# PERFORMANCE OF HEALTH STRATEGIES IN REDUCING HIV/AIDS PREVALENCE IN THE CATHOLIC DIOCESE OF HOMA BAY, KENYA

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A Research project submitted in partial fulfillment of the requirements for the Award of Master of Business Administration (Strategic Management) Degree of Kenyatta University

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## DECLARATION

This research project has never been presented to any other University for any award. It is therefore my original work

Sign:…… Date: ……

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This research project is presented for examination with my endorsement as the University Supervisor

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## DEDICATION

This research project is dedicated to the Rt. Rev. Philip A. Anyolo, bishop of the Catholic Diocese of Homa Bay whose generosity and love for education fueled my passion for the field of Strategic Management. It is also dedicated to all whose genuine prayers and good will fill our priestly service in the church with peace and progress.

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## OPERATIONAL DEFINITION OF TERMS

**Strategic Plan** The blueprint that details how an organization intends to attain specified and pre-designed objectives within stipulated timeline

**Strategy Implementation** A process through which a conceived corporate strategy is systematically transformed into expected outputs

**Organizational Strategy** Organizational strategy is an expression of how an organization needs to evolve over time to meet its objectives along with a detailed assessment of what needs to be done

**Strategy** The direction and scope of an organization over the long-term, which achieves advantage in a changing environment through configuration of resources and its competences with the aim of fulfilling the vision, goals and stakeholder expectations (Robinson & Scholes, 2007)

**Performance** Evidence-based change that is measurable by the use of pre-set indicators in an attempt to achieve organizational goals

**Health Strategies** Activities designed to reduce disease burden over a given period of time within the Catholic Diocese of Homa Bay

## ABBREVIATIONS & ACRONYMS

| | |
|---|---|
| **ART** | Anti-Retroviral Treatment/Therapy |
| **ARV** | Antiretroviral |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **CAFOD** | Catholic Agency for Overseas Development |
| **CDC** | Centre for Disease Control |
| **CDoHB** | Catholic Diocese of Homa Bay |
| **CIC** | *Codex Iuris Canonici* (The Code of Canon Law) |
| **CME** | Continuing Medical Education |
| **CORPs** | Community Owned Resource Persons |
| **EMU** | Efficiency Monitoring Unit |
| **FBOs** | Faith Based Organizations |
| **FGM** | Female Genital Mutilation |
| **HBC** | Home Based Care |
| **HIV** | Human Immune Virus |
| **IMAU** | Islamic Medical Association of Uganda |
| **ITNs** | Insecticide Treated Nets |

**KARP** Kenya Aids Response Program

**KRCHN** Kenya Registered Community Health Nurse

**NASCOP** National Aids and STI Control Program

**OIs** Opportunistic infections

**OVC** Orphan and Vulnerable Children

**PEPFAR** US President's Emergency Plan for AIDS Relief

**PLHIV** People Living with HIV

**PLWHAs** People Living with HIV/Aids

**PMTCT** Prevention of Mother to Child Transmission

**RNA** Ribonucleic Acid

**SCT** Social Cognitive Theory

**SPSS** Statistical Package for Social Sciences

**STC** Social Teaching of the Church

**TPB** Theory of Planned Behaviour

**TRA** Theory of Reasoned Action

**UNAIDS** United Nations program on HIV/AIDS

**URTISs** Urinary Tract Infections

**VCT** Voluntary Counseling and Testing

**W.H.O** World Health Organization

## ABSTRACT

HIV/AIDS prevalence within the two counties that constitute the Catholic Diocese of Homa Bay remains high despite numerous interventions and generous resource allocation both from the central and devolved governments as well as donor agencies. This study assessed the performance of health strategies in reducing Acquired Immune Deficiency Syndrome prevalence as enshrined in the 2012 – 2016 Strategic Plan of the Catholic Diocese of Homa Bay. The four strategies are; health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood. Relying on such theories as adult learning theory, social cognitive theory, theory of planned behavior and the theory of health seeking behaviour, this study investigated how application of various strategies yield results. Towards achieving this, the study purposely targeted the Catholic Diocese of Homa Bay to form a basis for objective generalization. The diocese has six deaneries with a total of 33 health facilities in whose purview the target population of 100 was constituted, whose views and opinions led to the study's generalizations. Cronbach's alpha reliability coefficient was employed to test internal consistency and thereby establish the reliability of the study instruments. Questionnaires were administered to collect data on performance indicators. The data was then processed and analyzed using descriptive and inferential statistical analyses, in which case, Pearson correlation coefficient and regression analysis were applied. Computer software, Statistical Package for Social Sciences (SPSS) version 20 was used to analyze the collected data. The analyzed data was presented in form of tables for ease of communication. The study's key findings in tandem with the study objectives were established. It emerged that, the correlation between health education awareness and success of reducing Human Immune Virus infections stood at .919 implying a strong positive association of 91.9 percent between health education awareness and success of reducing infections. It was also established that the correlation between health nutrition training and success of reducing new Human Immune Virus infections was at 0.75, implying a strong positive association of 75 percent between health nutrition training and strategic intervention in reducing prevalence. The study further revealed that the correlation between disease prevention practices and success of reducing Acquired Immune Deficiency Syndrome incidents was 0.64, implying a strong positive association of 64 percent between disease prevention practices and prevalence reduction. Regarding safe motherhood as a strategic initiative towards the reduction of new infections and mortality, it was found out that at 1 degrees of freedom, the computed F = 201.000 is greater than the critical F =.020. This implies that the overall regression model was significant. The study recommended key interventions towards mitigation from all sectors. Stakeholders with keen interest in reducing prevalence should help in improving prevention practices rather than curative ones. Safe motherhood should be a key pillar in reducing new Human Immune Virus infections in the Catholic Diocese of Homa Bay. The study opened a gap for further research exploring other strategies implemented to reduce Acquired Immune Deficiency Syndrome prevalence across dioceses and counties.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background of the Study

Organizational Strategy is an expression of how an organization needs to evolve over time to meet its objectives along with a detailed assessment of what needs to be done. Developing an organizational strategy first involves comparing the present state to the targeted state to define differences, and then stating what is required for the desired changes to take place; it also means the sum of the actions an organization intends to take to achieve long-term goals. Strategic plans take at least a year to complete, requiring involvement from all organizational levels (Kotter & Best, 2006).

Chandler (2002) points out that formal corporate strategy is a crucial strategic tool because it allows an organization to focus multiple resources on a single objective. Without a clear corporate strategy, organizations lose sight of their objectives and lack the drive and focus that a well-designed strategy provides. It provides management with a benchmark to measure an organization's success or failure. Nixon (2010) acknowledged the fact that a strategy may be good, but if its implementation is poor, the strategic objective for which it was intended may not be achieved. Implementing a plan, according to Pearce and Robinson (2007), is the process through which a set of agreed work philosophies is translated into functional and operational targets. Kotter and Best (2006) support this position when they state that implementation addresses the; who, where, when and how, and it is thus the tactic that drives the strategy of the organization.

Chandler (2002); noted that implementation of organizational plans involves activities that effectively put the plan to work. Strategy implementation may be categorised into two groups, structure and process. Structure explains the configuration of an organization showing the relationships that exists between its various parts, especially the different levels of implementation which could either be the corporate level, managerial level or the operational level. There are six major organizational structures necessary for the implementation of organizational plans. These include, functional, geographic, decentralised business units, matrix structure and the hybrid structure. The process element explains and includes leadership, culture, resources and other administrative procedures. The structure of the organization should be compatible with the chosen strategy if strategy implementation is to be successful. The concept and practice of implementing strategic plans has been embraced worldwide and across various sectors because of its perceived contribution to organizational effectiveness (Thompson & Strickland, 2007).

### 1.1.1 The Catholic Diocese of Homa Bay

A diocese is a portion of the people of God which is entrusted for pastoral care to a bishop (CIC, 1983). The Catholic Church in Kenya has 26 dioceses under the shepherd-ship of diocesan bishops, also called local ordinaries. Among the youngest of the Kenyan dioceses is the Catholic Diocese of Homa Bay.

The Catholic Diocese of Homa Bay (CDoHB) was curved from Kisii diocese in December 1993. It covers the two counties of Homa Bay and Migori of Southern Nyanza. Geographically it covers an area estimated to be about 7,778 sq. km with a population of 2 million. It borders Lake Victoria to the west and extends along the shore to Tanzania eastwards and borders Ngong',

Kisii diocese and the archdiocese of Kisumu. It has a rich cultural diversity encompassing the Luo, Abasuba, Kuria, Kisii, Luhya and the Maasai. The diocese has six deaneries namely; Asumbi, Mawego, Rapogi, Isebania, Mirogi and Tonga.

Table 1.1 below enumerates the deaneries in the Catholic Diocese of Homa Bay and their respective parishes.

***Table 1.1: Deaneries in the Catholic Diocese of Homa Bay and their respective parishes***

| Deanery | Parishes |
|---|---|
| 1. Asumbi | Asumbi, Rongo, Rodi, Homa Bay, Wandiji, Nyalieng'a |
| 2. Mawego | Mawego, Oriang, Oyugis, Raruowa, Kendu Bay |
| 3. Mirogi | Mirogi, Nyarongi, Ang'iya, Karungu |
| 4. Rapogi | Rapogi, Rakwaro, Ulanda, Osogo, Macalder |
| 5. Isebania | Isebania, Migori, Mabera, Kegonga, Ntimaru, Kehancha, Oruba |
| 6. Tonga | Tonga, Mfang'ano, Sindo, Mbita, Kakrigu, Nyagwethe |

**Source:** *Catholic Diocese of Homa Bay, 2016*

## 1.1.2 The Catholic Diocese of Homa Bay Plan on Health

The Catholic diocese of Homa Bay has two well established wings; the Pastoral and *Caritas* wing. The Bishop is the legal holder of the diocese with the diocesan secretariat doing the coordination and supervisory role for the pastoral and caritas (development) wings. Caritas Homa Bay is responsible for all the socio-economic programs run by the diocese. All these programs are tailored to address a number of challenges ranging from persistent droughts in parts of the diocese where food insecurity remains an enduring problem, communities within the diocese that practice Female Genital Mutilation (FGM) which robs the girl-child of a healthy and dignified existence, inadequate educational facilities in parts of the diocese as well as comparatively high levels of poverty and disease burden. Caritas Homa Bay reaches out to the

community with various responses to the foregoing challenges through six different programs; i.e. agriculture and environment, micro-enterprise development, justice and peace, education, water and sanitation, and health.

The choice of health for the purposes of the present study was because the disease burden within the catholic diocese of Homa Bay remains high in spite of curative and preventive strategies applied by various stakeholders. Frequent cholera outbreaks, alarmingly high malaria-related infant deaths and high TB infections are commonplace in the catholic diocese of Homa Bay. The two counties that form the catholic diocese of Homa Bay are among the top five worst affected by the HIV/AIDS pandemic. The top ten counties with highest prevalence account for about 65% of national HIV prevalence. These variations provide the need to develop geographically targeted interventions. The national HIV estimates, as shown in the table below, informs programmatic priority for Homa Bay and Migori counties both of which constitute the catholic diocese of Homa Bay.

***Table 1.2: Top 10 HIV prevalence by county***

| | **County** | **Adult HIV Prevalence (%)** |
|---|---|---|
| **1.** | Homa Bay | 25.7 |
| **2.** | Siaya | 23.7 |
| **3.** | Kisumu | 19.3 |
| **4.** | Migori | 14.7 |
| **5.** | Kisii | 8.0 |
| **6.** | Turkana | 7.6 |
| **7.** | Mombasa | 7.4 |
| **8.** | Nairobi | 6.8 |
| **9.** | Busia | 6.8 |
| **10.** | Nyamira | 6.4 |

*Source: Kenya HIV and AIDS Profile, NASCOP 2014*

### 1.1.3 Health Strategies

The Catholic diocese of Homa Bay has the following strategies embedded in her 2012-2016 strategic plan to respond to the need to reduce HIV/Aids prevalence; creating awareness on immunizations, Health education and nutritional training, treatment of minor conditions and referrals, involving men in care services, maternal and child care, promoting safe motherhood as well as scaling up interventions of cost effective treatment of such conditions as Malaria, TB, HIV&AIDS *(The Catholic Diocese of Homa Bay 2012-2016 Strategic Plan).*

Among the strategic activities that have specifically been designed to reduce the prevalence of HIV/AIDS are, awareness creation, health education and nutritional training, promoting safe motherhood, training on disease prevention practices, training CORPs, referrals for HIV testing, referral of HIV positive clients for care and treatment, couple counseling and testing, promoting formation of support groups, promoting existing VCT services, OVC support and training of HBC providers.

## 1.2 Statement of the Problem

The consistently high HIV/Aids prevalence rates in Homa Bay on the one hand, the massive resources – both human and financial invested in the fight against the epidemic with minimal result on the other; added to the reality of a high rate of new infections is not easy to understand. This is especially crucial if an assumption is to be made that the strategies are well implemented and all necessary resources readily available. Matching organization's activities to its environment and the organization's capabilities is vital to any successful implementation of strategic plans (Ndegwah, 2014). It is against the foregoing backdrop that the need to critique, in a way of evaluation, the performance of health strategies enshrined in the Strategic plan of the

catholic diocese of Homa Bay finds relevance. In a baseline survey carried out by CAFOD on 'reducing vulnerability to HIV and AIDS through capacity building in agro-enterprise development in Homa Bay district, it was found out that awareness and knowledge on reduction of transmission of HIV was generally high at 98.1%. This high disease burden negatively impacts on economic activities, as young people in their prime age spend most of their waking hours in hospitals. A high disease burden does not only affect the socio-economic power; it also deprives other equally important sectors a much needed financial support as it enjoys a generous financial budget both from the government as well as donor agencies. While implementation of strategies in any setting has its own hurdles, the success of every institution depends on the quality and commitment of its human resources to implement laid strategies (Bitange, Kipchumba, & Magutu, 2010). The present study thus endeavoured to identify any such hurdles that may peculiarly impede successful implementation of strategies on health in a faith-based organization.

