%	8%
"HIV Burden"	+	++	+++
<b>ADP</b>	<b>Nabibi</b>	<b>Winam</b>	<b>Bunyala</b>
Start date	2004	2000	1997
Population, 2005*	22,374	120,490	21,661
% Division's population	13%	32%	36%
HIV/AIDS projects	+	+++	++

\* 1999 Kenya Population and Housing Census data extrapolated to 2005 at a 2.4% growth rate.

\*\* Sentinel Surveillance System (SSS) data from the National AIDS and STDs Control Program (NASCO 2002).

\*\*\* Data from Government of Kenya (2003), available at WVK.

See other data and notes in Appendix 3.

### **III. Performance Monitoring and Evaluation Plan**

Component 1 of the KBA consists of the development of the KATSO Performance Monitoring and Evaluation Plan in terms of the refinement of an overall approach, the definition of a KATSO Master List of Indicators, and the design and test of elements of the Site Reporting System.

#### **A. Overall approach**

The KATSO Cooperative Agreement requires World Vision to submit a quarterly performance report to USAID/Kenya. This report should contain the following information:

- a. Results achieved during the quarter
- b. Results not achieved during the quarter
- c. Steps taken to improve performance
- d. Conclusion

In addition, KATSO senior management and technical staff in Nairobi,<sup>6</sup> hereafter called KATSO Management, need timely information on activities and progress from each site. They also need specific information on the project achievements to respond to ad hoc and urgent requests from USAID/PEPFAR, World Vision Kenya, or other partners and stakeholders. Finally, yet importantly, each KATSO Site Coordinator needs to track site activities and achievements to ensure sound implementation and adjustment of its own work plan.

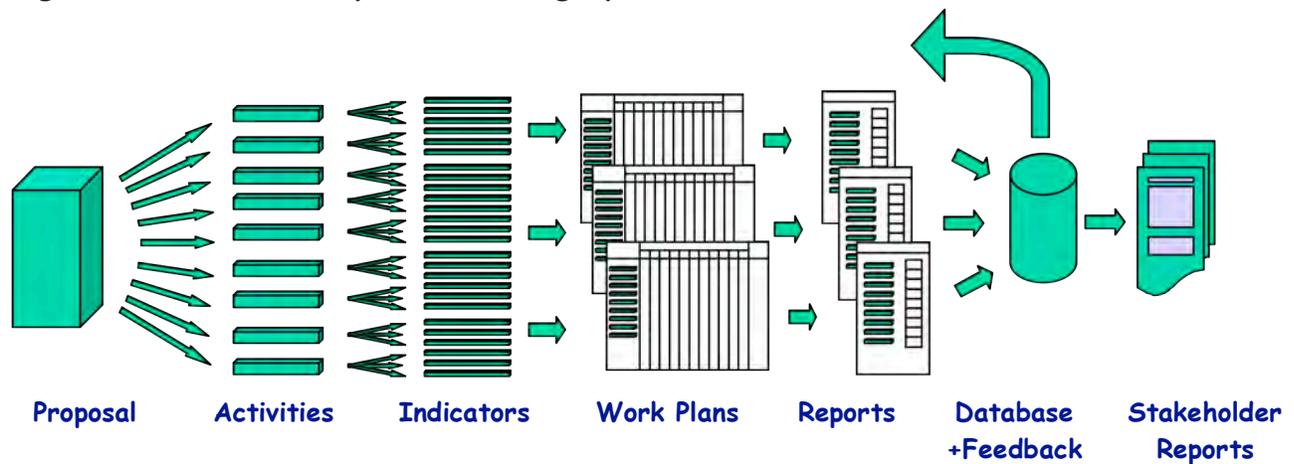
Within the first quarter of the project, KATSO Management had already established a planning system based on quarterly meetings with the field staff from the 10 sites. The KATSO work plan November 2004 – October 2005, consisting of a Gantt chart listing activities by Intermediate Results and a timeline indicating the month(s) at which each activity is to be implemented, has served as the guide for planning field activities. Overall project strategies and targets, defined in the Program Description of the Cooperative Agreement, were communicated to the Site Coordinators during the quarterly meetings and site visits by KATSO Management. Each site is expected to submit a monthly report. Before the KBA, performance indicators and targets had not yet been established for the KATSO and the sites' work plans and reports.

Before the KBA work began, KATSO staff from WVUS and WVK had already begun developing a series of outcomes and outputs indicators for the project. Figure 1, "How to set up a monitoring system," presents the overall approach that WVUS and WVK adopted for the development of these indicators. This approach, developed by World Vision for its Title II Development Assistance Programs, is easily adaptable, and already has been used in many different contexts. The software is available from WVUS to support the definition of the various components of the systems and manage the related data in a consistent manner.

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<sup>6</sup> At the time of the KBA, the KATSO senior technical and management staff in Nairobi comprised the Clinical Care Technical Specialist, also acting as the Project Manager, the OVC Technical Specialist, the Monitoring and Evaluation Specialist, and the Grant Accountant.

**Figure 1 How to set up a monitoring system**



*Source:* How to set up a Program Monitoring System. Module 1. Brett Gresham. World Vision. Undated.

In the context of KATSO, the simple steps illustrated in Figure 1 may be applied at both the KATSO Management and the site levels. At the KATSO Management level, for instance, activities to consider might include hiring, training and supervising the sites' staff, or conducting special studies or national level advocacy. Since the sites' staff have little to do with planning such activities, even if they may be directly concerned, these activities should not be included in their work plan and reports. On the other hand, at the KATSO sites' level, data on certain inputs, activities or outputs may be critical to the effective implementation of the site's own work plans, but may be of little interest at the KATSO Management level. Therefore they should not be included in KATSO Management's work plan and report.

The reporting, database and feedback elements in Figure 1 also need to be further specified by KATSO Management from both a KATSO Management and a KATSO sites' perspective. KATSO Management, for instance, must collect the reports from 10 sites and from other special activities, and must provide feedback to the 10 sites. In addition, KATSO management is responsible for collecting the data for outcome indicators, and for preparing and transmitting various reports to USAID/Kenya, World Vision US and other stakeholders. On the other hand, at the site level, data from all field workers must be collected and compiled; feedback must be provided to them and to local stakeholders; and various reports must be transmitted to KATSO Management. Both KATSO Management and the sites' staff need a database that is appropriate to their planning, reporting and feedback needs, responsibilities, and abilities. In principle, KATSO sites' staff need only to report on indicators that KATSO Management can use.

Building on the overall approach above, the KBA Team developed a KATSO Master List of Indicators for use by KATSO Management. Section B below describes the process and results of this work. During the KBA, the Team also developed a data collection form that they sent to the 10 KATSO sites to report on selected output indicators. Section C builds on the lessons from this first round of data collection from the sites and on the KATSO Master List of Indicators to propose a structure and key elements for the KATSO Site Reporting System.

## **B. KATSO Master List of Indicators**

Adopting and adapting the methodology illustrated in Figure 1, the KBA Team further developed KATSO's outcome and output indicators for each Intermediate Results (IRs) as defined in the Program Description of the Cooperative Agreement (see KATSO strategic framework in Appendix 2). All relevant PEPFAR indicators<sup>7</sup> were adopted first, followed by all relevant CHARMS indicators,<sup>8</sup> and finally, additional indicators were developed for the IRs that were not adequately covered by PEPFAR or CHARMS indicators.

PEPFAR defines two types of indicators that USAID Missions are required to report to the Office of the US Global AIDS Coordinator (OGAC) in Washington, and which each PEPFAR grantee is required to report to the Mission, as relevant to their program:

1. Outcome- and Impact-level indicators that "provide evidence for trends related to behaviour change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality."
2. Program-level data, depending on service/program area, that typically represent:
  - *Number of health services outlets/prevention programs.*<sup>9</sup> A service outlet is the lowest level of service, and a prevention program (mass media / community outreach) is counted at the level at which funds are obligated. Any service outlet or prevention program that receives at least some funding from the USG is counted.
  - *Number of clients served, disaggregated by sex.* Any client of a USG supported service or program is counted in its respective program category.
  - *Number of health workers/persons trained in the service.* A person trained more than once within a given reporting period and program category is only counted once for that period. A person trained in more than one program category during the same reporting period can be counted once for each category.

CHARMS indicators are those adopted by the Hope Initiative of the World Vision Partnership to monitor World Vision's HIV/AIDS response worldwide, particularly at the ADP level. WVK began implementing CHARMS in 2004, and, at the time of the KBA, WVK had received quarterly reports from 8 of the 10 ADPs involved in KATSO. At the ADP level, CHARMS defines indicators for the main components of the World Vision Hope Initiative:

- Prevention for children 5-15
- Care
- Advocacy
- Church/FBO Partnership

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<sup>7</sup> See: Indicators, Reporting Requirements and Guidelines, PEPFAR, September 30, 2004, Draft.

<sup>8</sup> See: World Vision Core HIV/AIDS Response Monitoring System (CHARMS): A Summary. November 2004.

<sup>9</sup> Section I of this report defines the PEPFAR service/program areas covered by the KATSO project.

To ensure consistent names, definitions and use of indicators across project documents, administrative units, and over time, the KBA Team first developed a KATSO Master List of Indicators (Appendix 5). This Master List defines all the project indicators from a KATSO Management perspective, that is, one of receiving and compiling data from the 10 sites and one reporting to WVK and USAID/PEPFAR mission. The Master List should be maintained by KATSO Management and used to prepare sub lists of indicators (see below).

To be a useful reference, the Master List of Indicators must have some internal consistency in its defining elements. The following rules are used in the KATSO Master List of Indicators in Appendix 5:

- The indicators are listed according to the structure of the KATSO Strategic Framework (see Appendix 2), with outcome listed before output indicators for each Intermediate Results. For each Intermediate Result, outcome indicators are given an order number separate from that for outputs indicators, which are numbered separately within each Activity.
- The indicator names are short for easy reference in other documents and forms, as well as in conversations. The same name can be used for the various uses of an indicator. For instance, the name “number of clients receiving VCT services” can be used for the specific indicator definition at the site level and for the specific definition at the KATSO Management level.
- The indicator definition specifies all the elements needed to avoid ambiguity in data collection and analysis, and to ensure internal and external comparability. The definition provided in the Master List is that from a KATSO Management perspective, and it may be necessary to adapt it when a sub list of indicators is prepared for a particular purpose. For instance, in the Master List, the indicator named “number of clients receiving VCT services” refers to the total number of clients receiving services in all 10 sites during the last quarter. At the site level, however, the same indicator name refers to the number of clients receiving services in the site area and during the last month.
- The definitions of the PEPFAR and the CHARMS indicators are provided in the Master List, with a reference to the relevant document and a page number for easy reference. The PEPFAR and CHARMS indicators should be adopted “as is” as a contribution to these two information systems.
- The four data sources in the Master List are those defined from a KATSO Management perspective: Household Survey (12 outcomes indicators); Site Reporting System (69 outputs indicators); KATSO Management or records (6 output indicators); and Annual review (1 outcome indicator).
- The frequency of reporting in the Master List refers to that of KATSO Management to USAID/Kenya: quarterly for output indicators, and annually or every two or three years for outcome indicators. KATSO Management may compile all the output data received from the 10 sites on a monthly basis to check the completeness and quality of the data, and provide early feedback (see Section C), but only report the totals on a quarterly basis.
- The persons responsible are those providing the data to KATSO management, and those processing them and those preparing the report to USAID/Kenya.

Once the Master List is established, KATSO Management must specify separate sub lists of indicators for different uses. Each indicator on these sub lists must be clearly related to one from the KATSO Master List of Indicators, although their defining characteristics may vary. At least four sub lists of indicators can be identified at this point:

1. A list of site core indicators, related to the activities that all sites are implementing;
2. A list of site special indicators, related to the activities that only a few sites are implementing (see ART, nonART and psychosocial activities);
3. A list of KATSO Management quarterly indicators, including site indicators and other indicators related to KATSO Management level activities;
4. A list of outcome indicators, which KATSO Management will collect and report on annually or every two or three years.

KATSO Management also needs to further specify most definitions of the indicators in the Master List to ensure their full meaning and usefulness. For instance, indicators of the number of individuals trained in a particular topic are only meaningful if the type of training is also specified (expected competence at the end of the training, or reference to a well-defined training curriculum adopted by KATSO). Indeed, adding or comparing the number of trainees across sites and over time is only meaningful if the training received is comparable; if not, further clarification (narrative) is warranted for each number reported. Indicators of the number of services or individuals operating “according to KATSO-defined standards” also imply that these standards are defined, approved and communicated in the first place, and implemented. Part of the development of the monitoring system is therefore to record those definitions for use throughout the project period and for clarification at any time. If those definitions, standards, or training curriculum do not exist, they must be developed.

### **C. Site Reporting System**

After reviewing the list of KATSO indicators, the KBA Team prepared and sent to the 10 Site Coordinators a form with a list of 52 activities with respective indicators. The form also included KATSO-level targets for the first year of implementation, and a series of columns for the Site Coordinators to fill: one “baseline” column, one column for each month of the year, a “total” column and a “responsibility” column.

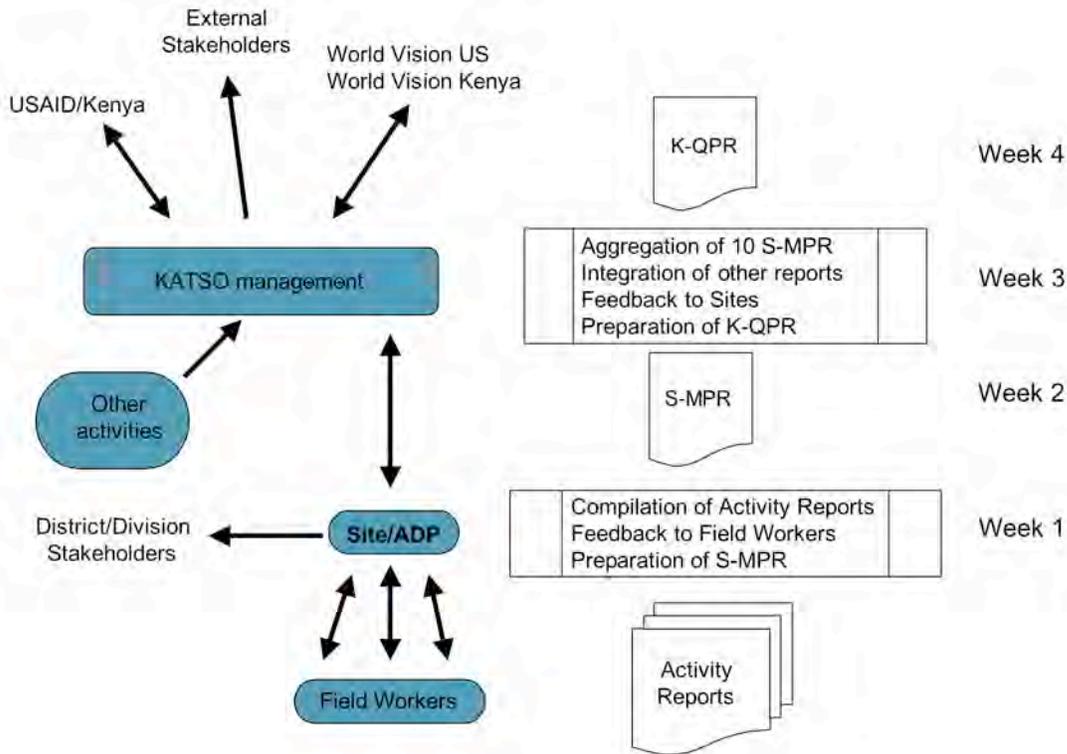
The Site Coordinators may have had difficulties with the tool, thus taking them more than one month to send the forms back to KATSO Management. Most of them did so after several email and phone reminders. In addition, most of the forms received were incorrect, inconsistent or unclear. This first round of data collection from the Site Coordinators provided important lessons for the future:

1. The Monthly Performance Reports are not substitutes for the site work plans, in which site-specific activities, targets and schedule are specified. Each site must report performance against their work plan. Even though many KATSO targets are the same for all sites at this point (“4000 OVCs served in each site,” for instance), it is likely that some of these targets will have to be adapted to the context and implementation capacity of each site.
2. The number of indicators should be kept small. KATSO Management may define 10-15 indicators that would be tracked over the years of KATSO implementation, and other indicators, which may be defined on a yearly basis, to support new activities and initiatives. KATSO Management may also assist each site in defining indicators that they can use at their level, but do not necessarily need to report on.

3. The review of the forms and data that KATSO management received from the Site Coordinators points to various details, not discussed here, to specify when finalizing the list of indicators for the Site Monitoring System. Two main issues among those are (1) whether one particular output number is that for the last reporting period or some cumulative number at the end of the reporting period, and (2) whether it is the results of the KATSO activities or that of all projects and partners in the KATSO area.
4. There is a need for a detailed users' guide or protocols on how to collect and report on the data required in the Sites. Once finalized, such a guide should be used for training the Site Coordinators and other staff responsible for preparing these reports, most of them being new to KATSO and HIV/AIDS care and support programs. At the minimum, these guidelines would include for each indicator:
  - The definition, using the same structure as in the Master List, but from the site perspective;
  - The specific data source (field workers activity reports, VCT center records, etc);
  - The person responsible for providing the data to the Site Coordinator (the Home-based OVC care giver supervisor, the in-charge of the VCT centre, etc);
  - A narrative description of the purpose and use, and of the data collection and calculation methods.

Figure 2 is a diagram of the information flow and reporting processes of the proposed KATSO Performance Monitoring System, with an indicative schedule for its of implementation. By the end of the first week of each month, the Site Coordinators should have received all activity reports from the various field workers, and compiled the appropriate data for feedback and reporting. By the end of Week 2, all the site reports should be available at the KATSO Management level. By the end of Week 3, KATSO Management should have compiled the data from the 10 sites and those from other activities. They should then be ready to provide feedback to the sites' staff. By the end of Week 4 every quarter, KATSO Management should have sent a KATSO Quarterly Report to USAID/Kenya, to World Vision Kenya and US, and to external stakeholder, as appropriate.

**Figure 2 KATSO Routine Information Flow and Reporting Processes**



The KBA Team developed 3 forms to be used in the Site Monitoring System (see Appendix 6):

1. The first form is proposed as KATSO Site Monthly Performance Report (S-MPR), slightly modified from that sent to the sites during the KBA. The form is in a spreadsheet format that can be used for data entry, transmission and filing. All KATSO sites seem to have the equipment and capacity to use spreadsheets on a routine basis. Hand-completed paper forms could still be used if necessary. The list of indicators is a selection from the KATSO Masters List of Indicators, to be finalized as explained above. The indicators' names are purposely the same as those in the Master List to ensure consistency. The exact definitions, to be specified in specific guidelines, must be appropriate for the KATSO site level, as discussed above: The reporting period is the last month, and the scope is the KATSO site area. The End-of-Year target for each indicator, as approved in the site's work plan, is entered in the second column of the form.

The S-MPR form covers all months of the year so that anyone at the site or at the KATSO management level can easily review the achievements of the year-to-date. However, each site reports only new data for the last month, unless a specific note is provided to justify a change or correction to the previous month's report. The form includes two "Total" columns. The first "Total" usually is the sum of the numbers in each month column until that of the month of the report; it can also be the number in the month column of the report for indicators consisting of a cumulative number. The second total is the "first total" divided by the annual

target for the site, as defined in the approved work plan of the KATSO site submitting the report. These two totals are calculated automatically in the spreadsheet when the data from the last month is entered. If completed by hand, the users' guide should provide a simple formula.

The data in the form in Appendix 6 are those received from one site during the KBA, and are provided for illustration purposes only.

2. The second form, the "KATSO Monthly Compilation of Site Monthly Performance Report," is for KATSO management to use every month to compile the data received from the 10 sites, verify the completeness and quality of the data received, and calculate the 10-site aggregate values of each indicator. This spreadsheet template easily shows the overall progress of the project and the variation across sites. It uses the same indicator names as that of the Site Monthly Performance Report. The End-of-Year Targets should be those in the approved KATSO management work plan, and be equal to the total of the targets of all sites. For each indicator, the spreadsheet includes one column for each site, in which the data received from the site for the month is simply entered. The spreadsheet also includes a "Total This Month" column, calculated as the sum of the numbers for each site, and a "Year-to-date Progress" column, calculated as the Total This Month divided by the End-of-Year Target. This monthly aggregation of the 10 S-MPR at the KATSO management level is for internal use, not for external reporting. This allows the KATSO staff to focus on the quality and timeliness of the data and on feedback to the field.

The data in the form in Appendix 6 are those received from the 10 sites during the KBA, and are provided for illustration purposes only.

3. The third form is a template for the KATSO Quarterly Performance Report (K-QPR) to be submitted to the USAID/Kenya Mission. The form should include selected indicators from the S-MPR and from other sources for activities at the KATSO management level. One column lists the annual target for each indicator, as per the approved KATSO management work plan. Two columns for each quarter then report for each indicator (1) the "Total-This-Quarter," that is, the totals of the corresponding data in the "Total-This-Month" column of the three KATSO Monthly Compilation of S-MPR of the quarter, and (2) the "Progress-To-Date," that is, the "Total-This-Quarter" divided by the KATSO annual target.

When finalizing the KATSO Performance Monitoring System, KATSO Management should develop two other forms: (1) a form for KATSO Five-year Targets, listing annual targets for each indicator for the 5 years of the project, and (2) a form for KATSO Site Annual Targets. This second form would provide the KATSO targets for the 10 sites for one year. These targets would be then included in each S-MPR, and the totals for 10 sites would be reported in the K-QPR. These 2 forms presenting the site-specific and KATSO-level targets constitute the critical link between planning (setting targets and defining activities and resources to achieve them) and performance monitoring (measuring the progress towards those targets).

## **D. Conclusions and next steps**

The KBA Team made significant progress defining a KATSO Master List of Indicators to be further developed at different levels of the project. They also tested outputs indicators and forms in the 10 KATSO sites, an exercise which enabled them to define the main elements of a performance monitoring system from the field workers up to KATSO Management and the USAID Kenya mission.

The next steps for KATSO Management in developing the KATSO performance monitoring system include:

- Further define the specific strategies, activities and plans for each KATSO Intermediate Results at the management and the site levels (narrative, include rationale for interventions and critical assumptions);
- Document the relevant technical and management standards for the key activities and services supported by KATSO such as training, home-based care for OVC and chronically ill adults, VCT services, behaviour change interventions for youths; and other activities, as possible. Plan for the development and adoption of standards for activities for which they do not exist yet.
- Review and obtain feedback on the list of indicators, related forms and performance monitoring system developed so far with (1) the USAID Mission, (2) the Site Coordinators and other field staff, and (3) the World Vision Kenya senior management staff, particularly the HIV/AIDS and the DME staff;
- Finalize and adopt the lists of indicators, targets, reporting forms and guidelines to be used at the Management and the site levels;
- Plan a well-defined pilot-test period to implement the Performance Monitoring System, with an objective of achieving one complete and consistent KATSO Quarterly Performance Report by a certain date. The system can be implemented using simple spreadsheets during this trial period (instead of developing a specific software). The pilot-test should include training of the staff involved in its implementation.
- Undertake an external review of the system at the end of the pilot-test period. Make the changes in the system as recommended by the review. Consider a higher level of automation of the system at that time.

In the broader context of the KATSO Performance Monitoring and Evaluation Plan, the KATSO Team should consider:

- Ensuring the participation of KATSO beneficiaries, staff, partners and stakeholders in the development and implementation of the monitoring system;
- Use the information from the site performance monitoring system to provide systematic feedback and develop work plans with the sites' staff during quarterly planning meetings;
- Establishing a system for identifying critical performance issues based on the monitoring data, and developing problems solving or operations research protocols to address them, as appropriate;
- Conduct annual performance reviews, including periodic (2-3 years) external reviews or evaluations.

## **IV. Household Surveys**

Component 2 of the KBA consists of three household surveys conducted in 3 of the 10 KATSO sites, purposely selected as representing areas with lower, intermediate and higher burden of HIV/AIDS, and areas of different socioeconomic background.

### **A. Specific Objectives**

The objectives of the KBA household surveys are:

1. To provide baseline measurements of KATSO outcome indicators;
2. To provide background information to interpret the baseline and later measurements of KATSO outcome indicators.
3. To provide background information to further inform the design and programming of KATSO.

### **B. Methodology and Implementation**

The methodology and implementation of the KBA surveys are described here in detail to (1) provide the information needed to interpret the findings, (2) ensure that follow-on surveys can be designed to provide comparable results, and (3) let WVK and WVUS learn from this first experience with such a survey.

#### *1. Questionnaire*

After defining the KATSO outcome indicators to be assessed through a population-based survey, the KBA Team first considered developing new questions for the questionnaires and overall survey methodology that World Vision is currently rolling out worldwide to assess the local impact of the ADPs on the Transformational Development Indicators. While this option would have provided the opportunity to develop and test tools that could be quite easily used by any ADPs implementing a TDI survey, the KBA Team decided that this option would require more time than was available for the design of the KATSO surveys.

The KBA Team then chose to use and adapt a household survey questionnaire that had recently been developed and tested by a UNICEF/MeasureDHS team. This UNICEF/MeasureDHS team presented the results and lessons learned from a pilot test of this questionnaire at a meeting in Washington on January 6, 2005, just before the KBA. The UNICEF/MeasureDHS questionnaire presents the advantages of having a similar structure and set of questions to those used in the Kenya DHS 2003, and the structure and exact formulation of questions required for the PEPFAR indicators relevant to KATSO. The KBA Team adapted these questionnaires<sup>10</sup> by changing some of the terms used, adding a few questions of particular interest to the KATSO staff, and reducing the number of questions to ensure feasibility of the three surveys within the available timeframe and resources.

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<sup>10</sup> The UNICEF/MeasureDHS team provided electronic copies of their questionnaires to the participants to the meeting above.

The KBA household survey questionnaire is included in Appendix 9. The questionnaire has two components: a household questionnaire to be answered by the household head or any adult knowledgeable about the composition of the household, and an individual questionnaire to be answered by adults aged 15-49, with specific questions only for youths aged 15-24. Table 4 presents the main topics and number of questions of these two components of the questionnaires.

**Table 4 Contents of the KBA Household and Individual Questionnaires**

Topic	Number and type of questions
<i>Household questionnaire</i>	
Household schedule/roster	21 questions about each household member (age, sex, intra-household relationships, education, orphanhood, chronic illness)
Household characteristics	11 questions on the type of housing, assets, and food security
Support for chronically ill people	9 questions about support received by each chronically ill person
Support for chronically ill people who died in last 12 months	8 questions to identify eligible deaths and 8 questions about support received by each of those eligible deaths
Support for Orphans and Vulnerable Children	6 questions to identify the eligible households with OVCs and 8 questions about the support received by each child in these households
<i>Individual questionnaire</i>	
Marriage	8 questions on marital status, age at marriage, age of spouse/partner
Sexual activity	<u>Youths only</u> : 14 questions on sexual debut, number and age of partner(s), abstinence, and condom use
Knowledge of AIDS	<u>Youths only</u> : 14 questions on modes of transmission and prevention measures
Voluntary Counselling and Testing	10 questions on number, timing, location and access to results of HIV tests
Stigma and discrimination	11 questions on attitudes and beliefs regarding PLWHAs and sexual behaviour
Psychosocial issues	9 questions on feelings about own mood and life

The KBA Team also developed the following tools to monitor the data collection:

1. Household Visit List – Enumerator: A list of all the households visited with the result of each visit recorded as “Completed” if at least the household interview has been conducted, or as “Refusal,” “Absent,” or “No one competent to answer the questions,” as the case may be.
2. Questionnaire Submission Sheet – Enumerator: A list of the numbers of Household and Individual Questionnaires and of Household Visit Lists submitted to the supervisors.
3. Questionnaire Reception Sheet – Supervisor: A list of the numbers of Household and Individual Questionnaires and of Household Visit Lists received from each enumerators, with the date of reception and the name of the enumerator.

4. Cluster Household Visits Summary – Supervisor (in Winam only): For each cluster, a list of all household visits by each enumerator, with the result of the visits and the number of individual questionnaires completed for each target group (females and males aged 12-24, and females and males aged 25-49). The supervisor submits this form with all the completed questionnaires for the cluster to the Survey Site Coordinator.

## 2. Sample design

In each KATSO area selected for a KBA household survey (Naivasha, Winam and Budalangi), the sample design consisted of a stratified cluster sample of 440 households, and 440 individuals from each of the four following target groups:

- Female young adult 12-24 years old
- Male young adult 12-24 years old
- Female older adult 25-49 years
- Male older adult 25-49 years

The sample of households was divided into two strata of equal size, one in the ADP and one in the remaining area of the Division. The equal-size stratification was made to ensure a minimum sample of 220 households in each area, and to allow for analyses relevant to each stratum and for statistical tests of the potential differences between them.

The cluster sampling design was justified by the lack of a reliable list of households at the Division level and by the logistical efficiency of this type of sample. Given the absence of data from similar surveys, a conservative design effect of 2 was taken into account in the sample size calculations to compensate for the loss in precision resulting from the cluster sampling. To ensure a sufficient number of clusters in each stratum, 22 clusters of 10 households were selected in each stratum.

The total sample size was determined based on the size needed to show statistically significant and meaningful differences in selected KATSO outcome indicators. These differences can be meaningful over time, as when comparing baseline and later-stage assessments, or when comparing populations in different areas (ADP versus non-ADP areas) or with different characteristics (male versus female; youth versus older adults; households with versus without OVCs). Various simulations were made using a standard formula that gives the sample size needed to detect differences between two proportions:

$$n = D * \frac{\left[ z_{1-\alpha} \sqrt{2p(1-p)} + z_{1-\beta} \sqrt{p_1(1-p_1) + p_2(1-p_2)} \right]^2}{(p_2 - p_1)^2},$$

where:  $n$  = sample for each group;  $D$  = Design effect;  $p_1$  = estimated proportion in one group or survey;  $p_2$  = estimated proportion in the other group or survey;  $p = (p_1 + p_2)/2$ ;  $z_{1-\alpha}$  = z score for 95% confidence, or 1.96 for a one-sided test;  $z_{1-\beta}$  = z score for 80% power, or 0.84.

A level of confidence of 95%, a power of 80%, a design effect of 2 and in most cases an assumed meaningful difference of 20% were used in these simulations, made for proportions based on various denominators such as households, sex-specific youths, OVCs, or chronically ill persons. For proportions of individuals with certain age, sex or OVC status, results from the formula were

adjusted for the expected distribution of these characteristics within households to obtain the sample size of households. Table 5 shows the number of various age- and sex-specific individuals and of OVCs expected to be identified through the enumeration of the individual members of 440 households, and the assumptions used for these calculations.

**Table 5 Expected individuals in a sample of 440 households**

Individual characteristics	Percentage of population	Individuals per Household		Expected Individuals in Sample	
		Total	Sex specific	Total	Sex specific
All	100%	7.0	3.5	3080	1540
Age					
0-4	20%	1.4	0.7	616	308
5-14	30%	2.1	1.1	924	462
15-24	25%	1.8	0.9	770	385
25-49	25%	1.8	0.9	770	385
0-17	50%	3.5	1.8	1540	770
OVC	10%	0.7	0.4	308	154

*Assumptions:* Household sample size = 440; average household size = 7.0; sex ratio (M/F) = 1; OVC prevalence = 20%.

As an example of the simulations described above, a sample size of 150 male youths at baseline and a few more years later would likely show a statistically significant difference in the proportion of those who never had sex if it increases from 50% to 70% between the two surveys. Since there are only 0.9 male youths per household and the response rate within each household would most likely not exceed 85%, the target sample of households in each survey should be at least 200. In addition, in order to detect such a difference in the ADP area and in the non-ADP area, or to compare results for this indicator between the ADP and non-ADP within one survey, this sample size should be achieved in each stratum, that is, a total sample of 400 households would be needed.

Several indicators for the same category of individuals are based on additional conditions, which increase the sample size requirements. Continuing with the example above, the indicator “proportion of male youths who never had sex and who intend to abstain” requires a sample of male youths adjusted by the proportion of male youths who never had sex, that is, a sample of 400 male youths or 800 households if the proportion of male youth who never had sex is 50%. Such adjustment is also needed for the indicators assessing the support received by OVCs. If an OVC prevalence of 20% is assumed, a total sample of 400 households would be sufficient to detect differences such as those described above between two surveys, but may be not differences between strata.

Other indicators require a far smaller sample of households for the same power and precision. This is the case for the “percentage of adults 15-49 with accepting attitudes towards PLWHAs,” for instance. Assuming the same sample calculation assumptions as those used above and an average number of adults aged 15-49 per household of 3.6, a total sample of 100 households would be sufficient if all adults in all households were successfully interviewed.

Some indicators are based on individuals who represent a much smaller proportion of the population than those mentioned above, and therefore require a far larger sample of households. This is the case for the indicators “percentage of chronically ill people who received support,” for instance. Even though the power of the KBA household survey to detect differences in such indicators is probably much lower than 80%, the KBA Team felt that simply obtaining estimates of the proportion of adult chronically ill in the population would already be a worthwhile results of the household surveys.

The 22 clusters in each stratum were allocated to sub locations with a probability proportional to their number of households, as reported by the 1999 Kenya Population and Housing Census. Appendix 10 presents, for each stratum of each survey, the list of sub locations, the cumulative number of households and the number of clusters allocated to each sub location through systematic random selection.

The selection of the clusters and households within each sub location was made slightly differently in each survey site. In Winam, for instance, the enumerators most familiar with a sub location suggested the most obvious way to divide it into the same number of neighbourhoods of equal size as the required number of clusters. One team of enumerators was then sent to each selected neighbourhood. The team of enumerators selected the first household randomly by spinning a pen on the floor near a central point such as the market or the house of a village chief, and by picking the first household in the direction pointed by the pen. Then they selected every next closest household until the target number of households and individuals for the cluster was achieved.

Within each household where a competent respondent accepted to proceed with the interview, the first task of the enumerator was to list all the household members, and ask a series of questions about them. In addition to collecting this data, this enumeration led to the identification of the household members eligible for the individual interviews (females and males aged 12-24, and females and males aged 25-49). To ensure that an adequate sample size would be available for each of these target groups and be representative of all the households in the cluster, the enumerators were instructed to proceed with the interview of at least, but no more than, one individual of each target group in all households. If there were more than two from any of the four categories of household members, the interviewer picked one individual at random and interviewed only that person. As it was unlikely that one individual from each target group would be successfully interviewed in 10 successive households, interviewers were instructed to continue visiting households and completing household questionnaires until at least 7 individuals in each category were interviewed. While doing so, they continued recording the outcome of each household visit in the form Household Visits Listing – Enumerators.

### 3. *Data collection*

At the request of the KATSO Project Manager, the local staff of the three selected sites made the arrangements for training and data collection activities. They recruited 24 persons with at least a high school certificate (“Form 4”) to serve as interviewers or supervisors during one week, and to participate in a two-day training workshop before the fieldwork. The number of interviewers and supervisors needed in each site was estimated as follows:

# Household Questionnaires (sample size)	440
# Household Questionnaires / interviewer-day	5
# Interviewer-day needed	88
# Supervisor-day (1 supervisors for 5 interviewers)	18
# Persons needed to complete survey in one 5-day week (rounded):	
# Interviewers:	20
# Supervisors:	4
Total:	24

The KBA Team conducted a 2-day training in Naivasha on February 8 and 9 and then in Kisumu on February 10 and 11. The interviewers and supervisors hired for Budalangi joined those hired for Winam for the training in Kisumu. The training schedule is in Appendix 7. The first day consisted of a briefing on the baseline survey, a review of the questionnaires including clarification, interpretation, restatement and translation of each question, and demonstrations and role-plays of interviews techniques. The second day consisted of a logistics and interview field practice, during which each enumerator had the opportunity to conduct a few household and individual interviews. At the end of each two-day training, the KBA Team held feedback sessions with the trainees. This feedback was used to modify the questionnaires and field implementation guidelines as appropriate.

