

FACTORS AFFECTING IMPLEMENTATION OF COMMUNITY BASED HUMAN IMMUNODEFICIENCY VIRUS PROJECTS IN MOMBASA COUNTY

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ABSTRACT

Communities have always tried to organize themselves to plan, start and implement many projects of their own, without waiting to be probed by the government to do so. While some of these projects succeed, a considerable number of them fail along the way before achieving the intended goals. Reasons for the success of some of the projects, and failure of some of them are not quite clear. The basic idea behind this research was to bring to light the various factors that affect implementation of community based HIV/AIDS projects, within Mombasa County. The study had the following specific objectives: To assess organizational related factors affecting community based HIV projects, to determine socio-economic factors affecting CBOs, to establish level of government involvement in community HIV/AIDS projects and to determine the level of community participation in CBO activities. The study adopted a descriptive survey design to collect primary data from primary sources at the place where the projects were being implemented. The list of CBOs implementing community based HIV/AIDS projects was obtained from the Mombasa District Gender and Social Office and this was used as a sampling frame for the study. 10% of the accessible population was considered adequate for descriptive study. Project members were selected by systematic random sampling techniques. The population for the project was 516 and the sample size 52. Questionnaires were used to collect data for the study by the researcher; these form the basis the finding. Descriptive statistics and Factor analysis method were used to analyse data through statistical package SPSS version 20. Principal Component Analysis, subsequent rotation (Varimax) was applied. Many correlations were in excess of 0.30 and both KMO and Bartlett's tests produced criteria that supported the

application of PCA. All the five indicators on Organizational factors had a mean greater than 3 and an average of 4 which correspond to “agree” in the Likert scale. This shows that the Organizational factors play an important role in implementation of HIV by CBOs. The study revealed that socioeconomic factors specifically economic status and provision of incentives affects the implementation projects by CBOs. Government involvement as well as Community participation was also found to significantly affect the implementation of community based HIV projects.

Key words: Acquired Immunodeficiency Syndrome, Community, Community-based project, Project management

INTRODUCTION

Background Information

Globally, more than 34 million people are estimated to be living with HIV, and 67 percent of them reside in sub-Saharan Africa. While more than 16 million people are eligible for antiretroviral therapy (ART), an estimated 8 million people in low- and middle-income countries were receiving antiretroviral ART at the end of 2011 (WHO/UNAIDS/UNICEF, 2011).

Community based organizations (CBOs) play a frontline role in HIV/AIDS prevention activities. However, they often face formidable challenges to the effective delivery of HIV prevention services to the populations they serve (Kelly *et al.*, 2000). These challenges

include client characteristics such as homelessness and injection drug use and CBO characteristics such as limited resources and high staff turnover. Despite these obstacles, CBOs are especially well situated to serve specific high-risk populations in local communities because they frequently are familiar with and connected with them (Kelly *et al.*, 2000).

Since 1988 in the United States of America, (USA) Congress has mandated direct funding of CBOs to provide support for the HIV prevention infrastructure in underserved communities. In 1997 the Centers for Disease Control and Prevention (CDC) directly funded 94 CBOs under Program Announcement 704 to develop HIV prevention interventions.

These organizations were funded to conduct one or two of the following types of interventions: individual-level, group-level, community-level, and street and community outreach (CDC, 1997).

In India, the government recognizes that structural interventions are required to address the complex social, economic, and legal factors that increase vulnerability to infection, and has provided an opportunity to attempt this at scale. The strategy is one of community mobilization, facilitating the active participation of community members in HIV prevention and other interventions. As community members receiving HIV prevention services have become more aware of their common problems, they have organized grassroots groups to reduce their isolation and address problems at a local level. Over time, these groups have formalized into CBOs, with the capacity to oversee programming and engage in policy activism (Bill & Melinda Gates Foundation, 2009).

In the context of HIV/AIDS projects in India, a CBO is an organisation whose membership comprises of the relevant social groups identified as being particularly vulnerable to HIV/AIDS, namely, female sex workers, men who have sex with men, and injecting drug users. And so, CBOs are organisations of these three identified social groups. In practice, CBOs often work in tandem with non-governmental organisations (NGOs). The difference is that the NGO workers are not necessarily ‘community members’, but are able to provide the CBO with the ‘technical support’ needed to run an intervention. Members of marginalized groups, such as sex workers and drug users often have been excluded from the educational, social and employment settings that would have helped them with all the cultural know-how needed to manage the bureaucratic requirements of a funded project. Hence the common need for ‘non-community-members’, in the organized form of an NGO (Chandrasekaran *et al.* 2006)

India has a long history of self-help groups that deal with local issues. Starting in the mid-1980s, savings and credit groups provided financial services to poor people and grew into a powerful social movement for improving the status and well-being of primarily rural low-income women, with more than 1.5 million groups by the early 2000s. By 2008, the emergence of community groups with dynamic leadership converged with federal and state government's plans, and this set in motion a more active fostering of CBOs. It was clear those communities that had initially been defined as target groups for service delivery had become powerful forces working for access not only to HIV prevention services but also to other social services and their rights as citizens of India (Deininger & Liu, 2009).