Research has shown that availability of resources does not always lead to successful implementation of laid down strategies. This study was therefore based on a further assumption that the near insignificant reduction of the HIV/AIDS prevalence might be due to other reasons outside implementation. While a number of research studies on performance of strategies and strategic plan implementation have been carried out in various organisations (Wambui, 2010), none had been undertaken to establish performance of health strategies on a religious organization. The present research sought to focus on individual strategies being implemented by the catholic diocese of Homa Bay to enable for an evaluation of their efficacy and consequent

relevance towards the need to cause a reduction in HIV/AIDS prevalence within the two counties under the jurisdiction of the diocese.

### 1.3 Research Objectives

The study was guided by the following objectives.

#### 1.3.1 General Objective

The general objective of the study was to evaluate the performance of HIV/Aids strategies in the Catholic Diocese of Homa Bay

#### 1.3.2 Specific Objectives

The study set out to achieve the following specific objectives:

i. To assess the relationship between health education awareness and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay
ii. To determine the relationship between health nutrition training and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay
iii. To examine the relationship between disease prevention practices and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay
iv. To assess the relationship between promotion of safe motherhood and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay.

### 1.4 Hypotheses of the Study

In order to draw scientific conclusions and present informed recommendations based on its findings, the study was based on the following hypotheses;

$H_{o1}$ Health education awareness does not affect HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay

$H_{o2}$ Nutritional training services do not affect HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay

$H_{o3}$ HIV/Aids prevention practices do not affect HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay?

$H_{o4}$ Promotion of safe motherhood does not affect HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay

### 1.5 Significance of the Study

It was anticipated that the study would be of crucial significance to all information users who include the government leaders, government agencies, NGOs and church based organizations. Other dioceses and funding partners are also set to benefit from the findings of this study. The diocesan secretariat of the Catholic Diocese of Homa Bay that supervises the implementation of the 2012-2016 Strategic Plan would particularly find this study useful. It would also provide invaluable information to donor agencies that support the health department of the CDoHB. The strategy executors would benefit from popular views and opinions on their commitment and approaches to implementing the strategies in place to help fight the spread of HIV/AIDS pandemic, while the external government agencies such as Efficiency Monitoring Unit (EMU), Vision 2030 Secretariat and auditors would easily access pre-requisite information for respective decision making.

### 1.6 Scope of the Study

The study was limited to the 'Performance of health strategies in reducing the prevalence of HIV/AIDS in the Catholic Diocese of Homa Bay, Kenya". The choice of Homa Bay diocese was reliably informed by the national statistics on prevalence rates within the country, which shows

Homa Bay and Migori counties contributing the highest percentage to new infections and people living with the HIV/Aids virus.

The study areas were the health institutions within the deaneries of the Catholic Diocese of Homa Bay namely; Asumbi, Mawego, Rapogi, Mirogi, Isebania and Tonga. Specific recommendations were pegged on strategies and how the work within the specific deaneries aiming to fulfill the implementation of organizational plan on health in the Catholic Diocese of Homa Bay realized the laid down objectives.

### 1.7 Limitations of the Study

The fact that this study relied for its findings on medical personnel involved in the work of implementation exposed it to the risk of defensive responses to portray their work as efficient. Efforts were however made to peruse through the medical records to corroborate the respondents' statements and the facts and figures within the facility databases.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

A guided review of literature as contained in this section was done for the purpose of understanding the study area and putting the research questions in their right scope and context. The key areas covered include conceptual framework, theoretical reviews, empirical literature review and summary of literature review and research gaps to be filled by the study.

## 2.2 Theoretical Review

For the purposes of this study, four theories on implementation of health based strategies were reviewed to form its conceptual basis.

### 2.2.1 Adult Learning Theory

Many dissemination and implementation strategies are underpinned in part by adult learning theory which proposes that personal motivation is critical to achieving behaviour change. An underlying assumption of learning theory is that practitioners are rational information seekers and decision makers and that once the information has been disseminated, behaviour change will simply follow. However, evidence clearly shows that simple distribution of information is insufficient for sustained behaviour change (Bero et al., 1998; Bywood et al., 2008a; Grimshaw et al., 2004; Oxman et al., 1995). Adult learning theory suggests that adults have specific needs that should be met in order to enhance their learning capacity. The study found in this theory an evidence-based approach to health education awareness initiatives carried out by health facilities within the catholic diocese of Homa Bay. The programmatic outreach exercises disseminate crucial information about the reality of the HIV/Aids pandemic through the use of audio-visuals and interactive sessions during which superstitious myths about the disease are disabused. The

accurate information received then serves as a motivation for behaviour change and in many cases courage to visit VCT centers. This theory is key in attempts to reduce and possibly eliminate stigmatization that works against all efforts to reduce HIV/AIDS prevalence.

Evidence from the various action researches reveal that adult learning theory was most frequently integrated in continuing medical education (CME) strategies (Fallowfield et al., 2002; Fallow field et al., 2003; Onion & Bartzokas, 1998; Pill et al., 1998; Suggs et al., 1998; White et al., 2004; Young et al., 1998). CME aims to increase knowledge and understanding about research and innovations and requires more active participation compared to simple distribution of materials. It relies on such participatory initiatives such as formation of support groups and organization of focus group discussions with a special emphasis on learning through discovery. Adult learning theory therefore offers within its postulates the most practical way of causing awareness, not only of the reality of HIV/AIDS, but also of its nature, epidemiology, prevention and management. It is on this theory that the first objective of this study is anchored, providing a lens through which the researcher can credibly appraise gains and progress, as well as recognize challenges.

### 2.2.2 Social Cognitive Theory

Social Cognitive Theory (SCT) posits that whether a person will change a health behaviour depends on self-efficacy, goals, and outcome expectancies. If individuals have a high level of confidence, they can change even when they are faced with many obstacles. If they are not confident about the behaviour in question, they will be less motivated to act or to persevere through obstacles or challenges as they arise. This theory has variously been lauded for its ability

to question deeply rooted cultural orientations as it at the same time helps disabuse the many misleading myths that initially shrouded the reality of HIV/AIDS in mystery. One reason for this is perhaps its appeal to human intelligence. It also offers empirical evidence of observable change before and after a proposed practice. Furthermore, it has proven efficacy on suggesting better nutritional choices and healthy eating habits. The present study found in this theory a means of proposing to PLWHAs dietary regimes that would be consistent with their condition. Important elements of SCT include reciprocal determinism, behavioural capability, expectations, and self-efficacy, observational learning, and reinforcements (Bandura, 1986). Against the backdrop of this theory exist numerous programmatic approaches by various donor agencies that implement integrated food security programs to vulnerable communities, where vulnerability almost always also mean the HIV/AIDS condition and its attendant effects. This theory, as already mentioned, informs the quest to correct the many erroneous perceptions and attitudes that accompanied the very first cases of HIV/AIDS which militated against any genuine attempts to mitigate its effects. The social cognitive theory lends credence to the second objective of this study which seeks to investigate the efficacy of health nutrition training as a strategic activity towards the need to reduce disease burden within the catholic diocese of Homa Bay with special emphasis on HIV/AIDS prevalence.

### 2.2.3 Theory of Planned Behaviour (TPB)

Adapted from the Theory of Reasoned Action, the theory of Planned Behaviour (TPB) places emphasis on the concept of 'behavioral intention', which is predicted by an individual's outcome expectancies, their attitude toward the behaviour and their normative beliefs as to whether others (influential or respected peers) think they should engage in the behaviour (Ajzen, 1991). This is

closely related to the concept of self-efficacy in social cognitive theory. TPB includes measures of control beliefs and perceived behavioral control which is thought to influence both intention and behaviour.

The TPB, which is the most extensively studied motivational theory, proposes that the proximal determinant of behaviour is the *intention* to act, which is influenced by the attitude towards the behaviour, subjective norms, and the perception of control over the behaviour (Hardeman et al., 2002). It has been used most frequently for predicting behaviour change. With information, persuasion, increasing skills, goal setting, rehearsal of skills, modeling, and planning/ implementing and social support as its most important components, TPB is used most often for identifying cognitive targets for change. An HIV/AIDS prevention practice which was the third strategy under investigation was anchored on this theory, whose success would then be gauged on measurable behaviour change. This theory it is, that informs all conjectures on prevention, ranging from blood safety through fidelity to voluntary testing and counseling (VCT) among other time honored prevention strategies. Separation of facts from falsehoods and distinction between sheer superstitions and realities about HIV/AIDS largely rely on this theory of planned behaviour (TPB). Prevention remains a more noble choice in comparison to prophylaxis which attracts higher financial obligations and may not be sustainable to many individuals due to their humble economic ability.

### 2.2.4 Theory of Health-Seeking Behaviour

Health-seeking behaviour theory postulates that an individual's deeds to the promotion of maximum well-being, recovery and rehabilitation could happen with or without health concerns and within a range of potential to real health concerns (Poortaghi et. al, 2015). Employing a

rigorous evolutionary concept analysis approach, the concept of health seeking behaviour was examined for its implications, use and significance in the discipline of nursing between the years 2000 and 2012. The definition of attributes, antecedents, and consequences of health seeking behaviour was performed through concept analysis. Core attributes (interactional, processing, intellectual, active, decision-making based and measurable). The antecedents of the concept were categorized as social, cultural, economic, disease pattern and issues related to health services. Health-seeking behaviour resulted in health promotion and disease risk reduction. In addition, it led to predicting the future probable burden of the disease, facilitation of the health status, early diagnosis, complete and effective treatment and complication control.

Safe motherhood with its attendant components such as antenatal care and safe delivery are requisite elements of health-seeking behaviour. The mandatory HIV testing of pregnant mothers helps medical personnel save infants whose mothers are found to be positive. This, impacts positively on reducing HIV/AIDS prevalence. HIV negative mothers are reminded of the need to carry out exclusive breastfeeding, at least for the first six months after delivery while children born with the virus are immediately enrolled into Anti-retroviral treatment (ART) programs. This theory stands out as unique because it is more an initiative of the beneficiary, who in pursuit of good health should find evidence-based practices that meet their needs and consequently works towards the achievement of desired results. It is on the foregoing theory that the researcher interrogated the fourth objective of this study.

## 2.3 Empirical Literature Review

African governments - through national Aids control programs - international development agencies, private voluntary organizations, and other nongovernmental groups across Africa have over the years devoted resources, time, and energy to developing low-cost interventions to arrest the spread of HIV and Aids (National Research Council, 1996). A number of studies carried out on various strategies implemented to help curtail the spread of HIV/Aids pandemic have presented a wide range of findings, determined by a host of factors ranging from the nature of the implementing agency, cultural orientation of the target populations and available resources among others. Some of the studies conducted on the health strategies under implementation by the CDoHB are highlighted hereunder;

### 2.3.1 Health education awareness and HIV/Aids prevalence reduction

(Nana Nimo, Appiah-Agyekum & Robert Henry Suapim, 2013); in their study, 'Knowledge and awareness of HIV/AIDS among high school girls in Ghana' report that 73.3% respondents interviewed agreed that knowing their status could help prevent infection. However, when follow up questions were asked on how many had taken HIV/AIDS tests recently or knew their status, as much as 77% of interviewees responded in the negative. The reality that only 13% had taken the test in recent times even though they knew that knowing their HIV status was key, is a clear pointer to the evident disconnect between awareness and prevalence. The study further reveals that even of the remaining 10% who had taken the test before, none was sure of their status after subsequent exposures.

Moswane (2013); on her findings in a study whose aim was to investigate the role of the churches in the prevention of HIV infections among young adults in the Polokwane municipality

of the Limpopo province, revealed that some churches in Polokwane played a significant role in HIV prevention among young adults. This, she says, was because churches were initially seen as judgmental, viewing HIV/Aids victims as sinners. This, she avers, exacerbated the stigma and consequent spread of the pandemic (Moswane, 2013). She strongly recommends that the Church should take up a key role in partnering with other agencies to reach out with compassion to the infected and the affected. HIV/AIDS education awareness is therefore ideally best carried out by faith-based organizations whose direct involvement at once reverses key challenges to efficacious awareness creation. Green (2001) remains emphatic that FBOs remain a great untapped potential in the global fight against AIDS. He strongly suggests that the newly initiated FBO programs should be carefully monitored and evaluated, so that valuable lessons can be noted for replication in other areas.

Moswane (2013) even goes as far as relating the apparent success of Social Learning Theory in causing behaviour change to the source of information, observing that since church leaders who are seen both as having knowledge on the topic and being accessible and trustworthy sources are involved, significant attitude change was evident.