The data collection took place between February 14 and February 22. The composition of the supervisors and interviewers teams, the use of data collection monitoring forms, the management of the questionnaires and the quality control procedures were organized slightly differently in the three sites. In Naivasha, the KBA Site Survey Coordinator used two additional days of training to further review the detail of the questionnaires and survey protocol, including the changes made after the two training sessions were completed the previous week. In Kisumu, the KBA Site Survey Coordinator immediately provided intensive one-to-one support to the supervisors to ensure they fully understood the questionnaires and knew how to check the quality of the questionnaires received from the interviewers; and held daily briefing meetings with all the interviewers and supervisors to review the problems encountered and answer all questions. In Budalangi, the Site Survey Coordinators provided an additional briefing on the first day of the survey, and followed up with the interviewers in the villages where they were assigned. The three Site Coordinators shared their respective approaches during a meeting in Nairobi after the data collection was completed, and found that the overall differences would not affect the comparability of the results.

#### 4. *Data entry*

The data entry was completed between February 23 and March 18, 2005.

The consultant first created a data entry program using EPI-INFO for Windows (v.3.2.2), purposely chosen as the widely known, easily available and free software also used by World Vision International for the TDI surveys. The data entry program allows for the creation of six related databases (household characteristics, household schedule, support for chronically ill people, support for persons who died in the last 12 months, support for OVCs, and individual interviews) and uses a series a data entry control procedures.

At the same time, WVK recruited six data entry clerks and arranged for the necessary computers and office space. The number of data entry clerks needed for each KBA site had been estimated as follows.

# HH questionnaires (expected sample size)	440
# HH Questionnaires / clerk-day	50
# Clerk-days needed	10
# Clerks needed to complete data entry in one 5-day week:	<u>2</u>

The KATSO MEO and the consultant supervised the entire data entry process, from February 28 to March 13 (more than twice the time initially estimated). The first two days were used to set up three computers and the appropriate work environment, to brief the data entry clerks and let them test the data entry program and processes, and to fix a few bugs in the data entry program. By the seventh day, the data from the first KBA site (Winam) had been entered, the data sets from the three computers had been merged, and a few problems with the data entry process had been identified and corrected. The data from the Naivasha survey were completely entered by the end of the tenth day and those from the Budalangi survey by the thirteenth day. The last day was spent to correct a few issues identified through the analyses of the merged data sets, primarily issues of numbering of the households that had created a limited number of duplicates or other invalid household numbers (less than 5% of the total).

## 5. *Data analysis*

The KATSO MEO and the consultant proceeded with data cleaning and preliminary data analyses immediately after the entry was completed. They presented the results of these preliminary analyses, consisting of about 70 indicators for each site, including the KATSO outcome indicators, to selected senior WVK staff on March 18. The KBA consultant then conducted additional analyses and presented these results to a dozen of senior WVK technical and management staff on April 5.

The results presented in the next section of this report are based on a series of additional analyses conducted by the KBA consultant to ensure that the analyses are consistent across data sets and sites, that data quality issues are properly identified and managed, and that the results can be reproduced and checked. A series of EPI-INFO data analysis programs were prepared and the same programs were run on the three survey data sets. One program merges the data sets from the three data entry computers into site-specific data sets, and checks for duplicate household and individual identification numbers. Another program relates the separate data sets created during data entry, selects or creates new variables and creates separate data sets for specific group of analyses. Finally, a series of programs focuses on these specific analyses, for instance the calculation of descriptive sample statistics, and construction of various general and KATSO outcome indicators.

## **C. Results**

### *1. Organization*

The main findings of the three KATSO baseline household surveys are presented in a series of tables below with a brief description. The analysis is primarily aimed at producing the baseline

values for 12 KATSO outcome indicators, along with those of the directly related indicators most relevant to the programming of KATSO. The 12 KATSO Indicators (KI) is presented in the tables below when appropriate, labelled KI1 to KI12 for easy reference. They are presented again in the last table in this section by the Strategic Objectives and Intermediate Results (see Table 18).

The results presented in this section include mostly proportions (expressed as percentages), sometimes constructed from a combination of quite complex variables (see proportion of children who are OVCs, for instance), and disaggregated by age and sex whenever relevant. Appendix 11 includes all the data presented in this section, and additional, directly related ones.

## 2. *Achieved Sample Size*

Table 6 shows the sample of households and individual interviews achieved in each survey site. The household interview response rate, defined as the percentage of household interviews completed out of the total households visited, was 72% in Naivasha and 83% in Winam.<sup>11</sup> The reasons for non-response are primarily the absence of a competent household member in Naivasha, and the refusal of all household members present at the time of the visit in Winam. In Naivasha, the interviewer team was not allowed to proceed with the survey in two clusters because of ethnic clashes in the area, combined with a suspicion by the local leaders about the purpose of the survey. These two clusters were replaced with two others with otherwise similar characteristics.

After consolidation of all the available data for the analyses presented in this report,<sup>12</sup> the effective sample of households is 534 in Naivasha, 776 in Winam and 527 in Budalangi. The number of completed household questionnaires exceeds the target sample size of 440 in each site as a result of the attempts to achieve the minimum sample size of 7 individual interviews in each cluster, that is, 308 individual interviews per site for each category of interviewee (female and male youths, and female and male adults).

The effective number of household members enumerated in each site, proportionate to the number of households, varies from 2899 in Naivasha to 4291 in Kisumu and 3134 in Budalangi. In the three sites, about half of these samples consist of children aged 0-17, the age group used for defining OVCs, and the other half of persons aged 18-59, the age group for defining chronically ill adults.

The sample sizes achieved for OVCs, chronically ill adults and deaths of a chronically adults in the household are much smaller, particularly in Naivasha. This therefore limits the interpretation of the data on the various types of support received for these persons.

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<sup>11</sup> In one cluster in Winam, data on the result of the visit households by the interviewers were not collected; these clusters are excluded from the calculation of the response rate in Winam. In Budalangi, these data were not collected at all.

<sup>12</sup> During data analysis, incorrect household identification made it impossible to relate some of the records from the different data sets for the Naivasha survey and resulted in a reduction of the above sample size by 20%. The problem is likely to have occurred at the end of the data entry process when attempting to add data on response rate. Correct identification and restoration of the full sample is probably possible with access to the questionnaires. Comparison of key indicators in the effective and the discarded portions of the sample suggests that the use of a smaller sample does not introduce significant bias.

The achieved sample size for individual interviews is about 80% of the minimum target sample size of 1232 in Naivasha and Busia, and 118% in Winam.<sup>13</sup> Here again, the sample size exceeds the target in Winam due to the attempt to reach 7 adult males in each cluster while interviewing at least one individual in each category for each completed household interview. The sample size of female youths is larger and that of male adults is smaller than expected in Winam and Budalangi, with the largest differentials found in Budalangi (only 128 males 25-49).

**Table 6 Achieved sample sizes**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
# Households Visited	927	916	-
# Households Interviewed	<b>669</b>	<b>793</b>	<b>532</b>
<i>% Response rate:</i>	72%	83%	-
<i>Household Questionnaire</i>			
# Household Interviews Targeted	440	440	440
# Household Interviews Completed	<b>534</b>	<b>776</b>	<b>527</b>
<i>% Achievement rate</i>	121%	176%	120%
# Household Members Enumerated	<b>2899</b>	<b>4291</b>	<b>3134</b>
Children 0-17	1412	2026	1743
Adults 18-59	1422	2196	1248
OVCs	178	882	1120
Adults Chronically Ill	17	103	101
Adults Deaths	13	62	119
<i>Individual Questionnaire</i>			
# Individuals Targeted	1232	1232	1232
# Individuals Interviewed	<b>1017</b>	<b>1455</b>	<b>995</b>
<i>% Response rate:</i>	82%	113%	80%
Female Youth 15-24	240	397	246
Male Youth 15-24	206	288	188
Female Adult 25-49	243	343	276
Male Adult 25-49	263	299	128

### 3. Household Characteristics

Table 7 shows selected household characteristics related to the indicators and discussion below. The average number of household members slightly increases from 5.4 in Naivasha to 5.6 in Winam and 6.0 in Budalangi. The percentage of households with less than 6 members decreases accordingly from 57% in Naivasha to 46% in Budalangi. The percentage of households without any child is also lower in Budalangi than in Naivasha, but is the highest in Winam, probably reflecting the high number of adults residing in this urban area for work purposes and without family or children.

The percentage of households with at least one chronically ill person increases from 4% in Naivasha to 13% and 20% in Winam and Budalangi, and that of households with at least one death of a chronically ill adult in the last 12 months increases from 2% in Naivasha to 5% and 11% in

<sup>13</sup> This target 1232 is that for the 4 types of individuals, for which 7 are targeted in each clusters, that is,  $4 \times 7 \times 44 = 1232$ .

Winam and Budalangi. The percentage of children whose primary care taker is their grandmother increases from 4% in Naivasha to 7% in Winam and 16% in Budalangi. The high rates and trends of these indicators, likely related the HIV/AIDS burden in the respective areas are confirmed repeatedly in the following tables and discussion.

One of the concerns of the KATSO project is the impact of the presence of OVC on food security at the household level. Table 7 also shows the results of four questions included in the household questionnaire for that purpose. Although these questions asked to the household heads or to any other competent person are quite subjective, the results show a consistent pattern across the four similar but different questions, with percentages decreasing from the first to the fourth. In addition, the increasing trends found for all these indicators from Naivasha to Winam and Budalangi is consistent with the known relative food security in these three areas. These findings support the use of these data for one of the key KATSO indicators for care and support to OVCs (see Table 10).

**Table 7 Households composition and food security**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<i>Household Composition</i>			
Average number of household members	5.4	5.6	6.0
% Households with less than 6 members	57%	54%	46%
% Households without any child (0-17yrs)	9%	12%	4%
% Households with 1+ chronically ill person	4%	13%	20%
% Households with 1+ deaths in past 12 months	2%	5%	11%
<i>Food security</i>			
% Households in which because of lack of food in the last 30 days:			
The size of children's meals was cut	42%	69%	85%
The children skipped meals	34%	61%	89%
The children were hungry	31%	57%	83%
The children did not eat a whole day	23%	46%	72%

#### 4. Age and Education

Table 8 shows the age distribution of the household members enumerated in the three KBA sites. The first age classifications presented in the table is commonly used in Sexual and Reproductive Health, Youth, and HIV/AIDS Prevention programs. The second classification is used in Care and Support Programs. The age distribution is overall that expected for Kenya and does not vary much from site to site, except for the quite younger age distribution in Budalangi. The relative sex ratios in these sites shows that this younger distribution in Budalangi is mainly due to a low proportion of males 25-49, a finding that may be related to higher out-migration or mortality in this group.

The reported primary and secondary school attendance rates are high in the three sites.<sup>14</sup> This is probably partially because these percentages are based on simple yes/no responses by the household interview respondents as to whether a particular household member aged 6 to 24 is attending school, without qualification about the frequency or timeliness of attendance. As expected, the attendance rates is the highest for primary school age children, and then decreases for secondary school age children and for post-secondary school age young adults. These three rates are highest in Budalangi, a finding that is not consistent with this otherwise more rural and isolated area.

**Table 8 Age distribution and education of household members**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Age distribution</b>			
% Total population who is aged:			
<i>Sexual and Reproductive Health:</i>			
0-4 years	12.9%	13.4%	14.1%
5-14 years	26.5%	25.4%	32.2%
15-24 years	27.5%	29.1%	23.9%
25-49 years	27.9%	28.5%	21.3%
<i>Care and Support:</i>			
0-17 years	48.7%	47.4%	56.0%
18-59 years	49.1%	51.4%	40.1%
Age-specific female odds ratio (25-49 / 15-24)	0.9	0.8	1.5
<b>School attendance</b>			
% Persons of school age attending:			
Primary school (6-13)	99.1%	95.1%	98.4%
Secondary school (14-17)	74.8%	80.5%	88.1%
Post-Secondary school (18-24)	19.1%	29.0%	37.3%

##### 5. Prevalence of Orphans and Vulnerable Children

Definitions of OVCs often vary with their purpose and with their institutional and individual users. For statistical purposes, two definitions are considered in this report: one based on individual or child criteria and one based on household criteria. Both definitions use the UN age group for children of 0-17 years,<sup>15</sup> hereafter called "children" unless specified otherwise.

The individual-level definition of OVCs include all children under 18 who are:

- *Orphans*, that is, who have at least one parent dead (mother or father), or

<sup>14</sup> The high primary school attendance found in this survey is consistent with the Gross Primary School Enrolment Ratios reported in the 1999 Kenya Population and Housing Census for these three districts, which are all higher than 100%.

<sup>15</sup> Several data sources for estimates of the number or prevalence of orphans use the age group 0-15. This is the case for the estimates of the prevalence of orphans from the DHS 2003 (xxx%) and the UNAIDS estimates of the number of children orphaned by AIDS (600,000 in 2001). Estimates based on this age group tend to be lower than those using the 0-17 age group since the proportion of children who are orphans increases with age.

- *Vulnerable*, that is, who have a chronically ill parent (mother or father), defined as a parent who has been sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household.

This definition is the one adopted in the PEPFAR guideline for monitoring, evaluation and reporting (PEPFAR 2004). Table 9 shows a consistent increase in the percentage of children meeting any of the criteria above from Naivasha to Winam and Budalangi. The highest percentages of children meeting one of these criteria are those who are paternal orphans, followed by those who are maternal orphans. The percentage of children who are orphans increases from 19% in Naivasha to 25% in Winam and 47% in Budalangi. Adding children who are vulnerable, the percentage of children who are OVCs is 21% in Naivasha, 32% in Winam and 52% in Budalangi.

The household-level definition of OVCs includes all children living in a household:

- Without any adult;
- With at least one chronically ill person;
- With at least one death of a chronically ill adult last year;
- With one or more maternal orphans; or
- With one or more paternal orphans.

These criteria are those used by the collaborative UNICEF/MeasureDHS study and included in the structure of the KBA questionnaire to identify the children eligible for the questions about the support received. The KBA Team did not include the OVC criteria *“Live in institutions or sleep on the street if these children comprise a significant number of children in the population,”* also included in the UNICEF/ MeasureDHS study. The KBA Team considered that these criteria did not apply to the context of the KATSO sites.

Table 9 shows the percentage of all households, that is, including households without a child, which meet each of the above criteria. As for the individual-level indicators, all these indicators show a consistent increase from lower levels in Naivasha to higher levels in Winam and even higher in Budalangi. The percentage of households in which there are children and that meet at least one of the above criteria, hereafter called the *“households with OVCs,”* increases from 23% in Naivasha to 40% in Kisumu and 68% in Budalangi. The percentage of children living in household with OVCs increases from 24% in Naivasha to 50% in Winam and 72% in Budalangi.

Although both individual-level - and household definitions adopted in these analyses have programmatic meaning, the individual-level definition is used from now on in this report unless stated otherwise. However, KATSO may use one or the other definitions depending on the purpose.

The last indicator in Table 9 shows that the proportion of children living in households with OVCs who are considered as OVCs themselves according to the individual-level definition varies with the sites. While this proportion reaches 88% and 72% in Naivasha and Budalangi, respectively, it is only 55 in Winam.

Appendix 12 includes three graphs summarizing the data in Table 9.

**Table 9 Individual and household level indicators of OVCs**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<i>Individual-level definition</i>			
% Children whose mother died	7%	14%	21%
% Children whose father died	16%	24%	42%
% Children whose both parents died	4%	12%	15%
% Children who are ORPHANS	<b>19%</b>	<b>25%</b>	<b>47%</b>
% Children whose mother is chronically ill	3%	5%	10%
% Children whose father is chronically ill	2%	7%	5%
% Children whose both parents are chronically ill	0%	1%	1%
% Children who are VULNERABLE	<b>4%</b>	<b>9%</b>	<b>12%</b>
% Children who are OVC	<b>21%</b>	<b>32%</b>	<b>52%</b>
<i>Female</i>	19%	32%	49%
<i>Male</i>	24%	32%	55%
<i>Household-level definition</i>			
% Households with children 0-17 AND :			
Without any adult 18-59 years old	0%	1%	2%
With at least one chronically person	3%	12%	17%
With one or more deaths in past 12 months	2%	5%	10%
With one or more maternal orphans	8%	20%	35%
With one or more paternal orphans	17%	30%	52%
With OVCs	<b>23%</b>	<b>40%</b>	<b>68%</b>
% Children who live in households with OVCs	<b>24%</b>	<b>50%</b>	<b>72%</b>
<i>Female</i>	21%	49%	71%
<i>Male</i>	27%	51%	74%
% Children living in households with OVCs who are OVCs according to the individual-level definition	88%	55%	72%

## 6. *School attendance, food security and support of OVCs*

Table 10 shows that in the three KBA sites, the percentage of children who are OVC increases with age, reaching levels of 31%, 45% and 62% of the children of secondary school age (14-17 years old) in Naivasha, Winam and Budalangi, respectively (see also graph on cover page of the report). As a result, between 73% and 81% of OVCs are of school-going age, a slightly older age distribution than in the general population of children 0-17 years old (between 65% and 70%). Between 78% and 92% of primary school age OVC and between 60% and 77% of secondary school age OVCs are attending school. These figures are slightly lower than those found for all children of these age groups (see Table 8), particularly for secondary school age children, suggesting some disadvantage with this respect.

The ratio of OVC to non-OVC households reporting signs of food insecurity, a key KATSO indicator, is calculated using the data from the four related questions presented in Table 7. This indicator addresses the concern that care and support programs for OVCs might create an undesirable situation whereby non-OVC children might become at a higher risk of living in a household with no food security. This indicator obviously otherwise assumes that all efforts are made to ensure food security of all children in all households. This ratio is clearly higher, between 1.5 and 1.7 for all four questions in Naivasha, where the percentage of households with no food security is otherwise the lowest for all questions (see Table 7). The OVC/non-OVC ratio is equal or close to 1 in Winam and Budalangi, suggesting that most children, irrespective of their OVC status, have the same need in those areas with otherwise a higher percentage of households with no food security than in Naivasha.

Table 10 also shows the percentage of OVCs who received medical, psychosocial, material, social and schooling support in the 12 months before the survey. The question asked to the household interview respondents specified that this support should be one "for which no one had to pay and which was provided by someone working for a program." Keeping support for schooling aside, these figures are in general lower than 10%, except for psychological support in Winam (10%) and material support in Budalangi (27%), which can probably be related to specific programs other than KATSO in those areas. The percentage of OVCs who received support for schooling in the 12 months before the survey is 38% and 35% in Naivasha and Budalangi, respectively, but only 17% in Winam. The percentage of children receiving any of the four types of support above in the 12 months before the survey, used as a key KATSO indicator, is equal or close to zero in all three sites since at least one support indicator is equal or close to zero in each site.

The percentage of OVCs who received social support in the last 12 months, and the percentage of OVCs who received psychosocial, material and social support in the last 3 months, are not available at this time because of errors in the data entry program that only appeared during data analysis. While data could be re-entered if needed, the quality of the data collected is uncertain, and the values of the indicators for support in the last 3 months can only be even lower than those for support in the last 12 months.

**Table 10 School attendance, food security and support of OVCs**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Children who are OVCs by school going age <sup>1</sup>			
Pre school (0-5)	12.4%	24.9%	40.4%
Primary school (6-13)	21.7%	29.5%	53.8%
Secondary age (14-17)	31.4%	45.5%	62.4%
% Distribution of OVCs by school going age			
Pre school (0-5)	18.6%	26.8%	23.1%
Primary school (6-13)	45.5%	37.9%	47.4%
Secondary age (14-17)	35.9%	35.2%	29.5%
% OVCs attending school			
Primary school (6-13)	97.6%	91.0%	96.9%
Secondary age (14-17)	68.9%	73.3%	84.0%
<b>KI9:</b> Ratio of OVC to Non OVC Households in which because of lack of food in the last 30 days:			
The size of children's meals was cut	1.5	1.0	1.0
The children skipped meals	1.8	0.9	1.1
The children were hungry	1.6	1.0	1.0
The children did not eat a whole day	1.7	0.9	1.0
<b>KI10:</b> % OVCs who received support in last 12 months:			
*Medical	2%	0%	8%
*Psychological	0%	10%	5%
*Material	7%	6%	27%
Social	n/a	n/a	n/a
*Schooling	38%	17%	35%
Any * above	<b>0.0%</b>	<b>0.0%</b>	<b>0.3%</b>

<sup>1</sup> See graph of children who are OVCs by school-going age and KATSO site on cover page of the report.

## 7. Chronically Ill Adults

Table 11 shows the percentage of adults aged 18-59 who report or have been reported as having been very sick in the last 12 months, increasing from 2% in Naivasha to 6% in Winam and 10% in Budalangi. The question specifies that "by very sick, one means too sick to work or do normal activities around the house for at least three months," the definition hereafter used for chronically ill adults. The percentage of adults aged 18-59 reported to have died in the last 12 months and have been chronically ill is increasing in a similar way from 1% in Naivasha to 3% in Winam and 9% in Budalangi.

Table 11 also presents the percentage of adults chronically ill in the last 12 months, including those who have died, who received four types of formal, organized support. As for the OVCs, the question specifies that this support is one "for which no one had to pay and which was provided by someone working for a program." The values obtained for these indicators in Naivasha are not shown because they are based on less than 50 chronically ill adults. The higher percentages for various types of supporting Winam and in Budalangi can probably be related to known programs in these areas. The PEPFAR indicator combining all the types of support received once a month (medical) or in last 30 days (other types of support) remains very low since it is always lower than

the lowest single support. The psychological support received by chronically adults (not included those who died) in the last 12 months is used as KATSO outcome indicators for IR1.1.

**Table 11 Prevalence and Support of Adults Chronically Ill**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Adults who were chronically ill in the last 12 months	<b>1.9%</b>	<b>6.3%</b>	<b>9.5%</b>
<i>Female</i>	2.0%	5.4%	5.8%
<i>Male</i>	1.8%	7.2%	12.5%
% Adults who were chronically ill and who died in last 12 months	<b>0.9%</b>	<b>2.8%</b>	<b>9.1%</b>
% Adults who were chronically ill (including those who died) who received the following support:			
Medical: <12 months	-	3%	23%
*Medical: 1/30 days	-	1%	19%
Psychological: <12 months	-	35%	17%
*Psychological: <30 days	-	25%	14%
Material: <12 months	-	7%	22%
*Material: <30 days	-	7%	13%
Social: <12 months	-	5%	7%
*Social: <30 days	-	2%	7%
Any of the * combined	-	<b>0%</b>	<b>5%</b>
<b>K12: % Adults who were chronically ill who received psychological support in the last 12 months:</b>	-	<b>42%</b>	<b>23%</b>

## 8. Young Adults/Youths

The young adults aged 15-24, hereafter called youths, make up about a quarter of the total population in the three sites (see Table 8). Table 12 shows that only between 29% and 52% the youths interviewed are attending school, and the majority who are doing so are of secondary school age (15-17). These rates are higher for males than for females. Overall, these school attendance rates are lower than those for the entire sample of youths (see Table 8), which suggests that mainly youths not attending school were at home at the time of the visit by the interviewers. Attendance rates in Budalangi are otherwise the highest, a surprising finding noted earlier.

About a third of youths are married or living with a partner as if married. This percentage is more than twice as high for female than for males in Naivasha, and more than three times in Winam and Bunyala, where it reaches 50% for females but only 13% for males. The percentage of youths aged 20-24 who were married by age 20 follows a similar pattern of increase from Naivasha to Budalangi and of gender differentials. The median age at first marriage is 17 years for females 20-24. The last indicator in Table 12, the percentage of married females 15-24 who have a husband or live as if married with a partner who is 10 or more years older, is typically directly associated with a higher risk of HIV infection. The results for the surveys show that it is the only such

indicator that is decreasing from Naivasha, where it reached 21%, to Winam and Budalangi where it decreases to 14% and 9%, respectively.

**Table 12 School attendance and marital status of youths**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Youths 15-24 attending school	<b>29%</b>	<b>40%</b>	<b>52%</b>
<i>Female</i>	21%	30%	41%
<i>Male</i>	37%	52%	64%
15-17	58%	77%	81%
18-24	15%	26%	30%
% Youths 15-24 married/lived with partner	<b>28%</b>	<b>34%</b>	<b>34%</b>
<i>Female</i>	39%	46%	50%
<i>Male</i>	16%	17%	13%
15-19	9%	19%	15%
20-24	47%	46%	66%
% Youths 20-24 who were married by age 20	<b>32%</b>	<b>29%</b>	<b>46%</b>
<i>Female</i>	45%	46%	62%
<i>Male</i>	11%	9%	17%
Median age at first marriage among females 20-24	17	17	17
% Married females 15-24 whose husband/partner is 10+ years older	<b>21%</b>	<b>14%</b>	<b>9%</b>

Although the majority of youths have heard of AIDS, between 10% and 30% of them fail to correctly answer simple questions on the transmission of HIV and on the most common misconceptions. Table 13 shows the percentage of correct answers to three standard questions on knowledge and three on misconceptions, which overall are between 68% and 94% across the three sites. When the six questions are combined, only 47% of youths are able to answer correctly all questions in Naivasha, primarily because of the lower percentage of those acknowledging “using a condom every time” as a way to prevent HIV infection. This percentage is slightly higher around 60 % in Winam and Budalangi.

**Table 13 Knowledge of HIV/AIDS among youths**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Youth who have ever heard of AIDS	99%	99%	99%
% Youth who know HIV infection can be prevented:			
By having only one partner	93%	91%	77%
By using a condom every time	68%	78%	82%
By abstaining from sexual intercourse	94%	88%	89%
% Youth who know HIV infection cannot come from:			
Mosquitoes	73%	84%	77%
Sharing food with a person with AIDS	80%	90%	85%
Witchcraft	86%	90%	85%
<b>KI3: % Youth who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</b>	<b>47%</b>	<b>60%</b>	<b>59%</b>
<i>Female</i>	42%	58%	49%
<i>Male</i>	54%	63%	73%
15-19	44%	53%	62%
20-24	51%	66%	54%

More than twice as many youths report they ever had sex (Table 14) than report being married or living with a partner as if married (Table 12). More youths also report having had sex in the last 12 months than being married (see Figure 1 and 2 in Appendix 13). This substantial premarital sexual activity is higher for males than for females (who are more frequently married) and higher in Winam than in Naivasha and Budalangi. More youths are involved in premarital sex in the age group 15-19 than in the age group 20-24. The median age at first sex is lower than that at first marriage, decreasing from 16 in Naivasha to 15 in Winam and 14 in Budalangi for females.

Comparing the percentage of youths who ever had sex by age 15 in the age group 15-19 with that in the age group 20-24 is equivalent to comparing this indicator at the time of the survey and five years before since youths aged 20-24 at the time of the survey were 15-19 years old five years ago. The data in Table 14 (also shown in Figure 3 in Appendix 13) suggests a decrease in the age of sexual debut in Naivasha and Winam, with the larger decrease for both females and males in Naivasha. There does not seem to have been any change in Budalangi, where the percentage of female youths who ever had sex by the age of 15 otherwise remains far higher than for males. While this apparent increase could in principle be due to a tendency by youngest youths to

exaggerate their actual sexual activity, there is no apparent reason for youths in Budalangi not to do so.

Between a third and a half of never married youths aged 15-24 in the three sites report that they have never had sex. The large majority of those in the three sites report that they intend to abstain until marriage, more so in Naivasha and Winam (96% and 98%, respectively) than in Budalangi (80%).

More than a third of never married youths in the three sites report that they had sex in the last 12 months. However, very few never married but sexually active youths in Naivasha (14%) and Budalangi (12%) report having used a condom the first they had sex. This percentage is higher (27%) in Winam where condoms are probably more accessible. The percentage of youths 15-24 who had sex in the last 12 months who reported having had sex with more than one partner is the lowest at 2% in Winam, and higher at 10% in Naivasha and 19% in Budalangi.

**Table 14 Sexual activity of youths 15-24**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Youths who are married/lived with partner or who ever had sex	69%	79%	65%
<i>Female</i>	76%	84%	74%
<i>Male</i>	60%	74%	52%
15-19	51%	71%	50%
20-24	86%	87%	91%
Median age at first sex among youth 20-24	16	15	15
<i>Female</i>	16	15	14
<i>Male</i>	16	15	15
% Youths 20-24 who ever had sex by age 15	8%	20%	19%
<i>Female</i>	8%	17%	27%
<i>Male</i>	7%	24%	6%
% Youths 15-19 who ever had sex by age 15	23%	30%	16%
<i>Female</i>	22%	28%	26%
<i>Male</i>	23%	32%	5%
<b>KI4:</b> % of Never Married Youths who have never had sex	46%	30%	54%
<i>Female</i>	41%	28%	51%
<i>Male</i>	50%	33%	55%
15-19	57%	37%	60%
20-24	28%	23%	28%
<b>KI5:</b> % of Never Married Youths who never had sex and intend to abstain	93%	97%	79%
<i>Female</i>	100%	94%	71%
<i>Male</i>	88%	100%	85%
15-19	94%	100%	77%
20-24	90%	-	-
<b>KI6:</b> % of Never Married Youths who ever had sex & used condom the 1st time	14%	27%	12%
<i>Female</i>	10%	25%	12%
<i>Male</i>	21%	30%	13%
15-19	9%	33%	11%
20-24	17%	21%	13%
<b>KI7:</b> % of Never Married Youths who had sex in the last 12 months	30%	40%	34%
<i>Female</i>	32%	41%	33%
<i>Male</i>	29%	40%	34%
15-19	25%	38%	28%
20-24	38%	44%	59%
<b>KI8:</b> % Youths who had sex in last 12 months who had more than one partner	10%	2%	19%
<i>Female</i>	7%	2%	18%
<i>Male</i>	-	3%	20%
15-19	-	5%	18%
20-24	8%	0%	20%

## 9. Voluntary Counselling and Testing

VCT has become available to more and more people in the last five years in Kenya, with the number of functional centres increasing from 3 in 2000 to 220 in 2004 (HHS/CDC, 2004). Table 15 shows that the percentage of adults 15-49 who had ever been tested by the time of the KBA survey is 11% in Naivasha and Budalangi but 33% in Winam, where VCT services are more accessible and have been available for a longer time than in the rural and more isolated areas of the two other sites. Indeed, two thirds of those who have ever been tested in Naivasha and Budalangi did so 12 months before the survey, as compared with only 40% in Winam.

Between half and two thirds of those tested in the last 12 months had never been tested before. Among those who had been tested before, only 22% in Winam and 33% in Naivasha had been tested between 3 and 6 months before the last VCT visit, but 67% had been tested during that period in Budalangi. The practice of performing a second test 3 to 6 months after the first one to detect the most recent infections seem to be better established in Budalangi.

In the three sites, the majority of persons tested declared they had received the results of their last test. The percentage of adults tested in the last 12 months, and who received the results, a KATSO outcome indicator, is 5% and 7% in Naivasha and Budalangi, respectively, and twice as high at 12% in Winam. Younger females and older males seem more inclined to seek and receive VCT services.

**Table 15 Voluntary Counselling and Testing**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Adults who have ever been tested for HIV	11.5%	33.0%	11.4%
% Adults ever tested who were tested less than 12 months ago	66.3%	42.7%	68.8%
% Adults ever tested who get the results	93.1%	93.6%	92.9%
% Adults ever tested who had been tested before	46.4%	34.7%	31.2%
<i>Time between two last tests:</i>			
Less than 3 months ago	0.0%	32.9%	22.2%
Between 3 and 6 months ago	33.3%	21.9%	66.7%
More than 6 months ago	66.7%	45.2%	11.1%
<b>KI12: % Adults receiving HIV test results in last 12 months</b>			
<b>5.3%</b>	<b>12.2%</b>	<b>6.8%</b>	
15-24: Female	6.4%	14.0%	6.2%
Male	7.6%	11.8%	3.2%
25-49: Female	5.8%	8.9%	5.3%
Male	2.3%	14.1%	16.0%

The answers to standard stigma and discrimination questions provided by the majority at adults 15-49 show a generally positive attitudes towards persons affected by HIV/AIDS in the three KBA sites. While about 95% of respondents would take care of a relative with AIDS in their own household, only about 80% declared they would buy fresh vegetables from a shopkeeper with AIDS or allow a teacher with AIDS teach their child at school.<sup>16</sup> The fourth standard stigma and discrimination question of one of the PEPFAR indicator was omitted in the KBA questionnaire. Combining three standard questions, only three quarters of the respondents show an accepting attitude towards persons affected by AIDS. This percentage may be slightly more common among males.

**Table 16 Stigma and discrimination**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Adults 15-49 who would:			
Buy fresh vegetables from a shopkeeper with AIDS	82%	87%	80%
Care for a relative with AIDS in own household	95%	94%	95%
Allow teacher with AIDS to teach own child	81%	84%	81%
<b>KI11:</b> % Adults 15-49 with accepting attitudes towards PLWHAs (who answered yes to 3 questions above)	71%	75%	71%
15-24:	67%	73%	71%
Female	66%	72%	70%
Male	69%	75%	73%
25-49:	73%	77%	72%
Female	64%	75%	70%
Male	82%	80%	77%

<sup>16</sup> The question for this indicator did not specify a "female" teacher (see PEPFAR 2004, page 73).

The KBA individual questionnaire includes 9 simple questions to assess the perception of the interviewees about their mood and general outlook towards life as measured through a four-level scale: Strongly Disagree, Disagree, Agree, Strongly Agree. Table 17 shows the percentage of all adults 15-49 who chose the two scores corresponding to “no depression.” (Depending on how the question is phrased, these two scores can be either SA or A, or D or SD.) When the nine questions are combined, less than a quarter of adults gave a “no depression” score to all nine questions in Winam and Budalangi, but about half did so in Naivasha. While this higher rate may be due to an actually better mental health status in this area, it may also be due to the slightly different interview approach used by the interviewers.<sup>17</sup> Although this indicator may be difficult to interpret without a standard reference, its variation may indicate actual differences in the mental health of respondents. For examples, the values of this last indicator are slightly lower among adults 25-49 than among youths 15-24, and markedly lower among females than among males in Budalangi.

**Table 17 Signs of depression**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
% Adults 15-49 responding that they Strongly Agree (SA), Agree (A), Disagree (D) or Strongly Disagree (SD) to the following questions:			
Are you happy? A/SA	98%	74%	92%
Do you feel stressed or worried? D/SD	80%	45%	59%
Do you feel good about yourself? A/SA	94%	69%	85%
Does your future look hopeless? D/SD	80%	75%	77%
Are you able to do things you need to do? A/SA	88%	77%	86%
Do you want to be alone these days? D/SD	74%	66%	71%
Is your health good? A/SA	95%	77%	85%
Do you get into fights? D/SD	90%	81%	86%
Do you hope things will turn alright? A/SA	96%	82%	85%
<b>KI1: % Adults 15-49 with “no sign of depression:”</b>	<b>54%</b>	<b>20%</b>	<b>25%</b>
15-24: Female	59%	23%	21%
Male	57%	22%	38%
25-49: Female	49%	20%	18%
Male	51%	15%	30%

<sup>17</sup> In Naivasha, the KBA Site Survey Coordinator taught a more categorical approach to asking these questions: The interviewers first asked the respondents to choose between the two answers suggesting “depression” and the two answers suggesting “no depression,” and then to choose one of those two answers.