There is also increasing evidence from Uganda, Thailand, Senegal and other countries with successful HIV/AIDS prevention programs that a diverse spectrum of community-based participation, in conjunction with high level political commitment, is the

most effective approach to controlling the epidemic (Hogle, 2002).

Gebre Selassie *et al.* (2002) concluded from their surveys of CBOs that their self motivation, acceptability in the community and potential in community mobilization makes them an ideal media for behavior change communication and stigma reduction and as a provider of home-based care in Ethiopia. In addition to formal CBOs, local voluntary support groups and agents must also be considered, since they have been found effective in caring for and reducing stigma against AIDS patients and orphans (Hailu, 2002).

In Kenya, the first case of HIV and AIDS was reported in 1984. In 1999 HIV/AIDS was declared a national disaster and the National AIDS Control Council (NACC) created to coordinate the multi-sectoral approach (Kenya Gazette, Legal Notice No. 170 of 1999). According to the KAIS (2013), 1.6 million people (6.3 percent of the population) are living with HIV. As of March 2013, of the

850,000 people in need of treatment, 614,400 were actively on ART (NASCOP, 2011).

Community systems and services are important in HIV care and treatment to ensure continuity of services, support for adherence to treatment, treatment retention, linkages to complementary services, referral of clients, and a reduction in stigma and discrimination. As the population in need of HIV care and treatment continues to grow in Kenya, it is imperative that the country use community systems to ensure an efficient and effective response in an already overstretched health system.

The government has acknowledged that AIDS is a threat to everyone and has called on the concerted efforts of everyone, CBOs included, to work towards stopping the spread of and mitigating negative socio-economic impacts of HIV and AIDS. As such, CBOs have played and continue to play essential and significant roles in ensuring that the rapid spread and adverse impact of HIV and AIDS is contained (MOMS & MOPHS, 2012).

CBOs play a crucial role in HIV programming including mobilizing, supporting and empowering communities to respond effectively to HIV and AIDS. The government of Kenya has worked in partnership with CBOs in HIV and AIDS interventions that include prevention, treatment and care services. In short, civil society organizations have collaborated with the government and development partners in delivering on the 'Three Ones principles' i.e. one Strategic plan, one National HIV and AIDS Coordinating Authority, and one Monitoring and Evaluation Framework mechanism proposed by UNAIDS (UNAIDS /WHO/UNICEF, 2011).

In the community, the fight against HIV/AIDS is spearheaded by projects aiming at stopping or reducing further spread of the epidemic. Community based projects vary in scale, purpose and duration. Community based projects are expected to be align themselves, be informed and be within the national framework that is based on the Three Ones principle (KNASP 2009/10 – 2012/13), the

strategy aims at achieving a reduction in number of new infections, reduction in AIDS-related mortality (deaths), reduction in HIV-related morbidity (illness, disease) and reduction in socio-economic impact of HIV at household and community levels. Community based HIV/AIDS services and interventions should therefore aim at contributing to the achievement of any of the results (NACC, 2009).

Problem Statement:

Communities have always tried to organize themselves to plan, start and implement many projects of their own that is of their common interest, without waiting to be probed by the government to do so. Community based interventions (CBIs) are defined as programs designed to address health or social problems within a community through the significant participation of members of that community in the planning, implementation, and evaluation of such efforts (Mansuri and Rao 2004).

Every year millions of shillings are awarded in sponsorship of community interventions to achieve the particular social or health issue

that they propose to address. With the growth in the funding of such efforts came an increasing demand for the assessment of whether such programs actually achieved what they proposed. Dozens of projects have been undertaken in the quest to reduce HIV infections in developing countries, but many of these projects either solved half the problem or did not meet expectation.

Political will and donor support in Kenya have combined to intensify programmatic and policy responses to the HIV/AIDS epidemic. In the civil service sector, local organizations attempt small-scale community work to meet the needs of PLHA with scarce human, monetary, and technical resources and without technical or managerial training. Often drawing on dedication and commitment of community volunteers, these organizations have great potential to address the needs of PLHIV in their communities; however they require capacity building, including training, network strengthening, and grant support.