### 2.3.2 Health nutrition training and HIV/Aids prevalence reduction

Oluduro (2010), in his study, 'The Role of Religious Leaders in Curbing the Spread of HIV/AIDS in Nigeria' asserts that religious leaders have a very key role in the fight against the spread of Aids. 'Their strengths and credibility, and their closeness to the communities afford them the chance to make a real difference in halting the spread of HIV/AIDS. Therefore, any messages on HIV/AIDS imparted by religious leaders are important in changing the attitudes and the behavioural patterns of their followers about the epidemic. According to Jansen (2009) as

quoted by Moswane (2013), conditions of poverty facilitate HIV transmission partly because the body's defense mechanisms are already run down through, *inter alia,* malnutrition and vitamin and trace element deficiency. Maintaining a healthy way of living is thus, in itself, a substantial step in the direction to preventing HIV infections. Concluding their study 'Nutritional Status of Adults Living with HIV/Aids at the University of Gondar Referral Hospital, Northwest Ethiopia', (Belaynew Wasiel, Yigzaw Kebede & Anwar Yibrie, 2010) observed that the prevalence of malnutrition was very high among PLHIV. They noted that weight loss was a major problem in HIV/AIDS patients. Opportunistic infections (OIs) were common with Tuberculosis being the commonest. Better income, longer duration on ART, improved clinical condition from the time of diagnosis, and absence of eating problem were positively associated with good nutritional status. Against the foregoing background, nutritional training has always remained a key strategy in any credible attempt to reduce HIV/AIDS mortality. It is especially important to underscore the fact that religious organizations find a place more readily in the grassroots, relating to individuals within the details of their everyday lives. There is indeed no known organization that is at once integrated into a people's culture, norms, attitudes and social activities as the church. Health nutrition training is therefore best offered by the faith-based health facilities. Growing trends of food supplements processed as tablets and the promotion of herbal medicine targeting PLHIV attests to the importance of food nutrients to a system attacked by HIV. It is in fact a truism to observe that the first medicine for HIV/AIDS is balanced diet. Health nutrition training therefore stands out as a strategic intervention towards reduction of both prevalence as well as mortality.

### 2.3.3 Disease prevention practices and HIV/Aids prevalence reduction

A study carried out by Green (2001) in Uganda revealed that involvement of faith-based organizations impacted significant behaviour change. He observes that apart from delay of sexual debut, about 7% of women and 10% of men aged 15-50 reported that they have adopted complete and sustained abstinence for HIV protection in the previous year by the mid-1990s. This rose to over 20% in 2000. A study on Factors Influencing Behaviour Change for the Prevention of the Spread of HIV/Aids among Students in Githunguri Division, Githunguri District, Kiambu (Ndegwa et al., 2012) found that slightly more females (60.5 %) than males (58.9%) thought they would be regarded as cowards when they abstained from sex. It can also be seen that more of those that had never had sex (59.9%) thought they were regarded in this manner. If the findings of the foregoing study are anything to go by, the role of peer pressure and its consequent influence on the behaviour of young people should be cogently factored in the efforts to curb new infections.

There is some evidence from impact studies, such as a UNAIDS "Best Practices" study of the Islamic Medical Association of Uganda (IMAU) which shows that AIDS prevention activities carried out through religious leaders has had significant direct impact on particular populations targeted. Green (2001) concludes that FBOs are best positioned of any group to promote fidelity and abstinence. This, he says, is their *comparative advantage*. It is worth noting that all health facilities implementing the strategies tailored to reduce the HIV/Aids prevalence are managed by the church as guided by her social teachings (STC). The target beneficiaries however are not strictly catholic faithful, but rather the entire human population; creed, gender, ethnicity and social class notwithstanding. Disease prevention practices in our context are all encompassing.

This is especially because HIV/AIDS strictly speaking is not a disease, but rather, a condition that renders the immune system weak and vulnerable. Any other pathogenic infection at once becomes potentially fatal, as the body's defense system is rendered weak. It then becomes crucial to employ disease prevention practices for all possible infections ranging from commonly treated tropical infections to more complicated illnesses like Tuberculosis.

### 2.3.4 Promotion of safe motherhood and HIV/Aids prevalence reduction

Mwaura (2009) in his study 'HIV/Aids Prevention Strategies in Kenya: A Critical Review', observes that data evidence reveals the reality that women continue to be disproportionately infected by HIV/AIDS in Kenya. He goes on to explain that in any given heterosexual encounter, women are more susceptible than men to infection with HIV. This, he asserts is mainly due to predisposing biological factors. Scaccabarrozzi (2008) as quoted by Mwaura (2009) concurs that women are more vulnerable to infection because a greater area of their mucous membrane is exposed during sex than in men; a greater quantity of fluids is transferred from men to women; there exists a higher viral content in male sexual fluids; and that the micro-tears that may occur in vaginal (or rectal) tissue due to sexual penetration expose women to infection. He goes ahead to propose this disparity as the underlying reason for the higher HIV/AIDS risk women and girls face. Any intervention focussing on women is therefore always poised to deliver better results with regard to prevalence reduction. Mwaura (2009) further proposes a number of strategies with proven success in neighboring Uganda, and which he recognizes as successful in Kenya as well. These include; preventing sexual transmission, preventing blood-borne transmission, blood safety (including routine screening of donated blood), preventing mother-to-child transmission and

social strategies and supportive policies. While he steers clear of any role that could be played by FBOs, his optimism on the efficacy of various strategies is obvious.

Promotion of safe motherhood therefore stands out as a dependable strategy in the quest to reduce HIV/AIDS prevalence. Vertical transmission, perhaps the most compelling evidence of the significance of viral load and transmission risk has been directly linked to MTCT of HIV/AIDS (Stefano, et al. 2005). They further observe that maternal viral load, as quantified by RNA polymerase chain reaction, is associated with increased risk in each mode of vertical transmission (Stefano, et al. 2005). Moswane (2013) accurately observes that the need to stem mother-to-child-transmission (MTCT) is an indispensable component towards significant prevalence reduction. 'MTCT', he avers, 'can occur during pregnancy, delivery, or breastfeeding. Thus, it is important that HIV-positive women be given antiretroviral (a regimen at the time of delivery) in addition to a one-week postpartum regimen for both the woman and her new-born. Access to VCT and adequate infrastructure to procure and administer ARV drugs cannot be over-emphasised for intervention purposes.' Promotion of safe motherhood activities includes assuring safety from Malaria, Cholera, Typhoid, Pneumonia and any other infections that are routinely attended to in the health facilities.

### 2.4 Summary of Literature Review and Research gaps

General literature suggests that implementation could be a major determinant of the organizational performance (Hitt et al., 2006). In the eventuality of two firms seeking to achieve the same organizational plan, the resultant performance is likely to be different. This might be explained once again in terms of strategies and their uniqueness resulting from their distinctive

use and development over time. Although resources might be the same, the resultant objective will anyway differ in terms of performance and eventually in terms of quality. A strategy, thus, produces different performance according to the plans of the organizations that are determined by its unique use of resources and capabilities. The nature of the organization also contributes greatly to the success of their implementation. This is often occasioned by such paradigms as McKinsey 7-S Model that recognizes seven factors critical for effective strategy execution as strategy, structure, systems, staff, skills, style and shared values which is synonymous to culture (Makena, 2014). These unique strategies; that is, health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood have hardly been exhaustively investigated and documented by any research for comprehensive analysis and dissemination.

Green (2001) in his widely quoted study '*The Impact of Religious Organizations in Promoting HIV/AIDS prevention'* focussed on behaviour change' occasioned by awareness creation by religious leaders in Kenya, Uganda, Senegal and Jamaica. His study neither discusses health strategy implementation within the framework of religious structures in a programmatic fashion nor does it seek to measure the possible extent or degree of causal relationship between any strategic activity and HIV/AIDS prevalence reduction. Moswane (2013) who specifically investigates the role of the churches in the prevention of HIV/Aids infection among the youth does not only fail to discuss the churches role in reducing prevalence among adults and the children, but also carries out her research in Polokwane municipality in Limpopo province, a far removed environment with a purely different culture. Oluduro (2010) focuses on the role of religious leaders rather than religious institution in curbing the spread of HIV/Aids in Nigeria.

Mwaura (2009) who studied HIV/Aids Prevention Strategies in Kenya, bases his entire investigation on the national government and international agencies such as the Global HIV/Aids working group, PEPFAR, UNAIDS among others. He hardly even alludes to the obvious role of faith-based organizations in HIV/Aids prevention. There is thus as yet no known study targeting the achievement of a Kenyan religious institution such as a catholic diocese on strategies to reduce the prevalence of HIV/AIDS. Researchers have studied the factors influencing the implementation of strategic plans in Counties (Kirui, 2011), Schools (Ndegwah, 2014), Universities (Makena, 2014), but none has focussed on performance of health strategies in reducing HIV/Aids prevalence in a religious organization. Furthermore, the fact that various strategies have effectively helped to bring down HIV/Aids prevalence rates elsewhere intensifies the need to investigate their performance in a diocese. The present study investigated the performance of health strategies in reducing HIV/Aids prevalence in the Catholic Diocese of Homa Bay.

## 2.5 Conceptual Framework

The study's thematic intent was based on preposition by Hill and Jones (2010) that strategy implementation involves the use of organizational design to pursue a business model successfully. Fig 2.1 below illustrates the study's conceptual framework.

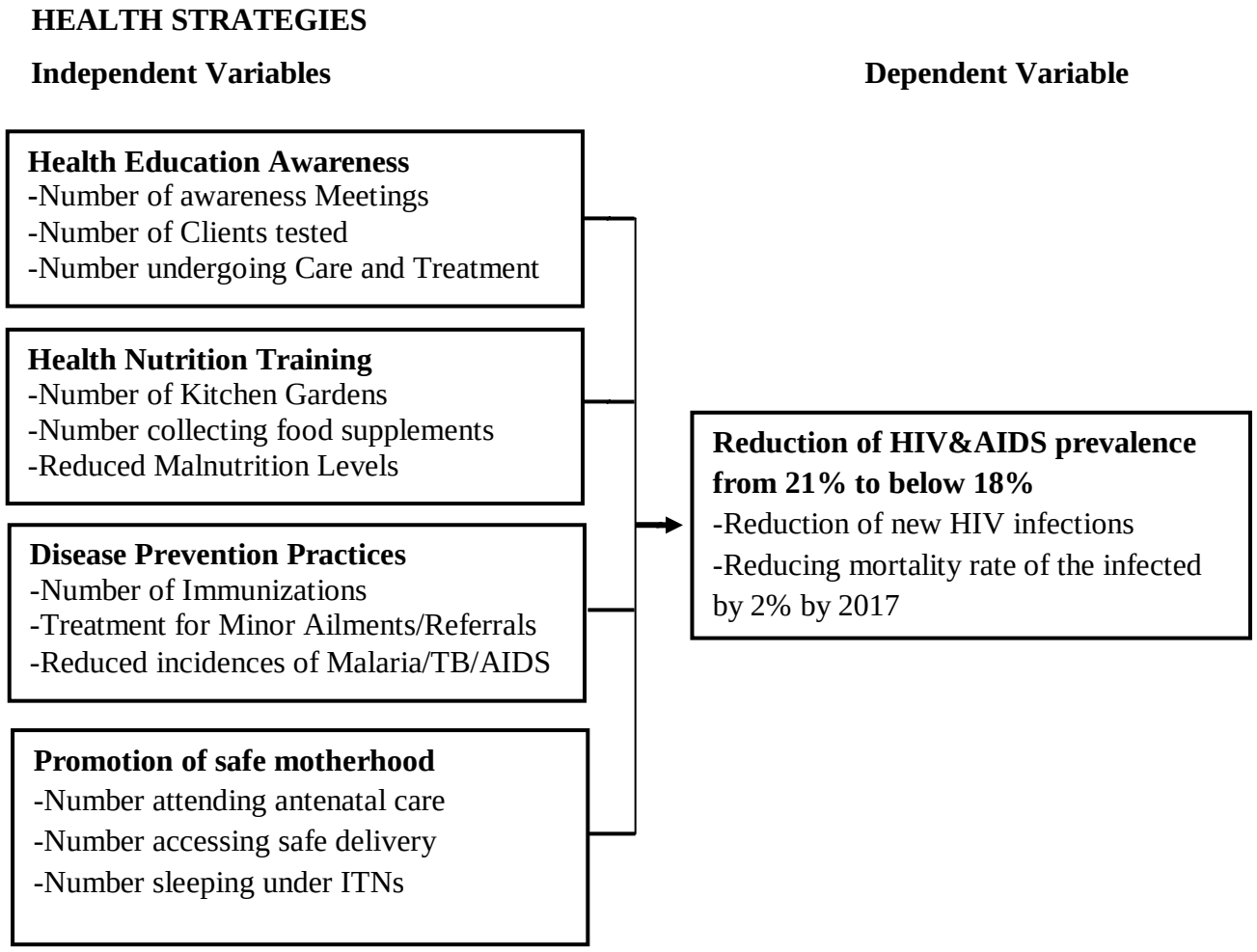


Fig. 2-1: Relationship between dependent and independent variables
**Source:** Adopted from Hill and Jones (2010)

As illustrated in Fig. 2.1 above, reduction of HIV/Aids prevalence depends on the effective implementation of the four independent strategies; that is, Health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood. It is important to note too that each of these stretegies are further broken into specific, measurable, attainable, realistic and time based (SMART) deliverables which then serve as indicators of evaluating goal attainment. Under health education awareness as a strategy for instance, the number of awareness meetings, the number of clients who volunteer to know their status and the number who having discovered that they are infected, begin treatment and care serve to deliver the ultimate objective of this strategy which is twofold, reduction of new infections as well as reduction of mortality rate of those already infected. This is true for the other three strategies as well. The overal impact of the four independent variables (Health strategies) on the dependent vaiable (HIV/Aids Prevalence reduction) is tabulated in Table 4.33 which gives a summary of all the study variables.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter introduced the research methodology that was used in meeting the pre-set study objectives. In particular, it explains the research design, target population, research instruments, research validity and reliability, data analysis and ethical considerations.