## *10. Summary of KATSO Outcome Indicators*

Table 18 is a summary presentation of the KATSO outcome indicators included in the tables above, but listed by the Intermediate Results that they measure. The formulation of some indicators may differ from that in the previous tables to ensure consistency with PEPFAR reference documents on monitoring and evaluation indicators (PEPFAR 2004). For simplicity's sake, only aggregate values are presented (age- and sex-disaggregated values are included in the tables above). These aggregate values are adjusted for the relative size of the strata in each site, and the confidence interval taking into account the cluster sampling design is provided for each value. The last table of Appendix 11 presents all these KATSO outcome indicators estimates, their 95% confidence intervals, and the sample size on which they are based. The estimates and 95% confidence intervals of the KATSO outcome indicators from each survey are also represented in three graphs in Appendix 14.

**Table 18 KATSO Outcome Indicators**

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>SO 1: Mobilized and strengthened community-led responses to improve care and support for OVC and others affected by HIV/AIDS, with special emphasis on engagement of churches and faith-based organizations.</b>			
<b>IR 1.1: Strengthened community networks for psychosocial care to people affected by HIV/AIDS</b>			
KI1: % Adults 15-49 showing no sign of depression	54% CI:47;60	20% CI:17;23	25% CI:18;32
KI2: % Adults 15-49 Chronically Ill with access to community psychosocial care and support [PEPFAR]	- CI: -	40% CI:29;51	22% CI:13;32
<b>IR 1.2: Increased capacity of OVC and their households to protect themselves from HIV infection</b>			
KI3: % Young people 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [PEPFAR]	47% CI:36;57	60% CI:54;65	60% CI:52;68
KI4: % Never Married Young People (15-24) who have never had sex [PEPFAR]	42% CI:37;50	31% CI:28;34	54% CI:45;62
KI5: % Never Married Young People (15-24) who never had sex and intend to abstain	95% CI:91;100	98% CI:95;100	83% CI:73;93
KI6: % Never Married Young People (15-24) who ever had sex and used condom the 1st time	12% CI:6;17	27% CI:23;31	12% CI:8;16
KI7: % Never Married Young People (15-24) who had sex in the last 12 months [PEPFAR]	34% CI:22;46	40% CI:35;45	34% CI:26;41
KI8: % Never Married Young People (15-24) who had sex in last 12 months who had more than one partner	11% CI:2.0;19	2% CI:0.3;3.0	20% CI:14;26
<b>IR 1.3 Improved livelihood support systems to meet basic needs of OVC and their families</b>			
KI9: Ratio of OVC to Non OVC Households in which because of lack of food in the last 30 days the children did not eat a whole day	1.8 CI:1.2;2.6	1.0 CI:0.8/1.2	1.1 CI:0.9/1.2
<b>SO 2 Improved enabling environments at division and district levels that actively support holistic care for OVC and others affected by HIV/AIDS</b>			
<b>IR 2.1: Improved multi-sectoral planning and collaboration for OVC support at division and district levels</b>			
KI10: % OVC living in HH that received, free of user charges, basic external support in caring for the child [PEPFAR]	0.0% CI: -	0.0% CI: -	0.3% CI: 0.0;0.6
KI11: % General population aged 15-49 with accepting attitudes towards PLWHAs [PEPFAR]	71% CI:65;76	75% CI:71;79	71% CI:65;77
<b>SO3: Reduced HIV Transmission and Improved Clinical Care and Support</b>			
<b>IR 3.1: Increased number of people who know their HIV-status</b>			
KI12: % General population aged 15-49 receiving HIV test results in last 12 months [PEPFAR]	4% CI:1.8;3.6	12% CI:10;14	6% CI: 8.3;3.7

CI: 95% Confidence Interval. See also Appendix 11 and Appendix 14.

## **D. Conclusions**

The KBA Team successfully designed and carried out data collection for three quite large household surveys in different parts of the country, and immediately proceeded with the data entry and preliminary analyses in only seven weeks. Further analyses of the data sets have provided reliable baseline values for most of the KATSO outcome indicators (see summary in Table 18). These analyses have also provided informative results for the KATSO programming (see for instance the estimates of prevalence of OVCs, in Table 9, and the series of indicators of sexual behaviour of youths, in Table 14). The survey data sets are otherwise available for secondary analyses most relevant to KATSO programming (see examples of such analyses in section VI).

Overall, the results of the three surveys confirm the initial “hypothesis” of the KBA Team that Naivasha represents an area of lower HIV burden than Winam, itself representing a lower HIV burden than Budalangi. Several indicators of the burden of HIV (OVC prevalence and the proportion of adults 18-59 who are chronically ill) or of potentially related factors (age of sexual debut and related high-risk behaviour among youths) show increasing trends from Naivasha to Winam and to Budalangi, which are consistent with this hypothesis. These findings call for the design of care and support strategies that vary across the KATSO sites.

The KBA Team faced several implementation challenges worth highlighting for future similar work by KATSO and World Vision Kenya. The main one is the short timeframe for the design, implementation, and analyses of the surveys. Under this heavy time pressure, the KBA Team was forced to rush through critical steps (formulation of specific survey objectives, detailed preparation of the questionnaires, preparing the communities, training the interviewers and supervisors, hiring and training data entry clerks, careful data entry), creating missed opportunities, mistakes, and eventually more complicated data to manage, analyze and interpret. More time than originally estimated was then required for adequate data cleaning, management, analysis and reporting of the survey data.

The following observations from the implementation of the three KBA surveys constitute other lessons for future KATSO surveys:

- *Questionnaire:* The KBA Team is indebted to the UNICEF/MeasureDHS Team who shared their questionnaires, which enabled the KBA Team to collect the adequate data for the otherwise quite complicated PEPFAR indicators. The well-designed structure and format of the questionnaires also contributed to the quality of the overall data sets. The fact that many indicators are directly comparable to those of the national level DHS is an added benefit. On the other hand, these questionnaires may be too complex and too long to be used routinely by ADPs, or even in a context like the KBA, particularly with limited training and inexperienced interviewers.
- *Questions:* Several questions in the KBA questionnaires appear to be too long and complex to be systematically read or asked, particularly the questions on the support received by OVCs and chronically ill adults, which characterize the type, timing, and source of support with the details needed for the PEPFAR indicators. Questions on schooling are probably too simplistic if there is any interest in assessing the actual attendance by age, and the differences between OVC and non-OVCs. Questions on sexual behaviour generated a lot of discomfort among

the interviewers during their training, but turned out to be relatively well managed. WVK/KATSO may wish to add a few more questions to better capture the non-responses to these questions in the follow-on surveys.

- *Response rates:* The KBA survey response rates appear rather low when compared with those of the Kenya DHS 2003. This probably reflects the absence of preparation of the community for the survey, which could be addressed in future surveys. The higher response rate for female youths than adult males is probably related to the more frequent presence of the former at the time of the interviewers' visits; and may also be related to the lower proportion of male adults in the community because of out-migration or mortality. The rather high non-response rates call for some adjustment if more detailed analyses than those presented here are conducted.
- *Sample size:* The achieved sample size seems adequate for most of the variables of interest when designing these surveys, and secondary analyses of the data sets to answer specific research questions are therefore warranted. For instance, the achieved sample size seems adequate for conducting analyses of some aspects of the sexual behaviour of youth by sub age groups and gender, which would provide useful information for the design and evaluation of related interventions.

The analyses presented in this report do not formally take into account sampling errors and statistical significance (except for the confidence intervals calculated for the KATSO outcome indicators), and therefore no recommendation is made regarding the best sample size for future surveys assessing the same indicators.

The survey estimates of the prevalence of chronically ill adults vary between 2% (Naivasha) and 10% (Budalangi), with about 100 chronically ill adults assessed for the support received in Winam (which has the highest sample size) and Budalangi (which has the highest prevalence), but only 17 in Naivasha (which has the lowest prevalence). For more complex and accurate assessments of the support that chronically ill adults receive, a different sampling scheme will probably yield better results, particularly in areas of lower burden of HIV/AIDS.

- *OVCs:* While the high levels and marked differences across the three sites may simply reflect the true increasing burden of HIV/AIDS,<sup>18</sup> other factors may have influenced these findings and are worth clarifying.

Three factors tend to support the apparently "high" prevalence of OVCs revealed in the KBA surveys:

1. Any comparison with data from other sources must take into account the exact definition of orphans or OVCs used. For instance, the prevalence rates of orphans and OVCs presented in this report are those for children below the age 18, while many other sources of such data are for children aged 0-15 years. The former indicator is typically higher because the OVC prevalence increases with age. Also, the prevalence

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<sup>18</sup> See Appendix 3 for estimates of prevalence of orphans at the district level, as calculated from GOK data for 2003, and at the provincial levels, as reported in the DHS 2003.

- of OVCs is higher than the prevalence of orphans, and higher than the prevalence of children orphaned by AIDS.
2. The OVC prevalence data from the KBA surveys are the most recent available at this time, and are expected to be higher than any other previous sources, everything else being the same, since the OVC prevalence in Kenya will keep increasing for a few years.
  3. Most other sources of data are aggregate data, at District, Provincial or National levels, and it is possible that the KATSO areas are located in areas with the highest HIV burden. The fact that ADPs are typically located in the poorest and most deprived areas support this explanation, although the fact that they are often located in rural areas does not.

Two factors tend to suggest that the prevalence of OVCs revealed in the KBA surveys may be “too high”, as compared to the “true” prevalence, particularly in Budalangi:

1. There might have been some degree of exaggeration in the respondents’ declaration of the orphans and vulnerable children, and possibly of chronically ill persons, presumably because the interviewer and the survey were perceived as part of a process to select children, chronically ill persons or households for assistance. This upward bias could have been more important in Budalangi, where the population is the most dependent on aid and the most familiar with the ways and procedures of aid agencies.
2. Interviewers might have had a tendency to select households with OVCs or chronically ill adults. This could have happened at the request of the population, “volunteering” to be interviewed for the reasons mentioned above, or because of the misunderstanding by the data collectors of the importance of selecting households randomly. The fact that no data on the interview response rate were collected in Budalangi suggests that this might indeed have been overlooked in this survey site, and may at least partially explain the very high prevalence of OVCs and chronically ill adults in this area.
3. The treatment of missing data during the analyses of the KBA survey data may have introduced “biases.” In general, missing data, either because of the absence of response by the interviewee (“do not know”) or because the questions was omitted by the interviewer or the data entry clerk, are removed from the sample in the results presented here. This treatment of missing data gives higher estimates than a more conservative treatment that assumes that the absence of response to a question about the living status of parent (or the chronically ill status of an adult) is equivalent to reporting that the parent is still alive (or not chronically ill). The magnitude of such a potential bias could be further investigated and quantified if needed.

Although the KBA consultant checked the entire series of programs several times, issues with the data analyses are still possible given the relatively complex programming involved in the calculation of the proportion of OVCs and the proportion of households with OVCs. If needed, the results presented here, or the original data, can be submitted for independent review or analysis, and the source of discrepancy, if any, can be clarified.

The KBA household surveys provided the opportunity to clarify the KATSO definition (or definitions) of OVCs to use in various contexts. The various estimates provided in this report can be used to estimate the number of the various types of OVCs in the various KATSO sites, within a range determined by the confidence interval of the estimates.

- *Youth:* Overall, the survey results on marriage and sexual activity of youths clearly show (1) the low age at marriage, particularly for females and in Budalangi, and (2) the high rates of premarital sexual activity, particularly for males and in Winam. The data also suggest a decrease in the age of sexual debut between the period 1995-1999 and 2000-2004. This type information certainly is critical to the design and evaluation of the KATSO behaviour change interventions for youths, and the data in the KBA surveys are worth more detailed analyses including statistical tests and multivariate analyses. A close look at these data may also point out the questions or topics for which the household survey may need to be complemented or replaced by other methods to better capture the dynamic of the sexual behaviour of youths, design the appropriate preventions programs, and evaluate their effectiveness.

Given the concern for early sexual debut and related practices in the context of the HIV epidemic and response, the KBA Team decided to extend the lower age limit for the individual interviews of youths from 15 to 12 years. A total of 308 individuals between 12 and 14 were successfully interviewed in all three sites. However, the priority for this report was to calculate the values for the indicators commonly used in HIV/AIDS programs, which typically use an age limit of 15, and the data for 12-14 year olds were not analysed for this report. They are available for further analysis if desired.

- *Adults:* Data on VCT, stigma and psychosocial status are available for all individuals. The simplest and standard VCT questions and results seem to have been straightforward and provide a reliable KATSO outcome indicator. The questions on stigma and discrimination presented here also have the value of being standard questions for monitoring and evaluation. Additional data on VCT and stigma and discrimination are available for further analysis.

The KBA Team did not have the opportunity to discuss the psychosocial questions with the WV staff responsible for that component of KATSO. Therefore, the team decided to simply use the standard tool included in the UNICEF/MeasureDHS questionnaire as a population-based complement to the otherwise ongoing baseline assessment of that component. KATSO Management should discuss the full interpretation of these results of the KBA surveys, and the assessment of their value for the evaluation of the KATSO psychosocial intervention, with the WV psychosocial staff.

A summary of the main findings of the KBA surveys by KATSO Intermediate Results is presented in section VI.A.

## **V. Focus Group Discussions**

Component 3 of the KBA consists of a series of Focus Group Discussions (FGDs) in the 3 sites where the Household Surveys were implemented. This section presents the design, implementation and main findings of these FGDs.

### **A. Design and Implementation**

The KBA Team identified the following topics of interest to be investigated through FGDs:

1. Knowledge of HIV/AIDS among youths and OVCs
2. Perception of need for and knowledge of VCT among youths and OVCs
3. Stigma and discrimination towards OVCs and PLWHAs among youths
4. Sexual activity among youths and perception of same among OVC household heads
5. Knowledge of OVCs' and PLWHAs' needs among OVC care givers
6. Adequacy of care and support to OVCs: Perception from OVCs, OVC caregivers, and CCC members
7. Adequacy of care and support to PLWHAs: Perception from OVC care givers and CCC members
8. Knowledge and perception of CCC members about the HIV/AIDS response in their community and about their role in same
9. Knowledge of Children's Rights among OVC caregivers and CCC members

The topics above were investigated through a series of 8 FGDs conducted by a team of one facilitator and one recorder in each KBA site (24 FGDs in total). The guidelines given to the three FGD teams are included in Appendix 15. These guidelines specify the respondent profile, the topics of interest, and the key questions for each FGD to be conducted. The guidelines include a template for note taking and reporting on each FGD. The FGD Team also received the list of main topics of interest above to organize their overall report.

The structure proposed for each FGD was:

- A brief introduction to welcome the respondents, present the purpose and ground rules for the exercise, and set the tone for the discussion;
- A group discussion of each question in each the guidelines, starting with the main questions in the guidelines and narrowing down with more specific sub questions or probes, as appropriate for the group;
- A closing session to summarize and check the main findings of the discussion and give an opportunity to the respondents to ask questions.

Each FGD team was expected to conduct and report on 2 or 3 FGDs per day and spend about one day to prepare their overall report according to the topics of interest above. The role of the facilitator was to lead and guide the discussion, do most of the talking, and prepare the individual FGD reports and the overall report. The role of the recorder was to take accurate and complete notes of what was said, including a clear identification of the questions and probes, and the context

and emotions of the answers. The recorder was also expected to assist the facilitator in the preparation of the individual FGD reports and the overall report.

Two KBA Team members briefed five of the six selected facilitators and recorders in Kisumu on Monday 14th. This briefing first included an introduction to World Vision and the KATSO project, a review of the purpose of each FGD, and the specification of the respondent's profiles and selection. The two KBA Team members then presented the FGD guidelines and discussed the main FGD questions, the facilitation methodology and the format and outline for the reports expected from each team. After the briefing, the FGD teams contacted and worked with the ADP office in each KBA site to identify and invite 8 to 12 respondents per FGD (no respondent were to participate to more than one group). These respondents were selected randomly from various villages in the KATSO site to ensure that each group of respondents is representative of the Division.

The respondent profile and the number of participants for each FGD in the three KBA sites are presented in the table below.

**Table 19 FGD Respondents profile and number of participants**

Respondents Profile	Number of Participants		
	Naivasha	Winam	Budalangi
1. Female Youth 12-15 years old (half OVCs)	12	9	10
2. Male Youth 12-15 years old (half OVCs)	14	10	11
3. OVC boys and girls aged 10-13	12, mixed	9 mixed	12
4. OVC boys and girls aged 14-17	12, mixed	10 mixed	12, mixed
5. OVC Care givers	12, mixed	10 mixed	11, mixed
6. OVC Household heads, young mothers/fathers	9	Unknown	12, mixed
7. OVC Household heads, grand parents	10 grdmas	9 grdmas	12, mixed
8. Community Care Coalition members	13, mixed	10 mixed	unknown

Community Care Coalition members included representatives of different OVC care groups supported by various NGOs, FBOs, Churches, CBO govt, etc.

Mixed: participants are a mixed group of boys

The KBA Team did not have the opportunity to meet with the FGD teams to discuss and cross-validate their findings.

Summaries of the three executive reports,<sup>19</sup> slightly edited for consistency of presentation, are placed in Appendix 16. The main findings and conclusions of these three reports are presented in the section below.

## **B. Findings**

### 1. Knowledge of HIV/AIDS among youths and OVCs

In the three FGD sites, both youths and OVCs respondents were knowledgeable about HIV/AIDS. They recognized that AIDS is a dangerous killer disease with no cure so far, and were able to cite the main signs and symptoms of AIDS. Most of the youths and OVCs know the difference

<sup>19</sup> These three reports and those from each FGDs are available at the WVK office in Nairobi

between the HIV and AIDS, saying that HIV is a virus that causes AIDS and that AIDS is the disease that kills. They also know that one may have the HIV virus and look healthy, and that AIDS is the disease where one has clearly noticeable symptoms and eventually dies.

Respondents were able to articulate that “One gets infected through having sexual intercourse with HIV infected persons.” and that people should try as much as they can to not be infected with HIV, through abstinence in particular. Many youths and OVC were aware of the ways in which people cannot contract HIV/AIDS. In Kisumu, the site where accessibility to condoms is probably the highest, all the groups of youths appeared to be very shy and uncomfortable with talking about condoms as a method of prevention against HIV infection, and they demonstrated an obvious ignorance on how condoms are used and on their effectiveness. None of the boys had used a condom although many had had sexual exposure.

In Kisumu, the FGD facilitators established that teachers have a significant influence on the perception and knowledge of youths with regard to HIV/AIDS. Other sources of information came out as the media (TV, radios, print literature and billboards) and their peers. The youths agreed that issues of HIV/AIDS were not discussed at home, and that parents and guardians were not significant contributors to their knowledge with this respect.

## 2. Perception of need for and knowledge of VCT among youths and OVCs

In the three sites, youths and OVCs seem to have a positive perception of the need for VCT. Youths recognized that one can only know his or her HIV status through the VCT centres, and this constitutes a major step towards changing one's way of life and taking control of their lives. Although some respondents thought that people had to pay for the test, the majority seems to be aware that VCT is free. They seem to know the VCT sites in their communities, and are able to discuss the right time to visit a VCT for a test, such as, “One should visit VCT before getting married,” or “Pregnant mothers must visit VCT and get tested to avoid passing the virus to their children,” or “People need to know their HIV status all the time and can get tested any time”.

In Naivasha, primary school age respondents do not seem to really understand what a VCT centre is, but seem to know that it is found in public hospitals and that it is free of charge. VCT is better understood among the secondary school age respondents, who also seem to be willing to be tested. Some youths, however, seem reluctant to being tested and fear exposure of their status. In Kisumu, primary school age respondents also appear to have more superficial knowledge about VCT than secondary school age respondents. No respondents had been tested, although several of them had sexual exposure.

In Budalangi, youths and OVCs pointed out that VCT centres were very few and far from the community. They recommended that VCT centres be brought closer to the people.

## 3. Stigma and discrimination towards OVCs and PLWHAs among youths

The majority of youth respondents seem to have an accepting attitude towards OVCs and PLWHAs, and they reject the notion of stigma and discrimination towards infected people. They said that they would offer assistance to these disadvantaged people in the community and would

continue loving them, providing them with basic needs, and helping them carrying out their daily duties.

Some respondents, however, also said that they would not like to stay with OVCs or PLWHAs for fear of getting infected. They said they would “keep-off” infected persons and that they wouldn’t use anything used by an infected person, including cups and spoons, and they wouldn’t shake hands with them. Some talked about infections such as cough that can be transmitted. Overall, stigma and discrimination clearly seem to be present in the communities.

#### 4. Sexual activity among youths and perception of same among OVC household heads

Many male youths responded that it is appropriate for young people to start having sex at the age of 16 years and above. However, female youth suggested that the actual age of sexual initiation could be at any age between 12-20 years. Several knew young girls, 12 and 15 years old who had given birth. Because of poverty, young girls often marry older men with long sexual histories, or are lured to “sugar daddies” or prostitution.

Parents and grandparents point out that youths begin having sexual intercourse too early and have multiple sexual partners. According to the household heads, when boys and girls have an early sexual initiation, they feel grown up and their parents are afraid to advise them. OVC household heads clearly expressed that premarital sex is bad and should be avoided at all cost.

In Kisumu, there was clear evidence that household heads were uncomfortable and reluctant to address issues of sexuality with youths, although they acknowledged that this was their primary responsibility; and that this should be done starting at the age of 12. They mentioned that this was difficult because youths spend most of their time outside homes (in schools) while parents are busy throughout the day. They expressed that they lacked appropriate forums and skills to communicate these messages effectively. Also, youths have several other sources of information, which increasingly influences their perceptions on various issues. Household heads also acknowledged that as society becomes increasingly liberal, youths are increasingly exposed to risky sexual behaviour like having multiple sexual partners, repeated pre-marital sex and early sexual debut even before they understand issues of sexuality. This trend is worrying to household heads and parents, who feel strongly that interventions should be put in place to save their youths from being wiped out by HIV/AIDS.

Many young people suggested the use of condoms as a prevention method, especially when one cannot abstain or maintain one single partner. However, in Kisumu, where accessibility to condoms is probably higher than in the other sites, all groups of youths seem very shy or uncomfortable talking about condoms, and demonstrated obvious ignorance on how they are used. None of the boys had used a condom, though quite a number had conceded to having had sexual exposure once or several times.

#### 5. Knowledge among OVC caregivers of OVCs’ and PLWHAs’ needs

OVC caregivers fully understood the problems of OVCs and PLWHAs. According to them, these two groups share the same needs for food, shelter, clothes, and medical and psychosocial care.

School fees are no longer a great problem for primary school OVCs, as the government provides free education for primary school, but become a problem when a child goes to secondary school.

Caregivers all agree that the basic needs of OVCs and PLWHAs are not being met “due to the high levels of poverty” in the community. Caregivers said that they may be willing to assist the OVCs and PLWHAs but cannot do so since they do not have enough resources for their own families. When OVCs and PLWHAs do not have food, caregivers are forced to go begging door to door to assist them. At times they are forced to borrow from shops to bring food to the OVCs. Some caregivers have taken OVCs into their own homes and care for them. Some well-wishers provide clothes and shelter.

Among other needs, medical care is a great problem for PLWHAs as there is not always a hospital near the community, and PLWHAs are not always willing to go to a hospital by fear of exposing their status.

OVC caregivers suggested training on home-based care to care for PLWHAs.

#### 6. Adequacy of care and support to OVCs: Perception from OVCs, OVC caregivers, and CCC members

In all three sites, OVCs, OVC caregivers and CCC members all perceive that care and support for OVCs is hardly adequate. OVCs said that they appreciate the care and support they get from their relatives and well-wishers but it is not adequate. They said that this is because the people in the community lack resources themselves. They need and want more in terms of provision of food, shelter, clothes, education, medication, and psychosocial support.

The CCC members also said that care and support for the OVCs was inadequate because their guardians are too poor. They said that the guardians need support with basic necessities to be able to provide for OVCs. CCC members revealed that though they try to help OVCs, their large numbers in the region is overwhelming. These children have many problems ranging from child rights abuses to psychological trauma and issues of discipline.

OVC caregivers also lament that they do not have adequate skills to effectively care for OVCs. “We still do not know many things.” The OVC caregivers suggested that they need training in home-based care so that they can also train the OVCs, who can in turn apply it to those they live with. They also need gloves and other medical equipment to help them handle those who are sick.

#### 7. Adequacy of care and support to PLWHAs: Perception from OVC care givers and CCC members

Both CCC members and OVC caregivers in all three sites perceive that what PLWHAs receive in terms of care and support is far from adequate. OVC caregivers say that they need much more food, medicine, shelter and financial support to enable them to cope with the array of needs of PLWHAs. The OVC caregivers said that community members are unable to meet their own basic needs, let alone provide for the PLWHAs. They also talked about the lack of information about

HIV/AIDS issues as being a major obstacle. They suggested training PLWHAs so that they could support themselves.

CCC members also perceive that the PLWHAs need to be educated about the HIV/AIDS pandemic and about their status, given the psychological and moral support they require. CCC members otherwise reveal they cannot meet the needs of the PLWHAs without more funding and training.

#### 8. Knowledge and perception of CCC members about the HIV/AIDS response in their community and about their role in it

The CCC members perceived AIDS as a main cause of poverty as it leaves orphans without anything by the time the parents die, typically after they have used their resources to buy drugs and quality food to keep their bodies healthy.

The CCCs are doing all they can to create awareness in their communities. They are carrying out sensitization and awareness-raising campaigns, counselling and guiding OVC and PLWHAs, and even providing nursing care. According to them, in one area the HIV/AIDS response has been positive among youths. The high-risk sexual behaviour has gone down in the last 2 years, and youths seem more willing to talk about sex. However, poverty keeps turning some to prostitution.

In the three sites, CCCs members are aware of what they have to do to scale up the HIV/AIDS response. However, they feel that they are hardly equipped for the rigor and magnitude of the task ahead of them. They said that they lack facilities, such as staff and offices. Other people or groups must join in the fight.

CCC members clearly expressed their desire to be used as coordination bodies given their grassroots influence and outreach in the community.

#### 9. Knowledge of Children's Rights among OVC caregivers and CCC members

In the three sites, CCC members seem to have a better knowledge and understanding of Children's Rights than the caregivers, but seem to find that Children's Rights only "exist in the books," and that their implementation is not easy. Nevertheless, they agree that it is their duty to teach the community about the Children's Rights and what is contained in the Children's Act.

In Naivasha, the nearest children's office is far from the community and CCC members proposed that it be brought nearer to the people.

## **C. Conclusions**

The KBA was able to commission a series of FGDs in the three KBA sites, and these which successfully generated information relevant to both programming and evaluation of KATSO.

The main findings are:

1. Good knowledge of HIV/AIDS among youths and OVCs.
2. Good knowledge of VCT among youths and OVCs. Need VCT centres closer to the community + confidentiality
3. Positive attitude of youths towards OVC/PLWHA, although not always
4. General opinion among youths that 16 is an appropriate age to begin sexual activity, although recognition that girls in particular may start as early as 12, often as a result of poverty and with older men. Parents and grandparents disapprove premarital sex but feel overwhelmed by the social pressures that youth face regarding sexual behaviour.
5. Caregivers understand the problems of OVCs and PLWHAs, and the difficulty to meet those needs in the context of poverty. Caregivers request training in home-based care.
6. General perception among OVCs, OVC caregivers, and CCC members that the care received by OVCs is hardly adequate, primarily due to lack of money in the community and the large numbers of OVCs.
7. General perception among CCC members and OVC caregivers that care and support to PLWHAs are far from adequate. Suggest that PLWHAs be educated about HIV/AIDS and trained on how to cope with their disease.
8. CCC members perceived AIDS as the main cause of poverty. CCC members are aware of what they have to do to scale up the HIV/AIDS response but feel that they are hardly equipped for the magnitude of the task.
9. Good understanding of Children's Rights by CCC members but not by OVC Care Givers. CCC members feel that the Children's Act is poorly implemented and the children's offices should be closer to the community.

Some limitations of the FGDs were:

- Very short time for the definition of the topics of interest and related questions, and for the preparation and training of the FGD facilitators;
- No debriefing with the facilitators and opportunity for cross-validation;
- Difficulty to assess the influence the facilitators may have had on their findings;
- Difficulty to assess the differences between OVCs and non-OVCs, and the differences between KBA sites areas.

## **VI. Overall conclusions and recommendations**

The conclusions related to the three KBA components are presented in the respective sections. This section presents conclusions and recommendations with respect to:

- The KATSO baseline assessment findings
- The KATSO design, monitoring and evaluation

### **A. KATSO Baseline Assessment Findings**

The KBA consisted of two types of data collection: three household surveys in KATSO sites of lower, intermediate and high burden of HIV/AIDS; and three series of focus group discussions in the same sites as those selected for the household surveys.

Overall, the results of the three surveys showed consistent variations in several indicators of the burden of HIV (prevalence of OVCs and chronically ill adults aged 18-59) or of potentially related factors (age of sexual debut and related high-risk behaviour among youths). These findings call for the design of care and support strategies that vary across the KATSO sites.

The main findings of the household surveys and focus group discussions assessments are summarized below by relevant KATSO Intermediate Results.

#### *SO1: Strengthened Community-Led Response*

IR 1.1: Strengthened community networks for psychosocial care to people affected by HIV/AIDS in Maragwa, Busia, and Teso districts

- Some organized psychosocial support already exists for chronically ill adults in Winam and Budalangi, where 42% and 23% of chronically ill adults, respectively, received such support in the 12 months before the surveys.
- The coverage of psychosocial services for OVCs is much lower, with 10% and 5% of OVCs having received such support in the 12 months before the surveys in Winam and Budalangi, respectively. There seems to be no organized psychosocial support for OVCs in Naivasha.

IR 1.2: Increased capacity of OVC and their households to protect themselves from HIV infection

- All youths have heard of AIDS, and most of them know at least one way to protect themselves against HIV infection. This is confirmed by the FGDs conducted with youths. However, less than two thirds of youths are able to correctly identify the three main ways of preventing sexual transmission of HIV and reject three major misconceptions about HIV transmission. This proportion is lower among females than among males, and lower for youths 15-19 than for youths 20-24.
- The majority of youths interviewed are sexually active. This sexual activity begins at a rather low age, and most frequently before marriage. Although parents clearly disapprove premarital sex, youths seem to recognize that sexual debut at 16 or earlier is common and acceptable. Marriage is more frequent and occurs earlier for females.

- Although youths are less likely to be sexually active before age 20, they are more likely to be sexually active but unmarried, which may place them in higher risk of HIV infection. Also, the age of sexual debut may have decreased over the last 10 years, particularly in urban areas (Winam).
- Both abstinence and faithfulness to one's partner seems well established among youths. Most never married youths who never had sex declared that they intend to be abstinent until marriage, and very few sexually active youths declared that they had more than one partners in the last 12 months. However, very few unmarried youths who already had sex declared that they had used a condom the first time. In general, youths in Budalangi reported a higher-risk behaviour.

IR: 1.3: Improved livelihood support systems to meet basic needs of OVC and their families

- Although food security remains an issue in all KBA sites, only in the site with relatively higher food security (Naivasha) are OVCs at higher risk than non-OVCs. In the two other sites, OVCs and non-OVCs have the same risk.

*SO2: Enabling Environment*

IR: 2.1: Improved multi-sectoral planning and collaboration for OVC support at division and district levels

- Very few OVCs currently receive organized medical, psychosocial, or material support, although various types of support exist in the three KBA sites, probably depending on local projects. Support for schooling is more frequent in the three sites.
- About three quarters of the adult population express accepting attitudes towards PLWHAs. This is true for both youths aged 15-24, as confirmed by the FGDs, and for adults aged 25-49.

*SO3: Prevention, Care and Support*

IR: 3.1: Increased number of people who know their HIV-status

- Very few adults were ever tested for HIV, and most of those were tested in the 12 months before the surveys. This suggests that the number of adults aware of their status is increasing, which is consistent with the recent increase in the availability of VCT services in Kenya.
- The proportion of adults who have ever been tested is three times higher in Kisumu than in the two other KBA sites, confirming the importance of the accessibility of services. Youths are well aware of the availability of these services but seem to need more accessible and confidential services.

IR: 3.2: Increased number of people living with HIV/AIDS receiving clinical care and support, including palliative care in Maragua, Busia and Teso Districts

- In the two KBA sites with higher prevalence of chronically ill adults, the coverage of adequate organized support for chronically ill adults is very low. In Budalangi, medical, psychosocial and material support reach about a third of chronically ill adults. In Winam, psychosocial support

reach slightly more than a third of the chronically ill adults, but the other types of support only reach 6% or lower.

- CCC member and care givers recognize that the support provided to PLWHAs is far from adequate, and attribute this to the large number of persons in need of such services, to the lack of resources in the community to organize such services, and to the lack of skills to provide this support

## **B. KATSO Design, Monitoring and Evaluation**

The KBA Team made significant progress defining a KATSO Performance Monitoring System, and the KBA validates the design of the project in terms of its overall goals and strategies, target population and degree of need. As KATSO management and field staff become familiar with the project and the challenges of its implementation, they will be able to also make final decisions about the monitoring system in terms of what to monitor (activities, standards and outputs), how to do it (indicators, data source, reporting system) and how to use the information to achieve the expected results (feedback; planning system; evaluation).

Specifically, KATSO now has the opportunity to finalize the KATSO Performance Monitoring and Evaluation Plan as outlined in section III, including:

- Refining the KATSO strategies outlined in the Program Description;
- Developing or defining technical standards for the main activities;
- Adopting the list of monitoring indicators, annual targets, forms and guidelines for the Management and sites' levels of the project;
- Conducting a pilot test of the Performance Monitoring System, and an external review after the first quarter of implementation;
- Integrating the Performance Monitoring System into the KATSO planning system;
- Conducting annual KATSO performance reviews, including periodic (2-3 years) external reviews or evaluations.

KATSO should complement its performance monitoring system with periodic special studies and assessments allowing for process and outcome evaluations. Potential designs for such studies, not exclusive, include:

- *Household surveys in the same three sites.* Using the same sample design and questionnaires, such surveys conducted in at least 2 years are the best way to establish trends in the KATSO outcomes indicators, and relate these to the other background variables included in the questionnaires. The KBA surveys were designed with the assumptions that such follow-on surveys would be done.
- *Simpler, lighter versions of the KBA surveys in other KATSO sites.* Building on the experience gained during the KBA, surveys with smaller sample size and shorter questionnaires can be conducted in the other KATSO sites to provide site-specific data for local level planning. Conducting such surveys may create a valuable sense of ownership of the data and the related programs by the KATSO staff and their local partners.
- *Lot Quality Assurance Sampling (LQAS) surveys.* This sampling approach has the potential to provide useful data using relatively small samples (for instance, 19 randomly selected households, youths, OVCs, or chronically ill adults) in each geographical area of managerial

significance. If data of sufficient quality are gathered from all project areas, they can be aggregated and constitute samples of size suitable for common statistical analyses such as estimating a proportion and confidence interval. Although this approach can provide useful information at the level of one individual or one area, it requires a well-defined program in terms of geographical coverage and managerial structure, a well-trained staff to collect the data, and a good information system to draw conclusions at the site or project level. This was not the case at the time of the KBA, but such conditions could rapidly become available within KATSO.