Projects can be constructed in many ways, but a project without proper planning, monitoring

and controlling is destined for failure. The reasons for project failures in developing countries cannot be found in a single book; this is because project failure is relative and cannot be generalized. It mainly depends on the overall structure of the country's economy and the attitudes of its citizens. In order to provide the most effective community approach, it is necessary that a study be conducted to determine what factors contribute to success or failure of such projects.

In Kenya 51% of all new HIV infections occur in 8 counties. Mombasa County is ranked fourth with a prevalence of 11.1% and incidence of 0.52%. This is after Homabay, Siaya and Kisumu counties respectively (NACC/NASCOP 2013). To reverse this trend, there is need for concerted efforts from all sectors involved in HIV/AIDs programmes within the county and more so from the communities. However, one of the barriers that restrict CBOs to implement effective HIV/AIDs interventions is limited organizational capacity for sustained impact (AMREF 2004).

General Objective

The purpose of this study was to determine factors affecting implementation of Community based HIV/AIDs projects in Mombasa County

RELATED LITERATURE

Theoretical Review

1. Theory of Change

Theory of Change defines all building blocks required to bring about a given long-term goal. This set of connected building blocks—interchangeably referred to as outcomes, results, accomplishments, or preconditions is depicted on a map known as a pathway of change/change framework, which is a graphic representation of the change process. Built around the pathway of change, a Theory of Change describes the types of interventions (a single program or a comprehensive community initiative) that bring about the outcomes depicted in the pathway of a change map. Each outcome in the pathway of change is tied to an intervention, revealing the often complex web

of activity that is required to bring about change (Centre for theory of change 2013).

It would not be complete without an articulation of the assumptions that stakeholders use to explain the change process represented by the change framework. Assumptions explain both the connections between early, intermediate and long term outcomes and the expectations about how and why proposed interventions will bring them about. Often, assumptions are supported by research, strengthening the case to be made about the plausibility of theory and the likelihood that stated goals will be accomplished.

Stakeholders' value theories of change as part of program planning and evaluation because they create a commonly understood vision of the long-term goals, how they will be reached, and what will be used to measure progress along the way. A Theory of Change is a specific and measurable description of a social change initiative that forms the basis for strategic planning, on-going decision-making

and evaluation. Like any good planning and evaluation method for social change, it requires participants to be clear on long-term goals, identify measurable indicators of success, and formulate actions to achieve goals.

It differs from any other method of describing initiatives in that it shows a causal pathway from here to there by specifying what is needed for goals to be achieved, it requires you to articulate underlying assumptions which can be tested and measured, it changes the way of thinking about initiatives from what you are doing to what you want to achieve and starts there. A Theory of Change provides a roadmap to get you from here to there. This is helpful with constituents; staff, partner's organizations and funders (Centre for theory of change 2013).

2. Implementation Theory

According to Connell & Kubisch (1998), several types of theories are important for thinking about community change. Implementation theory, for example, identifies

the activities—the what and the when—to be undertaken in any change process and their links to expected intermediate- and longer-term outcomes, most often codified in a program's logic model. Typical implementation theories for community-based programs include a sequenced set of major steps, commonly community diagnosis/assessment, planning, intervention, and evaluation.

Such theory is invaluable for spelling out the mechanics and activities but provides little understanding of the how and why—the underlying process, dynamics and conditions under which community change takes place. Moreover, many implementation theories are relatively generic and may not be linked to community dynamics, and although they may use information on context, it is frequently not clear how community context should affect the implementation process (Connell & Kubisch. 1998).

According to Weiss 1995 Logic models are frequently used for explaining

the how and why of community change which is the express purpose of an underlying theory of change. However, theories of community change are the least explored and offer the greatest promise for documenting the effectiveness of and improvements in community-based health promotion.

3. Characteristics of CBOs

Certain fundamental characteristics differentiate CBOs from other interest groups or commercial organizations. CBOs are made up of members who join on a voluntary basis and who have a common interest to perform a variety of service, humanitarian, development or social functions as defined by their mission. They are primarily humanitarian, development, social, or cooperative rather than commercial objectives. While some CBOs maybe affiliated to a political party, they do not seek to challenge a government as a political party (AMREF 2004).

4. The Role of Community Based Organizations

The role of CBOs in health is to advocate, facilitate and empower communities to

manage their health and gain access to healthcare. It is acknowledged that CBOs play a key role in mobilizing and organizing health promotion campaigns and health services. Their role in spearheading community response against HIV/AIDS is stipulated in global and country level multi-sectoral strategic frameworks. Within countries CBOs can, and do mobilize, empower and support communities to respond effectively to the HIV/AIDS epidemic (AMREF 2004).