## 3.2 Research Design

Research design seeks to provide answers to research questions and control variance. This study adopted both qualitative and quantitative research design. Quantitative research according to Yin (2003), is structured to examine a number of logical sub-units or units of analysis within organizations. Morris and Wood (1991) acknowledge the importance of descriptive design especially when the intent is aimed at gaining broader understanding of the context of the research and processes being enacted. They argue that the design has considerable ability to generate answers to the questions of 'why?' and when? 'What?' and 'how?' Quantitative methods of data analysis can be of great value to the researcher who is attempting to draw meaningful results from a large body of qualitative data. The main beneficial aspect is that it provides the means to separate out the large number of confounding factors that often obscure the main qualitative findings. This study therefore relied on qualitative data whose ultimate meaning was then extracted from quantitative analysis.

### 3.3 Target Population

The study carried out a survey on all the administrators and nurses in all the 33 diocesan health facilities. The use of a census was most appropriate because while the administrators are the custodians of all records and statistics as well as training manuals and disease surveillance tools, the nurses were best placed to respond to more personalized aspects of medical interventions since they provide home-based care (HBC) to the patients and interact with them on a daily basis. Furthermore, nearly all the nurses interact with different categories of patients across the two counties that constitute the diocese.

Table 3.1 below illustrates the target population that was comprised in the study.

***Table 3.1: Target Population***

| **Deanery** | **Parish** | **Health Facilities** | **Nurses** | **Target Admins** | **Target Nurses** | **Target Pop** |
|---|---|---|---|---|---|---|
| Asumbi | Asumbi | 01 | 03 | 01 | 03 | 04 |
| | Homa Bay | 02 | 06 | 02 | 06 | 08 |
| | Rodi | 01 | 02 | 01 | 02 | 03 |
| Mirogi | Mirogi | 02 | 03 | 02 | 03 | 05 |
| | Nyarongi | 01 | 02 | 01 | 02 | 03 |
| | Karungu | 02 | 05 | 02 | 05 | 07 |
| | Ang'iya | 02 | 02 | 02 | 02 | 04 |
| Isebania | Isebania | 01 | 02 | 01 | 02 | 03 |
| | Migori | 01 | 05 | 01 | 05 | 06 |
| | Mabera | 01 | 02 | 01 | 02 | 03 |
| | Kegonga | 01 | 02 | 01 | 02 | 03 |
| | Kehancha | 01 | 03 | 01 | 03 | 04 |
| | Oruba | 01 | 02 | 01 | 02 | 03 |
| Mawego | Mawego | 01 | 02 | 01 | 02 | 03 |
| | Oriang | 01 | 03 | 01 | 03 | 04 |
| | Oyugis | 01 | 02 | 01 | 02 | 03 |
| | Raruowa | 02 | 02 | 02 | 02 | 04 |
| Tonga | Tonga | 01 | 03 | 01 | 03 | 04 |
| | Mfang'ano | 01 | 02 | 01 | 02 | 03 |
| | Mbita | 01 | 02 | 01 | 02 | 03 |
| | Nyagwethe | 01 | 02 | 01 | 02 | 03 |
| Rapogi | Rapogi | 02 | 02 | 02 | 02 | 04 |
| | Macalder | 01 | 02 | 01 | 02 | 03 |
| | Rakwaro | 02 | 02 | 02 | 02 | 04 |
| | Ulanda | 01 | 02 | 01 | 02 | 03 |
| | Osogo | 01 | 02 | 01 | 02 | 03 |
| **TOTAL** | | **33** | **67** | **33** | **67** | **100** |

***Source:*** *Catholic Diocese of Homa Bay, 2016*

### 3.4 Data Collection Instruments

Primary data was collected using questionnaires that had mostly closed-ended questions. This is because structured and guided questions yield uniformity of results and easy analysis. A few open ended questions were however included since the subject of study (HIV/AIDS) generates responses that are sensitive, emotive and also personalized, which were equally crucial for the objectivity of the study. Secondary data was obtained through desk reviews of documented sources. Secondary data formed the basis for comparison with findings as a building block to answering research questions.

### 3.5 Data Collection Procedure

The researcher together with four research assistants physically met each of the 33 hospital administrators and 67 nurses within the diocese and administered the questionnaire. This was crucial since the researcher would conduct in-depth interviews which are optimal for collecting data, particularly when sensitive topics such as HIV/Aids are being explored. Duly filled questionnaires were then used for appropriate analysis.

### 3.6 Data Analysis

When used along with quantitative methods, qualitative research can help us to interpret and better understand the complex reality of a given situation and the implications of quantitative data. The researcher used the qualitative data to describe variation as well as to describe and explain relationships between the variables. According to Berelson (1952), content analysis is a research technique for the objective, systematic, and quantitative description of manifest content of communications. Inferential analysis used Pearson correlation coefficient and regression analysis. Descriptive statistics involved the use of percentages and mean scores to determine

varying degrees of response-concentration. These statistics were generated with aid of the computer software, Statistical Package for Social Sciences (SPSS) Version 20.0. The $R^2$ value of the variation in the performance of health strategies was explained by the variation in the independent variables jointly.

The regression equation of the form of

$Y=\beta_0+ \beta_1X_1+ \beta_2X_2 +\beta_3X_3+ \beta_4X_4 + E$

Where:

Y= Reduction of HIV/Aids prevalence

$\beta_0$= is the constant term

$X_1$=Health education awareness

$X_2$=Health nutrition training

$X_3$= Disease prevention practices

$X_4$= Promotion of safe motherhood

Was estimated.

E= the error term captures all relevant variables not included in the model because they are not observed in the data set. The error term in the equation was used for inferential analysis. Pearson's correlation coefficient when applied to a sample is commonly represented by the letter *r* and may be referred to as the sample correlation coefficient or the sample Pearson correlation coefficient. We can obtain a formula for *r* by substituting estimates of the co-variances and variances based on a sample into the formula above. So if we have one dataset $\{x_1...x_n\}$ containing *n* values and another dataset $\{y_1...y_n\}$ containing an n value; then the formula for r is;

$$r = r_{xy} = \frac{\sum_{i=1}^{n}(x_i - \bar{x})(y_i - \bar{y})}{\sqrt{\sum_{i=1}^{n}(x_i - \bar{x})^2}\sqrt{\sum_{i=1}^{n}(y_i - \bar{y})^2}}$$

Where: $n, x_i, y_i$ are defined as above

$\bar{x} = \frac{1}{n}\sum_{i=1}^{n} x_i$ (This is the sample mean: the term for y is similar)

### 3.7 Research instruments

#### 3.7.1 Instrument Validity

Dornyei (2003) argues that research instruments are measurement devices that must possess adequate reliability. A valid instrument measures what it claims to measure. Validity is determined by presence or absence of systematic error in data. This researcher relied on expert opinion of the supervisor to ensure that content and format of the questionnaires were appropriate.

#### 3.7.2 Instrument Reliability

A reliable instrument is one that is accurate, stable, consistent, dependable and predictable. Variables derived from test instruments are declared to be reliable only when they provide stable and reliable responses over a repeated administration of the test. The researcher used Cronbach's alpha reliability coefficient which normally ranges between 0 and 1. According to Gliem (2003) the closer Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in five-point Likert scale ranging from 1(strongly disagree) to 5 (strongly agree). Although the standards for what makes a "good" $\alpha$ coefficient are entirely arbitrary and depend on one's theoretical knowledge of the scale in question, many methodologists recommend a minimum $\alpha$ coefficient between 0.65 and 0.8 (or higher in many cases); $\alpha$ coefficients that are less than 0.5 are usually unacceptable, especially for scales purporting to be uni-dimensional. The researcher

carried out a pilot study to ascertain the reliability of the tool to be used for data collection to ascertain its ability to measure the study indicators

#### 3.7.2.1 Piloting and computation of Reliability index

Piloting was undertaken using 10 percent of the target population. The purpose of piloting was to establish the reliability of the instruments. The pilot data was entered into SPSS software version 20 and a database was developed. Table 3.2 below shows the processing summary of computing the reliability index.

**Table 3.2: Case Processing Summary of computing Cronbach's Alpha Index**

| Case Processing Summary | | | |
|---|---|---|---|
| | | N | % |
| Cases | Valid | 82 | 98.8 |
| | Excluded[a] | 1 | 1.2 |
| | Total | 83 | 100.0 |
| a. Listwise deletion based on all variables in the procedure. | | | |

**Source:** Research Data (2016)

#### 3.7.2.2 Reliability Index

Table 3.3 below shows the computed reliability index.

**Table 3.3: The Cronbach's Alpha Index**

| Reliability Statistics | | |
|---|---|---|
| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
| .81 | .10 | 102 |

**Source:** Research Data (2016)

From table 3.3 above, the Cronbach's Alpha index was computed and established at 0.81. This reliability index established that the study instruments reliably and consistently measured what they purported to measure. The questionnaire tool returned a highly acceptable score since Cronbach's alpha coefficient of over 0.7 qualifies a tool as reliable and valid (Nachmias & Nachmias, 2006; Newman, 2000; Lewis, 2003; Sekaran, 2006). The questionnaire was therefore used as the data collection tool for this strategy performance study. The pilot study database was developed into a full database upon which the study findings were analyzed. Descriptive statistics such as tabulations, frequencies, percentages were used to summarize, describe, analyze, and present the statistical information of this study. Correlation and regression analysis were used to establish the strength and causality of the study variable relationships. Analysis of the variance (ANOVA) was used to test the study hypotheses. Results extracted by content analysis from the qualitative data were then presented.

### 3.8 Data Presentation

The analyzed data was presented in form of tables for ease of comparison and information communication. The tables were generated with the aid of SPSS version 20.0. Leyla (2001) observes that SPSS offers extensive data handling capabilities. Furthermore, numerous statistical analysis routines can analyze small to very large amounts of data.

### 3.9 Ethical considerations

The researcher endeavored to preserve whole and entire the ethical concerns of carrying out this study. The researcher especially ensured that the process of data collection was carried out in utter respect of the respondents, Confidentiality of information, beneficence, justice and respect of communities. Informed consent of the participants was obtained before any appointment for interview was scheduled.

# CHAPTER FOUR
# RESEARCH FINDINGS AND DISCUSSION

## 4.1 Introduction

This chapter presents the responses from target population of the study whose main objective was to determine the performance of health strategies in reducing HIV/Aids prevalence within the Catholic Diocese of Homa Bay. The data was analysed through descriptive statistics and presented using tables and in prose using qualitative content analysis. The study also made valid replicable inferences on the data in various contexts. At the end of every variable described, hypothesis testing was done and analysis conducted to statistically determine whether the independent variables affect or influence the dependent variable.

## 4.2 Response Rate Analysis

The study targeted a population of 100 health workers in the diocesan health facilities within the catholic diocese of Homa Bay. A total of 82 respondents were successfully subjected to the data collection instrument. This represented a response rate of 82 percent. This is a very high response rate compared to previous studies wherein Ndegwah (2014) attained 65%, Aosa (1992) attained 52% and Abok (2013) who attained 55%. Statistical authors recommend 30% as suitable for a good study that can credibly be generalized. This response rate was thus established to be good hence data processing was commenced. The response rate is shown in table 4.1 below;

### 4.2.1 Response Rate

**Table 4.1 Response rate**

| Position | Frequency | Percent |
|---|---|---|
| Administrators | 25 | 20.5 |
| Nurses | 57 | 69.5 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

From the above table, the response rate was established as represented by 82 percent.

#### 4.3 Respondents' profile

The key personal information of respondents included gender, position in the health facility, qualification and length of time in the position held at the facility. Respondents profile has an important role to play in any study on HIV/AIDS, this is because as Moswane (2013) counsels, mitigating the impacts of AIDS in families requires a comprehensive approach and observing the relationships between cultural, political, personal practices and religious values in the community. Qualitative data would especially be analyzed while taking cognizance of the profile of each respondent.

### 4.3.1 Respondents' Gender

This question sought to establish gender distribution of the respondents. The results of gender distribution from table 4.3 indicate that majority (67.1%) of the respondents was female and minority (32.9%) was male. A high female representation is because of a general experience that nursing profession attracts more females than males. Furthermore, a higher population of nurses was targeted for the study since they carry out follow up visits to patients and also provide home based care to the infected. They are therefore best placed to help gauge the impact of the various

strategies under study. Flint (2011) observes that prevalence rates among young women far outstrip those among their male counterparts because of the physiological differences. More female respondents is therefore helpful for the study. This is because their input is not likely to be merely casual or pedestrian. It would be expected that their close relationship with the infected and the affected and their own vulnerability would help yield honest and well thought out responses to the study questions. Table 4.2 below shows the distribution of gender of the respondents.

**Table 4.2: Gender of respondents**

| Gender | Frequency | Percent |
|---|---|---|
| Female | 55 | 67.1 |
| Male | 27 | 32.9 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

## 4.3.2 Respondents' Position in the facility

This question sought to establish the position of the respondents in the health facility. Majority of respondents were nurses (65.5%), followed by administrators (30.5%). Every health facility can only have one administrator. The facilities however have more nurses as often dictated by their respective bed-capacities and the average number of patients visiting the facility on daily basis. Position in the facility was an important variable that enables the respondent to speak with authority and make useful suggestions for possible improvement. As Mwaura (2009) mentions in his study '*HIV/Aids Prevention Strategies in Kenya: A Critical Review,*' the millennium goal number six aims at halting and reversing the spread of AIDS by 2015. These projected timelines especially when taken into consideration by health officials serve as beacons against which

progress can be measured. The fact that the year 2015 elapsed before this study should be a clear challenge to the administration of the health facilities within the study area to reflect on the prevailing state of affairs and offer constructive critique.