KATSO should build its performance monitoring and evaluation capacity by:

- Preparing and maintaining a minimum set of readily available reference data directly relevant to the management of KATSO, such as:
  - *Site-specific data*: population (census); health and HIV statistics; types and number of health services; schools; number of OVCs; presence of other programs, projects, organizations (CBOs, FBOs, others) providing services similar to those provided by KATSO;
  - *General documentation*: other projects and services similar to those provided by KATSO; studies and assessments conducted by other organizations.
- Identifying and meeting the training needs of KATSO Management and sites' staff in monitoring and evaluation of HIV/AIDS care and support projects.

To maximize the return from the KBA, KATSO, WVK and other WV offices involved in HIV/AIDS care and support programs, should conduct:

- Secondary analyses of the three KBA survey data sets, which may include:
  - Combined analyses of the three survey data sets, to better identify the differences between sites and increase the sample size for certain analyses;
  - Age and gender analyses of youths' sexual behaviour, using multivariate analyses techniques;
  - Analyses of the socioeconomic determinants of the main indicators relevant to KATSO programming, including cluster-level characteristics (urban/residence; accessibility to health and other services; ethnicity; primary occupation; inclusion in an ADP) and household-level characteristics (composition; living arrangements; education of household heads; assets);
  - Analyses of the schooling, sexual behaviour and other differentials between OVCs versus non-OVCs, by type of OVCs;
  - Estimation of the number (and confidence interval) of the different types of OVCs according the definition used (individual- versus household-level), the area of residence (sites and ADPs), or other characteristics of interest.
- A systematic review of the methods and tools used for the KBA surveys (sample design, questionnaires, questions, indicators) to draw lessons for follow-on KATSO assessments and for broader applications than KATSO.

# **APPENDICES**

## **Appendix 1      Selected reference documents**

US Mission to Kenya, President's Emergency Plan for AIDS Relief 2005 Country Operational Plan, Parameters Papers for Program Elements and Instructions and Template for Expressions of Interest (Concept Papers)

The President's Emergency Plan for AIDS Relief. Indicators, Reporting Requirements, and Guidelines. Revised based on FY2005 Country Operations Plans. September 30, 2004. Draft.

KATSO Program Description, USAID - World Vision US Cooperative Agreement Number 623-A-00-05-00001-00.

How to set up a Program Monitoring System. Module 1. Another Development Project Management Module, compiled by Brett Gresham. World Vision. Undated.

Country Data Profile: Orphans. Countries Targeted by the Emergency Plan for AIDS Relief – Kenya. USAID, October 2003.

Country Profile: HIV/AIDS / Kenya, 2004. The Synergy Project, .S. Office of the Global AIDS Coordinator, Washington, D.C.

National HIV Prevalence in Kenya. The National AIDS and STDs Control Programme (NASCO), Nairobi, Kenya. March 2003.

Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections. Kenya 2004 Update. UNAIDS/WHO.

HHS/CDC Global AIDS Program (GAP) in Kenya – FY 2003. Last Updated September 2004.

HIV/AIDS Profiles: Kenya. International Programs Center, Population Division. U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro.

World Vision Core HIV/AIDS Response Monitoring System (CHARMS): A Summary. November 2004.

Bicego G., Rutstein S., and Johnson Kiersten. Dimensions of the emerging orphan crisis in sub-Saharan Africa. *Social Sciences and Medicine* 56:1235-1247, 2003.

## Appendix 2 KATSO Strategic Framework

<b>Goal</b>	<b>To reduce the spread and impact of HIV/AIDS in 10 districts in Kenya</b>
<b>SO 1</b>	<b>Mobilized and strengthened community-led responses to improve care and support for OVC and others affected by HIV/AIDS, with special emphasis on engagement of churches and faith-based organizations.</b>
<b>IR 1.1</b>	<b>Strengthened community networks for psychosocial care to people affected by HIV/AIDS in Maragwa, Busia, and Teso Districts</b>
Activity 1	Identify and train supervisors and group leaders
Activity 2	Conduct weekly support group meetings
Activity 3	Monitor the recovery process of group members
<b>IR 1.2</b>	<b>Increased capacity of OVC and their households to protect themselves from HIV infection</b>
Activity 1	Form and train Home-Based OVC Care givers
Activity 2	Set up peer support groups
Activity 3	Establish drop-in resources centres
<b>IR 1.3</b>	<b>Improved livelihood support systems to meet basic needs of OVC and their families</b>
Activity 1	Link out-of-school OVCs with existing vocational training centres
Activity 2	Train OVC and their families on appropriate farming skills
Activity 3	Conduct nutrition education
Activity 4	Provide appropriate material support through Gifts-In-Kind
<b>SO 2</b>	<b>Improved enabling environments at division and district levels that actively support holistic care for OVC and others affected by HIV/AIDS</b>
<b>IR 2.1</b>	<b>Improved multi-sectoral planning and collaboration for OVC support at division and district levels</b>
Activity 1	Conduct discussion sessions on advocacy for OVC and PLWHA
Activity 2	Facilitate the implementation of National OVC Guidelines
Activity 3	Foster local level advocacy for improved OVC policies and increased resources for PSS care
<b>SO 3</b>	<b>Reduced HIV Transmission and Improved Clinical Care and Support</b>
<b>IR 3.1</b>	<b>Increased number of people who know their HIV-status</b>
Activity 1	Promote Voluntary Counselling and Testing
<b>IR 3.2</b>	<b>Increased number of people living with HIV/AIDS receiving clinical care and support, including palliative care in Maragua, Busia and Teso Districts</b>
Activity 1	Establish or strengthen peer group and home-based care (in Busia and Teso in year 1)
<b>IR 3.3</b>	<b>Increased numbers of individuals with AIDS who are receiving Antiretrovirals (ARV) in Teso District</b>
Activity 1	Promote access to ARVs in Maragua and Teso

Source: Program Description, KATSO Grant Agreement.

### Appendix 3 Selected characteristics of 10 KATSO sites

See data notes next page.

Characteristics	KATSO Site									
	1	2	3*	4*	5	6	7*	8	9	10
<b>PROVINCE</b>	NAIROBI	CENTRAL	RIFT V.	WESTERN			NYANZA			COAST
Population, 1999	2,143,254	3,724,159	6,987,036	3,358,776			4,392,196			2,487,264
HIV Prevalence, NASCOP 2002	16%	9%	7%	11%			21%			9%
HIV Prevalence, DHS 2003	10%	9%	5%	5%			15%			9%
Orphan prevalence, DHS 2003	7%	11%	10%	9%			19%			10%
<b>DISTRICT</b>	Nairobi	Maragua	Nakuru	Busia	Teso	Bungoma	Kisumu	Suba	Migori	Kilifi
Population, 1999	434,884	387,969	1,187,039	370,608	181,491	876,491	504,359	155,666	514,897	544,303
Residence	U	R	SU	R	R	SU	U	R	R	SU
Ethnicity	Kikuyus	Kikuyus	Kikuyus	Luyhas	Iteso	Luyhas	Luos	Luos	Luos	Taitas
Main Occupation	N/A	N/A	Agric	Fishing	N/A	Sugar cane	Fishing	Fishing	Fishing	N/A
Health Services	+++	++	++	+	+	++	+++	+	+	+
HIV Prevalence, NASCOP 2002	13%	8%	6%	11%	6%	6%	26%	34%	4%	5%
<i>Highest 1997-2002</i>	17%	10%	7%	23%	6%	6%	33%	34%	11%	9%
<i>Lowest 1997-2002</i>	13%	5%	2%	10%	6%	6%	25%	31%	4%	5%
# Orphans 0-17 yrs, GOK 2003	42,488	14,556	77,780	17,271	12,466	57,610	75,971	41,605	87,426	20,009
Orphan prevalence, 2003**	18%	7%	12%	8%	12%	12%	27%	49%	31%	7%
HIV/AIDS Burden	++	+	+	+++	++	+	+++	+++	+++	++
<b>DIVISION (S)</b>	Embakasi	Makuyu	Naivasha	Budalangi	Angurai / Chakol	Webuye / Kaduyi	Winam	Central / Lambue	Nyatike	Kaloleni
# Division(s) in KATSO site	1	1	1	1	2	2	1	2	1	1
Population, 1999	434,884	58,273	158,679	53,356	99,470	278,265	329,958	45,940	65,502	197,033
# Orphans 0-17 yrs, GOK 2003	42,488	2,186	10,397	2,486	6,832	18,290	49,701	12,278	11,122	7,243
<b>ADP</b>	Soweto	Makuyu	Ndabibi	Bunyala	CSP	N/A	Winam	Lambue	Nyatike	Kaloleni
ADP start date	1995	1995	2004	1997	2001	-	2000	1999	1994	1993
ADP Population, 1999	225,675	74,622	19,872	19,239	181,491	N/A	107,017	45,940	42,151	33,397
% Division Population	52%	128%	13%	36%	182%	N/A	32%	100%	64%	17%
HIV/AIDS projects in the area	+			MSF/Sp	CSP/HACI		+++	Korean		
KATSO Targeted OVCs	4000	4000	4000	4000	4000	4000	4000	4000	4000	4000
% Division OVCs	8%	152%	32%	134%	49%	18%	7%	27%	30%	46%
KATSO Special component:										
ART					+					
NonART		+		+	+					
Psychosocial		+		+	+					

## Selected characteristics of 10 KATSO sites, continued.

### Data Notes:

\* : Site selected for the KATSO Baseline Assessment Household Surveys and Focus Group Discussions

**Population:** Population figures are from the 1999 Kenya Population and Housing Census. These figures are purposely not extrapolated to date to allow verification in the source if questions arise regarding the administrative definitions and names used for Province, District, Division and ADP. The main purpose of these figures in this table is to assess the relative size of the various administrative units rather than their absolute size. If needed for programming purposes, these figures can easily be extrapolated using the formula  $P_n = P_{1999} * (1 + 0.024)^n$ , where n is the number of years for which the extrapolation is needed, 0.024 is the 2001-2005 Kenya population growth rate (National Development Plan 2002-2008),  $P_{1999}$  is the 1999 Census figure, and  $P_n$  is the population at year 1999 + n.

**Population and number of orphans in Nairobi:** In Nairobi province, Districts are assimilated to Divisions. The KATSO site in Nairobi is the Division of Embakasi with a population of 434,884. The ADP in Embakasi covers 4 major slum areas (Soweto, Mukuru, Njiru and Kayole) in addition to 2 major peri-urban settlements (Ruai and Ngundu). The GOK number of orphans for Nairobi in 2003 is for the Province (209,396) and is adjusted in this table for the population size in Embakasi relative to the Province: # orphans in Embakasi =  $209,396 * 434,884 / 2,14,254 = 42,488$ .

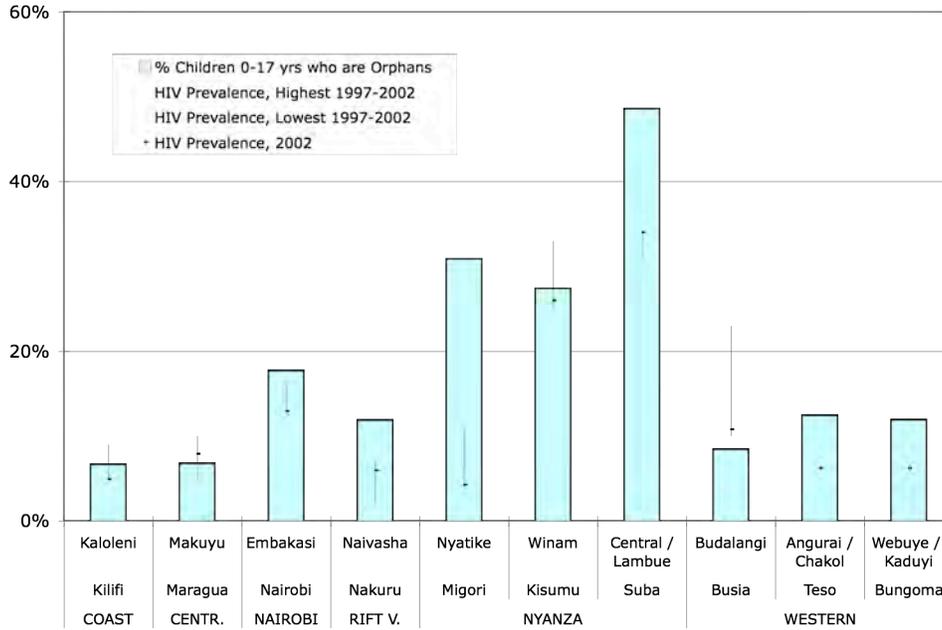
**Number and prevalence of orphans:** Orphan prevalence in Districts calculated by dividing the GOK number of orphans for 2003 by the number of children aged 0-17 in 2003, estimated as half of the 1999 population projected to 2003 using the 2001-2005 Kenya population growth of 2.4% (National Development Plan 2002-2008). Number of orphans in KATSO Division(s) calculated as the number of orphans in Districts adjusted by the relative size of the KATSO Division(s) population. Percentage of OVCs in the KATSO Division(s) that are targeted by KATSO calculated as 4,000 divided by the number of OVCs in the Division(s) (# orphans \* 1.20), multiplied by 100.

**Prevalence of HIV:** HIV prevalence data from the 2002 special study of the Sentinel Surveillance System data from 1990 to 2002 (NASCO, 2002). HIV prevalence data for each KATSO site chosen as those from the most closely related SSS site in that study.

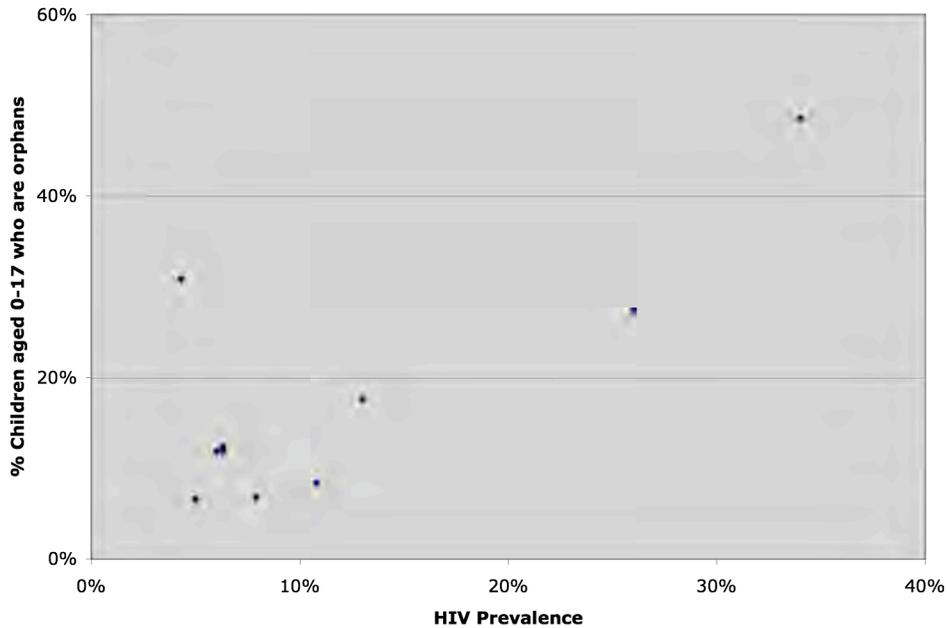
## Appendix 4 HIV and Orphan Prevalence in 10 KATSO Sites

See data sources and notes in Appendix 3.

**Figure 1. HIV Prevalence and Orphans Prevalence In the 10 KATSO sites**



**Figure 2 Orphans Prevalence by HIV Prevalence In 10 KATSO Sites**



**Appendix 5      KATSO Master List of Indicators**

## KATSO MASTER LIST OF INDICATORS

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>STRENGTHENED COMMUNITY-LED RESPONSE</b>				
<b>SO 1: Mobilized and strengthened community-led responses to improve care and support for OVC and others affected</b>				
<b>IR 1.1 Strengthened community networks for psychosocial support to people affected by HIV/AIDS in Maragwa, Busia, and Teso districts</b>				
<b>OUTCOME INDICATORS</b>				
1	% persons 15-49 reporting no symptom of depression	# persons 15-49 with depression score above KATSO-defined threshold / # persons 15-49 assessed	HHS	Every 2 to 3 years PM, MEO, Consultant
2	% OVCs receiving emotional/psychological support	NUMERATOR: # OVCs living in households that received emotional/psychological support in last 3 months DENOMINATOR: # OVCs surveyed [disaggregated by age and sex] [PEPFAR, p67]	HHS	Every 2 to 3 years PM, MEO, Consultant
3	% persons 18-49 with access to community psychosocial care and support	# chronically ill persons (including deaths in last 21 months) who received emotional and psychosocial support, such as companionship, counseling from trained counselor or spiritual support for which they did not have to pay in the last 12 months / # chronically ill persons (including deaths in last 12 months) [PEPFAR, p62]	HHS	Every 2 to 3 years PM, MEO, Consultant

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>OUTPUT INDICATORS</b>				
<b>Activity 1. Identify and train supervisors and group leaders</b>				
1 # IPT-G supervisors trained	Total # of IPT-G supervisors trained according to adopted KATSO curriculum during last quarter	KATSO MGT	Quarterly	PM, MEO
2 # IPT-G supervisors in place	Total # of IPT-G supervisors performing according to KATSO-defined terms of reference during last quarter	KATSO MGT	Quarterly	PM, MEO
3 # IPT-G group leaders trained	Total # of IPT-G group leaders trained according to KATSO-defined curriculum in all 3 KATSO PSS sites during last quarter	Site MPR	Quarterly	Site coord. MEO
4 # functional ITP-G groups	Total # ITP-G groups functioning according to adopted KATSO-defined standards in all 3 KATSO PSS sites during last quarter	Site MPR	Quarterly	Site coord. MEO
<b>Activity 2. Conduct weekly support group meetings</b>				
5 # weekly IPT-G meetings conducted	Total # of IPT-G meetings held according to KATSO-defined standards in all 3 KATSO PSS sites during last quarter	Site MPR	Quarterly	Site coord. MEO
6 # participants completing a set of IPT-G sessions	Total # of participants completing a set a of IPT-G sessions in all 3 KATSO PSS sites during last quarter	Site MPR	Quarterly	Site coord. MEO
<b>Activity 3. Monitor the recovery process of group members</b>				
7 % targeted IPT-G participants completing the group therapy	Total # of participants completing a set of sessions in all 3 KATSO PSS sites during last quarter / Total # participants expected to complete a set of sessions in all 3 KATSO PSS sites during last quarter	Site MPR	Quarterly	Site coord. MEO
8 # debriefing sessions with IPT-G group leaders	Total # of debriefing sessions held by IPT-G supervisors with IPT-G group leaders according to KATSO-defined standards in all 3 KATSO PSS sites	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON	
<b>IR 1.2 Increased capacity of OVCs and their households to protect themselves from HIV infection</b>					
<b>OUTCOME INDICATORS</b>					
1	% young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	# young people aged 15-24 who correctly answered HHS Questions F402 to F407 / # young people aged 15-24 interviewed [disaggregated by sex] [PEPFAR P1, p36]	HHS	Every 2 to 3 years	PM, MEO, Consultant
2	% never-married young people aged 15-24 who have never had sex	# of never-married young people aged 15-24 who have never had sex / # of never-married young people aged 15-24 [disaggregated by sex] [PEPFAR P2, p38]	HHS	Every 2 to 3 years	PM, MEO, Consultant
3	% never-married young people aged 15-24 who never had sex and intend to abstain	# % never-married young people aged 15-24 who never had sexual intercourse and report intending to abstain until marriage / # never-married young people aged 15-24 who never had sexual intercourse [disaggregated by sex]	HHS	Every 2 to 3 years	PM, MEO, Consultant
4	% young people aged 15-24 who ever had sex and used condom the 1st time	# young people aged 15-24 who already had sexual intercourse and report having used a condom the first time they had sexual intercourse / # of unmarried young people 15-24 who already had sexual intercourse [disaggregated by sex]	HHS	Every 2 to 3 years	PM, MEO, Consultant
5	% never-married young people aged 15-24 who had sex in the last 12 months	# never-married young people aged 15-24 who had sex in the last 12 months / # never-married young people aged 15-24 [PEPFAR P3, p39]	HHS	Every 2 to 3 years	PM, MEO, Consultant
6	% young people aged 15-24 who had sex in last 12 months who had more than one partner	# young people aged 15-24 who had sex in the last 12 months and who had more than one partner / # of young people aged 15-24 who had sex in the last 12 months [disaggregated by sex]	HHS	Every 2 to 3 years	PM, MEO, Consultant

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>OUTPUT INDICATORS</b>				
<b>Activity 1. Train and facilitate activities of Home-Based OVC Care givers (HBOC)</b>				
1 # NEW CCC formed	Total # of new Community Care Coalitions (CCC) that were formed in all 10 KATSO sites during last quarter [CHARMS, p11]	Site MPR	Quarterly	Site coord. MEO
2 # CCC currently operating	Total # of Community Care Coalitions (CCC) currently operating according to KATSO-defined standards in all 10 KATSO sites at the end of last quarter (excluding those that were newly formed during last quarter) [CHARMS, p11]	Site MPR	Quarterly	Site coord. MEO
3 # CCC members trained	Total # of new Community Care Coalitions (CCC) members trained according to KATSO-defined curriculum in all 10 KATSO sites during the last quarter	Site MPR	Quarterly	Site coord. MEO
# NEW HBOC selected	Total # of NEW HBOCs selected in all 10 KATSO sites during the last quarter	Site MPR	Quarterly	Site coord. MEO
4 # NEW HBOC trained	Total # of NEW HBOC trained in caring for OVC according to KATSO-defined curriculum in all 10 KATSO sites during the last quarter [PEPFAR, p25] [CHARMS, p12]	Site MPR	Quarterly	Site coord. MEO
5 # HBOC currently active	Total # of HBOC operating according to KATSO-defined standards in all 10 KATSO sites at the end of last quarter [CHARMS, p12]	Site MPR	Quarterly	Site coord. MEO
6 # OVCs	Total # of male and females OVC who currently have been identified in all 10 KATSO sites (including those newly identified and those who left the sites in last quarter) at the end of last quarter [CHARMS, p12]	Site MPR	Quarterly	Site coord. MEO
7 # OVCs served	Total # OVC served according to KATSO-defined standards in all 10 KATSO sites during last quarter [disaggregated by age and sex] [PEPFAR, p25] [CHARMS, p12]	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME		INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>Activity 2. Set up peer support groups</b>					
1	# NEW youth groups formed	Total # of youth groups formed in all 10 KATSO sites during last quarter	Site MPR	Quarterly	
2	# youth groups currently operating	Total # of youth groups currently operating according to KATSO defined standards in all 10 KATSO sites at the end of last quarter	Site MPR	Quarterly	Site coord. MEO
3	# youths participating in youth groups	Total # of youths participating in youth groups according to KATSO defined standards in all 10 KATSO sites at the end of last quarter	Site MPR	Quarterly	Site coord. MEO
4	# youth values-based life skills trainers trained	Total # of youth values-based life skills trainers trained according to KATSO-defined curriculum in all 10 KATSO sites during the last quarter	Site MPR	Quarterly	Site coord. MEO
5	# youths trained in values-based life skills	Total # of youths trained in values-based life skills according to KATSO-defined curriculum in all 10 KATSO sites during last quarter [CHARMS, p11]	Site MPR	Quarterly	Site coord. MEO
<b>Activity 3. Establish drop-in resource centers</b>					
1	# currently operating resource centers	Total # of drop-in resource centers operating according to KATSO-defined standards in all 10 KATSO sites at the end of last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON	
<b>IR 1.3 Improved livelihood support systems to meet basic needs of OVC and their families</b>					
<b>OUTCOME INDICATORS</b>					
1	Ratio of OVC to non-OVC households in which, because of lack of food in the last 30 days, children did not eat for a whole day	(# of households with OVCs in which children did not eat for at least one whole day because there was not enough food or money to buy food / # of households with OVCs ) / (# of households without OVCs in which children did not for at least one whole day because there was not enough food or money to buy food / # of households without OVCs)	HHS	Every 2 to 3 years	PM, MEO, Consultant
<b>OUTPUT INDICATORS</b>					
<b>Activity 1. Link out-of-school OVC with existing vocational training centers</b>					
1	# out-of-school OVCs receiving vocational skills training	Total # of out-of-school OVCs receiving vocational skills training according to KATSO-defined curriculum in all 10 KATSO sites during the last quarter	Site MPR	Quarterly	Site coord. MEO
2	# out-of-school OVCs equipped with entrepreneurship skills	Total # of out-of-school OVCs equipped with entrepreneurship skills [DEFINE] in all 10 KATSO sites during of last quarter	Site MPR	Quarterly	Site coord. MEO
3	# out-of-school OVC supported with business start-up kits	Total # of out-of-school OVC supported with business start-up kits [DEFINE] in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
<b>Activity 2. Train OVC and their families on appropriate farming skills</b>					
1	# TOT model farmers trained	Total # of model farmers trained as trainers in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
2	# HHs with OVCs trained in improved farming skills	Total # of HHs with OVCs trained in improved farming skills according to KATSO-adotped curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
3	# HHs with OVC aided with farm inputs/livestock	Total # of HHs with OVC aided with KATSO-defined packages of farm inputs/livestock during last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME		INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>Activity 3. Conduct nutrition education</b>					
1	# volunteers trained as TOT in nutrition for OVCs and PLWHAs	Total # of volunteers trained as TOT in nutrition for OVCs and PLWHAs according to the KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
<b>Activity 4. Provide appropriate material support through Gifts-In-Kind (GIK)</b>					
1	Total value (in \$) of GIK provided to OVC, PLWHA and their families	Total value (in \$) of GIK provided to OVC, PLWHA and their families	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON	
<b>ENABLING ENVIRONMENT</b>					
<b>SO 2 : Improved enabling environments at division and district levels that actively support holistic</b>					
<b>IR 2.1 Improved multi-sectoral planning and collaboration for OVC support at division and district</b>					
<b>OUTCOME INDICATORS</b>					
1	% OVCs living in households that received, free of user charges, basic external support in caring for the child	<p>NUMERATOR: # OVCs living in households that received free-of-user charges:</p> <ol style="list-style-type: none"> <li>1. Medical support in last 12 months</li> <li>2. Emotional/psychological support in last 3 months</li> <li>3. Material support in last 3 months</li> <li>4. Social support in last 3 months</li> <li>5. School-related support in last 12 months</li> </ol> <p>DENOMINATOR: # OVCs surveyed [disaggregated by age and sex] [PEPFAR O1, p67]</p>	HHS	Every 2 to 3 years	PM, MEO, Consultant
2	% general population with accepting attitudes toward PLWHA	<p>NUMERATOR: # of persons aged 15-49 whose answers to four standard questions showed an accepting attitudes toward PLWHA</p> <p>DENOMINATOR: # persons aged 15-49 WHO HAVE HEARD OF HIV [disaggregated by age and sex] [PEPFAR CB2, p73]</p>	HHS	Every 2 to 3 years	PM, MEO, Consultant
3	# Divisions with action plans for promoting the well-being of OVC and PLWHAs	<p>Total # of KATSO site Divisions with action plans for promoting well-being of OVC and PLWHAs at the end of last quarter</p> <p><u>Action plan</u>: Approved list of activities, timeline and budget</p>	Annual Review	Annually?	PM, MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>OUTPUT INDICATORS</b>				
<b>Activity 1. Conduct discussion sessions on advocacy for OVC and PLWHA</b>				
1 # monthly community advocacy meetings	Total # of monthly community advocacy meetings held by CDM with community groups in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
<b>Activity 2. Facilitate the implementation of National OVC Guidelines</b>				
1 # NEW OVC Task Forces formed	Total # of NEW OVC Task Forces formed according to KATSO-defined standards in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
2 # OVC Task Forces currently operating	Total # of OVC Task Forces currently operating according to KATSO-defined standards in all 10 KATSO sites at the end of last quarter	Site MPR	Quarterly	Site coord. MEO
3 # CCC/FBO/CBO leaders and HBCT members trained in advocacy skills	Total # of CCC/FBO/CBO leaders and HBCT members trained in advocacy skills according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
4 # OVC policies and guidelines disseminated	Total # of copies of each type of OVC policies and guidelines disseminated in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
5 # promising practices documented and disseminated	# promising practices on OVC programming documented and disseminated at the district and division levels [USAID/K]	KATSO MGT	Annually	PM, OVC Off.
<b>Activity 3. Foster local level advocacy for improved OVC policies and increased resources for PSS care</b>				
1 # awareness meetings held	Total # of awareness meetings held according to KATSO-defined standards in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
2 # people reached through awareness meetings	Total # of people reached through awareness meetings in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON	
<b>PREVENTION, CARE AND SUPPORT</b>					
<b>SO3: Reduced HIV Transmission and Improved Clinical Care and Support</b>					
IR 3.1 Increased number of people who know their HIV status.					
<b>OUTCOME INDICATORS</b>					
1	% the general population aged 15–49 receiving HIV test results in the last 12 months	# women and men 15-49 who received HIV test results in the last 12 months / # persons 15-49 [disaggregated by age and sex] [PEPFAR, p54]	HHS	Every 2 to 3 years	PM, MEO, Consultant
<b>OUTPUT INDICATORS</b>					
<b>Activity 1. Promote Voluntary Counseling and Testing</b>					
1	# VCT promotional campaigns held	Total # of promotional campaigns conducted according to KATSO defined standards in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
2	# people reached through VCT promotional campaigns	Total # of people reached through KATSO VCT promotional campaigns in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
3	# persons trained in VCT according to national and international standards	Total # persons trained in VCT according to national and international standards in all 10 KATSO sites during last quarter [PEPFAR, p16]	Site MPR	Quarterly	Site coord. MEO
4	# VCT supervisors trained	Total # of VCT supervisors trained according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	KATSO MGT	Quarterly	Site coord. MEO
5	# VCT counselors trained	Total # of VCT counselors trained according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
6	# laboratory technicians trained in rapid HIV testing	Total # of laboratory technicians trained in rapid HIV testing according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME		INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
7	# VCT sites supported to provide CT according to national and international standards [PEPFAR]	Total # VCT sites supported to provide CT according to national and international standards in all 10 KATSO sites during last quarter [PEPFAR]	Site MPR	Quarterly	Site coord. MEO
8	# clients receiving counseling and testing services	Total # clients receiving counseling and testing services in all 10 KATSO sites during last quarter [disaggregated by sex] [PEPFAR p16]	Site MPR	Quarterly	Site coord. MEO
9	# currently operating post-test clubs	Total # of post-test clubs currently operating according to KATSO-defined standards in all 10 KATSO sites at the end of last quarter	Site MPR	Quarterly	Site coord. MEO
10	# persons participating in post-test club activities	Total # of persons participating in KATSO-supported post-test club activities in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON	
IR 3.2 Increased number of people living with HIV/AIDS receiving clinical care and support including palliative					
<b>OUTCOME INDICATORS</b>					
1	% adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death, whose households have received, free of user charges, basic external support in caring for the chronically ill person	<p>NUMERATOR: # of men and women aged 18-59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more month before death, and whose households have received, free of user charges:</p> <ol style="list-style-type: none"> <li>1. Medical support at least once a month while sick</li> <li>2. Emotional in last 30 days</li> <li>3. Material support in last 30 days</li> <li>4. Social support in last 30 days</li> </ol> <p>DENOMINATOR: # of men and women aged 18-59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more month before death [disaggregated by age and sex] [PEPFAR]</p>	HHS	Every 2 to 3 years	PM, MEO, Consultant
<b>OUTPUT INDICATORS</b>					
<b>Activity 1. Establish of strengthen peer group and home-based care (in Busia and Teso in year 1)</b>					
1	# health workers trained to provide general HIV-related palliative care for HIV -infected individuals (diagnosed or presumed)	Total # of health workers trained in general HIV/AIDS palliative care according to KATSO adopted curriculum in all 10 KATSO sites during last quarter [PEPFARp23]	KATSO MGT	Quarterly	Site coord. MEO
2	# health centers supported for non-ART palliative care	Total # of health centers supported according to KATSO-defined criteria to provide non-ART palliative care in all 10 KATSO sites during the last quarter [PEPFARp23]	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
3 # clients provided with HIV-related palliative care	Total # of individuals provided with general HIV-related palliative care according to KATSO-defined standards in all 10 KATSO sites during the last quarter [disaggregated by sex] [PEPFARp23]	Site MPR	Quarterly	Site coord. MEO
3 # HBC trainers trained	Total # of HBC trainers trained in general HIV/AIDS palliative care according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
4 # HBC monitors trained	Total # of HBC monitors trained in general HIV/AIDS palliative care according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
5 # HBC givers trained	Total # of HBC givers trained in general HIV/AIDS palliative care according to KATSO adopted curriculum in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
7 # HBC givers provided with kits	Total # of HBC givers provided with KATSO defined kits for the provision of general HIV/AIDS palliative care in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
8 # HBC givers attending quarterly debriefing meetings	Total # of HBC givers attending quarterly debriefing meetings according to KATSO-defined standards in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO
9 # HBC clients referred	Total # of new clients of Patient Support Centers or Specialist Clinics referred by HBC givers for VCT or general HIV/AIDS palliative care in all 10 KATSO sites during last quarter	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
<b>IR 3.3 Increased number of PLWHAs receiving ART</b>				
<b>OUTCOME INDICATORS</b>				
1 % people with advanced HIV infection receiving ART	NUMERATOR: Total # of individuals with advanced HIV infection receiving ART at the end of last quarter in KATSO sites in Maragua and Teso DENOMINATOR: 0.15 * prevalence of HIV among adults * total population 18-59 at the end of last quarter in KATSO sites in Maragua and Teso [disaggregated by sex] [PEPFARp57]	Site MPR	Quarterly	PM, MEO, Consultant
<b>OUTPUT INDICATORS</b>				
<b>Activity 1. Promote access to ARVs in Maragua and Teso</b>				
1 # service outlets providing ART services	Total # of service outlets supported by KATSO and providing ART according to KATSO-defined standards in KATSO sites in Maragua and Teso at the end of last quarter [PEPFARp19]	Site MPR	Quarterly	Site coord. MEO
2 # NEW individuals with advanced HIV infection receiving ART	Total # NEW individuals with advanced HIV infection initiating ART according to KATSO-defined standards in KATSO sites in Maragua and Teso during last quarter [disaggregated by sex, age and pregnancy status] [PEPFARp19]	Site MPR	Quarterly	Site coord. MEO
3 # individuals with advanced HIV infection receiving ART	Total # of individuals with advanced HIV infection receiving ART according to KATSO-defined standards in KATSO sites in Maragua and Teso at the end of last quarter [disaggregated by sex, age and pregnancy status] [PEPFARp19]	Site MPR	Quarterly	Site coord. MEO

INDICATOR NAME	INDICATOR DEFINITION	DATA SOURCE	REPORTING FREQUENCY	RESPONSIBLE PERSON
4 # individuals with advanced HIV infection receiving ART for more than 12 months	Total # of individuals with advanced HIV infection receiving ART according to KATSO-defined standards in KATSO sites in Maragua and Teso for more than 12 months at the end of last quarter [disaggregated by sex, age and pregnancy status] [PEPFARp19]	Site MPR	Quarterly	Site coord. MEO
5 # health workers trained to deliver ART services	Total # of health workers trained in ART treatment provision and monitoring according to KATSO adopted curriculum in KATSO sites in Maragua and Teso during last quarter [PEPFARp19]	Site MPR	Quarterly	Site coord. MEO
6 # laboratory workers trained in CD 4 count	Total # of laboratory workers trained in CD4 count according to KATSO adopted curriculum in KATSO sites in Maragua and Teso during last quarter	Site MPR	Quarterly	Site coord. MEO

## **Appendix 6      KATSO Performance Monitoring Reports**

KATSO Site Monthly Performance Report – S-MPR

KATSO Monthly Compilation of Site Monthly Performance Reports

KATSO Quarterly Performance Report – K-QPR

KATSO Site:  
Month:

Date Submitted  
Initials

<b>Site Monthly Performance Report*</b>																
Indicator	End of Year Target	Reporting Month												Total This Month	Progress To Date Year-to-Date	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
<b>SO1</b>																
<b>IR.1.1</b>																
# IPT-G supervisors in place															0	#DIV/0!
# IPT-G group leaders trained	90														0	0
# functional ITP-G groups																
# weekly IPT-G meetings conducted																
# participants completing a set of IPT-G sessions	4500														0	0
% targeted IPT-G participants completing the group therapy															0	#DIV/0!
# debriefing sessions with IPT-G group leaders	90														0	0
<b>IR.1.2</b>																
# NEW CCC formed	14														0	0
# CCC currently operating																
# CCC members trained															0	#DIV/0!
# NEW HBOC selected	4000														0	0
# NEW HBOC trained	4000														0	0
# HBOC currently active	4000														0	0
# OVCs																
# OVCs served	40000														0	0
# NEW youth groups formed	100														0	0
# youth groups currently operating																
# youths participating in youth groups	10000														0	0
# youth values-based life skills trainers trained	40														0	0

Indicator	End of Year Target	Reporting Month												Total This Month	Progress To Date Year-to-Date	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
# youths trained in values-based life skills	10000														0	0
# currently operating resource centers	10														0	0
<b>IR.1.3</b>																
# out-of-school OVCs receiving vocational skills training	1200														0	0
# out-of-school OVCs equipped with entrepreneurship skills	1200														0	0
# out-of-school OVC supported with business start-up kits	1200														0	0
# TOT model farmers trained	400														0	0
# HHs with OVCs trained in improved farming skills	2400														0	0
# HHs with OVC aided with farm inputs/livestock															0	#DIV/0!
# volunteers trained as TOT in nutrition for OVCs and PLWHAs	400														0	0
<b>SO2</b>																
<b>IR.2.1</b>																
# monthly community advocacy meetings																
# NEW OVC Task Forces formed	14														0	0
# OVC Task Forces currently operating																
# CCC/FBO/CBO leaders and HBCT members trained in advocacy skills	280														0	0
# OVC policies and guidelines disseminated	840														0	0
# awareness meetings held	80														0	0
# people reached through awareness meetings															0	#DIV/0!