UNAIDS aptly recognizes that the outcome of the battle against AIDS will be decided at the community level, and local capacity for prevention, care and support efforts need to be recognized, affirmed and strengthened (UNAIDS 2011). Throughout the world, successful community-based programs, from peer support programs for people living with HIV to men encouraging other men to get tested, have been identified.

Table 2.1: Successful community-based HIV programs in other countries

Country	Program	Results
South Africa	Randomized control trial provided peer adherence support and nutrition to people living with HIV	Peer adherence support and nutrition can decrease delays in scheduled hospital visits
Tanzania	Community based volunteers linking HIV patients to medical workers	Fewer patients were lost to follow up due to increased support of family and community
Uganda	Comparison of home based ART delivery services to facility based ART delivery services	Patient survival and ability to suppress viral load were equivalent

Source: E²-Improving efficiency and effectiveness for health 2013

In Kenya, CBOs and NGOs have been used as entry points into communities to champion

activities, including advocacy, service delivery, and resource mobilization. Three projects in

particular demonstrate the effectiveness of community-based care. First, the African Medical Research Foundation financed CBOs and training of community health workers in home-based care (HBC) to conduct the Maanisha community-based project. The five-year project reached more than 64,000 people living with HIV with HBC and provided 37,000 clients with nutritional support(Wafula, Sam & Ndirangu 2009).

Second, the AMPATH program in western Kenya has shown home-based counseling and testing (HCT) for HIV to be effective. The program has demonstrated an acceptance rate of over 90 percent for testing and a high number of linkages to care and treatment. More than 550,000 persons have been tested for HIV through HCT(AMPATH 2013).

Third, the USAID-funded mothers2mothers (m2m) program was successfully implemented in 77 facilities. This is a peer support program in which HIV-infected mothers mobilize their peers to seek services through health facilities. The m2m program uses a “Prevention with Positives” approach by training and employing HIV-positive

mothers to provide high-quality support and education to their peers in the healthcare setting. More than 170 mentor mothers have been employed to support the more than 22,000 pregnant and postnatal women. Other major community-based care and support programs in Kenya include the USAID-supported APHIA II and APHIAplus projects. These projects typically train community health workers to provide home-based care, track and refer clients for services, follow up with pregnant mothers for services to prevent mother-to-child HIV transmission, and identify (USAID 2012).

Models of Community Based Interventions

a. Funding, technical assistance and support programmes

These organizations are non-governmental entities providing a support function to community-based organizations (CBOs) in: mobilizing and channeling funds; providing technical assistance and training for home-based care; project management; report writing; and project monitoring and evaluation. Such structures could be one vehicle for public-NGO partnerships to promote the development of

community-based action, and could also play a co-ordination and standard setting role.

b. Advocacy and community mobilization projects

Community mobilization programmes are often perceived as easy to develop. However, they are a time consuming endeavor requiring specific skills in the areas of motivating and sustaining community involvement, developing partnerships and linkages, and creating opportunities where all participants feel equally respected and able to make a valued contribution.

c. Drop-in centers/support groups

This model is perhaps the most common form of community-based care and support. It consists of a simple facility where people can receive HIV counseling and education, and can participate in support group activities. Most providers feel that the traditional support group model centered on verbal problem exploration and psychosocial counseling, is not sufficient, and combine it with an income generating activity (IGA). This has a twofold benefit: participants are engaged in an activity that facilitates conversation, and the

activity has the potential to generate some income.

With the income generated they are able to fund the activities of the drop-in centre. Support groups are reported to build self-confidence, help people cope with their diagnosis, overcome depression and create social networks for people who are isolated. Bonds are formed outside of the group, resulting in assistance with small chores for sick members. Through support group activities, HIV-infected adults can also be engaged in discussions about the future placement of their children, and to acquire the documentation which is necessary to access welfare grants.

d. Home visiting

Drop-in centre activities may include a home or 'friendly' visiting service. Volunteers visit patients in their homes and spend time talking and educating patients and their family about basic care needs. They also provide support with cooking, cleaning and helping with errands, including accompanying patients to health facilities. They may also arrange access to food parcels and other material support.

e. Comprehensive home-based care

Comprehensive home-based care programs provide, in addition to the above, varying degrees of palliative care. These programs tend to be run by more established NGOs (such as Hospice, Red Cross Society and church linked groupings). Training of caregivers includes supportive counseling, cleaning and dressing of wounds, oral hygiene, and supervision of drug taking and in certain instances, necrotic wound care, pain management and diagnosis of opportunistic infections. The package of services also often includes DOTS (Directly Observed Treatment Short-course) for tuberculosis.