Table 4.3 below shows the distribution of position of respondents who participated in the study.

**Table 4.3: Position in the facility**

| Position | Frequency | Percent |
|---|---|---|
| Administrator | 25 | 30.5 |
| Nurse | 57 | 69.5 |
| Total | 82 | 100.00 |

**Source:** Research data, (2016)

### 4.3.3 Respondents' qualifications

This question sought to establish the academic qualification of the respondents. Majority of respondents had attained KRCHN qualification accounting for 50 percent; these were closely followed by Diploma in nursing as represented by 31.7 percent. Those with unspecified diploma qualifications were represented by 18.3 percent. The unspecified diplomas were mostly those held by administrators who studied management and financial accounting courses. Respondents' qualification was important for this study since it served as a useful criterion in making decisions to clean or even eliminate aspects of data that were not consonant with the area of study. Table 4.4 shows the distribution of the qualification of the respondents who participated in the study.

**Table 4.4 Qualification of the respondents**

| Qualification | Frequency | Percent |
|---|---|---|
| KRCHN | 41 | 50.0 |
| Diploma in nursing | 26 | 31.7 |
| Diploma | 15 | 18.3 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

### 4.3.4 Respondents' Length of time in position

Table 4.5 below shows the distribution of the length of time in the respondent's respective positions in the health facilities in which they worked.

**Table 4.5: Length of time in the position in the organization**

| Duration | Frequency | Percent |
|---|---|---|
| Below 5 years | 32 | 39.0 |
| 6 – 10 years | 25 | 30.4 |
| 11 – 20 years | 12 | 14.6 |
| 21 – 25 years | 8 | 9.8 |
| 26--30 years | 5 | 6.2 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

This question sought to establish the length of time each respondent had held their respective positions within the health facility. Majority of respondents had worked for a duration of less than five years (39%), followed by those who had worked for durations ranging between 6 and 10 years (30.4%).

Length of time of service within the facility is an important variable in establishing the trends of HIV/Aids prevalence reduction since the strategic plan was launched in 2012 to the time of the study. The fact that only 39% of the respondents had served for a period below five years and the other 61% had served for years ranging between 6 to 30 years was good for the study as a larger percentage of the respondents had the necessary institutional memory to notice change.

### 4.3.5 Most Frequently Treated Illnesses

The distribution of commonly treated diseases is shown in table 4.6 below.

**Table 4.6: Most frequently treated diseases at the health facilities**

| **Diseases commonly attended to** | **Responses** | |
|---|---|---|
| | **N** | **Percent** |
| Malaria | 82 | 17.1% |
| Respiratory tract infection | 41 | 8.5% |
| URTI | 56 | 11.7% |
| HIV | 25 | 5.1% |
| Diarrhea | 41 | 8.5% |
| P.U.D. | 15 | 3.1% |
| Hypertension | 41 | 8.5% |
| Anemia | 15 | 3.1% |
| Opportunistic infection | 67 | 14.0% |
| T B | 15 | 3.1% |
| Pneumonia | 41 | 8.5% |
| Skin disease | 41 | 8.5% |
| **Total** | **480** | **100.0%** |

**Source:** Research data, (2016)

This question sought to establish the disease burden within the area of study. This was important for the ultimate study findings because reduction of HIV/AIDS prevalence cannot be achieved in isolation. Malaria and opportunistic Infections (OIs) had the highest prevalence rate (17.1%) and 14.0 percent respectively. The fact that all respondents listed Malaria as a frequently treated disease underscores the need to step up disease prevention and safe motherhood as strategies

towards reduction of the disease burden within the area of study. Among the most useful disease prevention strategy was sleeping under insecticide treated mosquito net. It is worth noting too that the opportunistic infections came second only after Malaria. HIV/AIDS was established at 5.1 percent prevalence rate. This is consonant with the statistics from the National Aids and STI control program (NASCOP, 2014) on HIV/Aids prevalence within Homa Bay and Migori Counties. This study therefore confirms both the national statistics as well as the findings of a baseline survey by CAFOD (2014).

### 4.4 Descriptive analysis for study variables

## 4.4.1 Health education awareness and HIV/AIDS prevalence reduction

The first objective of the study was to assess the relationship between health education awareness and HIV Aids Prevalence within the catholic diocese of Homa Bay. Table 4.7 below shows the distribution of the response to the question; do you have health awareness campaigns within your deanery run by your health facility?

**Table 4.7: Do you have health awareness campaigns within deanery run by your health facility?**

| Health Education awareness | Frequency | Percent |
|---|---|---|
| Yes | 41 | 50.0 |
| No | 41 | 50.0 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

As illustrated in table 4.7 above, 50 percent of the respondents had conducted health awareness campaigns within their deaneries. Those who did not conduct health awareness campaigns within their deaneries also comprised of 50 percent. It is imperative to note therefore that the resultant

measurable impact attributable to awareness creation would only be the impact of half the target population.

Table 4.8 shows the distribution of the frequency of health awareness campaigns conducted in the deaneries.

**Table 4.8: How frequently are health awareness campaigns undertaken?**

| Frequency of health awareness campaigns | Frequency | Percent |
|---|---|---|
| Monthly | 26 | 45.6 |
| weekly | 16 | 28.1 |
| quarterly | 15 | 26.3 |
| **Total** | **57** | **100.0** |

**Source:** Research data, (2016)

Facilities that conducted health awareness campaigns on a monthly basis were represented by 45.6 percent, being the majority. This was followed by those that carried out awareness campaigns weekly (28.1%) closely followed by those that organized the same activity on a quarterly basis (26.3%). In sum, a large percentage represented by 73.7% carried out health education awareness campaigns every month.

Concerning quality of health education, most of the respondents accounting for 71.9 percent were of the view that it was moderate while minority of respondents as represented by 28.1 percent were of the opinion that it was of strong quality and therefore effective.

Table 4.9 below shows the distribution of quality of health education awareness provided by health institutions.

**Table 4.9: Quality of health education awareness provided by health facilities**

| Quality of health education | Frequency | Percent |
|---|---|---|
| Moderate | 41 | 71.9 |
| Strong | 16 | 28.1 |
| **Total** | **57** | **100.0** |

**Source:** Research data, (2016)

Table 4.10 below shows the distribution of level of agreement regarding indicators of successful health awareness campaign meetings done. Mwaura, (2009) recommends in his study the need to scale up VCT services as well as awareness campaigns.

**Table 4.10: Level of agreement regarding indicators of successful health awareness campaign meetings done.**

| Successful health awareness campaign indicators | Frequency | Valid Percent |
|---|---|---|
| Strongly agree | 25 | 30.5 |
| Agree | 16 | 19.5 |
| Neutral | 41 | 50.0 |
| Total | 82 | 100.0 |

Source: Research data, (2016)

As pertains to successful health awareness campaign meetings done, most respondents accounting for 50 percent had a neutral view. Over 30 percent strongly agreed to the opinion that the health awareness campaigns done were successful. Table 4.11 below shows the ratings of the success of the health awareness campaigns.

**Table 4.11: Rating success of awareness campaigns in reducing new HIV infections**

| Success of awareness campaigns in reducing new HIV infections | Frequency | Percent |
|---|---|---|
| Weak | 25 | 30.5 |
| Moderate | 16 | 19.5 |
| Strong | 41 | 50.0 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

Regarding the rate of success of awareness campaigns in reducing new HIV infections, most respondents were of the view that it was strong as represented by 50 percent while those with the opinion that it was weak were represented by 30.5 percent. Minority of respondent accounting for 19.5 percent were of the view that it was moderate.

### 4.4.2 Correlation between Health Education awareness and HIV/AIDS prevalence within the catholic diocese of Homa Bay

Table 4.12 below shows the relationship between health education awareness and HIV/AIDS prevalence.

**Table 4.12: Correlation between Health Education awareness and HIV/AIDS prevalence**

| Correlations | | | |
|---|---|---|---|
| | | HEALTH EDUCATION AWARENESS: Do you have health awareness campaigns within deanery run by your health facility? | Rating success of awareness campaigns in reducing new HIV infections |
| HEALTH EDUCATION AWARENESS: Do you have health awareness campaigns within deanery run by your health facility? | Pearson Correlation | 1 | .919** |
| | Sig. (2-tailed) | | .000 |
| | N | 82 | 82 |
| Rating success of awareness campaigns in reducing new HIV infections | Pearson Correlation | .919** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 82 | 82 |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | |

**Source:** Research data, (2016)

At 0.01 significance level, the correlation between health education awareness and success of reducing HIV/AIDS infections was established at .919 implying a strong positive association of 91.9 percent between health education awareness and success of reducing HIV/AIDS infections. The positivity of the correlation means that when health education awareness increases, success of reducing new HIV/AIDS also increases. This finding attests to the efficacy of awareness campaigns as had been established by Oluduro (2010) who reported significant impact in Nigeria after concerted efforts by religious leaders. The findings of Nana Nimo, Appiah-Agyekum &

Robert Henry Suapim (2013) however casts aspersions on this finding, something that would clearly be understandable because their study was on school girls whose use of such knowledge or awareness on HIV/Aids may be affected by their age. According to Seele (2003) as quoted by Moswane, (2013), the Church is the only institution able to mobilize the masses and disseminate appropriate information. It can be effective in doing so because it still enjoys the respect and the support of the people. It is thus incumbent on the catholic diocese of Homa Bay to step up all initiatives designed to increase awareness.

### 4.4.3 ANOVA for health Education Awareness

The analysis of the variance (ANOVA) was used to the test the first hypothesis of the study.

**4.4.3.1 Testing Hypothesis HO1**: Health Education awareness does not affect HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay

Table 4.13 presents analysis of the variance that was used the test the first hypothesis of the study.

**Table 4.13: Testing of the first Hypothesis $H_{O1}$**

| ANOVA | | | | | |
|---|---|---|---|---|---|
| Rating success of awareness campaigns in reducing new HIV infections | | | | | |
| | Sum of Squares | df | Mean Square | F | Sig. |
| Between Groups | 53.122 | 1 | 53.122 | 435.600 | .000 |
| Within Groups | 9.756 | 80 | .122 | | |
| Total | 62.878 | 81 | | | |

**Source:** Research data, (2016)

At 1 degrees of freedom, the computed F = 435.600 is greater than the critical F =.00. This implies that the overall regression model was significant. This is because when the computed F is greater than the significant F, then a conclusion that the overall regression model was fit in

estimating variation in the response variable. The rule of thumb is that when F computed is greater than the significant F we reject the null hypothesis and thereby accept the alternate hypothesis that; $\mathbf{H_{a1}}$: Health Education awareness affects HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay.

### 4.4.4 Qualitative findings on health Education Awareness and HIV/Aids prevalence

One respondent opined that staff were ill equipped with information to enable them have increased capacity to undertake health education awareness programs. This was perceived as fundamental in reduction of incidents of infection of HIV/AIDS. Reduction of communicable diseases including HIV/AIDS requires use of specific national guidelines and manuals to promote preventive medical interventions. It was opined that weekly, monthly and quarterly health awareness campaigns were being undertaken in the study site. NASCOP/KARP/WHO program manuals were established as the most often used in creating health awareness campaigns. Another respondent was of the opinion that shortage of health care workers impacted negatively on awareness creation. Furthermore, the need to offer HIV/AIDS awareness in educational institutions was variously expressed. Two respondents suggested that primary and secondary school curricula be reviewed to include aspects of awareness creation to enable the children grow and develop with the right concepts surrounding the HIV/AIDS prevalence rates. One respondent expressed the need for the government to make deliberate efforts to disseminate information about the HIV/AIDS pandemic in public gatherings.

### 4.5 Health nutrition training and HIV/AIDS prevalence

The second objective of the study was to investigate the relationship between health nutrition training and HIV/AIDS prevalence rates within the catholic Diocese of Homa Bay. The analysis relating to the second study objective is hereby presented. Table 4.14 shows the distribution of the usefulness of health nutrition training on provision of nutrition advice to clients.

**Table 4.14: Usefulness of Strategic Health Nutrition training as intervention in attending to PLWHAs**

| Is strategy useful intervention | Frequency | Percent |
|---|---|---|
| Yes | 57 | 69.5 |
| No | 25 | 30.5 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

Pertaining to the usefulness of the strategic intervention of nutritional training in attending to PLWHAs, majority of respondents accounting for 69.5 percent agreed that it was a useful strategy while a minority of respondents represented by 30.5 percent was of a contrary opinion. Nutritional training guides those living with HIV/AIDS in choosing healthy foods and adopting healthy eating habits. Table 4.15 below shows the distribution of the reasoning behind the agreement that nutrition training intervention in attending to PLWHASs is strategically fruitful.