Indicator	End of Year Target	Reporting Month												Total This Month	Progress To Date Year-to-Date	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
<b>S03</b>																
<b>IR.3.1.</b>																
# VCT promotional campaigns held	320														0	0
# people reached through VCT promotional campaigns															0	#DIV/0!
# VCT counselors trained	40														0	0
# laboratory technicians trained in rapid HIV testing	20														0	0
# VCT sites supported to provide CT according to national and international standards [PEPFAR]	20														0	0
# clients receiving counseling and testing services	90000														0	0
# currently operating post-test clubs	20														0	0
# persons participating in post-test club activities	400														0	0
<b>IR.3.2.</b>																
# health centers supported for non-ART palliative care	20														0	0
# clients provided with HIV-related palliative care	3200														0	0
# HBC trainers trained	20														0	0
# HBC monitors trained	40														0	0
# HBC givers trained	400														0	0
# HBC givers provided with kits	400														0	0
# HBC givers attending quarterly debriefing meetings	400														0	0
# HBC clients referred															0	#DIV/0!

Indicator	End of Year Target	Reporting Month												Total This Month	Progress To Date Year-to-Date	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
<b>IR.3.3.</b>																
# service outlets providing ART services	4														0	0
# NEW individuals with advanced HIV infection receiving ART	200														0	0
# individuals with advanced HIV infection receiving ART	4														0	0
# individuals with advanced HIV infection receiving ART for more than 12 months	4														0	0
# health workers trained to deliver ART services	40														0	0
# laboratory workers trained in CD 4 count	4														0	0

Month:

Year:

<b>KATSO Monthly Compilation of Site Monthly Performance Reports*</b>													
Indicator Name	End of Year Target	KATSO SITE										Total This Month	Progress Year-to-Date
		Kilifi	Maragua	Nairobi	Nakuru	Migori	Kisumu	Suba	Busia	Teso	Bungoma <sup>a</sup>		
<b>SO1</b>													
<b>IR.1.1</b>													
# IPT-G supervisors in place												0	#DIV/0!
# IPT-G group leaders trained	90									30		30	33.3%
# functional IPT-G groups													
# weekly IPT-G meetings conducted													
# participants completing a set of IPT-G sessions	4500											0	0.0%
% targeted IPT-G participants completing the group therapy	0											0	#DIV/0!
# debriefing sessions with IPT-G group leaders	90											0	0.0%
<b>IR.1.2</b>													
# NEW CCC formed	14	1		2			1	2	18	2	2	28	200.0%
# CCC currently operating													
# CCC members trained		35		120		0	30	0	0	128		313	#DIV/0!
# NEW HBOC selected	4000	400		530	1150	400	380	400	400	400	400	4460	111.5%
# NEW HBOC trained	4000	120		120		40	350	400	400	400	400	2230	55.8%
# HBOC currently active	4000											0	0.0%
# OVCs													
# OVCs served	40,000	3110		700		4000	3800	4000	4000		4000	23610	59.0%
# NEW youth groups formed	100	0		14		0		38	13			65	65.0%
# youth groups currently operating													

Indicator Name	End of Year Target	KATSO SITE										Total This Month	Progress Year-to-Date	
		Kilifi	Maragua	Nairobi	Nakuru	Migori	Kisumu	Suba	Busia	Teso	Bungoma <sup>a</sup>			
# youths participating in youth groups	10,000			290				1140	360			1790	17.9%	
# youth values-based life skills	40	0		112		0		38	28			178	445.0%	
# youths trained in values-based life skills	10,000	0		86		0		1140	15	100		1341	13.4%	
# currently operating resource centers	10	0				0		1	2			3	30.0%	
<b>IR.1.3</b>														
# out-of-school OVCs receiving vocational skills training	1200			57		120		45	19			241	20.1%	
# out-of-school OVCs equipped with entrepreneurship skills	1200					0			0			0	0.0%	
# out-of-school OVC supported with business start-up kits	1200					0			0			0	0.0%	
# TOT model farmers trained	400	40		34		40	31	40	31	40	40	296	74.0%	
# HHs with OVCs trained in improved farming skills	2400					0		156	0			156	6.5%	
# HHs with OVC aided with farm inputs/livestock								156	0			156	#DIV/0!	
# volunteers trained as TOT in nutrition for OVCs and PLWHAs	400	40				40			74		40	194	48.5%	
<b>S02</b>														
<b>IR.2.1</b>														
# monthly community advocacy meetings														
# NEW OVC Task Forces formed	14	6		2		1		2	2		4	17	121.4%	
# OVC Task Forces currently operating														

Indicator Name	End of Year Target	KATSO SITE										Total This Month	Progress Year-to-Date
		Kilifi	Maragua	Nairobi	Nakuru	Migori	Kisumu	Suba	Busia	Teso	Bungoma <sup>a</sup>		
# CCC/FBO/CBO leaders and HBCT members trained in advocacy skills	280					0	27			128		155	55.4%
# OVC policies and guidelines disseminated	840	2		1					1		9	13	#REF!
# awareness meetings held	80			12		8			19		2	41	51.3%
# people reached through awareness meetings	-					7200				8000	200	15400	#VALUE!
<b>S03</b>													
<b>IR.3.1.</b>													
# VCT promotional campaigns held	320					0		4	0			4	1.3%
# people reached through VCT promotional campaigns						0		110	0			110	#DIV/0!
# VCT counselors trained	40					0	4	26	0		100	130	325.0%
# laboratory technicians trained in rapid HIV testing	20					0		3	0		30	33	165.0%
# VCT sites supported to provide CT according to national and international standards [PEPFAR]	20					0		7			20	27	135.0%
# clients receiving counseling and testing services	90000					0		286	-		9000	9286	10.3%
# currently operating post-test clubs	20			1		1		2	3		30	37	185.0%
# persons participating in post-test club activities	400					15		37	80		500	632	158.0%
<b>IR.3.2.</b>													
# health centers supported for non-ART palliative care	20								3			3	15.0%

Indicator Name	End of Year Target	KATSO SITE										Total This Month	Progress Year-to-Date
		Kilifi	Maragua	Nairobi	Nakuru	Migori	Kisumu	Suba	Busia	Teso	Bungoma <sup>a</sup>		
# clients provided with HIV-related palliative care	3,200			200					490		2200	2890	90.3%
# HBC trainers trained	20	4		3				2	48		2	59	295.0%
# HBC monitors trained	40							2	0		3	5	12.5%
# HBC givers trained	400			130					98		100	328	82.0%
# HBC givers provided with kits	400			40					98			138	34.5%
# HBC givers attending quarterly debriefing meetings	400	1		40								41	10.3%
# HBC clients referred				100								100	#DIV/0!
<b>IR.3.3.</b>													
# service outlets providing ART services	4								0			0	0.0%
# NEW individuals with advanced HIV infection receiving ART	200											0	0.0%
# individuals with advanced HIV infection receiving ART	4								0			0	0.0%
# individuals with advanced HIV infection receiving ART for more than 12 months	4								0			0	0.0%
# health workers trained to deliver ART services	40							10	4			14	35.0%
# laboratory workers trained in CD 4 count	4								0			0	0.0%

\* Data from KBA test, provided for illustration purposes

## KATSO Quarterly Performance Report

INDICATOR NAME	Annual Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
		Total This Quarter	Progress Year-to-Date (%)						
SO1 IR 1.1 ...									

## Appendix 7 Training Schedule for HHS enumerators

TIME	TOPIC(s)	FACILITATOR
DAY 1 – IN-CLASS TRAINING		
8.30-9.00 AM	Participants registration	Site/ADP Coordinator
9.00-10.00 AM	Introduction <ul style="list-style-type: none"> <li>- Self introductions</li> <li>- About WV and KATSO</li> <li>- The DME cycle</li> <li>- Baseline- meaning and use</li> </ul>	Simpson T
10.00-11.00 AM	Overview of the instruments	Marc D
11.00-11.30 AM	Break	Site /ADP Coordinator
11.30-1.00PM	Review of questionnaires (understanding, interpretation, restatement and translation of questions)	Marc D
1.00-2.00PM	Lunch break	Site/ADP Coordinator
2.00-3.00 PM	Survey protocol	Marc D/Geoffrey
3.00-4.00 PM	Interviewing techniques	Marc D
4.00-5.00PM	Role plays and feedback	Geoffrey O
5.00-5.30 PM	Closing/ Q&A	Geoffrey O
DAY II – FIELD TESTING OF INSTRUMENTS		
8.00-9.00 AM	Logistics: pairing, mapping & directions, transport, stationary, field guides, lunch, remuneration	Geoffrey O/ADP Manager
9.00AM-1.00 PM	Field testing	All
1.00-2.00 PM	Lunch	Site/ADP Coordinators
2.00-4.00 PM	Feedback and suggestions for improvements (tools & logistics)	Marc D
4.00-5.00 PM	Closing/Q&A	Geoffrey O

## Appendix 8 List of HHS enumerators and supervisors

	SUPERVISOR		ENUMERATORS
	<b>NAIVASHA, clusters 1-22</b>		
1	Salome Mukuria	1	Lillia Kamau
		2	Sarah Mwangi
		3	Samuel Maina
		4	Leos Nduati
		5	Paul Waweru
		6	Salome Mukuria
2	Jane Wangari	1	Peter Karanja
		2	Wilfred Kimani
		3	Bernard Kamau
		4	Nicholas Kimau
		5	Julius Maina
		6	Jane Wangari
3	Paul Kamanu	1	Michael Ngure
		2	Francis Kimani
		3	Hawa Abdullai
		4	Anne Wambiru
		5	Joseph Mutahi
		6	Paul Kamanu
4	Michael Githinji	1	Changalwa Mulunga
		2	Jenner Ole Nchoko
		3	James Njuguna
		4	Bonaya Godana
		5	John Maina
		6	Michael Githinji
	<b>NAIVASHA, clusters 23-44</b>		
1	Salome Mukuria	1	Lillia Kamau
		2	Sarah Mwangi
		3	Samuel Maina
		4	Leos Nduati
		5	Francis Kimani
		6	Salome Mukuria
2	Paul Kamanu	1	James Njuguna
		2	Paul Waweru
		3	Wilfred Kimani
		4	Anne Wambiru
		5	Joseph Mutahi
		6	Paul Kamanu
3	Jane Wangari	1	Peter Karanja
		2	Nicholas Kimani
		3	Bernard Kamau
		4	Julius Maina
		5	Hawa Abdullai
		6	Jane Wangari
4	Michael Githinji	1	Changalwa Mulunga
		2	Jenner Ole Nchoko
		3	Michael Ngure

	SUPERVISOR		ENUMERATORS
		4	Bonaya Godana
		5	John Maina
		6	Michael Githinji
	<b>KISUMU</b>		
1	Joseph Onyango	1	Peter Yogo
		2	Stephen O. Sande
		3	Caroline Auma
		4	Winnie Akoko
		5	Maureen Ageng'o
2	Victor Odindo	1	Michael Donde
		2	Stephen Muguga
		3	Edwin Wambaraya
		4	Collette Owino
		5	Amollo Wycliffe
3	Beatrice Kipserem	1	Fred Osome
		2	Dennis Otieno
		3	Agnes Auma
		4	Folther Momanyi
		5	William Oyomo
4	Rachael Jakoyo	1	Silas Otieno
		2	Edwina
		3	Lucy Odada
		4	Jackton Kisia
		5	Loice Adoyo
	<b>BUNYALA</b>		
1	Onjoro Achiebo	1	Masiga Matilda
		2	Anthony Mang'eni
		3	Lawrence Obongoya
		4	Celestine
		5	Benjamin Bedah
		6	Arwah Lucas
2	Jemimah A.	1	Sumbah Willis
		2	Peter Agunda
		3	Felix Chitoma
		4	Ernest Mwanjo
		5	Moses Ngang'a
3	Cosmas Okale	1	Osembo Lucas
		2	Francis Sidoka
		3	Gladys Auma
		4	Brenda Ndira
		5	Rose Nyamanga

## **Appendix 9      Household Survey Questionnaire**

**KATSO BASELINE SURVEY  
HOUSEHOLD QUESTIONNAIRE**

**INFORMED CONSENT**

Hello. My name is \_\_\_\_\_ and I am working with World Vision Kenya. We are conducting a survey on care of children and HIV/AIDS. We would very much appreciate your participation in this survey. I would like to ask you about some important health issues. This information will help World Vision Kenya to plan services for children and chronically people. The survey usually takes between 30 minute and one hour to complete depending on how many people live in your household.

Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual questions or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer: \_\_\_\_\_

Date: \_\_\_\_\_

**IDENTIFICATION**

Division \_\_\_\_\_

Location \_\_\_\_\_

Sub Location \_\_\_\_\_

Village \_\_\_\_\_

CLUSTER NUMBER .....

HOUSEHOLD NUMBER .....

LINE NO. OF RESPONDENT TO HOUSEHOLD QUESTIONNAIRE .....


**INDIVIDUAL INTERVIEWS COMPLETION**

	ELIGIBLE	INTERVIEW COMPLETED	NOT SELECTED	NOT PRESENT	REFUSED
FEMALE YOUTH 12-24	<input type="checkbox"/>				
MALE YOUTH 12-24	<input type="checkbox"/>				
FEMALE 25-49	<input type="checkbox"/>				
MALE 25-49	<input type="checkbox"/>				
TOTAL PERSONS IN HOUSEHOLD	<input type="checkbox"/>				

<p><b>SUPERVISOR</b></p> <p>NAME _____</p> <p>DATE _____ <input type="checkbox"/> <input type="checkbox"/></p>	<p><b>SURVEY COORDINATOR</b></p> <p>NAME _____</p> <p>DATE _____ <input type="checkbox"/> <input type="checkbox"/></p>	<p><b>KEYED BY</b></p> <p>NAME _____</p> <p>DATE _____ <input type="checkbox"/> <input type="checkbox"/></p>
--	--	--

**A. HOUSEHOLD SCHEDULE:** Now we would like some information about the people who usually live in your household or who are staying with you now.

**\* CODES FOR Q. 3 (RELATIONSHIP TO HEAD OF HOUSEHOLD)**

01 = HEAD	05 = GRANDCHILD	10 = MATERNAL NIECE/NEPHEW
02 = WIFE OR HUSBAND	06 = PARENT	11 = OTHER RELATIVE
03 = SON OR DAUGHTER	07 = PARENT-IN-LAW	12 = ADOPTED/FOSTER/STEPCHILD
04 = SON-IN-LAW OR DAUGHTER-IN-LAW	08 = BROTHER OR SISTER	13 = NOT RELATED
	09 = PATERNAL NIECE/NEPHEW	98 = DON'T KNOW

**\*\*CODES FOR Q. 8**

01 = Farmer	02 = Vendors
03 = Casual workers	
04 = Teachers	05 = Business M/W
06 = Civil servants	
07 = Others	

**\*\*\*CODES FOR Q. 11 (EDUCATION GRADE)**

00 = FOR LESS THAN ONE YEAR
01 to 12 = GRADE 1 to 12
55 = Vocational training
88 = University

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	OCCUPATION	ELIGIBLE FOR INDIV. SURVEY	IF AGE 5 YEARS OR OLDER		
							EDUCATION		
							Has (NAME) ever attended school?	What is the highest grade (NAME) completed***	IF AGE 5-24 YEARS Is (NAME) attending school?
(1)	(2)	(3)	(4)	(7)	(8)	(9)	(10)	(11)	(12)
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.	What is the relationship of (NAME) to the head of the household?*	Is (NAME) male or female?	How old is (NAME)? RECORD AGE AT LAST BIRTHDAY  RECORD 00 IF LESS THAN ONE YEAR OLD	What is (NAME)'s main occupation?	CIRCLE LINE NUMBER OF ALL MEN AND WOMEN AGE 12-49 WHO USUALLY LIVE HERE OR STAYED HERE LAST NIGHT	YES NO 1 2 Q.13 ↙ ↘	GRADE <input type="text"/>	YES NO 1 2
01		<input type="text"/>	M F 1 2	<input type="text"/>	<input type="text"/>	01	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
02		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	02	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
03		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	03	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
04		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	04	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
05		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	05	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
06		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	06	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
07		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	07	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
08		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	08	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
09		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	09	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2
10		<input type="text"/>	1 2	<input type="text"/>	<input type="text"/>	10	1 2 Q.13 ↙ ↘	<input type="text"/>	1 2

TICK HERE IF CONTINUATION SHEET USED

Just to make sure that I have a complete listing:

1) Are there any other persons such as small children or infants that we have not listed?	YES	<input type="checkbox"/>	ENTER EACH IN TABLE
2) Are there any people who may not be members of your family, such as domestic servants or friends who usually live here?	YES	<input type="checkbox"/>	ENTER EACH IN TABLE
3) Are there any guests or temporary visitors staying here, or anyone else who stayed here last night, who have not been listed?	YES	<input type="checkbox"/>	ENTER EACH IN TABLE

**\*\*\*\* CODES FOR Q.13 THROUGH Q.18**  
 THESE QUESTIONS REFER TO THE BIOLOGICAL PARENTS OF THE CHILD.  
 IN Q.15 AND Q.18, RECORD '00' IF PARENT NOT LISTED IN THE HOUSEHOLD SCHEDULE

**\*\*\*\*\* CODES FOR Q.20**

01=MOTHER	06=FATHER-IN-LAW	12=OLDER BROTHER
02=FATHER	07=GRANDMOTHER	13=NOT RELATED FEMALE
03=WIFE	08=GRANDFATHER	14=NOT RELATED MALE
04=HUSBAND	09=AUNT	
05=MOTHER-IN-LAW	10=UNCLE	
	11=OLDER SISTER	

IF AGE 0-17 YEARS								IF AGE 18-59 YEARS
PARENTAL SURVIVORSHIP AND RESIDENCE****						PRIMARY CARE-GIVER	RELATIONSHIP TO CARE-GIVER	
Is (NAME)'s natural mother alive?	IF MOTHER ALIVE		Is (NAME)'s natural father alive?	IF FATHER ALIVE				
	Does (NAME)'s natural mother live in this household? IF YES: What is her name? RECORD MOTHER'S LINE NUMBER IF NO: RECORD "00"	IF MOTHER DOES NOT LIVE IN HOUSEHOLD Has (NAME)'s mother been very sick for at least 3 months during the past 12 months? By very sick, I mean that she was too sick to work or do normal activities around the house for at least three of the past 12 months.		Does (NAME)'s natural father live in this household? IF YES: What is his name? RECORD FATHER'S LINE NUMBER IF NO: RECORD "00"	IF FATHER DOES NOT LIVE IN HOUSEHOLD Has (NAME)'s father been very sick for at least 3 months during the past 12 months? By very sick, I mean that he was too sick to work or do normal activities around the house for at least three of the past 12 months.	Who is the primary caregiver for (NAME)?  RECORD LINE NUMBER OF PRIMARY CARE-GIVER  IF NONE, RECORD 00'AND SKIP TO 21	What is the relationship of (NAME) to his/her primary caregiver?*****	
(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)
Y N DK 1 2 8 ↓ Q.16	<input type="text"/>	Y N DK 1 2 8	Y N DK 1 2 8 ↓ Q.19	<input type="text"/>	Y N DK 1 2 8	<input type="text"/>	<input type="text"/>	Y N DK 1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8
1 2 8 ↓ Q.16	<input type="text"/>	1 2 8	1 2 8 ↓ Q.19	<input type="text"/>	1 2 8	<input type="text"/>	<input type="text"/>	1 2 8



37 CHECK COLUMN 7 OF HOUSEHOLD SCHEDULE.

AT LEAST ONE CHILD AGE 0-17 LIVING IN THE HOUSEHOLD  ↓

NO CHILDREN AGE 0-17 LIVING IN THE HOUSEHOLD  → 101

38	In the last 30 days did you ever cut the size of your child(ren)'s meals because there was not enough food or money to buy food?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
39	In the last 30 days did the child(ren) living in your household ever skip meals because there was not enough food or money to buy food?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
40	In the last 30 days was/were the child(ren) living in your household ever hungry but there was not enough food or money to buy food?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
41	In the last 30 days did the child(ren) living in your household ever not eat for a whole day because there was not enough food or money to buy food?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

**C1. SUPPORT FOR CHRONICALLY ILL PEOPLE**

101	CHECK COLUMNS 7 AND 21 IN THE HOUSEHOLD SCHEDULE: NUMBER OF SICK PEOPLE AGE 18-59 ..... <input style="width:40px;" type="text"/> <input style="width:40px;" type="text"/>			
	AT LEAST ONE <input style="width:40px;" type="text"/>	NONE	<input style="width:40px;" type="text"/>	201
102	ENTER IN THE TABLE THE LINE NUMBER AND NAME OF EACH SICK PERSON AGE 18-59, BEGINNING WITH THE FIRST SICK PERSON LISTED IN THE HOUSEHOLD SCHEDULE. ASK THE QUESTIONS ABOUT ALL OF THESE PEOPLE. IF THERE ARE MORE THAN 3 SICK PEOPLE, USE ADDITIONAL QUESTIONNAIRE(S).			
103	LINE NUMBER AND NAME FROM COLUMNS 1 AND 2 OF THE HOUSEHOLD SCHEDULE	1ST SICK PERSON NAME _____ LINE NUMBER <input style="width:40px;" type="text"/>	2ND SICK PERSON NAME _____ LINE NUMBER <input style="width:40px;" type="text"/>	3RD SICK PERSON NAME _____ LINE NUMBER <input style="width:40px;" type="text"/>
104	You told me that in your household, (NAME OF EACH SICK PERSON IN 103) has(ve) been very sick for at least three of the past 12 months. I would like to ask you about any formal, organized help or support that your household may have received for [that/each of those] person(s) for which you did not have to pay. By formal, organized support I mean help provided by someone working for a program. This program could be government, private, religious, charity, or community based.			
105	Now I would like to ask you about the support you received for (NAME).  In the last 12 months, has your household received any medical support for (NAME), such as medical care, supplies or medicine, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 107) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 107) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 107) ← DK ..... 8
106	Did your household receive any of this support at least once a month while (NAME) was sick?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8
107	In the last 12 months, has your household received any emotional or psychological support for (NAME), such as companionship, counseling from a trained counselor, or spiritual support for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 109) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 109) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 109) ← DK ..... 8
108	Did your household receive any of this support in the past 30 days?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8
109	In the last 12 months, has your household received any material support for (NAME), such as clothing, food, or financial support, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 111) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 111) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 111) ← DK ..... 8
110	Did your household receive any of this support in the past 30 days?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8
111	In the last 12 months, has your household received any social support for (NAME), such as help in household work, training for a caregiver, or legal services, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 113) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 113) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 113) ← DK ..... 8
112	Did your household receive any of this support in the past 30 days?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8
113	GO BACK TO 105 IN NEXT COLUMN; OR, IF NO MORE SICK PEOPLE, GO TO 201.			

**C2. SUPPORT FOR PERSONS WHO HAVE DIED**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
201	Now I would like to ask you a few more questions about your household. Think back over the past 12 months. Has any usual member of your household died in the last 12 months?	YES .....	1		→ 301 → 301
		NO .....	2		
		DON'T KNOW .....	8		
202	How many household members died in the last 12 months?	NO. OF PERSONS .....			<input type="text"/>
203	What was the name of the person who died (most recently) (before him/her)?	204 Was (NAME) male or female?	205 How old was (NAME) when (s)he died?	206 Was (NAME) very sick for at least three of the 12 months before s(he) died? By very sick, I mean that (NAME) was too sick to work or do normal activities around the house for at least 3 months.	207 ELIGIBLE (CIRCLE "YES" IF 205 = 18-59 AND 206 = "YES")
		MALE FEMALE 1 2	<input type="text"/>	YES NO DK 1 2 8	YES NO 1 2
		1 2	<input type="text"/>	1 2 8	1 2
		1 2	<input type="text"/>	1 2 8	1 2
208	CHECK 207: PERSONS 18-59 WHO HAVE DIED AND WERE SICK AT LEAST ONE "YES" <input type="checkbox"/>				→ 301
209	ENTER IN THE TABLE THE NAME OF EACH PERSON AGE 18-59 WHO DIED AND WAS SICK. ASK THE QUESTIONS ABOUT EACH OF THESE PEOPLE. IF MORE THAN 3 PEOPLE WHO DIED AND WERE SICK, USE ADDITIONAL QUESTIONNAIRE(S).				
210	NAME OF EACH PERSON WHO DIED AND WAS SICK	1ST DEATH NAME _____	2ND DEATH NAME _____	3RD DEATH NAME _____	
211	I would like to ask you about any formal, organized help or support that your household may have received for [NAME OF EACH PERSON IN 210] for which you did not have to pay. By formal, organized support I mean help provided by someone working for a program. This program could be government, private, religious, charity, or community based.				
212	Now I would like to ask you about the support your household received for (NAME) before (he/she) died. In the last 12 months, did your household receive any medical supplies for (NAME), such as medical care, supplies or medicine, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 214) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 214) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 214) ← DK ..... 8	
213	Did your household receive any of this support at least once a month while (NAME) was sick?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	
214	In the last 12 months, did your household receive any emotional or psychological support for (NAME), such as companionship, counseling from a trained counselor, or spiritual support, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 216) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 216) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 216) ← DK ..... 8	
215	Did your household receive any of this support in the last 30 days before (NAME)'s death?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	
216	In the last 12 months, did your household receive any material support for (NAME), such as clothing, food, or financial support, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 218) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 218) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 218) ← DK ..... 8	
217	Did your household receive any of this support in the last 30 days before (NAME)'s death?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	
218	In the last 12 months, did your household receive any social support for (NAME), such as help in household work, training for a caregiver, or legal services, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 220) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 220) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 220) ← DK ..... 8	
219	Did your household receive any of this support in the last 30 days before (NAME)'s death?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	
220	GO BACK TO 212 IN NEXT COLUMN; OR, IF NO MORE PEOPLE HAVE DIED, GO TO 301.				

**C3. SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																								
301	CHECK COLUMN 7 IN THE HOUSEHOLD SCHEDULE: <b>ANY CHILD AGE 0-17?</b>  AT LEAST ONE CHILD AGE 0-17 <input type="checkbox"/>	NO CHILD AGE 0-17 <input type="checkbox"/>	END																																																																								
302	CHECK COLUMN 7 IN THE HOUSEHOLD SCHEDULE: <b>ANY ADULT AGE 18-59?</b>  AT LEAST ONE ADULT AGE 18-59 <input type="checkbox"/>	NO ADULT AGE 18-59 <input type="checkbox"/>	307																																																																								
303	CHECK COLUMN 21 IN THE HOUSEHOLD SCHEDULE: <b>ANY ADULT AGE 18-59 WHO IS ILL?</b>  NOT A SINGLE YES IN COLUMN 21 <input type="checkbox"/>	AT LEAST ONE YES IN COLUMN 21 <input type="checkbox"/>	307																																																																								
304	CHECK 205 IN SECTION C2: <b>ANY ADULT AGE 18-59 WHO DIED IN PAST 12 MONTHS?</b>  NO ADULT AGE 18-59 IN 205 <input type="checkbox"/>	AT LEAST ONE ADULT AGE 18-59 IN 205 <input type="checkbox"/>	307																																																																								
305	CHECK COLUMNS 13 AND 15 IN THE HOUSEHOLD SCHEDULE:  OTHER <input type="checkbox"/>	IF ONE "NO" IN 13 OR ONE "YES" IN 15 <input type="checkbox"/>	307																																																																								
306	CHECK COLUMNS 16 AND 18 IN THE HOUSEHOLD SCHEDULE:  IF ONE "NO" IN 16 OR ONE "YES" IN 18 <input type="checkbox"/>	OTHER <input type="checkbox"/>	END																																																																								
307	LIST ALL CHILDREN 0-17 IN HOUSEHOLD <table style="width:100%; margin-top: 10px;"> <tr> <td style="width:5%;">1)</td> <td style="width:20%;">LINE NUMBER</td> <td style="width:10%;"><input style="width:20px; height:20px;" type="text"/></td> <td style="width:10%;"><input style="width:20px; height:20px;" type="text"/></td> <td style="width:15%;">NAME</td> <td style="width:20%;"><hr style="border: none; border-top: 1px solid black;"/></td> <td style="width:10%;">AGE</td> <td style="width:10%;"><input style="width:20px; height:20px;" type="text"/></td> <td style="width:10%;"><input style="width:20px; height:20px;" type="text"/></td> </tr> <tr> <td>2)</td> <td>LINE NUMBER</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> <td>NAME</td> <td><hr style="border: none; border-top: 1px solid black;"/></td> <td>AGE</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> </tr> <tr> <td>3)</td> <td>LINE NUMBER</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> <td>NAME</td> <td><hr style="border: none; border-top: 1px solid black;"/></td> <td>AGE</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> </tr> <tr> <td>4)</td> <td>LINE NUMBER</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> <td>NAME</td> <td><hr style="border: none; border-top: 1px solid black;"/></td> <td>AGE</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> </tr> <tr> <td>5)</td> <td>LINE NUMBER</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> <td>NAME</td> <td><hr style="border: none; border-top: 1px solid black;"/></td> <td>AGE</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; 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border-top: 1px solid black;"/></td> <td>AGE</td> <td><input style="width:20px; height:20px;" type="text"/></td> <td><input style="width:20px; height:20px;" type="text"/></td> </tr> </table> <p style="margin-top: 10px;">IF THERE ARE MORE THAN EIGHT CHILDREN TO BE LISTED, USE AN ADDITIONAL QUESTIONNAIRE.</p>			1)	LINE NUMBER	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	NAME	<hr style="border: none; border-top: 1px solid black;"/>	AGE	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	2)	LINE NUMBER	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	NAME	<hr style="border: none; border-top: 1px solid black;"/>	AGE	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	3)	LINE NUMBER	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; 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height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	7)	LINE NUMBER	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	NAME	<hr style="border: none; border-top: 1px solid black;"/>	AGE	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	8)	LINE NUMBER	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>	NAME	<hr style="border: none; border-top: 1px solid black;"/>	AGE	<input style="width:20px; height:20px;" type="text"/>	<input style="width:20px; height:20px;" type="text"/>
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308	RECORD THE LINE NUMBER AND NAME OF EACH CHILD LISTED IN 307, BEGINNING WITH THE FIRST CHILD LISTED. ASK THE QUESTIONS ABOUT EACH OF THESE CHILDREN. IF THERE ARE MORE THAN 8 CHILDREN TO BE LISTED, USE AN ADDITIONAL QUESTIONNAIRE.				
309	LINE NUMBER AND NAME FROM 307	1ST CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	2ND CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	3RD CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	4TH CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>
310	I would like to ask you about any formal, organized help or support that your household may have received for (NAME OF EACH CHILD IN 309) and for which you did not have to pay. By formal, organized support I mean help provided by someone working for a program. This program could be government, private, religious, charity, or community based.				
311	Now I would like to ask you about the support your household received for (NAME).  In the last 12 months, has your household received any <b>medical</b> support for (NAME), such as medical care, supplies or medicine, for which you did not have to pay?	YES ..... 1 NO ..... 2 DK ..... 8			
312	In the last 12 months, has your household received any <b>emotional</b> or <b>psychological</b> support for (NAME), such as companionship, counseling from a trained counselor, or spiritual support, which you received at home and for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8
313	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
314	In the last 12 months, has your household received any <b>material</b> support for (NAME), such as clothing, food, or financial support, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8
315	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
316	In the last 12 months, has your household received any <b>social</b> support for (NAME) such as help in household work, training for a caregiver, or legal services for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8
317	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
318	CHECK 307: AGE OF CHILD	AGE 0-4 <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/>	AGE 0-4 <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/>	AGE 0-4 <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/>	AGE 0-4 <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/>
319	In the last 12 months, has your household received any support for (NAME'S) <b>schooling</b> , such as allowance, free admission, books or supplies for which you did not have to pay?	YES ..... 1 NO ..... 2 DK ..... 8			
320	GO BACK TO 311 IN NEXT COLUMN; OR, IF NO MORE CHILDREN, CONTINUE WITH INDIVIDUAL INTERVIEW WITH ELIGIBLE RESPONDENT.				