Project Phases

Every project is made up of phases that need to be completed and within these phases tasks are broken down (unique set of challenges) to make management easier. Collectively the project phases are referred to as the project life cycle, and each phase usually includes a set of activities intended to establish the desired level needed to ensure a transition to the next step in the cycle. Before each phase is brought to a close, a review is conducted to conclude whether to proceed with the next phase, cancel the entire project, or repeat the previous phase (Wideman 2004).

The four basic phases identified by Westland (2006) include initiation, planning, execution, and closure.

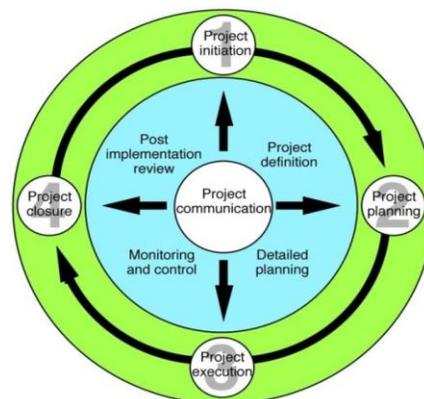


Figure 2.1: The four phases of the project life cycle (Westland 2006)

of the project life cycle (Westland

Project Life Cycle (Project life span)

Just like human beings projects have a birth stage, a growth stage, maturity stage and an ending stage (death). All projects are structured to have a beginning and an end, but it is also crucial to take particular note of the middle stage since it is within this stage that most activities occurs, to pave way for project completion.

Patel & Morris (1999) argue “the life cycle is the only thing that distinguishes a project from a non-project” in the sense that life cycles and projects share common characteristics of having specific beginning and end time (specific time schedule). A clearer explanation indicates the wrong usage of the word “cycle” in the term “project life cycle”; this is because a cycle is defined as any complete series of repeated events, but this definition reverses the original definition of a project as being a “one-time” activity accomplishable within a particular time schedule.

According to Wideman (2004) a more appropriate term in this sense would be

“project life span”. Even though, processes within projects are similar in nature, there is no particular lifecycle that applies to all projects and for this reason project managers are challenged with the responsibility of critically thinking so as to figure out the project lifecycle stages that are required for successful project completion. In many cases, projects fail to deliver because of the application of “One-Size-Fits-All” project management, a method which limits all sorts of projects to the same lifecycle.

Management of community projects

Project management stems from the need to plan and coordinate large, complex multifunctional efforts (Richman, 2012). Managing project without project management is like playing football without game plan. According to Martin and Tate (2001) project management is a set of tool, techniques, and knowledge that when applied, helps you produce better results for the projects.

The project manager should be a person, who can create and lead a stimulated, aggressive team and further indicated that the project

manager must be people oriented, thus be concerned with the behaviour of his team members and their reactions (Pieterse, 2001).

The project manager must possess the necessary basic management skills and be well versed in project management (Pieterse, 2001).