**Table 4.15: Reasons for usefulness of health nutrition training intervention**

| Reasons | Frequency | Percent |
|---|---|---|
| Good nutrition enables patient respond well to medicines taken | 26 | 31.7 |
| Prevents opportunistic infections | 56 | 68.3 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

Concerning the reasons of the strategic intervention of nutritional training in attending to PLWHAs, majority of respondents accounting for 68.3 percent agreed citing prevention of opportunistic infections while minority of respondents represented by 31.7 percent were of the view that good nutrition enables patients to respond well to medication hence achieving effective drug adherence. This training prepares them to assimilate the ART drugs and helps bolster the natural capacity of the body to fight infections, repair damaged tissues and restore damaged cells. Table 4.16 below shows the distribution of rate of efficacy of health nutritional advice as strategy of improving the health of PLWHAs

**Table 4.16: Rate of efficacy of health nutritional advice as strategy of improving the health of PLWHAs**

| Rating | Frequency | Percent |
|---|---|---|
| Weak | 26 | 31.7 |
| Strong | 56 | 68.3 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

Concerning the reasons of the strategic intervention of nutritional training in attending PLWHAs, majority of respondents accounting for 68.35 percent agreed citing a rating of strong, while minority of respondents represented by 31.7 cited a weak rating as represented by 31.7 percent. This is especially because natural food and food supplements improve the clinical condition of PLWHAs (Belaynew Wasiel, Yigzaw Kebede & Anwar Yibrie, 2010). According to Moswane (2013), the HIV/AIDS epidemic has continued to undermine the welfare and physical state of many people in the world. His suggested viable strategy to combat the effects of AIDS is to encourage partnerships and networking. This, he says is the most important tool for any form of sustainable initiative for PLWHAs. One of the desired achievements of the training is to

demonstrate to clients the need, especially for those on ARTs to purpose to eat natural vegetables from their own farms.

Table 4.17 below shows the distribution of rate of success of health nutritional advice on reducing mortality rate of PLWHAs.

**Table 4.17: Success of health nutrition advice on reducing mortality rate of PLWHAs**

| Rating | Frequency | Percent |
|---|---|---|
| Weak | 25 | 30.5 |
| Moderate | 41 | 50.0 |
| Strong | 16 | 19.5 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

Concerning the success of the intervention of health nutritional training in attending to PLWHAs, majority of respondents accounting for 50 percent and 30.5 percent cited a rating of moderate and weak respectively while minority of respondents represented by 19.5 percent cited a strong rating. The obvious assumption is that those attending these trainings are aware of their status as well as the consequences of attracting a new strain of the virus in one's body system. The result is reduced HIV/AIDS deaths and reduction of new infections, which leads to reduction of prevalence.

### 4.5.1 Correlation between health nutrition training and HIV/AIDS prevalence within the Catholic diocese of Homa Bay

Table 4.18 below shows the relationship between health nutrition training and HIV/AIDS prevalence.

**Table 4.18: Correlation between health nutrition training and HIV/AIDS prevalence**

| Correlations | | | |
|---|---|---|---|
| | | HEALTH NUTRITION TRAINING: Provision of health nutrition advice to clients | Do you find this strategy useful intervention in attending to PLWHAs and reduction of HIV new infections |
| HEALTH NUTRITION TRAINING: Provision of health nutrition advice to clients | Pearson Correlation | .[a] | 0.75** |
| | Sig. (2-tailed) | | . |
| | N | 82 | 82 |
| Do you find this strategy useful intervention in attending to PLWHAs and reduction of HIV new infections | Pearson Correlation | 0.75** | 1 |
| | Sig. (2-tailed) | . | |
| | N | 82 | 82 |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | |

**Source:** Research data, (2016)

At 0.01 significance level, the correlation between health nutrition training and success of reducing HIV/AIDS infections was established at 0.75 implying a strong positive association of 75 percent between health nutrition training as a strategic intervention in reducing HIV/AIDS infections. The positivity of the correlation means that when health nutritional training increases, effectiveness of strategic interventions in attending to PLWHAs and of reducing new HIV/AIDS infections also increases. Health nutrition training is particularly aimed at bolstering the

immunity of those already infected. It is always coupled with acceptance of one's condition in the quest to live positively with the condition. Improvement of longevity through a nutritional regimen that ensures healthy and normal life also always reduces chances of causing new infections.

## 4.5.2 ANOVA for Health Nutrition training and HIV/Aids prevalence

Table 4.19 below tests the second hypothesis of the study.

**4.5.2.1 Testing Hypothesis HO2**: Nutritional training services do not affect HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay.

**Table 4.19: Testing of the second Hypotheses $H_{O2}$**

| ANOVA | | | | | |
|---|---|---|---|---|---|
| Nutritional training services in reducing new HIV infections | | | | | |
| | Sum of Squares | Df | Mean Square | F | Sig. |
| Between Groups | 53.122 | 1 | 53.122 | 231.600 | .024 |
| Within Groups | 9.756 | 80 | .122 | | |
| Total | 62.878 | 81 | | | |

**Source:** Research data, (2016)

At 1 degrees of freedom, the computed F = 231.600 is greater than the critical F =.024. This implies that the overall regression model was significant. This is because when the computed F is greater than the significant F, then a conclusion that the overall regression model was fit in estimating variation in the response variable. The rule of thumb is that when F computed is greater than the significant F we reject the null hypothesis and thereby accept the alternate hypothesis that; $\mathbf{H_{a1}}$: Nutritional training services affect HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay.

### 4.5.3 Qualitative findings on Health nutrition training and HIV/Aids prevalence

Promotion of healthy living was perceived by respondents as a key mitigating strategy in reduction of HIV/AIDS prevalence deaths. Balanced diet was opined by one respondent to be fundamental. Nutritional counseling received wide consensus among the respondents as very important intervening strategy in combating HIV/AIDS. A female respondent opined that lack of trained nutritionists was a challenge in the study area. Improved immunity of the HIV/AIDS patients was viewed as the greatest benefit of health nutrition training strategy as a means of combating HIV/AIDS.

### 4.6 Disease prevention practices and HIV/Aids prevalence reduction

The third objective of the study was to examine the relationship between disease prevention practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay. The analysis relating to the third study objective is hereby presented. Table 4.20 shows the distribution of Quality of disease prevention measures recommended by health institutions within the area of study. To the question; what is the quality of disease prevention measures recommended by your health institution, the responses were as tabulated below;

**Tale 4.20: Quality of disease prevention measures recommended by your health institution**

| Quality of disease prevention | Frequency | Percent |
|---|---|---|
| Weak | 25 | 30.5 |
| Strong | 57 | 69.5 |
| Total | 82 | 100.0 |

**Source:** Research data, (2016)

Concerning quality of disease prevention measurers recommended by health institutions, most respondents represented by 69.5 percent were of the opinion that it was strong compared to minority of respondents accounting for 30.5 percent who were of the view that it was weak.

In relation to results of effective disease prevention, most respondents accounting for 80.5 percent agree to the view that it was effective while minority of respondents represented by 19.5 percent strongly agreed to the same opinion. Table 4.21 shows the distribution of results of effective disease prevention.

**Table 4.21: Results of effective disease prevention**

| Results of effective disease prevention | Frequency | Percent |
|---|---|---|
| Strongly agree | 16 | 19.5 |
| Agree | 66 | 80.5 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

The study established a reduction in the incidents of Malaria/TB/AIDS as represented by 81.7 percent of the respondents who strongly agreed and 18.3 percent of the respondents who agreed. Reduced incidences of Malaria are attributable to a national government initiative to distribute free insecticide treated mosquito nets in the area of study. An intensive campaign on the need to test for TB after a bout of coughing for more than two weeks also served to reduce TB incidences as government health facilities began offering free TB treatment. Table 4.22 below shows the distribution of reduced incidents of Malaria/TB/AIDS

**Table 4.22: Reduced incidents of Malaria/TB/AIDS**

| Reduced incidents of Malaria/TB/AIDS | Frequency | Percent |
|---|---|---|
| Strongly agree | 67 | 81.7 |
| Agree | 15 | 18.3 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

Most respondents accounting for 62.7 percent were of the view that more than 50% is the portion of clients seek advisory on disease prevention while 10% - 30% of clients do not routinely seek advisory on disease prevention. Table 4.23 below shows the distribution of the portion of clients who seek advisory on disease prevention.

**Table 4.23: Portion of clients who seek advisory on disease prevention**

| Portion of clients | Frequency | Percent |
|---|---|---|
| 10% - 30% | 25 | 37.3 |
| More than 50% | 42 | 62.7 |
| **Total** | **67** | **100.0** |

**Source:** Research data, (2016)

### 4.6.1 Correlation between Disease prevention practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay

Table 4.24 below shows the correlation of disease prevention practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay.

**Table 4.24: Correlation between Disease prevention practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay**

| Correlations | | | |
|---|---|---|---|
| | | DISEASE PREVENTION PRACTICES: Does your health facility recommend disease prevention measures to clients | Reduced incidences of TB/AIDS |
| DISEASE PREVENTION PRACTICES: Does your health facility recommend disease prevention measures to clients | Pearson Correlation | .[a] | .64** |
| | Sig. (2-tailed) | | . |
| | N | 82 | 82 |
| Reduced incidences of TB/AIDS | Pearson Correlation | .64** | 1 |
| | Sig. (2-tailed) | . | |
| | N | 82 | 82 |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | |

**Source:** Research data, (2016)

At 0.01 significance level, the correlation between disease prevention practices and success of reducing HIV/AIDS incidents was established at 0.64 implying a strong positive association of 64 percent between disease prevention practices and reduction of HIV/AIDS incidents. The positivity of the correlation means that when disease prevention practices increase, reduction of TB/ HIV/AIDS incidents increase or improve. This finding agrees with UNAIDS 'Best

Practices' impact study as quoted by Green (2001) which lists prevention activities carried out by religious leaders as effective in reducing HIV/Aids prevalence.

Table 4.25 shows the distribution of disease prevention practices established in the study.

**Table 4.25: Distribution of disease prevention practices**

| | Responses | |
|---|---|---|
| | N | Percent |
| Immunization | 57 | 11.5% |
| Health education | 82 | 16.5% |
| Early diagnosis and treatment | 82 | 16.5% |
| HIV testing services | 82 | 16.5% |
| Drug adherence | 41 | 8.2% |
| Treatment of opportunistic infections | 41 | 8.2% |
| Laboratory services | 56 | 11.3% |
| many patients put under ARVs | 56 | 11.3% |
| Total | 497 | 100.0% |

**Source:** Research data, (2016)

Relating to disease prevention practices, majority of respondents accounting for 16.5 percent cited health education, early diagnosis and treatment and HIV testing services as key preventive practices respectively while minority of respondents represented by 11.5 percent cited immunization as a fundamental disease prevention practice. Minority of respondents accounting for 11.3 percent opined that laboratory services and patients put under ARVs are important disease prevention practices. Early diagnosis and treatment alongside HIV testing services and Health education are listed by all respondents at 16.5 percent with a cumulative rating of 49.5 percent as the most effective disease prevention practices. This is because early diagnosis and treatment especially of STIs as well as health education with HIV testing services as part of educational package collectively cause behavioural change alluded to in the theory of planned

behaviour (TPB) which proposes proximal determinants of behaviour as the intention to act (Hardeman et al., 2002). Mwaura (2009), in his study 'HIV/Aids Prevention Strategies in Kenya: A Critical Review' avers; 'According to the CDC, preventing new infections represents the only long-term, sustainable means to stem the global HIV/AIDS pandemic (CDC 2006)'. The present findings are a further confirmation of this position.

## 4.6.2 ANOVA for disease prevention practices

**4.6.2.1 Testing Hypothesis HO3**: HIV/AIDS prevention practices do not affect HIV/AIDS prevalence rates within the catholic dioceses of Homa Bay. Table 4.26 below shows the testing of the third hypothesis of the study.

**Table: 4.26: Testing of the third hypothesis ($H_{O3}$)**

| ANOVA | | | | | |
|---|---|---|---|---|---|
| Disease Prevention practices in reducing new HIV incidents | | | | | |
| | Sum of Squares | df | Mean Square | F | Sig. |
| Between Groups | 55.111 | 1 | 53.122 | 18.711 | .031 |
| Within Groups | 8.352 | 80 | .122 | | |
| Total | 61.261 | 81 | | | |

**Source:** Research data, (2016)

At 1 degrees of freedom, the computed F = 18.711 is greater than the critical F =.031. This implies that the overall regression model was significant. This is because when the computed F is greater than the significant F, then a conclusion that the overall regression model was fit in estimating variation in the response variable. The rule of thumb is that when F computed is greater than the significant F we reject the null hypothesis and thereby accept the alternate

hypothesis that; **$H_{a3}$**: Disease prevention practices affect HIV/AIDS incident rates within the Catholic Diocese of Homa Bay.

### 4.6.3 Qualitative findings on disease prevention practices and HIV/Aids prevalence

Drinking clean and safe water was perceived to be key disease prevention strategy in combating HIV/AIDS. Hand washing was established to be fundamental too. Covering one's mouth while coughing was opined to be a good strategy in disease prevention. The foregoing practices were especially appraised as means of keeping at bay disease causing pathogens that may introduce opportunistic infections in PLWHAs. Safe disposal of medical waste received more weight by the respondents as very important in mitigating HIV/Aids. Use of treated mosquito nets was cited as a disease prevention strategy of great significance. Immunization was advanced by respondents to be key in disease prevention strategy towards combating HIV/Aids deaths. Abstinence was opined to be the best strategy in preventing new HIV/Aids infections.

### 4.7 Promotion of safe motherhood and HIV/AIDS prevalence

Regarding the promotion of safe motherhood as a strategy towards HIV/AIDS prevalence reduction, half of the respondents accounting for 50 percent strongly agreed that efforts to secure the health of both mother and child yielded positive results in the fight against the HIV/AIDS pandemic. The other half of respondents agreed to the opinion that the results of safe motherhood such as attendance of prenatal care were effective. Table 4.27 below shows the distribution of results of safe motherhood practices.