309	LINE NUMBER AND NAME FROM 307	5TH CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	6TH CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	7TH CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	8TH CHILD NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>
310	I would like to ask you about any formal, organized help or support that your household may have received for (NAME OF EACH CHILD IN 309) and for which you did not have to pay. By formal, organized support I mean help provided by someone working for a program. This program could be government, private, religious, charity, or community based.				
311	Now I would like to ask you about the support your household received for (NAME).  In the last 12 months, has your household received any <b>medical</b> support for (NAME), such as medical care, supplies or medicine, for which you did not have to pay?	YES ..... 1 NO ..... 2 DK ..... 8			
312	In the last 12 months, has your household received any <b>emotional</b> or <b>psychological</b> support for (NAME), such as companionship, counseling from a trained counselor, or spiritual support, which you received at home and for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 314) ← DK ..... 8
313	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
314	In the last 12 months, has your household received any <b>material</b> support for (NAME), such as clothing, food, or financial support, for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 316) ← DK ..... 8
315	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
316	In the last 12 months, has your household received any <b>social</b> support for (NAME) such as help in household work, training for a caregiver, or legal services for which you did not have to pay?	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DK ..... 8
317	Did your household receive any of this support in the past 3 months?	YES ..... 1 NO ..... 2 DK ..... 8			
318	CHECK 307: AGE OF CHILD	AGE 0-4 <input type="text"/> <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/> <input type="text"/>	AGE 0-4 <input type="text"/> <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/> <input type="text"/>	AGE 0-4 <input type="text"/> <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/> <input type="text"/>	AGE 0-4 <input type="text"/> <input type="text"/> (SKIP TO 320) ← AGE 5-17 <input type="text"/> <input type="text"/>
319	In the last 12 months, has your household received any support for (NAME'S) <b>schooling</b> , such as allowance, free admission, books or supplies for which you did not have to pay?	YES ..... 1 NO ..... 2 DK ..... 8			
320	GO BACK TO 311 IN NEXT COLUMN; OR, IF NO MORE CHILDREN, CONTINUE WITH INDIVIDUAL INTERVIEW WITH ELIGIBLE RESPONDENT.				

**KATSO BASELINE SURVEY  
INDIVIDUAL QUESTIONNAIRE (AGE 12-49 YEARS)**

**INFORMED CONSENT**

Hello. My name is \_\_\_\_\_ and I am working with World Vision Kenya. We are conducting a survey on care of children and HIV/AIDS. We would very much appreciate your participation in this survey. I would like to ask you about some important health issues. This information will help World Vision Kenya to plan services for children and chronically people. The survey usually takes between 30 minute and one hour to complete depending on how many people live in your household.

Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual questions or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer:

Date:

**INDIVIDUAL IDENTIFICATION**

CLUSTER NUMBER .....

HOUSEHOLD NUMBER .....

LINE NUMBER OF RESPONDENT .....

AGE OF RESPONDENT .....

SEX OF RESPONDENT ..... 1 = MALE  
2 = FEMALE


	Can you read?	YES .....	1	→ 301
		NO .....	2	
	Can you write?	YES .....	1	
		NO .....	2	
	In which language can you read or write?	ENGLISH .....	1	
		KISWAHILI .....	2	
		BOTH .....	3	
		OTHERS: _____ (SPECIFY)	4	

**D. MARRIAGE**

NO.	QUESTIONS AND FILTERS		CODING CATEGORIES	SKIP
301	<p align="center">MALE <input type="checkbox"/></p> <p>Are you currently married or living together with a woman as if married?</p>	<p align="center">FEMALE <input type="checkbox"/></p> <p>Are you currently married or living together with a man as if married?</p>	<p>YES, CURRENTLY FORMERLY MARRIED 1</p> <p>YES, LIVING WITH A MAN/WOMAN 2</p> <p>NO, NOT IN UNION 3</p>	<p>→ 304</p>
302	<p>Have you ever been married or lived together with a woman?</p>	<p>Have you ever been married or lived together with a man?</p>	<p>YES, FORMERLY MARRIED 1</p> <p>YES, LIVED WITH A MAN/WOMAN 2</p> <p>NO 3</p>	<p>→ 320</p>
303	<p>What is your marital status now: are you widowed, divorced, or separated?</p>	<p>What is your marital status now: are you widowed, divorced, or separated?</p>	<p>WIDOWED 1</p> <p>DIVORCED 2</p> <p>SEPARATED 3</p>	<p>→ 310</p>
304	<p>Is your wife/partner living with you now or is she staying elsewhere?</p>	<p>Is your husband/partner living with you now or is he staying elsewhere?</p>	<p>LIVING TOGETHER 1</p> <p>STAYING ELSEWHERE 2</p>	
307	<p>Please tell me the name of your wife (the woman you are living with as if married).</p> <p>RECORD THE NAME AND THE LINE NUMBER FROM THE HOUSEHOLD QUESTIONNAIRE FOR SPOUSE AND LIVE-IN PARTNER. IF THE PERSON IS NOT LISTED IN THE HOUSEHOLD, RECORD '00'.</p>	<p>Please tell me the name of your husband (the man you are living together with as if married).</p>	<p>NAME _____</p> <p>LINE NUMBER <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>308</p> <p>How old was your wife/husband/partner on his/her last birthday?</p> <p>AGE <input type="text"/> <input type="text"/></p>
310	<p>Have you been married or lived with a woman only once or more than once?</p>	<p>Have you been married or lived with a man only once or more than once?</p>	<p>ONLY ONCE 1</p> <p>MORE THAN ONCE 2</p>	<p>→ 312</p>
311	<p>In what month and year did you start living with your wife/partner?</p>	<p>In what month and year did you start living with your husband/partner?</p>	<p>MONTH <input type="text"/> <input type="text"/></p>	
312	<p>Now I would like to ask about when you married or began living with a woman as if married for the very <u>first</u> time.</p> <p>In what month and year did you <u>first</u> marry or start living with a woman as if married?</p>	<p>Now I would like to ask about when you married or began living with a man as if married for the very <u>first</u> time.</p> <p>In what month and year did you <u>first</u> marry or start living with a man as if married?</p>	<p>DON'T KNOW MONTH 98</p> <p>YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>DON'T KNOW YEAR 9998</p>	
313	<p>How old were you when you started living with her?</p>	<p>How old were you when you started living with him?</p>	<p>AGE <input type="text"/> <input type="text"/></p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
<b>E. SEXUAL ACTIVITY</b>			
320	CHECK FOR AGE :  CHECK FOR THE PRESENCE OF OTHERS.  BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.	IF AGE 25-49 <input type="checkbox"/> →  IF AGE 12-24 <input type="checkbox"/> ↓	425
321	Now I need to ask you some questions about sexual activity in order to gain a better understanding of some family life issues.  How old were you when you <u>first</u> had sexual intercourse (if ever)?	NEVER ..... 00  AGE IN YEARS ..... <input type="text"/> <input type="text"/>  FIRST TIME WHEN STARTED LIVING WITH (FIRST) HUSBAND/WIFE/PARTNER. . . . . 95	→ 324  → 324
322	Do you intend to wait until you get married to have sexual intercourse for the first time?	YES ..... 1 NO ..... 2 DON'T KNOW/UNSURE ..... 8	→ 348
324	The <u>first</u> time you had sexual intercourse, was a condom used?	YES ..... 1 NO ..... 2 DON'T KNOW/DON'T REMEMBER ..... 8	
325	How old was the person you first had sexual intercourse with?	AGE OF PARTNER ..... <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98	→ 328
326	Was this person older than you, younger than you, or about the same age as you?	OLDER ..... 1 YOUNGER ..... 2 SAME AGE ..... 3 DON'T KNOW/DON'T REMEMBER ..... 8	→ 328
327	Would you say this person was ten or more years older than you or less than ten years older than you?	TEN OR MORE YEARS OLDER ..... 1 LESS THAN TEN YEARS OLDER ..... 2 OLDER, UNSURE HOW MUCH ..... 3	
328	When was the <u>last</u> time you had sexual intercourse?  IF 12 MONTHS OR MORE, ANSWER MUST BE CONVERTED AND RECORDED IN YEARS.	DAYS AGO ..... <input type="text"/> <input type="text"/> WEEKS AGO ..... <input type="text"/> <input type="text"/> MONTHS AGO ..... <input type="text"/> <input type="text"/> YEARS AGO ..... <input type="text"/> <input type="text"/>	→ 348

		LAST SEXUAL PARTNER	SECOND-TO-LAST SEXUAL PARTNER	THIRD-TO-LAST SEXUAL PARTNER																		
329	The last time you had sexual intercourse with this (second/third) person, was a condom used?	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8	YES ..... 1 NO ..... 2 DK ..... 8																		
332	What was your relationship to the person with whom you last had sexual intercourse?  IF BOYFRIEND/GIRLFRIEND, SUGAR DADDY, SWEETHEART: Were you living together as if married?  IF YES, CIRCLE '02' IF NO, CIRCLE '03'	HUSBAND/WIFE ..... 01 (SKIP TO 337) ← LIVE-IN PARTNER ..... 02 BOYFRIEND/GIRLFRIEND NOT LIVING WITH RESPONDENT ..... 03 CASUAL ACQUAINTANCE ..... 04 COMMERCIAL SEX WORKER ..... 05 OTHER ..... 96 (SPECIFY)	HUSBAND/WIFE ..... 01 (SKIP TO 337) ← LIVE-IN PARTNER ..... 02 BOYFRIEND/GIRLFRIEND NOT LIVING WITH RESPONDENT ..... 03 CASUAL ACQUAINTANCE ..... 04 COMMERCIAL SEX WORKER ..... 05 OTHER ..... 96 (SPECIFY)	HUSBAND/WIFE ..... 01 (SKIP TO 338) ← LIVE-IN PARTNER ..... 02 BOYFRIEND/GIRLFRIEND NOT LIVING WITH RESPONDENT ..... 03 CASUAL ACQUAINTANCE ..... 04 COMMERCIAL SEX WORKER ..... 05 OTHER ..... 96 (SPECIFY)																		
333		<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">WOMAN</td> <td style="text-align: center;">MAN</td> </tr> <tr> <td style="text-align: center;">↓</td> <td style="text-align: center;">↓</td> </tr> <tr> <td style="text-align: center;">(SKIP TO 337) ←</td> <td style="text-align: center;">(SKIP TO 337) ←</td> </tr> </table>	WOMAN	MAN	↓	↓	(SKIP TO 337) ←	(SKIP TO 337) ←	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">WOMAN</td> <td style="text-align: center;">MAN</td> </tr> <tr> <td style="text-align: center;">↓</td> <td style="text-align: center;">↓</td> </tr> <tr> <td style="text-align: center;">(SKIP TO 337) ←</td> <td style="text-align: center;">(SKIP TO 337) ←</td> </tr> </table>	WOMAN	MAN	↓	↓	(SKIP TO 337) ←	(SKIP TO 337) ←	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">WOMAN</td> <td style="text-align: center;">MAN</td> </tr> <tr> <td style="text-align: center;">↓</td> <td style="text-align: center;">↓</td> </tr> <tr> <td style="text-align: center;">(SKIP TO 338) ←</td> <td style="text-align: center;">(SKIP TO 338) ←</td> </tr> </table>	WOMAN	MAN	↓	↓	(SKIP TO 338) ←	(SKIP TO 338) ←
WOMAN	MAN																					
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WOMAN	MAN																					
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WOMAN	MAN																					
↓	↓																					
(SKIP TO 338) ←	(SKIP TO 338) ←																					
334	How old is this person?	AGE OF PARTNER <input style="width: 30px; height: 20px;" type="text"/> (SKIP TO 337) ← DON'T KNOW ..... 98	AGE OF PARTNER <input style="width: 30px; height: 20px;" type="text"/> (SKIP TO 337) ← DON'T KNOW ..... 98	AGE OF PARTNER <input style="width: 30px; height: 20px;" type="text"/> (SKIP TO 338) ← DON'T KNOW ..... 98																		
335	Is this person older than you, younger than you, or about the same age?	OLDER ..... 1 YOUNGER ..... 2 SAME AGE ..... 3 DON'T KNOW ..... 8 (SKIP TO 337) ←	OLDER ..... 1 YOUNGER ..... 2 SAME AGE ..... 3 DON'T KNOW ..... 8 (SKIP TO 337) ←	OLDER ..... 1 YOUNGER ..... 2 SAME AGE ..... 3 DON'T KNOW ..... 8 (SKIP TO 338) ←																		
336	Would you say this person is ten or more years older than you or less than ten years older than you?	TEN OR MORE YEARS OLDER . 1 LESS THAN TEN YEARS OLDER . 2 OLDER, UNSURE HOW MUCH ... 3	TEN OR MORE YEARS OLDER . 1 LESS THAN TEN YEARS OLDER . 2 OLDER, UNSURE HOW MUCH ... 3	TEN OR MORE YEARS OLDER . 1 LESS THAN TEN YEARS OLDER . 2 OLDER, UNSURE HOW MUCH ... 3																		
337	Apart from [this person/these two people], have you had sexual intercourse with any other person in the last 12 months?	YES ..... 1 (GO BACK TO 329 ← IN NEXT COLUMN)  NO ..... 2 (SKIP TO 348) ←	YES ..... 1 (GO BACK TO 329 ← IN NEXT COLUMN)  NO ..... 2 (SKIP TO 348) ←																			
338	In total, how many different people have you had sexual intercourse with in the last 12 months?  IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS GREATER THAN 95, WRITE '95.'			NUMBER OF PARTNERS <input style="width: 30px; height: 20px;" type="text"/>  DON'T KNOW ..... 98																		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
348	Do you know of a place where a person can get condoms?	YES ..... 1 NO ..... 2	→ 401
349	Where is that?  Any other place?  RECORD ALL SOURCES MENTIONED.	PUBLIC SECTOR GOVERNMENT HOSPITAL ..... A GOVT. HEALTH CENTER ..... B FAMILY PLANNING CLINIC ..... C CONTACT INVESTIGATOR/ AIDS/CONDOM-MAN/WOMAN . D OTHER PUBLIC ..... E (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR ..... F PHARMACY ..... G NGO/YOUTH CL..... H OTHER PRIVATE MED. .... I (SPECIFY) OTHER SOURCE SCHOOL ..... J SHOP/SUPERMARKET ..... K STREET VENDOR ..... L BAR/HOTEL ..... M PARTNER/FRIEND/RELATIVES . N OTHER ..... X (SPECIFY)	

**F. KNOWLEDGE OF HIV/AIDS**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	YES ..... 1 NO ..... 2	→ 605
402	Can people reduce their chances of getting the AIDS virus by having just one sex partner who is not infected and who has no other partners?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
403	Can people get the AIDS virus from mosquito bites?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
404	Can people reduce their chances of getting the AIDS virus by using a condom every time they have sex?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
405	Can people get the AIDS virus by sharing food with a person who has AIDS?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
406	Can people reduce their chance of getting the AIDS virus by abstaining from sexual intercourse?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
407	Can people get the AIDS virus because of witchcraft, cast, or because of other supernatural means?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
408	Is there anything (else) a person can do to avoid or reduce the chances of getting AIDS or the virus that causes AIDS?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	└→ 410
409	What can a person do?  Anything else?  RECORD ALL WAYS MENTIONED.	ABSTAIN FROM SEX ..... A USE CONDOMS ..... B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER ... C LIMIT NUMBER OF SEXUAL PARTNERS ..... D AVOID SEX WITH PROSTITUTES ... E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS ..... F AVOID SEX WITH HOMOSEXUALS . G AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY . H AVOID BLOOD TRANSFUSIONS ..... I AVOID INJECTIONS ..... J AVOID SHARING RAZORS/BLADES . K AVOID KISSING ..... L AVOID MOSQUITO BITES ..... M SEEK PROTECTION FROM TRADITIONAL PRACTITIONER ... N OTHER _____ W (SPECIFY) OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
410	Is it possible for a healthy-looking person to have the HIV virus?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
411	Can the virus that causes AIDS be transmitted from a mother to her baby: During pregnancy? During delivery? By breastfeeding?	YES NO DK DURING PREG. .... 1 2 8 DURING DELIVERY ... 1 2 8 BREASTFEEDING ... 1 2 8	
412	CHECK 411: AT LEAST <input type="checkbox"/> OTHER <input type="checkbox"/> ONE 'YES' ↓		→ 414
413	Are there any special medications that a doctor or a nurse can give to a woman infected with the AIDS virus to reduce the risk of transmission to the baby?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
414	Is there any special medication that people infected with the AIDS virus can get from a doctor or a nurse?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
<b>G. VOLUNTARY COUNSELING AND TESTING</b>			
425	I don't want to know the results, but have you ever been tested to see if you have the AIDS virus?	YES ..... 1 NO ..... 2	→ 433
426	When was the last time you were tested?	LESS THAN 12 MONTHS AGO ..... 1 12 - 23 MONTHS AGO ..... 2 2 OR MORE YEARS AGO ..... 3	
427	The last time you had the test, did you yourself ask for the test, was it offered to you and you accepted, or was it required?	ASKED FOR THE TEST ..... 1 OFFERED AND ACCEPTED ..... 2 REQUIRED ..... 3	
428	I don't want to know the results, but did you get the results of the test?	YES ..... 1 NO ..... 2	
429	Where was the test done?	PUBLIC SECTOR GOVERNMENT HOSPITAL ..... 11 GOVT. HEALTH CENTER ..... 12 VCT CENTER ..... 13 FAMILY PLANNING CLINIC ..... 14 OTHER PUBLIC ..... 15 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ ..... 21 PRIVATE LABORATORY ..... 22 MISSION ..... 23 OTHERS: ..... 24 (SPECIFY)	
430	I don't want to know the results, but had you ever been tested before that last time you just told me about?	YES ..... 1 NO ..... 2	→ 435
431	How many months did you wait between the two tests?	LESS THAN 3 MONTHS ..... 1 BETWEEN 3 AND 6 MONTHS ..... 2 MORE THAN SIX MONTHS? ..... 3 DON'T KNOW ..... 8	
432	Why did you go for a second test?	HAD AN APPOINTMENT ..... 1 WANTED TO BE SURE ..... 2 WAS REQUIRED ..... 3 OTHERS ..... 4 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
433	Do you know of a place where people can go to get tested for the virus that causes AIDS?	YES ..... 1 NO ..... 2	→ 435
434	Where is that?  Any other place?  RECORD ALL SOURCES MENTIONED.	PUBLIC SECTOR GOVERNMENT HOSPITAL ..... 11 GOVT. HEALTH CENTER ..... 12 VCT CENTER ..... 13 FAMILY PLANNING CLINIC ..... 14  OTHER PUBLIC ..... 15 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC/ ..... 21 PRIVATE LABORATORY ..... 22 MISSION ..... 23 OTHERS: ..... 24 (SPECIFY)	

**H. STIGMA AND DISCRIMINATION INTERNAL**

435	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
436	If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for her or him in your own household?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	
437	If your child's teacher had the AIDS virus but was not sick, would you allow him/her to continue teaching your child?	SHOULD ALLOW TO TEACH ..... 1 SHOULD NOT ALLOW TO TEACH ..... 2 DK/NOT SURE/DEPENDS ..... 8	
438	Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have the AIDS virus or has the AIDS virus?	YES ..... 1 NO ..... 2 DK ANYONE WITH AIDS ..... 3 DON'T KNOW ..... 8	→ 443
439	Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have the AIDS virus or has the AIDS virus?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
440	Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have the AIDS virus or has the AIDS virus?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
443	Should children age 12-14 be taught about using a condom to avoid AIDS?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	
444	Should children age 12-14 be taught to wait until they get married to have sexual intercourse in order to avoid AIDS?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	
445	Do you believe that young men should wait until they are married to have sexual intercourse?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	
446	Do you believe that young women should wait until they are married to have sexual intercourse?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	
447	Do you believe that married men should only have sex with their wives?	YES ..... 1 NO ..... 2 DK/NOT SURE/DEPENDS ..... 8	

**I. PSYCHOSOCIAL ISSUES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP
605	I'm going to read some statements that describe how people sometimes feel. Please tell me whether or not you <u>strongly agree</u> , <u>agree</u> , <u>disagree</u> , or <u>strongly disagree</u> with these statements.	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	
	A) Are you happy?	1	2	3	4	
	B) Do you feel stressed or worried?	1	2	3	4	
	C) Do you feel good about yourself?	1	2	3	4	
	D) Does your future look hopeless?	1	2	3	4	
	E) Are you able to do things you need to do in your daily life? (such as school, work, etc.).	1	2	3	4	
	F) Do you want to be alone these days?	1	2	3	4	
	G) Is your health good?	1	2	3	4	
	H) Do you get into fights?	1	2	3	4	
	I) Do you hope that things will turn allright for you?	1	2	3	4	

## Households visits listing - Enumerator

VILLAGE NAME \_\_\_\_\_

CLUSTER NUMBER

#	Name of Household Head	Completed	No one competent to answer	No one present	Refusal	Comments
1						
2						
3						
4						
5						
6						
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27						
28						
29						
30						

	Name	Date	Signature
ENUMERATOR 1:			
ENUMERATOR 2:			







## Appendix 10 Household Surveys Sampling Frames

Location	Sub-location	Households	Cumul. Total	# Clusters	Cluster name	Cluster #				
<b>NAIVASHA Division</b>										
<b>ADP strata</b>										
Maiella	Maiella	1,949	1,949	8	Gatamaiyu	1				
					Kahuho	2				
					Town center	3				
					Goigoi	4				
					Mukura utuku	5				
					Dry A	6				
					Dry C	7				
					Kahumbu	8				
	Kongoni	1,098	3,047	5	Ngongi center	9				
					Ngunyumu	10				
					Kianungu	11				
					Laini saba	12				
					Kongoni	13				
Ndabibi	Ndabibi	791	3,838	3	Bahati	14				
					Muthakwa	15				
					Kirima	16				
Moindabi	Kipkonyo	512	4,350	2	Huruma	17				
					Phase 3	18				
	Moindabi	906	5,256	4	Mithuri	19				
					Milima Mbili	20				
	Elai	21								
	Kagimbi	22								
<b>Non-ADP strata</b>										
Hell's Gate	Olkaria	8,874	8,874	5	Kwa Muhia	23				
					Gold smith	24				
					Narasha	25				
					Oreno	26				
					Masai Centre	27				
					Site	28				
					Mirera	29				
	Mirera	6,227	15,101	3	Mwicingiri	30				
					Kabati	31				
					Site	32				
Naivasha town	Sokoni	9,124	24,225	5	Nyondia	33				
					KCC	34				
					Council	35				
					Unit	36				
					Longonot	37				
Longonot	Lake View	2,474	26,699	1	Longonot TP*	37				
					Longonot	2,484	29,183	3	Haraka Scheme	38
									Sisioni	39
Naivasha East	Karati	1,712	30,895	1	North Karati	40				
					Terambete	2,124	33,019	1	Kasarani	41
	Mununga	2,122	35,141	1	Mununga	42				
					Maraigushu	2,522	37,663	1	Maraigushu	43
									2	Maraigushu

Location	Sub-location	House-holds	Cumul. Total	# Clusters	Cluster name	Cluster #
<b>WINAM</b>						
<b>ADP strata</b>						
Kondele	Migosi	3,339	3,339	3	Central Lower Upper	1 2 3
C.Kolwa	Kasule	2,650	5,989	3	Lower Central Upper	4 5 6
C.Kolwa	Nyalunya	1,958	7,947	1	Nyalunya	7
E. Kisumu	Kogony	3,845	11,792	3	Lower Central Upper	8 9 10
Kondele	Manyatta "A	10,869	22,661	9	Mosque Corner legio Manyatta school Corner mbuta Love bar/gesoko Corner mbaya/sijeh Manyatta market White gate Kosawo school	11 12 13 14 15 16 17 18 19
Kondele	Nyawita	3,440	26,101	3	Obunga Kamakowa Market	20 21 22
E.Kolwa	Mayenya	932	27,033	0	-	-
<b>Non-ADP strata</b>						
E. Kisumu	Kanyakwar	2,609	2,609	1	Kanyakwar	23
	Dago	997	3,606			
	Mkendwa	160	3,766			
East Kolwa	Chiga	1,670	5,436	1	Chiga	24
	Buoye	1,046	6,482			
West Kolwa	Manyatta "B	6,035	12,517	3	Siany Gesoko Auji	25 26 27
	Nyalenda "A	7,069	19,586	2	Western Kowino Market	28 29
	Nyalenda "B	6,887	26,473	3	Pandi Kilo Dunya	30 31 32
Central Kisumu	Korando "A	2,172	28,645	1	Korando "A	33
	Korando "B	1,208	29,853			

Location	Sub-location	House-holds	Cumul. Total	# Clusters	Cluster name	Cluster #
East Kajulu	Got Nyab.	731	30,584	1	Got Nyabondo	34
	Kadero	1,215	31,799			
Township	Okok	725	32,524	1	Okok	35
	Bandari	1,615	34,139			
	Kaloleni	3,008	37,147	1	Kaloleni	36
	Northern	1,989	39,136	1	Northern	37
	Southern	2,420	41,556	1	Southern	38
West Kajulu	Konya	2,396	43,952	1	Konya	39
SW Kisumu	Wathorego	1,768	45,720	1	Wathorego	40
	Kanyawegi	1,354	47,074			41
	Ojolla	1,595	48,669	1	Ojolla	41
North Kisumu	Osiri	1,420	50,089			
	Bar "A"	802	50,891	1	Bar "A"	42
	Bar "B"	817	51,708			
Miwani	Nyahera	1,858	53,566	1	Nyahera	43
	Centr. Miwani	291	53,857			
	East Miwani	614	54,471			
	North Miwani	482	54,953			
	West Miwani	848	55,801	1	West Miwani	44
<b>BUDALANGI</b>						
<b>ADP strata</b>						
Bunyala Central	Magombe West	948	948	5	Bwalwanga	21
					Bubongo	22
					Siduhumi-A	23
					Khumalaya	24
					mukhobola-B	25
	Magombe E.	576	1,524	3	Nandikinya	28
				Khulugingo	27	
				Khusiobuya	26	
Magombe C.	712	2,236	3	Inyura	31	
				Mungoma B	30	
				Ebuongo B	29	
Khajula	Mabinju/Mab	610	2,846	2	Bukeki	34
					Mau-mau	35
	Lugare	443	3,289	3	Makhoma B	36
					Galalani	37
				Siuna	38	
Rugunga	415	3,704	1	Buyanga	39	
Bunyala South	Rukala	560	4,264	1	Inimbo	40
	Ebulwani	262	4,526	2	Isambia	41
					Ebulwani	42
	Obaro	434	4,960	2	Bukhuma	43
Nyapala					44	

Location	Sub-location	House-holds	Cumul. Total	# Clusters	Cluster name	Cluster #
<b>Non-ADP strata</b>						
Bunyala West	Bukani	1,478	1478	4	Butaru Sifwoma Bugula Mumusenyeye	1 2 3 4
	Siginga	610	2088	2	Lunyofu Budonga	6 5
	Bukoma	932	3020	3	Sianyange Kenda Bukeji mukhokho	9 8 7
Bunyala North	Bulemia	1250	4270	3	Rudacho A Bwohola Bubango	10 11 12
	Sisenye	725	4995	2	Openji Missing	13 14
	Mundere	303	5298	1	Bwakama	15
Bunyala East	Budalangi	842	6140	3	Sibanje Buchiriba Siakula	16 17 18
	Mudembi	694	6834	2	Mumbaya Mangongo	32 33
	Ruambwa	979	7813	2	Busweti-A Siriba	19 20

**Appendix 11     Results from household surveys**

## KATSO BASELINE ASSESSMENT

### HOUSEHOLD SURVEYS RESULTS

#### CONTENTS

	Page
Sample Size Achievement	2
Response rate	
Household questionnaire	
Individual Questionnaire	
Households and Household Members Characteristics	3
Household composition	
Food security	
Age Distribution	
Sex Ratio	
School attendance	
Orphans and Vulnerable Children 0-17 years old	4
Children who are OVCs	
Households with OVCs	
School attendance of OVCs	
Food security	
Support	
Adults Chronically Ill Aged 18-59 Years	5
Youths 15-24 Years Old	6
School attendance of youths	
Marriage	
Knowledge of HIV/AIDS	
Sexual activity	7
Adults 15-49 years old	8
Voluntary Counseling and Testing	
Stigma and discrimination	
Psycho-social	9
KATSO Performance Indicators	10
Legend	11
Notes on age and sex disaggregation	

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Sample Size Achievement</b>			
<b>Response rate</b>			
# Households Visited	927	916	n/a
# Household Interviewed	<b>669</b>	<b>793</b>	<b>532</b>
% Response rate:			
% Households visited where interview was completed	72.2%	82.9%	n/a
% Households visited with no competent member	4.4%	1.8%	n/a
% Households visited with no one present	18.1%	4.0%	n/a
% Households visited where all competent members refused	5.3%	11.3%	n/a
<b>Household questionnaire</b>			
# Household Interviews Targeted	440	440	440
# Household Interviews Completed	<b>534</b>	<b>776</b>	<b>527</b>
% Achievement rate <sup>1</sup>	121.4%	176.4%	119.8%
# Household Members Enumerated	<b>2899</b>	<b>4291</b>	<b>3141</b>
# Children 0-17 years old	1412	2026	1747
# Adults 18-59 year old	1422	2196	1251
# Children 0-17 assessed for support in last 12 months	<b>178</b>	<b>882</b>	<b>1120</b>
Female	68	431	523
Male	110	448	597
# Adults 18-59 Chronically Ill assessed for support in last 12 months	<b>17</b>	<b>103</b>	<b>101</b>
Female	6	69	70
Male	11	34	31
# Deaths of 18-59 Chronically Ill assessed for support in last 12 months	<b>13</b>	<b>62</b>	<b>119</b>
<b>Individual Questionnaire</b>			
# Individual Interviews Targeted	1232	1232	1232
# Individual Interviews Completed	<b>1017</b>	<b>1455</b>	<b>995</b>
% Achievement rate <sup>1</sup>	82.5%	118.1%	80.8%
12-14	65	95	148
15-24 Female	240	397	246
Male	206	288	188
25-49 Female	243	359	276
Male	263	312	131
Age-specific female odds ratio (25-49 / 15-24) <sup>2</sup>	0.79	0.83	1.56

<sup>1</sup> Calculated in spreadsheet as: 100\*# Interviews completed / # Interviews Targeted

<sup>2</sup> Defined as [F(25-49)/M(25-49)]/[F(15-24)/M(15-24)]

Indicator	Survey site			
	Naivasha	Winam	Budalangi	
<b>Households and Household Members Characteristics</b>				
<b>Household composition</b>				
Mean Household Size	5.4	5.6	6.0	
% Household with less than 6 members	56.9%	54.0%	45.7%	
% Household without any child (0-17yrs)	9.2%	11.9%	3.6%	
% Households without any adult 18-59 years old	0.0%	1.3%	2.3%	
% Households with 1+ chronically ill person	3.9%	12.6%	19.9%	
% Households with 1+ deaths in past 12 months	1.9%	5.3%	10.6%	
<i>Primary Care Giver</i>				
% Children whose mother is the primary care giver	83.9%	32.9%	48.2%	
% Children whose father is the primary care giver	6.2%	32.2%	21.9%	
% Children whose grandmother is the primary care giver	4.2%	7.0%	15.6%	
<i>Children living arrangements</i>				
% Children whose mother does not live in household	4.1%	6.2%	7.7%	
% Children whose father does not live in household	6.8%	7.4%	9.3%	
<b>Food security</b>				
% Children living in households in which because of lack of food in the last 30 days:				
--the size of children's meals was cut	41.9%	69.2%	85.4%	
--the children skipped meals	34.3%	60.7%	89.3%	
--the children were hungry	31.0%	57.4%	82.6%	
--the children did not eat a whole day	22.9%	46.1%	71.6%	
<b>Age Distribution</b>				
% Distribution of household members by age:				
	Years:			
	0-4	12.9%	13.4%	14.1%
	5-14	26.5%	25.4%	32.2%
	Youths: 15-24	27.5%	29.1%	23.9%
	25-49	27.9%	28.5%	21.3%
	50+	5.2%	3.6%	8.4%
	Children: 0-17	48.7%	47.4%	56.0%
	Adults: 18-59	49.1%	51.4%	40.1%
	60+	2.2%	1.2%	3.8%
% Distribution of children by school-going age:				
	Pre school: 0-5	31.7%	34.6%	30.2%
	Primary school: 6-13	43.7%	40.6%	45.3%
	Secondary school: 14-17	24.6%	24.8%	24.6%
<b>Sex Ratio</b>				
% Females by age				
	0-4	56.8%	41.5	54.9
	5-14	45.6%	51.5	46.9
	15-24	50.6%	54.1	47.5
	25-49	49.1%	48.0	57.9
Age-specific female odds ratio (25-49 / 15-24) <sup>1</sup>				
		0.94	0.78	1.53
<b>School attendance</b>				
% Children currently attending school by school-going age				
	Primary school: 6-13	99.1%	95.1%	98.4%
	Secondary school: 14-17	74.8%	80.5%	88.1%
	Post-secondary school: 18-24	19.1%	29.0%	37.3%
% Youths currently attending school				
		37.5%	46.0%	58.0%
	Female	35.2%	36.3%	50.0%
	Male	39.6%	57.1%	65.2%
	15-19	58.7%	61.3%	74.7%
	20-24	9.3%	25.2%	21.2%

<sup>1</sup> Defined as  $[F(15-19)/M(15-19)]/[F(20-24)/M(20-24)]$

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Orphans and Vulnerable Children 0-17 years old</b>			
<b>Children who are OVCs</b>			
% Children whose mother died	6.6%	13.5%	20.7%
% Children whose father died	16.2%	23.9%	41.9%
% Children whose both parents died	3.9%	11.9%	15.4%
% Children who are ORPHANS	<b>18.7%</b>	<b>25.4%</b>	<b>46.5%</b>
% Children whose mother is chronically ill, does not live in household	0.0%	0.3%	0.4%
% Children whose father is chronically ill, does not live in household	0.0%	0.8%	0.0%
% Children whose mother is chronically ill, live in household	2.7%	4.7%	10.5%
% Children whose father is chronically ill, live in household	1.8%	6.5%	5.9%
% Children whose mother is chronically ill	2.6%	4.9%	10.2%
% Children whose father is chronically ill	1.7%	7.2%	5.0%
% Children whose both parents are chronically ill	0.4%	1.3%	1.3%
% Children who are VULNERABLE	<b>3.5%</b>	<b>9.4%</b>	<b>11.8%</b>
% Children who are OVC	<b>21.1%</b>	<b>31.9%</b>	<b>51.9%</b>
<i>Female</i>	18.5%	32.3%	48.8%
<i>Male</i>	23.6%	31.7%	54.9%
<b>Households with OVCs</b>			
% Households with children without any adult 18-59 years old	0.0%	0.5%	2.3%
% Households with children with at least one chronically ill (CI) adult	3.2%	11.9%	16.9%
% Households with children with one or more CI adult deaths in past 12 m.	1.7%	4.9%	10.2%
% Households with one or more maternal orphans	7.7%	20.2%	34.9%
% Households with one or more paternal orphans	17.2%	30.0%	52.4%
% Households with one or more OVCs	<b>23.2%</b>	<b>39.8%</b>	<b>67.9%</b>
% Children who live in households with OVCs	<b>24.1%</b>	<b>50.2%</b>	<b>72.4%</b>
<i>Female</i>	20.6%	49.3%	71.0%
<i>Male</i>	27.4%	51.2%	73.7%
% Children who live in households with OVCs who are OVCs	88.4%	55.0%	71.7%
<b>School attendance of OVCs</b>			
% Children who are OVC by school going age			
Pre school: 0-5	12.4%	24.9%	40.4%
Primary school: 6-13	21.7%	29.5%	53.8%
Secondary school: 14-17	31.4%	45.5%	62.4%
% Distribution of OVCs by school going age			
Pre school: 0-5	18.6%	26.8%	23.1%
Primary school: 6-13	45.5%	37.9%	47.4%
Secondary school: 14-17	35.9%	35.2%	29.5%
% OVCs currently attending school			
Primary school: 6-13	97.6%	91.0%	96.9%
Secondary school: 14-17	68.9%	73.3%	84.0%
<b>Food security</b>			
Ratio of OVC to Non OVC Households in which because of lack of food in the last 30 days:			
The size of children's meals was cut	1.5	1.0	1.0
The children skipped meals	1.8	0.9	1.1
The children were hungry	1.6	1.0	1.0
<b>KI9</b> The children did not eat for a whole day	<b>1.7</b>	<b>0.9</b>	<b>1.0</b>
<b>Support</b>			
% OVCs (as per above definition) assessed for support received	44.8%	80.6%	80.9%
% Non-OVCs who were not assessed for support	97.5%	82.4%	72.3%
% OVC living in households that received, free of user charges, basic external support in caring for the child			
*Medical <12 m	2.1%	0.0%	7.5%
*Psychological <12 m	0.0%	10.1%	5.4%
*Material <12 m	7.0%	5.9%	27.3%
Social <12 m	n/a	n/a	n/a
*Schooling (only 5-17) <12 m	38.1%	17.3%	35.3%
<b>KI10 All * combined:</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.3%</b>