Conceptual Framework

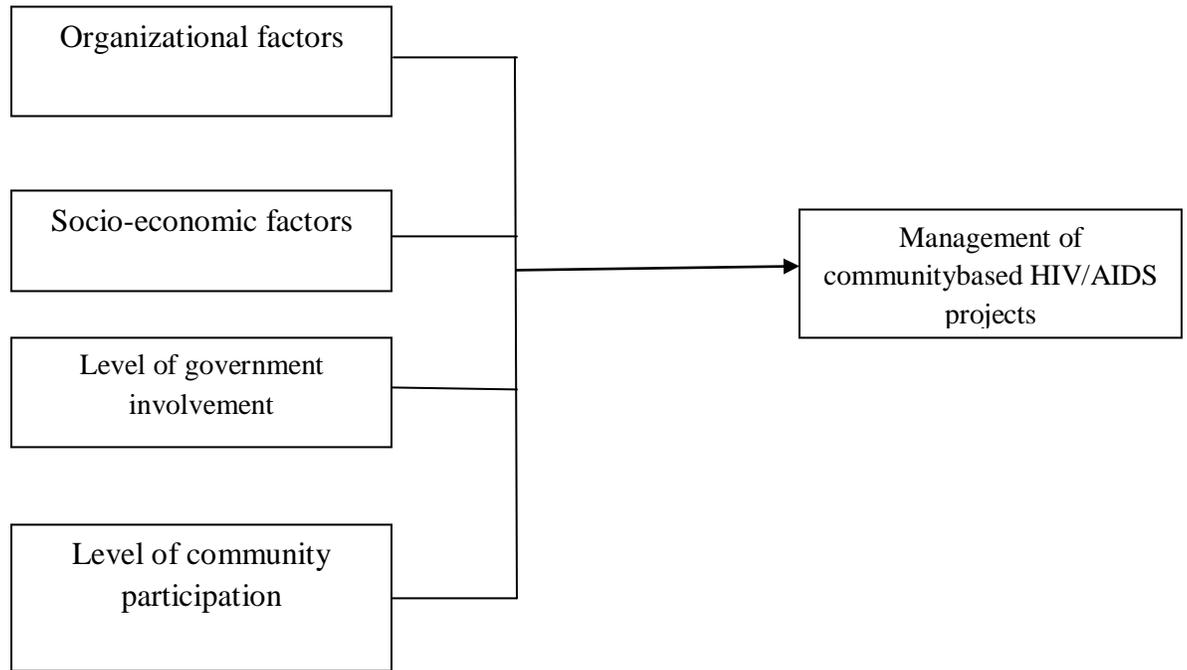


Figure 2.2: Conceptual Framework

Source: Author 2014

Organizational Factors

Studies of community based organizations have documented comparable success factors among CBOs. In their assessment one of the critical factors noted was organizational competency for effective community- driven

prevention, care and support, and advocacy interventions (Lassner 2010).

Project Management

Within a community, the fight against HIV/AIDs consists of projects aimed at stopping further spread of the epidemic and improving lives of those infected and affected.

An important component for the success of a project is good project management. Richman (2012), outlined planning, directing, organizing, staffing, controlling, and coordinating as the classic functions of project management.

Leadership and Governance:

Good leadership and governance are essential elements of effective CBO implementing HIV/AIDS interventions. Leaders have a responsibility to provide vision and direction, safeguard the values of the organization, ensure accountability and properly plan for the implementation of project activities (Lassner 2010).

Management of financial resources:

Financial management involves planning, organizing, controlling and reporting on the financial resources of an organization. CBOs must ensure that donated funds and other resources are properly used to achieve the purpose for which they were obtained, and also achieve organizational mission and objectives (AMREF 2011)

Technical Capacity

HIV/AIDS interventions are aimed at preventing infection or alleviating suffering of those already infected or affected. Community based implementing organizations should therefore have a certain level of technical capacity in their areas of intervention of HIV and AIDS (AMREF 2011)

Monitoring and Evaluation

Many projects fail to sustain because their activities are not monitored. Therefore, community projects should be monitored in order to establish the progress of the projects, identify the strength and weakness of the project, compare with other community projects and check whether the work is costing too much and achieving too little (Ravhura, 2010). Organizations should routinely monitor and evaluate the progress of their HIV/AIDS activities to ensure that resources are used efficiently and that goals are being met.

Socio-Economic Factors

Though economic reasons, internal policies and structural rigidities may partly account for the poor performance of community projects, explanatory factors responsible for this trend have not been clearly identified and widely researched. However, it has been hypothesized that participation is influenced by the availability of conducive opportunities and resources. Kabwegyere and Migot-Adholla (1981) argue that socio-economic factors such as education, rural or urban residence, sex, age, marital status, income, religion and family size influence participation. They argue that if the score on each of these variables is low then participation is reduced and in that context, development becomes insignificant.

A number of studies indicate that factors such as socioeconomic benefits, age and education influence people's participation in projects. Chowdhury(2004) argues that a majority of people participate in projects because of anticipated economic benefits and/or because of social status. He observes that a poor socio-economic background in terms of occupation

and level of income influences the extent of participation in projects. He also observes that people's level of education influences their participation in projects.

Age is also one of the factors that have been observed to determine community participation in activities.

Government Involvement in Community-Based Projects

A historical, political and social analysis of the country is critical in addition to the usual economic analysis to carefully assess whether the government has capacity to support community- based development in a manner consistent with both upward commitment and downward accountability. There should be commitment by the country to a cultural change in the institutional environment, which has to become more participatory, responsible and transparent, with downward accountability (Mansuri & Rao, 2004).

According to Haider (2009) government involvement contributes to the success of

community approaches, dampen resistance and lead to support for such activities and linking community-based projects to government policies and institutions can extend the reach of such projects and their sustainability. Risks of government involvement on the other hand are Community-based projects may become a part of government bureaucracy rather than an innovative and participatory community approach and government interference in decision making process may undermine community empowerment.

Community Involvement in Projects

Several decades of development funding have demonstrated the failures of the ‘top-down’ approach to reach and benefit the rural poor (Cernea & Ayse, 1997). This realization has led to the adoption of the ‘bottom-up’ approach to development. However, despite the recent upsurge in the ‘bottom-up’ approach to development, project beneficiaries are still not fully participating in the identification, planning, implementation and monitoring and

evaluation of projects that are meant to improve their lot (Blackman, 2003).

Even when an element of ‘participation’ is built into projects, it is all too often largely in terms of local investment of labor and not in real decision-making. Beneficiary communities are only informed after plans have been made and that this is done through formal meetings where the officers justify their plans but modification is not considered (APO, 2002). Limited community participation in the implementation and management of projects means that the projects have few chances of sustainability (Rahmato, 1991).