**Table 4.27: Results of safe motherhood practices: Number attending prenatal care**

| Results of safe motherhood | Frequency | Percent |
|---|---|---|
| Strongly agree | 41 | 50.0 |
| Agree | 41 | 50.0 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

Table 4.28 below shows the distribution of numbers accessing safe delivery.

**Table 4.28: Number accessing safe delivery**

| Number accessing safe delivery | Frequency | Percent |
|---|---|---|
| Strongly agree | 16 | 19.5 |
| Agree | 40 | 48.8 |
| Neutral | 26 | 31.7 |
| **Total** | **82** | **100.0** |

**Source:** Research data, (2016)

Most respondents accounting for 48.8 percent and 19.5 percent agreed and strongly agreed to the view that there were a good number of pregnant mothers accessing safe delivery within the area of study.

### 4.7.1 Correlation between promotion of safe motherhood and HIV/Aids prevalence rates within the Catholic diocese of Homa Bay

Table 4.29 shows the correlation between safe motherhood and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay

**Table 4.29: Correlation between safe motherhood practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay**

| Correlations | | | |
|---|---|---|---|
| | | Safe motherhood | Reduced incidences of TB/AIDS |
| Safe motherhood | Pearson Correlation | .[a] | .56** |
| | Sig. (2-tailed) | | . |
| | N | 82 | 82 |
| Reduced incidences of TB/AIDS | Pearson Correlation | .56** | 1 |
| | Sig. (2-tailed) | . | |
| | N | 82 | 82 |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | |

**Source:** Research data, (2016)

At 0.01 significance level, the correlation between safe motherhood practices and success of reducing HIV/AIDS incidents was established at 0.56 implying a strong positive association of 56 percent between safe motherhood practices and reduction of HIV/AIDS incidents. The positivity of the correlation means that when safe motherhood practices increase, reduction of TB/ HIV/AIDS incidents increase or improve. The fact that women who are in their reproductive

age are also the ones who are sexually active makes this strategy one of the most useful in an attempt to reduce HIV/Aids prevalence. Any strategy focusing on them therefore at once yields two-pronged results; reduction of new infections during delivery as well as reduction of mortality of PLWHAs.

### 4.7.2 Promotion of safe motherhood activities

Table 4.30 below shows the distribution of safe motherhood activities undertaken in the health facilities investigated in this study

**Table 4:30: Promotion of Safe motherhood activities**

| | Responses | |
|---|---|---|
| | N | Percent |
| Antenatal profiling | 57 | 15.4% |
| HIV testing | 67 | 18.1% |
| Prenatal exercises | 82 | 22.2% |
| Health education in breast feeding | 82 | 22.2% |
| PMTCT | 41 | 11.1% |
| Immunization | 41 | 11.1% |
| Total | 370 | 100.0% |

**Source:** Research data, (2016)

Relating to promotion of safe motherhood activities, majority of respondents accounting for 22.2 percent cited prenatal exercises and health education in breast feeding as fundamental activities in promoting safe motherhood respectively while 18.1 percent of respondents cited HIV testing as critical in promoting safe motherhood. Importantly, 15.4 percent were of the view that antenatal profiling greatly promoted safe motherhood. Minority of respondents accounting for 11.1 percent opined that PMTCT and immunization were important activities in promoting safe motherhood.

### 4.7.3 ANOVA for promotion of safe motherhood

**4.7.3.1 Testing of Hypothesis $H_{o4}$:** Promotion of safe motherhood does not affect HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay. Table 4.31 below tests the fourth hypothesis of the study.

**Table: 4.31: Testing of the fourth hypothesis ($H_{O4}$)**

| ANOVA | | | | | |
|---|---|---|---|---|---|
| Promotion of safe motherhood in reducing new HIV incidents | | | | | |
| | Sum of Squares | df | Mean Square | F | Sig. |
| Between Groups | 61.213 | 1 | 52.222 | 201.000 | .020 |
| Within Groups | 7.251 | 80 | .134 | | |
| Total | 56.421 | 81 | | | |

**Source:** Research data, (2016)

At 1 degrees of freedom, the computed F = 201.000 is greater than the critical F =.020. This implies that the overall regression model was significant. This is because when the computed F is greater than the significant F, then a conclusion that the overall regression model was fit in estimating variation in the response variable. The rule of thumb is that when F computed is greater than the significant F we reject the null hypothesis and thereby accept the alternate hypothesis that; $H_{a4}$: Promotion of safe motherhood affects HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay.

### 4.7.4 Qualitative findings on promotion of safe motherhood and HIV/AIDS prevalence

Health education was opined to be part of promotion of safe motherhood by the sampled respondents. Hospital delivery as opposed to home delivery was viewed by the respondents as

fundamental in combating HIV/Aids. Specialized pediatric care and immunization were proposed by respondents as crucial towards promotion of safe motherhood as a health strategy towards reduction of HIV/Aids prevalence in the study area. Antenatal and post-natal care, use of insecticide treated mosquito nets and prompt malarial prophylaxis treatment of pregnant women were cited as key strategies in promotion of safe motherhood. Antenatal profiling of pregnant mothers was singled out as a key strategy in monitoring disease surveillance within the localities of the study area. Health education in breastfeeding and immunization were also mentioned as important activities of safe motherhood, both of which served more to secure the baby from infection.

### 4.8 Coefficient of determination ($R^2$)

The coefficient of determination establishes the explanatory power the predictor variables have over variation of the response variable.

**Table 4.32: Coefficient of determination ($R^2$)**

| Model Summary | | | | |
|---|---|---|---|---|
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| 1 | .214[a] | .413 | .042 | .51728 |

a. Predictors: (Constant), Health strategies
b. Predicted variables: Reduction of HIV Prevalence

**Source:** Research data, (2016)

In the analytical model of this study, the predicted variable is reduction of HIV/AIDS while the predictor variables comprised of; health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood. The coefficient of determination ($R^2$) was established at 0.413 with standard error of estimation of 0.5. This implies that 41.3 percent

variation in the predicted variable (Reduction of HIV prevalence) is explained by the independent variables namely; health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood. This means also that 58.7 explanatory powers on variation on reduction of HIV prevalence are attributable to the error term (e) in the regression model which is other factors apart from the independent variables. This is due to the fact that no studies can 100% exhaustively explain factors behind a phenomenon.

**Table 4.33: Coefficients of combined variables**

| **Coefficients[a]** | | | | | |
|---|---|---|---|---|---|
| Model | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. |
| | B | Std. Error | Beta | | |
| (Constant) | 0.61 | .175 | | 8.371 | .000 |
| Health education awareness | 0.92 | .174 | .56 | 7.332 | .001 |
| Health Nutrition training | 0.23 | .167 | .11 | 7.222 | .000 |
| Disease prevention practices | 0.18 | .723 | .01 | 7.546 | .003 |
| Promotion of Safe motherhood | 0.33 | .675 | .22 | 6.875 | .000 |
| a. Dependent Variable: Dummy variable for reduction of HIV/AIDS Prevalence | | | | | |

**Source:** Research data, (2016)

### 4.9 Validating the regression equation

From table 4.35 above, we use unstandardized coefficients to validate the linear regression model of the study as illustrated hereunder;

$Y=\beta_0+ \beta_1X_1+ \beta_2X_2 +\beta_3X_3+ \beta_4X_4 + E$

Where:

Y= Reduction of HIV/Aids prevalence

$\beta_0$= is the constant term

$X_1$=Health education awareness

$X_2$=Health nutrition training

$X_3$= Disease prevention practices

$X_4$= Promotion of safe motherhood

$$Y = 0.61 + 0.92X_1 + 0.23X_2 + 0.18X_3 + 0.33X_{4+}e$$

The explanatory variables have significant explanatory power over the response variable. This was fundamental in the variation of reduction of HIV/Aids prevalence. These results were based on stepwise multiple regression model. The SPSS platform discriminates variables when they are thought to be related (collinear) and keeps in the regression model the one that had a more significant contribution. The others are listed as excluded. On this basis, health education awareness, health nutrition training, disease prevention practices and promotion of safe motherhood as predictor variables had explanatory power of 92 percent, 23 percent, 18 percent and 33 percent respectively over variation in the predicted variable; reduction of HIV/AIDS prevalence. All these explanatory variables have a significant contribution to variation in reduction of HIV/AIDS.

### 4.10 Chapter Summary

This chapter has presented descriptive data analysis relying on frequency tables, percentages and correlation coefficients for clarity. Reliability test was also carried out to ascertain the ability of the questionnaire to yield consistent results. The profiles of the respondents as well as the most frequently treated illnesses was presented at the beginning of the chapter followed by the responses from each variable section of the questionnaire. The Cronbach's Alpha index was computed and established at 0.81 as shown previously in table 4.3. This figure falls within the

acceptable levels of data reliability and consistency as suggested by statistics scholars among them Gliem (2003), Newman (2000) and Sekaran (2006). Each of the four independent variables was then correlated with the dependent variable to ascertain the inherent extent of causality. ANOVA tables were then used to test the study hypotheses whose alternate hypotheses were found to be true. Using a stepwise regression model, it emerged that each of the four independent variables had significant contribution to variation in reduction of HIV/Aids prevalence.

# CHAPTER FIVE

## SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

### 5.1 Introduction

This chapter presents the summary of the research findings and discusses the broader implications of the findings for theory, practice, policy and further research in government departments of health, Faith based organizations, NGOs implementing HIV/AIDS related programs as well as in the field of strategy. The study sought to investigate the performance of health strategies in reducing HIV/AIDS prevalence in the catholic diocese of Homa Bay, Kenya. The study was guided by the following objectives; to assess the relationship between health education awareness and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay, to determine the relationship between health nutrition training and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay, to examine the relationship between disease prevention practices and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay and to assess the relationship between promotion of safe motherhood and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay.

The study adopted both qualitative and quantitative research design. Descriptive statistics such as frequencies, percentages and tabulation were used to summarize, describe, analyze and present the study findings. This chapter summarizes the findings of the study and the statistical analysis. The presentation is organized around specific objectives and research hypotheses to assess the results by evaluating and interpreting them. The conclusions are in tandem with the specific objectives and research hypotheses. The recommendations refer to suggestions for further study or proposal for change. Each recommendation relates to each conclusion.

## 5.2 Summary of key findings

The summary of the study's key findings are hereby presented per objective.

The first objective of the study sought to assess the relationship between health education awareness and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay. It was found out that, the correlation between health education awareness and success of reducing HIV/AIDS infections was established at .919 implying a strong positive association of 91.9 percent between health education awareness and success of reducing HIV/AIDS infections. Put differently, all factors held constant, health education awareness should cause a significant reduction in the prevalence of HIV/AIDS. This finding agrees with earlier studies such as those of Moswane (2013), Oluduro (2010) and Mwaura (2009) whose findings reveal a positive relationship between awareness and HIV/Aids prevalence reduction.

The second objective was to determine the relationship between health nutrition training and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay. According to the study's findings, the correlation between health nutrition training and success of reducing HIV/AIDS infections was established at 0.75 implying a strong positive association of 75 percent between health nutrition training and strategic intervention in reducing HIV/AIDS infections. Healthy nutrition particularly helps to boost immunity of PLWHAs, thereby significantly reducing HIV/Aids related complications and deaths. This finding is consistent with that of Belaynew Wasiel, *et al* (2010) who observe that prevalence of malnutrition among PLHIV was the most predisposing factor to their the high HIV/AIDS mortality.

The third objective was to examine the relationship between disease prevention practices and HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay. It was established in the

study that the correlation between disease prevention practices and success of reducing HIV/AIDS incidents stood at 0.64 implying a strong positive association of 64 percent between disease prevention practices and reducing HIV/AIDS incidents. Green (2001) in his study attests to the efficacy of disease prevention practices, especially promotion of fidelity in marriage and abstinence. Mwaura (2009) goes farther to list such activities as prevention of sexual transmission, prevention of blood-borne transmission, blood safety, prevention of mother to child transmission and social support as some of the most reliable disease prevention practices. Oluduro (2010) maintains that, the fact that many religious leaders do not have the technical knowledge on HIV/AIDS from a medical perspective presents the need to arrange for constant and regular training of religious leaders on HIV/AIDS prevention, as well as care. This will enable them to serve both as educators as well as disseminators of this information to their congregations.

The fourth objective was aimed at assessing the relationship between promotion of safe motherhood and HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay. It emerged that at 1 degrees of freedom, the computed F = 201.000 is greater than the critical F =.020. This implies that the overall regression model was significant. Safe motherhood as a strategy towards reducing HIV/Aids prevalence is particularly useful in reducing mother to child transmission. This finding is in line with that of Mwaura (2009) who warns that without intervention, about 40% of HIV - positive pregnant women will pass on the infection to their babies during pregnancy, delivery and the post-natal period through breastfeeding. He asserts that without preventive interventions, about 10-20% of infants born to infected mothers will contract the virus through breast milk if breastfed for two years. A further reason that necessitates sufficient focus on this strategy is the reality that most of these women are in their

reproductive age and are often at their peak with regard to sexual activity. This is usually around the age of 24 – 39 when their possibility of entertaining more than one sexual partner is equally probable. Promotion of safe motherhood therefore at once minimises new infections as well as reduces HIV/AIDS mortality.