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Adults Chronically Ill Aged 18-59 Years</b>			
% Adults who are chronically ill	<b>1.9%</b>	<b>6.3%</b>	<b>9.5%</b>
<i>Female</i>	2.0%	5.4%	5.8%
<i>Male</i>	1.8%	7.2%	12.5%
% Adults chronically ill who died in the last 12 months <sup>1</sup>	<b>1.9%</b>	<b>2.8%</b>	<b>9.1%</b>
% Adults chronically ill identified and assessed for support received	-	81.7%	82.9%
% Adults not chronically ill identified and not assessed	-	100.0%	99.8%
% Adults chronically ill who received support in the last 12 months:			
Medical <12 m	-	3.00%	32.6%
*Medical 1/m	-	0.00%	26.1%
Psychological <12 m	-	41.80%	22.8%
*Psychological <30 d	-	29.60%	19.6%
Material <12 m	-	5.9%	29.3%
*Material <30 d	-	5.9%	16.3%
Social <12 m	-	5.9%	10.1%
*Social <30 d	-	3.1%	9.8%
<b>All * combined:</b>	-	<b>0.0%</b>	<b>6.5%</b>
% Adults chronically ill who died in the last 12 months and who received support in the last 12 months:			
Medical <12 m	-	4.8%	7.6%
*Medical 1/m	-	4.8%	7.6%
Psychological <12 m	-	12.7%	7.6%
*Psychological <30 d	-	9.8%	5.0%
Material <12 m	-	9.5%	10.1%
*Material <30 d	-	9.5%	7.6%
Social <12 m	-	0.0%	2.5%
*Social <30 d	-	0.0%	2.5%
<b>All * combined:</b>	-	<b>0.0%</b>	<b>2.5%</b>
% Adults who were chronically ill (including those who died) who received support in the last 12 months: <sup>2</sup>			
Medical <12 m	-	3.4%	23.3%
*Medical 1/m	-	1.1%	19.2%
Psychological <12 m	-	35.1%	17.2%
*Psychological <30 d	-	25.0%	14.2%
Material <12 m	-	6.7%	22.2%
*Material <30 d	-	6.7%	13.1%
Social <12 m	-	4.5%	7.3%
*Social <30 d	-	2.4%	7.1%
<b>All * combined:</b>	-	<b>0.0%</b>	<b>5.0%</b>
<b>KI2</b>			

<sup>1</sup> Calculated in spreadsheet as : # deaths of adult chronically ill in last 12 months / (# adults enumerated + 0.5 \* # deaths of adult chronically ill in last 12 months )

<sup>2</sup> Calculated in spreadsheet as weighted average of % of adults chronically ill assessed for support and % of deaths of adult chronically ill assessed for support)

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Youths 15-24 Years Old</b>			
<b>School attendance of youths</b>			
% Youths 15-24 <i>interviewed</i> attending school	<b>28.8%</b>	<b>40.1%</b>	<b>51.6%</b>
<i>Female</i>	20.5%	30.4%	41.2%
<i>Male</i>	36.6%	51.7%	64.3%
15-17	58.1%	77.1%	81.1%
18-24	14.5%	25.5%	29.6%
15-19	51.7%	74.7%	69.5%
20-24	2.8%	21.0%	16.7%
<b>Marriage</b>			
% Youths 15-24 married/lived with partner	<b>28.4%</b>	<b>33.6%</b>	<b>34.1%</b>
<i>Female</i>	39.1%	45.7%	50.0%
<i>Male</i>	15.5%	17.1%	13.0%
15-19	9.2%	18.5%	15.4%
20-24	46.6%	46.3%	66.0%
% Youths aged 20-24 married by age 20:	<b>32.1%</b>	<b>29.4%</b>	<b>46.2%</b>
<i>Female</i>	45.1%	46.0%	61.8%
<i>Male</i>	11.0%	8.6%	16.7%
% Youths aged 20-24 married by age 15:	<b>1.4%</b>	<b>3.8%</b>	<b>11.5%</b>
<i>Female</i>	2.3%	5.1%	17.6%
<i>Male</i>	0.0%	2.1%	0.0%
% Youths aged 15-19 married by age 15:	<b>2.0%</b>	<b>5.9%</b>	<b>4.4%</b>
<i>Female</i>	4.2%	8.2%	8.5%
<i>Male</i>	0.0%	2.6%	0.0%
Median age at first marriage among ever married youths	<b>17</b>	<b>17</b>	<b>17</b>
<i>Female</i>	17	17	17
<i>Male</i>	-	-	-
15-19	-	15	-
20-24	18	18	18
% Married female 15-24 whose husband/partner is 10+ years older	<b>20.8</b>	<b>13.7%</b>	<b>9.4%</b>
<b>Knowledge of HIV/AIDS</b>			
% Youths who have ever heard of AIDS	98.9%	98.6%	98.6%
% Youths who know HIVinfection can be prevented by:			
Having only one partner	92.7%	90.9%	77.1%
Using a condom every time	68.1%	78.2%	81.5%
Abstaining from sexual intercourse	94.1%	87.9%	88.5%
% Youths who know HIV infection cannot come from:			
Mosquitoes	73.3%	84.0%	77.4%
Sharing food with a person who has AIDS	80.2%	90.1%	84.5%
Witchcraft	86.0%	89.9%	85.1%
<b>K13</b> % Youths who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (6 questions above)	<b>47.2%</b>	<b>60.2%</b>	<b>59.2%</b>
<i>Female</i>	41.5%	58.3%	48.5%
<i>Male</i>	53.8%	62.9%	72.6%
15-19	43.6%	53.4%	62.2%
20-24	50.6%	66.4%	54.3%

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Sexual activity</b>			
% Youths who are married/lived with partner or who ever had sex	<b>68.6%</b>	<b>79.4%</b>	<b>64.7%</b>
Female	75.9%	83.7%	74.4%
Male	59.7%	73.5%	51.9%
15-19	50.7%	70.5%	49.6%
20-24	85.9%	87.2%	90.6%
% Youths 20-24 who ever had sex by age 20:	<b>74.0%</b>	<b>78.1%</b>	<b>88.5%</b>
Female	75.8%	84.6%	94.1%
Male	71.1%	69.7%	77.8%
% Youths 20-24 who ever had sex by age 15:	<b>7.5%</b>	<b>19.8%</b>	<b>19.2%</b>
Female	8.1%	16.5%	26.5%
Male	6.6%	23.9%	5.6%
% Youths 15-19 who ever had sex by age 15:	<b>22.5%</b>	<b>29.8%</b>	<b>15.8%</b>
Female	22.2%	28.1%	25.5%
Male	22.9%	32.2%	4.8%
Median age at first sex among youth aged:	<b>16</b>	<b>15</b>	<b>15</b>
Female	16	15	14
Male	16	15	15
15-19	15	15	15
20-24	17	16	16
<b>KI4</b> % Never Married Youths who have never had sex	<b>45.6%</b>	<b>30.4%</b>	<b>53.5%</b>
Female	41.0%	27.8%	51.2%
Male	49.7%	32.9%	55.3%
15-19	56.5%	36.7%	59.6%
20-24	27.7%	22.5%	27.8%
<b>KI5</b> % Never Married Youths who never had sex and intend to abstain	<b>93.1%</b>	<b>97.4%</b>	<b>79.0%</b>
Female	100.0%	94.4%	71.4%
Male	88.2%	100.0%	85.0%
15-19	94.0%	100.0%	77.1%
20-24	90.3%	-	-
<b>KI6</b> % Never Married Youths who ever had sex & used condom the 1st time	<b>13.9%</b>	<b>26.7%</b>	<b>12.2%</b>
Female	9.5%	24.9%	11.7%
Male	21.1%	29.5%	13.3%
15-19	9.0%	32.9%	11.4%
20-24	16.5%	21.3%	13.0%
% Youths who had sex in the last 12 months	<b>48.2%</b>	<b>57.8%</b>	<b>54.4%</b>
Female	57.6%	61.5%	63.0%
Male	36.3%	61.5%	42.9%
15-19	34.0%	<b>39.7%</b>	37.9%
20-24	61.5%	<b>65.1%</b>	82.7%
<b>KI7</b> % Never Married Youths who had sex in the last 12 months	<b>30.4%</b>	<b>40.4%</b>	<b>33.5%</b>
Female	31.6%	40.7%	32.5%
Male	29.3%	40.0%	34.2%
15-19	25.3%	38.2%	27.8%
20-24	38.4%	43.5%	58.8%
<b>KI8</b> % Youths who had sex in last 12 months who had more than one partner			
Female	9.8%	<b>1.9%</b>	<b>18.9%</b>
Male	7.0%	1.6%	18.4%
15-19	-	2.5%	20.0%
20-24	7.9%	0.0%	20.0%

Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Adults 15-49 years old</b>			
<b>Voluntary Counseling and Testing</b>			
% Adults who have ever been tested for HIV	<b>11.5%</b>	<b>33.0%</b>	<b>11.4%</b>
15-24	10.4%	30.0%	9.1%
Female	11.1%	31.3%	11.1%
Male	9.6%	29.1%	6.5%
25-49	12.5%	36.1%	14.0%
Female	17.3%	38.1%	9.6%
Male	8.0%	33.8%	22.9%
% Distribution of ever-tested adults by time since last test			
Less than 12 months ago	66.3%	42.7%	68.8%
Between 12 and 23 months ago	9.5%	21.8%	28.1%
Two or more years ago	24.2%	35.5%	3.1%
% Adults ever been tested for HIV who get the results of the tests	<b>93.1%</b>	<b>93.6%</b>	<b>92.9%</b>
<b>KI12</b> % Adults having been tested for HIV and received the test results in last 12 months			
15-24	<b>5.3%</b>	<b>12.2%</b>	<b>6.8%</b>
Female	6.9%	13.0%	<b>4.9%</b>
Male	6.4%	14.1%	6.2%
25-49	7.6%	11.9%	3.2%
Female	4.0%	11.9%	8.8%
Male	5.8%	9.0%	5.3%
Male	2.3%	14.3%	16.0%
% Adults ever been tested for HIV who had already been tested before	<b>46.4%</b>	<b>34.7%</b>	<b>31.20%</b>
% Distribution of adults ever been tested for HIV who had already been tested before by time between last two tests			
Less than 3 months ago	-	32.9%	22.2%
Between 3 and 6 months ago	-	21.9%	66.7%
More than 6 months ago	-	45.2%	11.1%
<b>Stigma and discrimination</b>			
% Adults who would buy vegetables from a shopkeeper with AIDS	<b>82.2%</b>	<b>87.1%</b>	<b>80.1%</b>
15-24	80.6%	85.8%	81.5%
Female	79.1%	86.2%	78.8%
Male	82.3%	84.9%	85.2%
25-49	83.6%	88.4%	78.3%
Female	75.3%	87.3%	75.5%
Male	91.4%	89.5%	85.6%
% Adults who would care for a relative with AIDS in own household	<b>95.0%</b>	<b>93.8%</b>	<b>95.1%</b>
15-24	96.3%	92.3%	93.3%
Female	97.0%	93.1%	93.4%
Male	95.4%	90.9%	93.1%
25-49	93.9%	95.2%	<b>96.9%</b>
Female	92.1%	94.1%	96.7%
Male	95.4%	96.4%	97.7%
% Adults who would allow teacher with AIDS to teach own child	<b>81.1%</b>	<b>83.6%</b>	<b>80.8%</b>
15-24	75.8%	84.0%	77.1%
Female	73.4%	82.3%	76.6%
Male	78.8%	85.8%	77.8%
25-49	85.8%	83.1%	85.1%
Female	82.2%	79.9%	82.6%
Male	89.0%	87.3%	90.4%
<b>KI11</b> % Adults with accepting attitudes towards PLWHAs (3 questions above)			
15-24	<b>70.5%</b>	<b>75.1%</b>	<b>71.4%</b>
Female	67.3%	73.2%	71.0%
Male	66.1%	71.5%	69.6%
25-49	68.8%	74.6%	73.1%
Female	73.4%	77.0%	72.0%
Male	63.9%	75.0%	69.7%
Male	82.0%	79.6%	77.3%

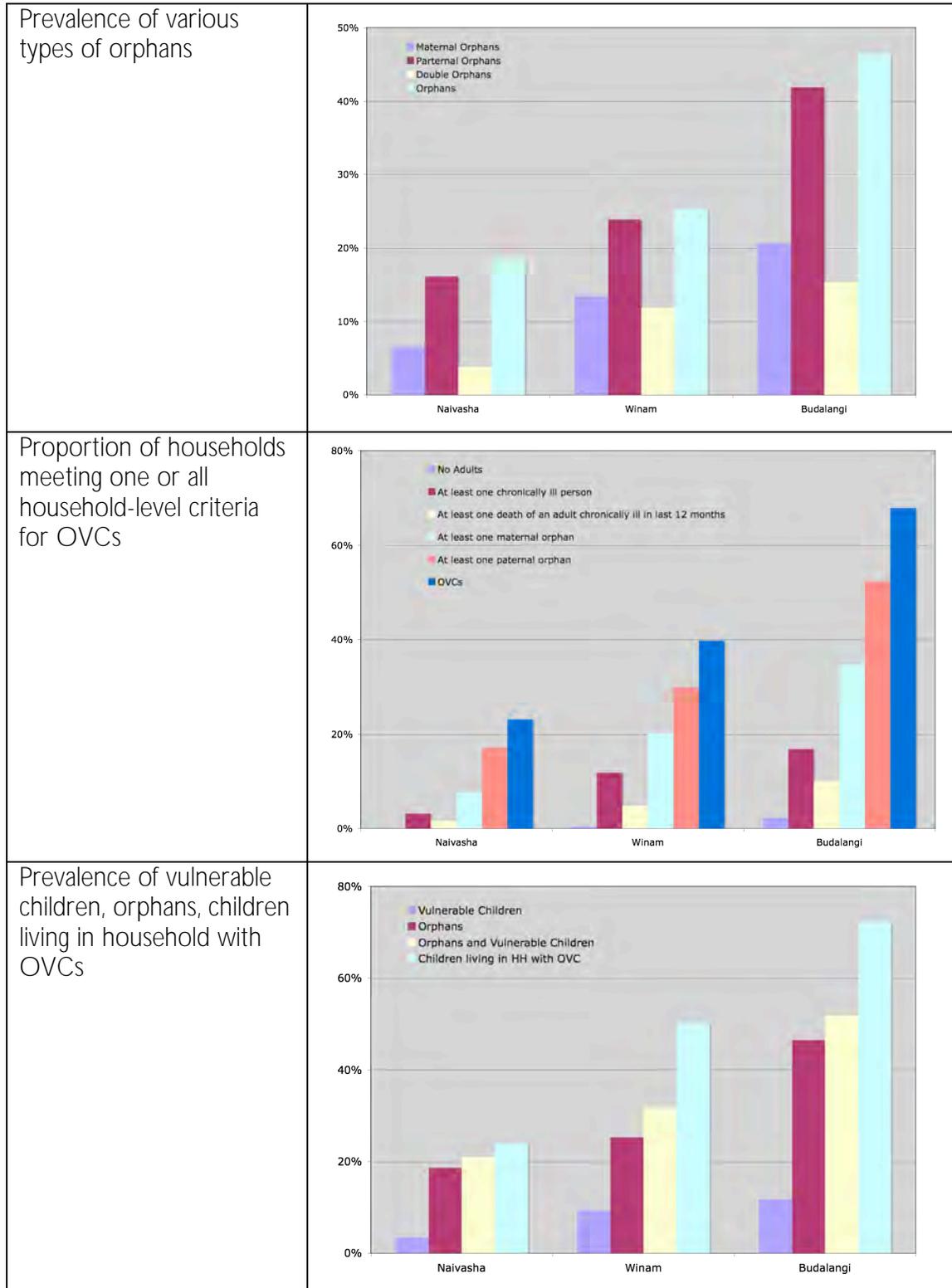
Indicator	Survey site		
	Naivasha	Winam	Budalangi
<b>Psycho-social</b>			
% Adults responding that they Strongly Agree (SA) or Strongly Disagree (SD) to the following questions:			
Answer:			
Are you happy?	SA 53.2%	30.9%	30.9%
Do you feel stressed or worried?	SD 32.9%	13.2%	8.2%
Do you feel good about yourself?	SA 40.5%	28.3%	19.9%
Does your future look hopeless?	SD 36.1%	31.7%	25.6%
Are you able to do things you need to do in your daily life?	SA 47.0%	42.8%	12.6%
Do you want to be alone these days?	SD 28.8%	27.9%	22.6%
Is your health good?	SA 57.6%	36.5%	20.8%
Do you get into fights?	SD 41.1%	44.4%	56.7%
Do you hope that things will turn alright for you?	SA 56.4%	46.3%	26.1%
% Adults with "no strong sign of depression," that is, who provide the answer most suggestive of the absence of depression to all the above questions			
	<b>14.1%</b>	<b>2.4%</b>	<b>0.4%</b>
15-24	15.7%	2.8%	7.0%
Female	17.2%	4.1%	1.3%
Male	13.6%	1.1%	0.0%
25-49	12.8%	1.9%	0.0%
Female	13.6%	1.8%	0.0%
Male	12.1%	2.0%	0.0%
% Adults responding that they Strongly Agree (SA), Agree (A), Disagree (D) or Strongly Disagree (SD) to the following questions:			
Answer:			
Are you happy?	A/SA 97.5%	73.6%	91.9%
Do you feel stressed or worried?	D/SD 80.1%	44.8%	59.4%
Do you feel good about yourself?	A/SA 93.6%	68.6%	84.5%
Does your future look hopeless?	D/SD 80.2%	74.6%	76.6%
Are you able to do things you need to do in your daily life?	A/SA 87.7%	77.1%	86.2%
Do you want to be alone these days?	D/SD 73.8%	65.5%	70.7%
Is your health good?	A/SA 94.7%	76.9%	84.6%
Do you get into fights?	D/SD 89.5%	81.1%	85.9%
Do you hope that things will turn alright for you?	A/SA 96.4%	81.8%	85.2%
<b>KI1</b> % Adults with "no sign of depression," that is, who provide one of the two possible answers suggesting the absence of depression to all the above questions:			
	<b>53.6%</b>	<b>20.0%</b>	<b>24.8%</b>
15-24	58.1%	22.3%	27.8%
Female	58.8%	23.0%	20.5%
Male	57.1%	22.1%	37.5%
25-49	49.8%	17.5%	22.0%
Female	48.6%	19.8%	17.6%
Male	50.8%	15.4%	30.0%

Indicator	Survey site			
	Naivasha	Winam	Budalangi	
<b>KATSO Performance Indicators</b>				
<b>SO 1: Mobilized and strengthened community-led responses to improve care and support for OVC and others affected</b>				
IR 1.1: Strengthened community networks for psychosocial care to people affected by HIV/AIDS				
<b>KI1</b> % Adults 15-49 showing no sign of depression	n	891	1273	785
	%	<b>53.6%</b>	<b>20.0%</b>	<b>24.8%</b>
	UCL	60.0%	2294.0%	31.2%
	LCL	47.2%	1697.0%	18.4%
<b>KI2</b> % Adults 18-49 Chronically Ill with access to community psychosocial care and support [PEPFAR]	n	-	98	92
	%	-	<b>39.8%</b>	<b>22.0%</b>
	UCL	-	50.7%	31.6%
	LCL	-	28.9%	12.5%
IR 1.2: Increased capacity of OVC and their households to protect themselves from HIV infection				
<b>KI3</b> %Young People (15-24) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [PEPFAR]	n	343	571	368
	%	<b>46.7%</b>	<b>59.6%</b>	<b>59.7%</b>
	UCL	57.2%	64.8%	67.5%
	LCL	36.2%	54.3%	52.0%
<b>KI4</b> % of Never Married Young People (15-24) who have never had sex [PEPFAR]	n	298	401	284
	%	<b>42.1%</b>	<b>30.6%</b>	<b>53.6%</b>
	UCL	49.6%	34.4%	61.7%
	LCL	34.6%	26.7%	45.4%
<b>KI5</b> % of Never Married Young People (15-24) who never had sex and intend to abstain	n	131	117	143
	%	<b>95.5%</b>	<b>97.8%</b>	<b>82.9%</b>
	UCL	100.0%	100.5%	92.5%
	LCL	90.9%	95.1%	73.3%
<b>KI6</b> % of Never Married Young People (15-24) who ever had sex and used condom the 1st time	n	288	501	270
	%	<b>11.8%</b>	<b>27.2%</b>	<b>11.9%</b>
	UCL	17.3%	30.9%	16.4%
	LCL	6.3%	23.4%	7.5%
<b>KI7</b> % of Never Married Young People (15-24) who had sex in the last 12 months [PEPFAR]	n	286	384	278
	%	<b>34.3%</b>	<b>40.4%</b>	<b>33.6%</b>
	UCL	46.0%	45.4%	41.3%
	LCL	22.5%	35.4%	26.0%
<b>KI8</b> % Young People (15-24) who had sex in last 12 months who had more than one partner	n	112	312	222
	%	<b>10.6%</b>	<b>1.7%</b>	<b>20.0%</b>
	UCL	19.2%	3.0%	26.5%
	LCL	2.0%	0.3%	13.5%
IR 1.3 Improved livelihood support systems to meet basic needs of OVC and their families				
<b>KI9</b> Ratio of OVC to Non OVC Households in which because of lack of food in the last 30 days the children did not eat a whole day	n	284/988	557/1173	869/788
	RR	<b>1.8</b>	<b>1.0</b>	<b>1.1</b>
	UCL	2.6	1.2	1.2
	LCL	1.2	0.8	0.9
<b>SO 2 Improved enabling environments at division and district levels that actively support holistic care for OVC and</b>				
IR 2.1: Improved multi-sectoral planning and collaboration for OVC support at division and district levels				
<b>KI10</b> % OVC living in HH that received, free of user charges, basic external support in caring for the child [PEPFAR]	n	157	662	894
	%	<b>0.0%</b>	<b>0.0%</b>	<b>0.3%</b>
	UCL	n/a	n/a	0.0%
	LCL	n/a	n/a	0.6%
<b>KI11</b> % General population aged 15-49 with accepting attitudes towards PLWHAs [PEPFAR]	n	899	1296	796
	%	<b>70.5%</b>	<b>75.1%</b>	<b>71.4%</b>
	UCL	75.7%	79.0%	77.4%
	LCL	65.4%	71.2%	65.3%
<b>SO3: Reduced HIV Transmission and Improved Clinical Care and Support</b>				
IR 3.1: Increased number of people who know their HIV-status				
<b>KI12</b> % General population 15-49 receiving HIV test results in last 12 months [PEPFAR]	n	938	1347	841
	%	<b>3.8%</b>	<b>12.0%</b>	<b>6.0%</b>
	UCL	5.8	14.1%	8.3%
	LCL	1.8	10.0%	3.7%


Legend			
<b>KI#</b>	KATSO Indicator #		
	Data not available		n/a
	Less than 50 observations; result not reported		-
<b>For KATSO Performance Indicator Table:</b>			
	Sample size	#	
	Percentage (or Relative Risk) adjusted for stratification by ADP	(RR) %	
	Upper Confidence Limit	UCL	
	Lower Confidence Limit	LCL	

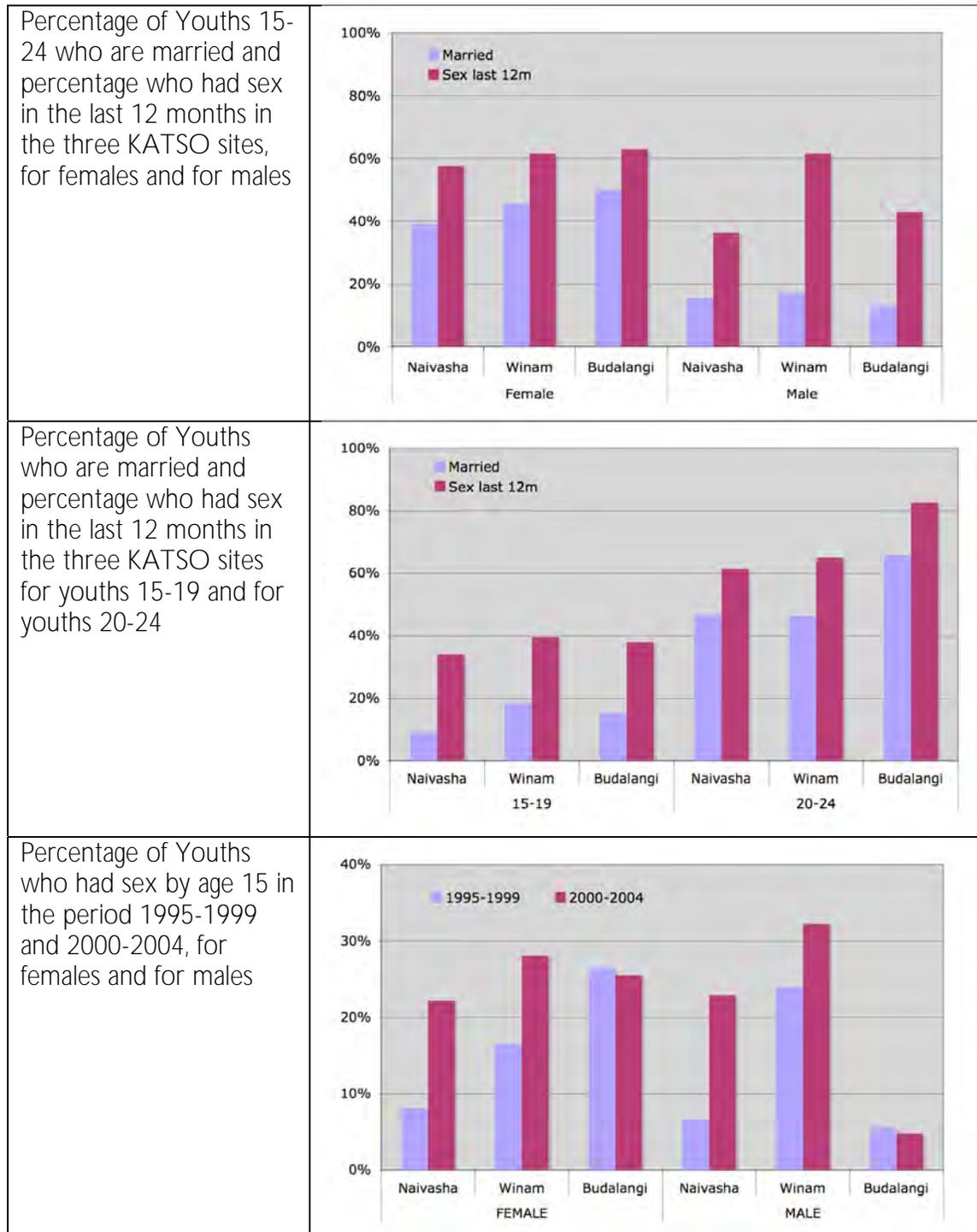
Note on Age and Sex Disaggregation:				
<b>Schematic representation of the possible levels of age and sex disaggregation</b>				
		Sex		
		Female	Male	row total
Age	A	1	2	3
	B	4	5	6
	column total	7	8	9
<b>For Youths 15-24, results are disaggregated by age (15-19 and 20-24) and by sex</b>				
		Female	Male	
	15-19	1	2	3
	20-24	4	5	6
		7	8	9
	Aggregate value	<b>9</b>		
	Disaggregation by sex	<i>Female</i> 7	<i>Male</i> 8	* **
	Disaggregation by age	15-19 3	20-24 6	
<b>For Adults 15-49, results are disaggregated by age (15-24 and 25-49) and then by sex within each age group</b>				
		Female	Male	
	15-24	1	2	3
	25-49	4	5	6
		7	8	9
	Aggregate value	<b>9</b>		
	Disaggregation by age	15-24 3	25-49 6	
	Disaggregation by sex	<i>Female</i> 1	<i>Male</i> 2	* same as 7 for youths ** same as 8 for youths
		25-49 4	15-24 5	

## Appendix 12 Prevalence of OVCs in three KATSO sites



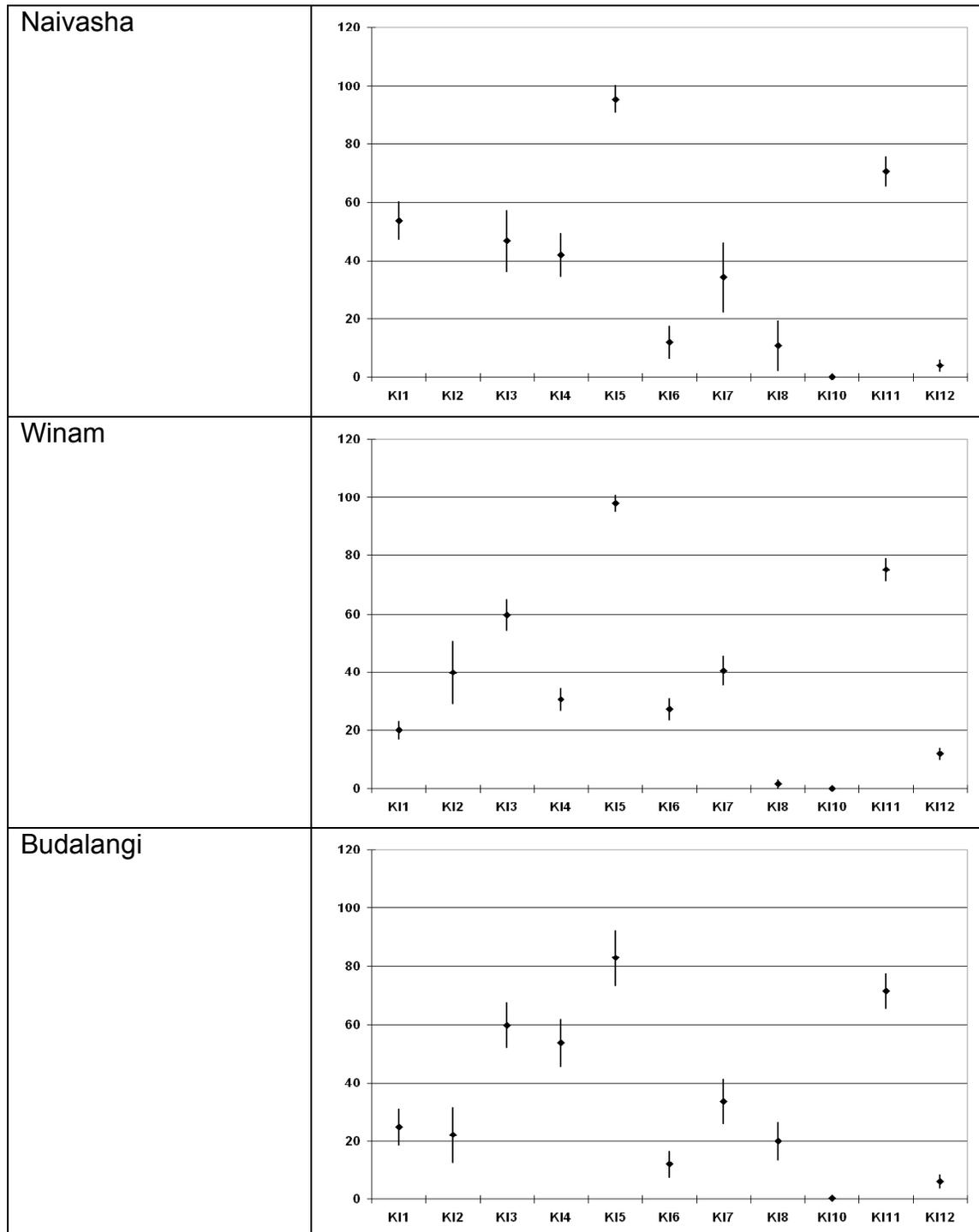
See data source in Appendix 11.

## Appendix 13 Sexual behavior of youths



See data source in Appendix 11.

## Appendix 14 KATSO Outcome Indicators



KI: KATSO Indicator. See definitions and data source of KATSO Outcome Indicators in Section IV.C.10 of the report and in Appendix 11.