Lack of reliable data on effective community participation in projects constitutes a major constraint to policy-makers, planners and managers. This frequently leads to incorrect assessment of the needs of people hence, making it difficult for governments and development agencies to properly measure progress achieved by projects in improving livelihoods of communities. This often leads to

poor performance of the projects and eventual failure (Karki, 2001).

Recognizing the central role of communities in the project cycle, it is important for project donors/sponsors (Government, Private or Non-Governmental) to involve all stakeholders in the design and implementation of HIV/AIDs projects so as to ensure beneficiary ownership and also to instill virtues of accountability, transparency and sustainability. Active participation of beneficiaries in project design and implementation will also enable donors/sponsors to identify and address the factors leading to poor community participation in such projects.

Mansuri & Rao, (2004) indicate that community based initiatives is the active involvement of the members of a defined community in at least some aspects of project design and implementation. The key objective is the incorporation of local knowledge into the project decision making process.

In Japan, it was indicated that the critical element of sustainable disaster management is

communities' participation the activities. It was further indicated that the common elements of community involvement are partnership, participation, empowerment and ownership by local people. People should own problems, consequences and challenges of any mitigation and preparedness initiative, it is necessary to take people's involvement further into policy and strategy (Pandey & Okazaki, 2005).

In Mali limited community participation contributed to community development problems and constraints because communities did not fully support and participate in development activities. Community participation tends to be limited to financial management and not to promoting and ensuring the sustainability of project actions. It was also indicated that in Mali the participation of women in community development projects was insufficient (Nzau-Muteta, Nzeyimana & N'Quessan, 2005)

Community-based initiatives seek to empower local community groups and institution by

giving the community direct control over, project planning, execution and monitoring, through a process that emphasizes inclusive participation and management (Haider, 2009). The success of participatory projects may also be affected by how well heterogeneity is managed, by what resources and strategies are used to bring communities together and how effectively differences are debated (Mansuri & Rao 2004).

According to SMARTE (2010) community involvement is a very important aspect of revitalization for any community and indicated that without community buy-in, a project may never get off the ground or will not be accepted once it is completed. It was further indicated that community involvement should be used to generate not only ideas for revitalization projects and their implementation, but also ideas to further improve existing project features. Community members may have special issues or concerns that, if incorporated into a project at the outset, may help to reduce the likelihood of

challenges to risk assessment results, and potential remediation or revitalization plans.

METHODOLOGY

Research design

Research designs are the specific procedures involved in the research: data collection, data analysis and report writing (Creswell, 2012). This study employed a descriptive survey research design and will involved quantitative approaches in terms of instruments and data analysis. Descriptive survey design involves collection of data from a sample of a population in order to determine the current status of that population with respect to one or more variables (Mugenda & Mugenda 2003).

Population

Quinlan (2011) defines population as all individuals, items or units relevant to the study and comprised of individuals, groups, organization, documents, campaigns, incidents and so on. This study will be conducted within Mombasa County, targeting CBOs implementing community HIV/AIDs projects.

As at the end of 2013 a total of 19 CBOs were registered with the District Gender and Social Services as conducting HIV/AIDS activities. The list of these CBOs was used as a sampling frame for the study. The population of the research is 516

Sample and sampling method

A sample is a subgroup of the target population that the researcher plans to study for generalizing about the target population (Creswell, 2012). The numbers of the samples was in proportion to the relevant population to ensure the generalization of the results of the sample from the whole population. After

getting the CBOs; the researcher employed a simple random sampling technique to identify respondents who are members of the CBOs.

According to Mugenda & Mugenda (2003), simple random sampling is a probabilistic sampling technique which ensures each subject, object or respondents have an equal chance of representation.

According to Cavana, *et al* (2001), a sampling frame is a list of elements from which the sample is actually drawn and closely related to the population. The sample size is computed as shown below by taking 10% of total population in each CBO.