### 5.3 Discussions

The strong positive association of 91.9% between health education awareness and success of reducing HIV/Aids as established by this study echoes the work of the National Research Council (1996) that applauded African governments as well as international development agencies, private voluntary organizations, and other nongovernmental groups that have over the years devoted resources, time, and energy to developing low-cost interventions to arrest the spread of HIV and Aids through awareness creation. The findings are also in tandem with the works of Nana Nimo, Appiah-Agyekum & Robert Henry Suapim, (2013) that established that, while knowledge and awareness does help reduce new infections, the ultimate results when this strategy when solely applied are not necessarily predictable. Green (2001) reports success in prevalence reduction in Uganda while Oluduro (2010) reports positive results achieved by religious leader's awareness campaigns in Nigeria. On the contrary, a baseline survey carried out by CAFOD in Homa Bay diocese and the findings of Nana Nimo, Appiah-Agyekum & Robert Henry Suapim (2013) in their study 'Knowledge and awareness of HIV/AIDS among high school girls in Ghana' reveal that without supporting strategies, awareness alone does not significantly cause reduction of new infections as revealed by the number of girls who thought it worthwhile to seek to know their status even when they admitted that they were sexually active.

Mwaura (2013) appraises a cocktail of strategies complete with supporting policies, which he fronts as the reason behind the success story of Uganda's onslaught on the HIV/Aids pandemic.

## 5.4 Conclusions

In line with its specific objectives and study hypotheses, the researcher wishes to make the following conclusions;

Health education awareness is fundamental in mitigating HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay. This study has demonstrated that a greater awareness translates into reduced prevalence. Efforts to create and sustain awareness should therefore be made by all concerned parties in the fight against the HIV/AIDS scourge. Religious institutions and FBOs should particularly be on the frontline in creating awareness and addressing stigma and other retrogressive attitudes that militate against all efforts to reduce HIV/AIDS prevalence.

Health nutrition training as a strategy in reducing HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay is effective as it improves the longevity of those already infected and improves the general well-being of individuals.

The study concludes that disease prevention practices play a pivotal role in the reduction of the incidents of HIV/AIDS prevalence rates within the Catholic Diocese of Homa Bay. The need to step up disease prevention practices cannot be emphasized enough. While the major focus should be on the prevention of HIV/AIDS, the diocese and other FBOs should find it necessary to escalate their disease prevention strategies in all forms and work towards reducing disease burden within the catholic diocese of Homa Bay.

Finally relating to the fourth objective, this study concludes that promotion of safe motherhood is a key imperative in mitigation efforts of reducing HIV/Aids prevalence rates within the Catholic Diocese of Homa Bay.

### 5.5 Recommendations

Based on the findings, the following recommendations were made;

The government, both at county and national levels should make deliberate efforts to formulate policies and strategies to increase health education awareness relating to mitigation of HIV/AIDs prevalence rates in the Catholic Diocese of Homa Bay and beyond. In the same vein, the legislature both at national and county levels should undertake new legislative works and make laws that promote efforts and strategies that increase health education awareness relating to mitigation of HIV/AIDs prevalence rates in the Catholic Diocese of Homa Bay

Non-governmental organizations and FBOs compliment government efforts in improving health nutritional training as a means of addressing the HIV/AIDs in the Catholic Diocese of Homa Bay.

The government, both county and national should create conducive environments to enable them reach as many people as possible. Improvement of preventive rather than the curative approach should be emphasized to everyone interested in combating the HIV/Aids pandemic.

Safe motherhood is a key pillar in mitigating the HIV/AIDS prevalence in the Catholic Diocese of Homa Bay. It particularly helps to reduce mother to child transmission and so reduce new infections. Furthermore, since reproductive age is also the age of escalated sexual activity, both government and donor agencies keen on HIV/Aids prevalence reduction should purpose to

channel more resources to women of reproductive age, as well as on activities that ensure safe motherhood.

### 5.6 Areas for Further Research

Even though the objectives were clear and successfully accomplished, certain areas remain unclear and require further research. First, the study focused only on the performance of four strategies. A number of other strategies under implementation in the CDoHB strategic plan need to be studied as well. Secondly, this study focussed on the health facilities which serve as implementation agencies. It would be helpful for a similar study to be carried out from the point of view of the beneficiaries; that is, from the members of the public who access the said health facilities; especially the PLWAHs and the pregnant mothers. Finally, a similar study should be carried out in other dioceses, faith based organizations and counties.

### 5.7 Chapter Summary

Chapter five presented the summary, discussions, conclusions and recommendations of the study. The structure of the chapter was guided by the study objectives and hypotheses. The main objective of chapter five was to present in a nutshell the key findings of the study and the extent to which they were in agreement with the past empirical studies and theoretical arguments. The chapter reviewed the study objectives and hypotheses and gave reasons for these findings. Finally, the chapter presented recommendations based on the study findings and proposed areas for further research.

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# APPENDIX I

## LETTER OF TRANSMITTAL

Kenyatta University
P.O Box 43844
Nairobi
01st October, 2016

Thro'
HEAD OF DEPARTMENT BUSINESS ADMINISTRATION
KENYATTA UNIVERSITY

TO:
……..
……..
Dear Sir/Madam,

**RE: DATA COLLECTION**

I am John Abraham Ayieko, an MBA student at Kenyatta University. I write to humbly seek your consent to participate in an interview for purposes of data collection.

The collected data will assist in drawing scholarly conclusions on Performance of Health Strategies in Reducing HIV/Aids Prevalence in the Catholic Diocese of Homa Bay, Kenya

All the views ascertained from your institution will only be used for the purpose of this study and will not be shared with any other person or institution.

Ayieko John Abraham

# APPENDIX II

# STUDY QUESTIONNAIRE

**Appendix 1: Data collection checklist**
Date of interview:
Person interviewed and position in organization:
Gender
Qualifications
Length of time on position in the organization:
*Organizational information*
Name of Health Facility
Year started in the Diocese
Frequently treated illnesses
Number of professional personnel
Any other Information

*Questions*

### (I) Health Education Awareness

1. Do you have health education awareness campaigns within the deanery run by your health facility?

   If yes, how frequently and why? If No, why?

2. What is your extent of agreement regarding the quality of health education awareness provided by your health institution? (1-Weak, 2-moderate, 3-Strong)

   1 2 3 (Circle as appropriate)

   What reason (s) would you give for your response?

3. Does the health facility have fully endorsed training manuals and guides on key success areas?

   Which types of manuals in particular?

   Who develops the manuals?

4. Do you engage the services of experts on the health awareness campaigns?

   If Yes, how frequently and Why? If No, why?

   .....

   .....

   .....

5. What is your level of agreement regarding the following key indicators of successful health awareness campaign?

(1-Strongly Agree) (2-Agree) (3-Neutral) (4-Disagree) (5-Strongly Disagree)

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Awareness meetings done | ( ) | ( ) | ( ) | ( ) | ( ) |
| Number of clients tested | ( ) | ( ) | ( ) | ( ) | ( ) |
| Number undergoing care and treatment | ( ) | ( ) | ( ) | ( ) | ( ) |

How would you rate the success of awareness campaigns in reducing new HIV infections?

(1-Weak, 2-moderate, 3-Strong). 1 2 3 (Circle as appropriate)

**(II) Health Nutrition Training**

6. Does your health facility provide health nutrition advice to clients?

Yes ( ) No ( ) (Tick as appropriate)

Do you find this strategy a useful intervention in attending to PLWHAs?

Explain your response.

7. What is your extent of agreement regarding the quality of healthy nutrition advisory services provided by your health institution? (1-Weak, 2-moderate, 3-Strong)

1 2 3 (Circle as appropriate)

What reason(s) would you give for your response?

8. Do you engage the services of nutrition experts in the provision of healthy nutrition advisory services?

Yes ( ) No ( ) (Tick as appropriate)

If yes, what reason(s) would you give for your response? If No, why?

Do you consider this strategy successful in reducing the spread of HIV/Aids in the community?

Yes ( ) No ( ) (Tick as appropriate)

9. What is your level of agreement regarding the reliability of the following as key indicators of a competent nutritional advice?

(1-Strongly Agree) (2-Agree) (3-Neutral) (4-Disagree) (5-Strongly Disagree)

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Number of Kitchen Gardens | ( ) | ( ) | ( ) | ( ) | ( ) |
| Regular collection of food supplements | ( ) | ( ) | ( ) | ( ) | ( ) |
| Malnutrition Levels | ( ) | ( ) | ( ) | ( ) | ( ) |

10. How would you rate accessibility of your clients to healthy nutritional advisory services?

Extremely high [ ]
High [ ]
Moderate [ ]
Low [ ]
Extremely low [ ]

11. How do you rate the efficacy of health nutritional advice as a strategy of improving the health of PLWHAs? (1-Weak, 2-moderate, 3-Strong)

1 2 3 (Circle as appropriate)

12. How do you rate the success of Health nutrition advice on reducing mortality rate of PLWHAs? (1-Weak, 2-moderate, 3-Strong)

1 2 3 (Circle as appropriate)

**(III) Disease Prevention Practices**

13. Does your health facility practice and recommend disease prevention measures to clients?

Yes ( ) No ( ) (Tick as appropriate)

If yes, kindly list some of the measures and if No, why?

14. What is your extent of agreement regarding the quality of disease prevention measures recommended by your health institution? (1-Weak, 2-moderate, 3-Strong)

1 2 3 (Circle as appropriate)

What reason (s) do you give for your response?

15. What is your level of agreement regarding the following results of effective disease prevention?

(1-Strongly Agree) (2-Agree) (3-Neutral) (4-Disagree) (5-Strongly Disagree)

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| No. of Immunizations | ( ) | ( ) | ( ) | ( ) | ( ) |
| Treatment for Minor ailments | ( ) | ( ) | ( ) | ( ) | ( ) |
| Reduced incidences of Malaria/TB/AIDS | ( ) | ( ) | ( ) | ( ) | ( ) |

Any other (Specify): ……

16. Do you engage the services of disease prevention experts in your health institution?

Yes ( ) No ( ) (Tick as appropriate)

If yes, how effective has this been, and if No, What reason (s) can you give?

17. What approximate portion of you clientele seek advisory on disease prevention?

Less than 10% ( )

10% -30% ( )

31% - 50% ( )

More than 50% ( )

Give reasons for your answer

……

……

**(IV) Promotion of safe motherhood**

18. Does your health facility practice and recommend prenatal care?

Yes ( ) No ( ) (Tick as appropriate)

If yes, kindly list some of the activities carried out in prenatal clinic, and if No, Why?

19. What is your extent of agreement regarding the success of promotion of safe motherhood among the community members (1-Weak, 2-moderate, 3-Strong)

1 2 3 (Circle as appropriate)

What reason (s) do you give for your response?

20. What is your level of agreement regarding the following results of safe motherhood practices

(1-Strongly Agree) (2-Agree) (3-Neutral) (4-Disagree) (5-Strongly Disagree)

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Number attending prenatal care | ( ) | ( ) | ( ) | ( ) | ( ) |
| Number accessing safe delivery | ( ) | ( ) | ( ) | ( ) | ( ) |
| Pregnant mothers sleeping under ITNs | ( ) | ( ) | ( ) | ( ) | ( ) |

Any other (Specify): ……

21. Do you engage the services of pediatrician in your health institution?

Yes ( ) No ( ) (Tick as appropriate)

If yes, how effective has this been, and if No, What reason (s) can you give?

……

……

22. What approximate portion of you clientele seek advisory on safe motherhood?

Less than 10% ( )

10% -30% ( )

31% - 50% ( )

More than 50% ( )

Kindly explain why in your honest opinion this is so…….

……

23. What approximate portion of you clientele attend post-natal care faithfully?

Less than 10% ( )

10% -30% ( )

31% - 50% ( )

More than 50% ( )

Kindly explain why in your honest opinion this is so.

**Thank you!**

**KENYATTA UNIVERSITY**
**GRADUATE SCHOOL**

E-mail: dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 810901 Ext. 57530

Internal Memo

FROM: Dean, Graduate School DATE: 23rd September, 2016

TO: Ayieko John Abraham REF: D53/OL/KSU/24618/2014
C/o Business Administration Department.

SUBJECT: APPROVAL OF RESEARCH PROJECT PROPOSAL

This is to inform you that Graduate School Board, at its meeting of 21st September, 2016 approved your Research Project Proposal for the M.B.A Degree Entitled, "Performance of Health Strategies in Reducing HIV/AIDS Prevalence in the Catholic Diocese of Homa Bay, Kenya".

You may now proceed with data collection, subject to clearance with the Director General, Commission for Science, Technology & Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking forms per semester. The form has been developed to replace the progress report forms. The supervision Tracking Forms are available at the University's website under Graduate School webpage downloads.

Thank you.

GIDEON KAIMENYI
FOR: DEAN, GRADUATE SCHOOL

c.c. Chairman, Department of Business Administration

Supervisors:

1. Mr. Eliud Obere
C/o Department of Business Administration
Kenyatta University

GK/rwm

KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 8710901 Ext. 57530

Our Ref: D53/OL/KSU/24618/2014

DATE: 23rd September, 2016

Director General,
National Commission for Science
& Innovation,
P.O. Box 30623-00100,
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION FOR AYIEKO JOHN ABRAHAM– REG. NO. D53/OL/KSU/24618/2014

I write to introduce Mr. Ayieko John Abraham who is a Postgraduate Student of this University. He is registered for M.B.A. degree programme in the Department of Business Administration.

Mr. Ayieko intends to conduct research for an M.B.A Project Proposal entitled, "Performance of Health Strategies in Reducing HIV/AIDS Prevalence in the Catholic Diocese of Homa Bay, Kenya".

Any assistance given will be highly appreciated.

Yours faithfully,

for MR. LUCY N. MBAABU
FOR: DEAN, GRADUATE SCHOOL

GK/rwm