## Appendix 15 Focus Group Discussions Guidelines

### Sample format for Individual FGD report

Date	
Location	
Facilitator's name	
Recorder's name	
Number and characteristics of respondents (age, residence, others as appropriate)	
Comments on process (as relevant to the analysis)	

### Individual Question report

Question 1: \_\_\_\_\_  
\_\_\_\_\_

Key answers / points	Notable Quotes

FGD Respondent Profile	Topics of interest	Questions (Begin with main questions in bold, then probe and narrow down with sub questions in bullets)
<p>1. Female Youth aged 12-15</p> <p>2. Male Youth aged 12-15</p> <p>Note: Topics of Interest and Questions are the same for the two groups of respondents above.</p>	<p><b>Knowledge of HIV/AIDS, including perceptions, beliefs, and misconceptions</b></p> <ul style="list-style-type: none"> <li>- Signs &amp; symptoms [weight loss, fever, general weakness; chronic cough; skin infection; diarrhea]</li> <li>- Major modes of transmission [sexual intercourse; mother-to-child transmission; blood transfusion; unsafe injections; sharing razor blades]</li> <li>- Preventive sexual behavior [Abstinence; Be faithful; Condoms; Decide to go for VCT]</li> </ul>	<p><b>1. Can you explain what is AIDS?</b></p> <ul style="list-style-type: none"> <li>- What is it?</li> <li>- What is the difference between HIV and AIDS?</li> </ul> <p><b>2. Can you describe the problems that people with HIV, the virus that causes AIDS, might have?</b></p> <ul style="list-style-type: none"> <li>- Can you describe what could happen to someone with HIV after 5 or 10 years?</li> <li>- Is it possible for a healthy-looking person to have the HIV virus?</li> </ul> <p><b>3. Can you explain how you can get infected with HIV, the virus that causes AIDS?</b></p> <ul style="list-style-type: none"> <li>- Do you know of any other way you could get infected with HIV?</li> <li>- Could you get infected with HIV by shaking hands with someone who has Hs IV?</li> </ul> <p><b>4. Can you explain how you can protect yourself from getting infected with HIV, the virus that causes AIDS?</b></p> <ul style="list-style-type: none"> <li>- Can you think of any other way?</li> <li>- Can you explain how condoms can protect you from getting infected with HIV infection?</li> </ul>
	<p><b>Perception of need for and knowledge of where to go for VCT</b></p>	<p><b>5. Can you explain how you can know if you are infected with HIV or not?</b></p> <ul style="list-style-type: none"> <li>- Have you heard of VCT?</li> <li>- When would you like to have a test?</li> <li>- Do you know where to go to have a test?</li> </ul>

FGD Respondent Profile	Topics of interest	<b>Questions</b> (Begin with main questions in <b>bold</b> , then probe and narrow down with sub questions in bullets)
	<b>Stigma &amp; Discrimination</b>  - Feelings about PLWHAs  - Feelings about Orphanhood	<b>6. Do you know anyone who is infected with HIV, the virus that causes AIDS?</b> - How do you know that person? - Can you describe that person? <b>7. If you heard that your teacher had HIV but was not sick, would you continue going to school as before?</b> - Would you want to change class or school? - What would you do if you knew that your friend had HIV? <b>8. Do you know anyone who lost one or both of his or her parents?</b>
	<b>Sexual Activity</b>  - Sexual debut  - Condom use	<b>9. When do young people of your age begin having sexual intercourse?</b> - Do you know of anyone of your age who has already had sex? - Do you know at what age they had sex for the first time? - When do you think people of your age should begin having sex? <b>10. Can you explain how to use a condom?</b> <b>11. How effective is a condom?</b> - Is it always effective <b>12. Can you talk about the different form of sexual activities?</b>

FGD Respondent Profile	Topics of interest	<b>Questions</b> (Begin with main questions in <b>bold</b> , then probe and narrow down with sub questions in bullets)
<b>3. OVCs 10-13</b>	<b>Care &amp; Support</b> - Perceptions of adequacy of care and support - Feelings of security & protection	<b>1. How do you meet your basic needs?</b> - Shelter? - Food? - School? - Clothes? - Medical care? <b>2. Who do you go to you at home when you have a problem?</b> - Homework? - Basic needs? - Need to talk? - Medical care?

FGD Respondent Profile	Topics of interest	Questions (Begin with main questions in <b>bold</b> , then probe and narrow down with sub questions in bullets)
4. OVCs 14-17	<p><b>Knowledge of HIV/AIDS, including perceptions, beliefs, and misconceptions</b></p> <ul style="list-style-type: none"> <li>- Signs &amp; symptoms [weight loss, fever, general weakness; chronic cough; skin infection; diarrhea]</li> <li>- Major modes of transmission [sexual intercourse; mother-to-child transmission; blood transfusion; unsafe injections; sharing razor blades]</li> <li>- Preventive sexual behavior [Abstinence; Be faithful; Condoms; Decide to go for VCT]</li> </ul>	<ol style="list-style-type: none"> <li><b>1. Can you explain what is AIDS?</b> <ul style="list-style-type: none"> <li>- What is it?</li> <li>- What is the difference between HIV and AIDS?</li> </ul> </li> <li><b>2. Can you describe the problems that people with HIV might have?</b> <ul style="list-style-type: none"> <li>- Can you describe what could happen to someone with HIV after 5 or 10 years?</li> <li>- Is it possible for a healthy-looking person to have the HIV virus?</li> </ul> </li> <li><b>3. Can you explain how you can get infected with HIV, the virus that causes AIDS?</b> <ul style="list-style-type: none"> <li>- Do you know of any other way you could get infected with HIV?</li> <li>- Could you get infected with HIV by shaking hands with someone who has HIV?</li> </ul> </li> <li><b>4. Can you explain how you can protect yourself from getting infected with HIV, the virus that causes AIDS?</b> <ul style="list-style-type: none"> <li>- Can you think of any other way?</li> <li>- Can you explain how condoms can protect you from getting infected with HIV infection?</li> </ul> </li> </ol>
	<p><b>Care &amp; Support</b></p> <ul style="list-style-type: none"> <li>- Perceptions of adequacy of care and support</li> <li>- Feelings of security &amp; protection</li> </ul>	<ol style="list-style-type: none"> <li><b>5. How do you meet your basic needs?</b> <ul style="list-style-type: none"> <li>- Shelter?</li> <li>- Food?</li> <li>- School?</li> <li>- Clothes?</li> <li>- Medical care?</li> </ul> </li> <li><b>6. Who listens to you at home when you have a problem?</b> <ul style="list-style-type: none"> <li>- Homework</li> <li>- Basic needs</li> <li>- Need to talk</li> </ul> </li> </ol>

FGD Respondent Profile	Topics of interest	Questions (Begin with main questions in <b>bold</b> , then probe and narrow down with sub questions in bullets)
	Livelihood support	<ul style="list-style-type: none"> <li>- Medical care</li> </ul> <p><b>7. How do you contribute to the welfare of your family?</b></p> <ul style="list-style-type: none"> <li>- How do you assist your brothers and sisters</li> <li>- Have you been trained in any skill?</li> <li>- What do you plan to do in the future with this respect?</li> </ul>
5. OVC Care givers	<p><b>Knowledge:</b></p> <ul style="list-style-type: none"> <li>- Problems affecting OVC and PLWHAs</li> <li>- Knowledge of Children's Rights</li> </ul> <p><b>Perceptions</b></p> <ul style="list-style-type: none"> <li>- Adequacy of OVC care &amp; support</li> <li>- Adequacy of PLWHAs care &amp; support</li> <li>- Adequacy of their skills to care for OVCs and PLWHAs (self-confidence)</li> </ul>	<p><b>1. What are the main problems of people affected by AIDS in your area?</b></p> <ul style="list-style-type: none"> <li>- OVCs?</li> <li>- PLWHAs?</li> </ul> <p><b>2. Do you think the basic needs of OVCs are protected in your community?</b></p> <ul style="list-style-type: none"> <li>- Shelter? Food? School? Clothes? Medical care?</li> <li>- Can you explain what is the Children's Act?</li> </ul> <p><b>3. What type of assistance is provided to PLWHAs in your community?</b></p> <ul style="list-style-type: none"> <li>- Basic needs: Shelter? Food? School? Clothes? Medical care?</li> <li>- Type of clinical services: Home-based care? ARVs? Psychosocial support? Nutrition?</li> <li>- Specific organizations working in their communities?</li> </ul> <p><b>4. Are you able to adequately care for OVCs and PLWHAs?</b></p> <ul style="list-style-type: none"> <li>- Skills?</li> <li>- Time?</li> </ul>

FGD Respondent Profile	Topics of interest	Questions (Begin with main questions in bold, then probe and narrow down with sub questions in bullets)
<p>6. OVC Household heads - young mothers and fathers</p> <p>7. OVC Household heads - grand parents</p> <p>Note: Topics of Interest and Questions are the same for the two groups of respondents above.</p>	<p>Perceptions of discussing sexuality with their children</p> <p>Perceptions &amp; prevalence of risky sexual behaviors in their community</p> <p>Knowledge of OVC &amp; PLWHA needs</p> <p>Perception of their own needs</p>	<p><b>1. What is the role of parents in teaching children about sexuality?</b></p> <ul style="list-style-type: none"> <li>- Who should do so?</li> <li>- From what age?</li> </ul> <p><b>2. What are the risky sexual practices that are prevalent among youth in the community?</b></p> <ul style="list-style-type: none"> <li>- Early initiation</li> <li>- Multiple partners</li> <li>- Premarital sex</li> </ul> <p><b>3. Do you think the basic needs of the OVCs you are caring for are met?</b></p> <ul style="list-style-type: none"> <li>- Shelter?</li> <li>- Food?</li> <li>- School?</li> <li>- Clothes?</li> <li>- Medical care?</li> </ul> <p><b>4. What kind of assistance do you need most to meet the basic needs of the OVCs you are caring for?</b></p> <ul style="list-style-type: none"> <li>- Shelter?</li> <li>- Food?</li> <li>- School?</li> <li>- Clothes?</li> <li>- Medical care?</li> </ul>

FGD Respondent Profile	Topics of interest	Questions (Begin with main questions in bold, then probe and narrow down with sub questions in bullets)
<b>8. Community Care Coalition members</b>	<p><b>Knowledge:</b></p> <ul style="list-style-type: none"> <li>- Problems affecting OVC and PLWHAs</li> <li>- Knowledge of Children's Rights</li> </ul> <p><b>Perceptions</b></p> <ul style="list-style-type: none"> <li>- HIV/AIDS prevention and care efforts</li> <li>- Adequacy of OVC care &amp; support</li> <li>- Adequacy of PLWHAs care &amp; support</li> <li>- Trends in behavioral change in their communities</li> </ul>	<p><b>1. What are the main problems of people affected by AIDS in your area?</b></p> <ul style="list-style-type: none"> <li>- OVCs?</li> <li>- PLWHAs?</li> </ul> <p><b>2. Do you think the basic needs of OVCs are protected in your community?</b></p> <ul style="list-style-type: none"> <li>- Shelter?</li> <li>- Food?</li> <li>- School?</li> <li>- Clothes?</li> <li>- Medical care?</li> </ul> <p><b>3. Have you had any cases of child abuses among OVCs?</b></p> <ul style="list-style-type: none"> <li>- Mistreatment by foster parents</li> <li>- Child labor</li> <li>- Discrimination</li> <li>- Have you ever taken action for such cases?</li> </ul> <p><b>4. What government structures exist to ensure that the rights of children are protected?</b></p> <ul style="list-style-type: none"> <li>- Laws, Guidelines</li> <li>- Ask for examples</li> </ul> <p><b>5. Do you think the basic needs of PLWHAs are protected in your community?</b></p> <ul style="list-style-type: none"> <li>- Shelter?</li> <li>- Food?</li> <li>- School?</li> <li>- Clothes?</li> <li>- Medical care?</li> </ul> <p><b>6. How has the sexual behavior changed in the last few years among young people?</b></p> <ul style="list-style-type: none"> <li>- What have been the main changes?</li> </ul>

FGD Respondent Profile	Topics of interest	<b>Questions</b> (Begin with main questions in <b>bold</b> , then probe and narrow down with sub questions in bullets)
	<ul style="list-style-type: none"> <li>- CCC's capacity for scaling up HIV/AIDS response</li> </ul>	<ul style="list-style-type: none"> <li>- Among people less than 18?</li> <li>- Among people older than 18?</li> <li><b>7. What type of assistance is provided to PLWHAs in your community?</b> <ul style="list-style-type: none"> <li>- Basic needs: Shelter? Food? School? Clothes? Medical care?</li> <li>- Type of clinical services: Home-based care? ARVs? Psychosocial support? Nutrition?</li> <li>- Specific organizations working in their communities?</li> </ul> </li> <li><b>8. How well the CCC is prepared to scale up the HIV/AIDS response?</b> <ul style="list-style-type: none"> <li>- Prevention</li> <li>- Care</li> <li>- Treatment</li> </ul> </li> </ul>

## Appendix 16      **Focus Group Discussions Results**

### **Nalvasha, Nakuru**

#### **FGD respondents profile and attendance**

1. Female Youth 12-15 years old (among which half OVCs):  
12 girls; location Mirela, 18.02.05
2. Male Youth 12-15 years old (among which half OVCs):  
14 respondents, not clear % of OVCs; Ndabibi; 17.02.05
3. OVC boys and girls aged 10-13:  
12 respondents, boys & girls; 16.02.05
4. OVC boys and girls aged 14-17:  
12 respondents, mixed OVCs and Non-OVCs; Mairasha Town; 18.02.05
5. OVC Care givers:  
12 respondents, residents of Kongoni, Moidabi & Ngondi; 17.02.05. Mixed age and sex
6. OVC Household heads, mothers/fathers:  
9 respondents; Kipkunjo; 21.02.05
7. OVC Household heads, grand parents:  
10 respondents (grandmothers only), all >56 years old; Kabati; 19.02.05
8. Community Care Coalition members:  
13 respondents; Naivasha; 21.02.05; cooperative and challenging. Mixed age and gender. Representatives of different OVC care groups (NGO, FBO, Church, CBO govt, etc)

#### **SUMMARY OF FGDs BY TOPIC OF INTEREST**

##### 1. Knowledge of HIV/AIDS among youths and OVCs

Youth and the OVCs are knowledgeable about HIV/AIDS. Both the OVCs and the youth agreed that AIDS is there and that AIDS is a dangerous killer disease that has no cure so far, and that people should try as much as they can not to be infected with the IV, the virus that causes AIDS.

The youth and the OVCs in the area know the difference between HIV and AIDS, some saying that HIV is a virus that causes AIDS and that AIDS is the disease that kills. One respondent differed from the others by saying that AIDS doesn't kill but what it does is to reduce the human body's immune system, leaving the body prone to dangerous diseases like "coughing", TB, diarrhea and so on.

They also said that HIV is when you have the virus with you and no signs of infection, while AIDS is the disease where one has noticeable symptoms that can be clearly seen and one eventually dies.

##### 2. Perception of need for and knowledge of VCT among youths and OVCs

The perception of need for and knowledge of VCT among the youth and among OVCs was quite positive, with the youth in the area agreeing that it's only through the VCT centres that one would know his or her HIV status. They said that it's the only major step towards changing one's way of life and taking control of their lives.

At primary school level, many didn't understand what a VCT is, though they knew that it is found in public hospitals and that it is free of charge. While in secondary school, VCT was well understood and they were willing to go for the test. However, some seemed reluctant, as they feared exposure of their status.

The OVCs also agreed that VCT is a major step towards self-acceptance and one would know what to do with his/her HIV positivity or negativity status.

In various areas that we visited, VCT centres were very few and far from the community, hence the youth and the OVCs recommended that VCT centres be brought closer to the people.

### 3. Stigma and discrimination towards OVCs and PLWHAs among youths

Generally, the majority of the youth in the area have an accommodating feeling towards the OVCs and PLWHAs, and they reject the idea of stigma and discrimination towards the unprivileged infected people. They said that they could offer assistance to these disadvantaged people in the community because use it was unfortunate that these people were infected by HIV/AIDS. They said they would continue loving them, provide basic needs if available, and continue helping the infected and affected people in carrying out their daily duties.

Those who seemed to differ from their friends' loving and helping attitude towards infected people, said that they would not like to stay with them since they feared they would also be infected. They said they would keep-off the infected persons and that they wouldn't use anything including cups, spoons, used by the infected people and they wouldn't shake hands with them.

### 4. Sexual activity among youths and perception of same among OVC household heads

The feeling of sexual activity among youths in the area was that young people should start having sex at the age of 16 years and above. However, female youth suggested that the appropriate age to initiate sex is at different ages between 12-20 years. Several knew young girls, 12 and 15 years old who have given birth. Many young people suggested the use of condoms especially where one could not abstain or maintain one single partner who is infected.

The perception of the sexual activity among the youth by the OVC household heads was that premarital sex is bad and should be avoided at all cost. They said that today's youth have more than one partner and one cannot tell who spread the disease. When boys and girls have early initiation to sex they feel grown up and their parents are afraid to advise them.

### 5. Knowledge of OVCs' and PLWHAs' needs among OVC care givers

The basic needs of OVCs and PLWHAs are not met, due to the level of poverty in the community. Caregivers said that though one may be willing to assist the OVCs and PLWHAs, they cannot since they do not have enough even for their own families. When OVCs and PLWHAs do not have food, caregivers are forced to go begging door to door to assist the family. At times they are forced to borrow from shops so as to buy food for the OVCs.

Medical care was stated as a great problem as there is no hospital near the community. PLWHAs are also not willing to go to hospital for fear that their status will be exposed.

Clothes and shelter are provided by well-wishers. Some caregivers have made it their duty to take OVCs into their homes and care for them.

School fees are no longer a great problem as the government has provided free education for primary school. Books and uniforms for OVCs are got through fund raising. When time comes for a child to go to secondary school, however, it becomes difficult as the care givers are unable to help.

Caregivers suggested that they be trained on home-based care as to care for PLWHAs.

6. Adequacy of care and support to OVCs: Perception from OVCs, OVC care givers, and CCC members

The OVCs said that care and support they get comes from their relatives and well-wishers who provide for all their basic needs. Although this support is not adequate, they appreciate the assistance they get. They said that the people in the community lack money, therefore there's not enough shelter, food, clothes, school fees and even medical care.

The OVCs said they would help others who will be underprivileged when they grow up and would offer any assistance available to them.

The OVC caregivers said that the basic needs of the OVCs are not met due to the poverty level in the community with the OVCs hardly having enough to eat, clothes shortage, lack of school fees, and not able to meet their medical care bills.

The OVC caregivers suggested that they needed to be trained on home-based care so that they can also train the OVCs, who can in turn apply it to those they live with.

The CCC members said that there was inadequacy of care and support among the OVCs because their guardians live below the poverty line. They argued that for the guardians to support the OVCs, they also needed to be supported with the basic necessities for them to provide the OVCs.

7. Adequacy of care and support to PLWHAs: Perception from OVC care givers and CCC members

The OVC caregivers said there was inadequacy of care and support to the PLWHAs given that the area is dry, thereby members of the community are unable to meet their basic needs, let alone provide to the PLWHAs.

The OVC caregivers highlighted the issue of poverty, saying that the majority of the people living around this region have barely enough to eat, and if they do, it's not a balanced diet. They also talked about lack of information about HIV/AIDS issue as a major block towards the fight against the disease, and if PLWHAs are trained they can carefully support themselves.

The perception of the CCC members about the adequacy of care and support among the PLWHAs was that PLWHAs need to be educated / enlightened about their status, given the psychological and moral support they require. They said that education is power and that PLWHAs will require to be educated and sensitized about the HIV/AIDS pandemic.

8. Knowledge and perception of CCC members about the HIV/AIDS response in their community and about their role in same

The CCC members perceived AIDS as the main cause of poverty. They said that the nature of HIV is to leave the orphans without anything, because by the time the parents die, they'll have used all their resources to buy drugs and quality food to keep their bodies healthy.

According to them, the HIV/AIDS response is positive among the youth, and youth seem more willing to talk about sex. However, poverty has turned some to prostitution. The CCC is doing all they can to create awareness in their communities. However, they said that they lack facilities, such as staff and offices.

#### 9. Knowledge of Children's Rights among OVC care givers and CCC members

The OVC caregivers were not aware of the content of the Children's Act.

CCC members are aware of the Children's Rights though, as they put it, they exist only in books. According to them, the Chief is the least qualified person to deal with issues affecting children. This is because chiefs are prone to bribery, which could hinder them from effectively acting towards such issues.

The nearest children's office is 104 kilometers from Naivasha. Therefore, they proposed that the office be brought nearer to the people.

The CCC agreed that it is their duty to teach the community about the Children's Rights and what is contained in the Children's Act. Unless the community knows about the Children's Act, it is about to fail protecting its children's rights.

## Winamu, Kisumu

### **FGD respondents profile and attendance**

1. Female Youth 12-15 years old (among which half OVCs): 9
2. Male Youth 12-15 years old (among which half OVCs): 10
3. OVC boys and girls aged 10-13: 9, mixed
4. OVC boys and girls aged 14-17: 10, mixed
5. OVC Care givers: 10, mixed
6. OVC Household heads, mothers/fathers:
7. OVC Household heads, grand parents: 9 grandmothers
8. Community Care Coalition members: 10, mixed

### **SUMMARY OF FGDs BY TOPIC OF INTEREST**

1. Knowledge of HIV/AIDS among youths and OVCs

The youth generally demonstrated a fairly good understanding of the definition of HIV/AIDS, its causes, sign and symptoms, the difference between HIV and AIDS, and the modes of transmission. They understood AIDS as a condition that is deadly and has no cure.

They were unanimous to say that the basics on HIV/AIDS were covered in their school curriculum and by their teachers. Teachers emerged as having a significant influence on the perception and knowledge of youth with regard to their understanding of HIV/AIDS. Other sources of information came out as the media (TV, radios and print), literature and billboards. Another significant source of information was their peers, who provide a fertile means of transfer of ideas although may also be a source of misconceptions. The youth agreed that issues of HIV/AIDS were not discussed at home and that parents and guardians were not significant contributors to their knowledge base.

The respondents were emphatic that since the disease has no cure, abstinence was the only way of prevention. Knowledge of the ABC of prevention also emerged from the discussion. Knowledge of condoms as a method of prevention seemed wanting, with all the groups of youths being very shy or uncomfortable with talking about it, exhibiting significant ignorance on how they are used and posing queries on their effectiveness. Out of all the boys, none had used a condom though quite a number had conceded to having had sexual exposure once or several times.

Sexual debut was noted to be from a relatively low age, often as early as 12 among the boys. Girls, however, could not discuss freely the topic of sexuality, perhaps due to the fact that the interviewers were males.

## 2. Perception of need for and knowledge of VCT among youths and OVCs

Knowledge of VCT among youth seemed rather low and superficial. The majority seemed relatively not conversant with this concept, a part from a few who cited media as their source of information. A popular slogan on TV about "Chanukeni Pamoja" aroused some thoughts about VCT but the majority did not seem to understand what it entailed, especially the younger youth aged 10-12yrs. The slightly older OVC aged 14-17yrs demonstrated relatively better understanding of VCT as pertaining to counseling and testing for HIV.

The OVC cited the following as some of the VCT sites known to them: Provincial General Hospital, Magadi Catholic, and Lumumba Health Center. Their poor knowledge of the VCT sites demonstrates their low knowledge of where to go for the services. None of the youths/OVC had been tested although quite a number obviously had had sexual exposure, sometimes more than a single encounter. This shows the need to increase knowledge about VCT among youth.

## 3. Stigma and discrimination towards OVCs and PLWHAs among youths

The youth generally expressed a lot of empathy and sympathy for these two vulnerable groups, whom they acknowledged are in their communities. They defined orphans as those children who have lost one or both parents.

Some of the challenges faced by the OVCs included lack/inadequacy of basic needs and loss of parental love that adversely impacts on their upbringing. Most of the OVCs were living with and being taken care of by their relatives, including grand parents, uncles, aunts and even some their siblings (elder brothers). They deplore the heavy burden endured by their guardians, who have other children to take care of, which impacts negatively on their access to basic needs and quality of life. Fellow students felt sorry for them, but there was no explicit indication of discrimination. Teachers empathized and attempted to address their problems while treating them like any other children in school.

The youth confirmed knowing PLWHAs, some having passed away after a sustained period of suffering from various ailments. None however talked of their parents as falling in this category. They argued that these people suffer myriad of problems due to their conditions that require a lot of specialized attention as they fall sick very often, they are frail and cannot work to earn an income. They conceded that there was general fear of these people, especially as they began to deteriorate and get very sick. They talked about the notion that certain infections such as coughs could be spread, especially considering the nature of the houses they resided in.

Stigma and discrimination seems to be rampant among the communities. It came out clearly that some unfavorable comments were often made to warn the youth about HIV/AIDS but using PLWHAs as an example to deter them from indulging in sexuality.

## 4. Sexual activity among youths and perception of same among OVC household heads

There was clear evidence that household heads were uncomfortable and reluctant to address issues of sexuality with the youth. They cited the dynamics of the modern society as a significant contributing factor to this situation, as the youth spend most of their time outside homes (in schools) while parents are busy throughout the day trying to make ends meet. While acknowledging that discussing sexuality with the youth was their primary responsibility, they were

of the opinion that they lacked appropriate forums, a factor that is compounded by their lack of skills to communicate these messages effectively.

Rapid urbanization rates has also impacted on their ability to act as an effective source of knowledge on sexuality since the youth have several other sources of information, which increasingly influences perceptions of youth on various issues. Public video shows, which are not supervised and/or controlled, are rampant in residential areas, thus exposing youths to obscene movies adulterating their minds as far as sexuality is concerned.

The household heads opined that the appropriate age at which sexuality issues ought to be discussed with the youth is from about 12 years. This according to them was the age where children start experiencing body changes, and it is critical to provide them with the necessary guidance and knowledge manage these changes effectively. Most youth experiment and experience sexual debut at this age.

They also acknowledged that risky sexual behaviors were rampant in their communities as youth become increasingly adventurous and society more liberal. They are thus variously exposed to risky sexual behavior like having multiple sexual partners, repeated pre-marital sex and early sexual debut before they understand issues of sexuality well. In this era of runaway HIV/AIDS, this trend is worrying to the household heads/parents, who feel strongly that interventions should be put in place if they are to save their youths from being wiped out by the deadly scourge. They noted that as youth develop fast and mostly away from their parents/guardians, intervening sometimes poses a great challenge and could lead to rebellion.

They were of the opinion that girls were more vulnerable, and even exposed more to abuse by their male counterparts or even grown ups, explaining rising cases of defilement and rape currently experienced in our communities. On the other hand, the patriarchic nature of most of our communities has encouraged the boys to engage in sexual relationships with multiple sex partners as they are viewed by their peers as "heroes."

#### 5. Knowledge of OVCs' and PLWHAs' needs among OVC care givers

The caregivers defined basic needs as those things without which one cannot live, e.g. food, shelter, housing, health care, education and clothing. The challenge of meeting these needs had become increasingly difficult as the numbers of OVCs and PLWHAs has continuously increased and the capacity of the community to take care of them has declined.

Care givers highlighted the following as problems afflicting OVCs:

- High rates of school dropouts
- Health problems
- Lack of adequate and proper shelter
- Poor nutrition
- Inadequate family/social support
- Poor socialization, resulting in rampant cases of delinquents
- Poor clothing

Poverty was considered as the principal cause of the above problems, exacerbated by the increasing numbers of OVCs progressively eroding the capacity of the community caregivers to effectively take care of these children.

PLWHAs afflictions also evolve around accessibility to basic needs and include:

- Lack of access to proper medication
- Poor nutrition
- Poor shelter

- Lack of adequate community psychosocial support
  - Stigmatization due to relative ignorance among community
- Caregivers called for interventions that can boost their income and enhance their capacity to address the issue of the basic needs of these two vulnerable groups.

6. Adequacy of care and support to OVCs: Perception from OVCs, OVC care givers, and CCC members

Discussions with the three groups revealed that current care and support initiatives were grossly inadequate for the OVCs. Current practices are that care of the orphans is provided by their relatives within the same communities. Caregivers here include aunts, uncles, siblings, and grand-parents. Institutional support through orphanages is not common though members of the CCCs contend that there are cases where CBOs run small orphanages.

The major challenge to effective care and support essentially revolves around the poverty in the community. Resources are limited as compared to the escalating numbers of OVCs. Thus support/coping structures within the communities have been overstretched and inadequate.

CCCs and caregivers decried lack of adequate and appropriate skills that would enable them to provide support and care more effectively.

Development agencies assisting communities have not invested much on care and support of OVCs, thus do not support small interventions from local CBOs.

CCC members were emphatic that advocacy and sensitization on support and care and on the rights of the OVCs was imperative for community to appreciate their status/plight.

7. Adequacy of care and support to PLWHAs: Perception from OVC care givers and CCC members

Both groups acknowledged that the plight of PLWHAs was significantly ignored, thereby exposing them to some of the following afflictions:

- Inadequate access to basic needs
- Stigmatization, as the condition is still strongly associated to immorality
- Overstretched capacity of the community coping structures (e.g. CCC, Caregivers and various CBOs/FBOs)
- Lack of essential medical care to mitigate the opportunistic infections
- Psychosocial problems due to lack of trained counselors and an eroded social cohesion.

The presence of so many problems was an indication that care and support for these vulnerable groups is not adequate, compromising the quality of their life.

8. Knowledge and perception of CCC members about the HIV/AIDS response in their community and about their role in same

CCCs draw their membership from institutions providing various services that support the livelihood and well being of local communities. These stakeholders already have on-going initiatives within the program area, particularly those addressing the HIV/AIDS problem, which nonetheless have not been very effective as they are isolated and largely poorly coordinated. Some of the present initiatives highlighted by the CCC members included awareness creation on HIV/AIDS among the youth, care and support for OVCs and widows, promotion of prevention initiatives and behavior change, Income Generating Activities, and nutritional programs, to mention but a few.

HIV/AIDS interventions/responses need to be comprehensive in order to address the varied needs of the PLWHAs, thus the need for capacity building in areas such as effective care and support of those ailing with AIDS through effective home based care programs. CCC members expressed the desire to be used as a network that would co-ordinate and harmonize other groups and initiatives within their communities since their respective groups have a grass root influence and outreach within the community.

9. Knowledge of Children's Rights among OVC care givers and CCC members

CCC members and caregivers both expressed concern about their ignorance of the Rights of Children, thus their inability to protect or enforce them. A few were aware of the recently enacted Children's Act but not of the details that could enable them to address certain abuses of OVCs such as cases of child labour or situation where OVCs have to fend for daily survival of the household. They thus expressed desire to be trained on the Rights of Children to enable them be more effective in their protection.

## Budalangi, Busia

### **FGD respondents profile and attendance**

1. Female Youth 12-15 years old (among which half OVCs)  
10 respondents. Bunyala West. 18.02.05
2. Male Youth 12-15 years old (among which half OVCs)  
11 respondents. Bunyala West. 18.02.05
3. OVC boys and girls aged 10-13  
12 respondents. Khajula. 17.02.05
4. OVC boys and girls aged 14-17  
12 respondents, 6 boys, 6 girls. Single. Bunyala West. 19.02.05
5. OVC Care givers  
11 respondents. Mixed age and sex. Bunyala East.16.02.05
6. OVC Household heads, mothers/fathers  
12 respondents. Mixed age and sex. Bunyala East. 17.02.05
7. OVC Household heads, grand parents  
12 respondents. Mixed age and sex. Bunyala East 16.02.05
8. Community Care Coalition members  
Number respondents not provided. Mixed age and gender. Representatives of different OVC care groups (NGO, FBO, Church, CBO govt, etc)

### **SUMMARY OF FGDs BY TOPIC OF INTEREST**

1. Knowledge of HIV/AIDS among youths and OVCs

Many youths know what AIDS is and several were able to tell the difference between HIV and AIDS. Almost all OVC and youths were able to point out the signs and symptoms of HIV/AIDS. They did this quite spontaneously and accurately. When asked how one gets infected with HIV, most of them stated, "One gets infected through having sexual intercourse with HIV infected persons." Additionally, many youths and OVC were obviously aware of the ways in which people cannot contract HIV/AIDS. These OVC and youth know that it is possible for a healthy looking person to be HIV positive.

2. Perception of need for and knowledge of VCT among youths and OVCs

Although some think that people can only obtain VCT when they have money to pay for the test, a clear majority of these youths and OVC recognize the need of VCT and are aware that it is free. They know that it is a voluntary counseling and testing center and that they need to go there to get tested in order to know their HIV status. Youth and OVC are aware of the VCT sites in Budalangi Division. They were able to discuss the right time to visit the VCT for a test. Many gave valid answers such as, "One should visit VCT before getting married" and "Pregnant mothers must visit VCT and get tested to avoid passing the virus to their children." "People need to know their HIV status all the time and can get tested any time". The OVC and youths also showed that they know exactly what goes on at a VCT center.

3. Stigma and discrimination towards OVCs and PLWHAs among youths
4. Sexual activity among youths and perception of same among OVC household heads

This issue presented an interesting comparison. The reality of what the youth engage in is exactly the way household heads perceive it. It is true that just as the parents and grandparents point out, the youth begin having sexual intercourse too early and have multiple sexual partners. At the same time, because of poverty, young girls marry older men with long sexual histories, or are lured into prostitution. The youth confirms this when asked, "Yes, there are people of my age who have already had sexual intercourse, including participants of the FGD." Some communities have instituted restrictions to reduce sexual activity during community events.

5. Knowledge of OVCs' and PLWHAs' needs among OVC care givers

It was revealed through the FGD that the caregivers fully understand the needs of OVC and PLWHAs. According to the caregivers, these two groups share the same needs. OVC and PLWHAs all need food, shelter, clothes, and medical care. The only difference was the need for school fees and school uniforms for OVC, which other PLWHAs may not need. Among other needs for PLWHAs, "The community assists them in the form of clothes, food, and medication." Both groups need psychosocial care.

6. Adequacy of care and support to OVCs: Perception from OVCs, OVC care givers, and CCC members

The perception from OVC, OVC caregivers and CCC members about the adequacy of care and support among OVC is the same. All these three groups are of the opinion that the care and support among OVC, though given, is hardly adequate. Caregivers lament that they do not have adequate skills to effectively care for OVC. "We still do not know many things." They also need gloves and other medical equipment to help them handle those who are sick. They point out, "Give us gloves to protect ourselves as we care for the sick." Additionally, the OVC themselves feel that the care and support provided to them is still wanting. They need and want more in terms of provision of food, shelter, clothes, education, medication, and psychosocial support, which they complain is lacking. One foster parent told an OVC, "Go away, I did not tell your mother to die."

CCC members, too, revealed that though they really try to help these children, the great numbers of OVCs in the region overwhelms them. They admit that they feed them, but it is a challenge. These children have too many problems ranging from child rights abuse to psychological trauma, problems to do with the discipline of the OVCs. CCC members point out that "Grandparents do not teach manners to OVCs".

7. Adequacy of care and support to PLWHAs: Perception from OVC care givers and CCC members

Both the CCC members and OVC caregivers are of the opinion that what PLWHAs received in the form of care and support is far from adequate. OVC caregivers say that they need much more food, medicine, shelter and financial support to enable them to cope with the array of

their needs. CCC members too are aware of the many needs of the PLWHA but reveal they cannot cope without more funding and training. "If we can only be trained further, we would really help these people." They continually point out, "But we need funding." However, the caregivers feel that the CCC members who are among those who assist PLWHAs should do more than they are presently doing.

8. Knowledge and perception of CCC members about the HIV/AIDS response in their community and about their role in same

CCC members are aware of what they have to do to scale up the HIV/AIDS response. Already they are carrying out sensitization and awareness creation, campaigns, counseling and guiding OVC and PLWHAs and even providing nursing care. Chechemka, a local CBO is doing it already. The CCC members however feel that though they understand their role and are ready to play it, they are hardly equipped for the rigor and magnitude of the task ahead of them. Other people or groups must join in the fight.

9. Knowledge of Children's Rights among OVC care givers and CCC members

Knowledge of Children's Rights among OVC caregivers and CCC members showed a marked difference. While CCC members have fully grasped what is entailed when one speaks of children's rights, the caregivers knew of only mistreatment and rape as forms of child abuse. It was obvious that education about children's rights has to be targeted at caregivers.

Conclusions from the FGD facilitator:

The FGDs explicitly revealed that the message about HIV/AIDS regarding transmission and protection has been received even up to the grass roots and to the youth who are the "window of hope". The OVC and PLWHAs have needs that everyone in the community knows about. Interventions then, must be targeted at tackling these needs and empowering the infected and affected persons to be able to take better care of themselves. Members of the CCC have to work closely with OVC caregivers who best understand 'the real face of HIV/AIDS'. They have to help provide adequate medication and construct more VCT sites.

The results of the focus group discussions carried out for the different groups of the population in Budalangi mirror the real situation on the ground. If the problems and needs of the OVC and PLWHAs stated therein are tackled, and interventions tailored towards the same, it will be possible to scale up HIV/AIDS response. It will also mould a society that is self reliant and healthy.