Table 3.1: Sample Frame and Sample Size

S/No.	Name of CBO	Sample Frame	Sample Size
1.	Jamii Bora	16	2
2.	Maganda CHW Development	33	3
3.	Vyemani C.U	54	5
4.	Standing Firm	28	3
5.	Narcol	15	2
6.	Safe Heaven	20	2
7.	Mbungoni Community Initiative	38	3
8.	Okoa timbwani	23	3
9.	Zenith Community Project	40	3
10.	Bomu Rocina Orphans	23	3
11.	Smart Reasonable	16	2
12.	Kazi Ni Sasa	22	3
13.	Pamoja Tunaweza	20	2

14.	Digital Ten Network	24	3
15.	King'orani Initiative Muslim Youth	32	3
16.	Network for people Living with HIV	60	4
17.	Lahuka Women Empowerment Project	25	3
18.	Inuka Support Group	11	1
19.	Solace Youth Development	16	2
	TOTAL	516	52

Research instrument

The study used questionnaires as instruments to collect data. According to Creswell (2012) a questionnaire is a form used in the survey design that participants in the study complete and return to the researcher. The basic objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue (Babbie&Mouton 2001). This instrument was chosen since it is a convenient tool as it facilitates quick and easy derivation of information, and given time constraints a questionnaire is the ideal tool for collecting data (Onen & Oso 2009).

This study used closed ended type of questionnaire with pre-set questions with a

limited number of multiple choices .The researcher will design and distribute questionnaires to respondents. The details of the questionnaires were explained to participants so that they understood how to approach questionnaires and what is expected from them.The questionnaire was divided into two sections; the section giving the personal information of the respondents and that which provided information based on the thematic areas.

Data analysis and interpretation

According to Devos (1998) analysis is a reasoning strategy with the objective of breaking down complex whole and resolving it into meaningful parts. Data interpretation was further defined as a process whereby recorded

observations are used to describe events and test hypotheses (Dane, 1990).

In this research data, were checked for accuracy and completeness before they were entered into a computer. Analysis of this data was done by use of Statistical Package for Social Sciences Version 20. Descriptive statistics and factor analysis were used to analyze the data so as to answer the research questions.

Factor analysis is as a statistical method used to describe variability among observed, correlated variables in terms of a potentially lower number of unobserved variables called factors. Factor analysis searches for such joint variations in response to unobserved latent variables. The observed variables are modeled as linear combinations of the potential factors plus "error" terms (Landau & Brian 2004).

$$F_i = W_{i1}X_1 + W_{i2}X_2 + W_{i3}X_3 + \dots + W_{ik}X_k$$

Where:

F_i = estimate of i th factor

W_i = weight or factor score coefficient

k = number of variables

RESEARCH FINDINGS AND

DISCUSSION

Study Variables

The findings on the main variables as analyzed using descriptive statistics are presented as shown in the paragraphs that follow.

Findings on Organizational factors

This variable aimed at answering the research question "How do organizational factors affect the implementation of Community based HIV/AIDS projects by CBOs in Mombasa County?" It was assessed using five main indicators of; Knowledge in project Management, Training in Leadership and governance, adequate financial management knowhow, HIV/AIDS skills and M& E during implementation and a five point Likert scale was used. Findings are presented below.

Table 4.5 Descriptive statistics on Organizational factors

	N	Min	Max	Mean	Std. Dev
Knowledge in project management	43	1.00	5.00	4.1860	.95757
Training in Leadership and governance	43	1.00	5.00	4.2558	.97817
Adequate financial management knowhow	43	1.00	5.00	3.5116	1.12063
HIV/AIDS skills	43	1.00	5.00	4.0698	.93593
M& E during implementation	43	2.00	5.00	4.3256	.86523

All the five indicators had a mean greater than 3 and an average of 4 which correspond to “agree” in the Likert scale. This shows that the Organizational factors play an important role in implementation of Human Immunodeficiency Virus projects by community based organizations. This is in agreement with Lassner (2010) who said that good leadership and governance are essential elements of effective CBO implementing HIV/AIDS interventions. This author also added that leaders have a responsibility to provide vision and direction, safeguard the values of the organization, ensure accountability and properly plan for the implementation of project

activities. The findings also correspond to Ravhura (2010) who suggested that community projects should be monitored in order to establish the progress of the projects, identify the strength and weakness of the project, compare with other community projects and check whether the work is costing too much and achieving too little. Organizations should routinely monitor and evaluate the progress of their HIV/AIDS activities to ensure that resources are used efficiently and that goals are being met.

The findings above are further augmented by the specific indicators responses which are indicated in table 4.6.

Table 4.6: Frequency of Responses on Organizational Factors

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Project Management						
Knowledge in project management influences	1					

implementation of community based HIV projects	2	4	17	19	43	
Leadership and Governance						
Training in leadership and governance is likely to influence HIV projects implementation by CBOs	1	2	1	17	21	43
Financial Management						
Members of the CBO have adequate financial management knowhow for successful project implementation	4	2	12	18	7	43
Technical capacity						
Do the officials, volunteers and members have the necessary HIV/AIDS skills to do their duties well?	0	3	2	23	14	43
Monitoring and evaluation						
The organization prepares work plans for implementation and carries out M& E during implementation	0	2	5	13	23	43

As indicated in the above table a majority of the respondents either agreed or strongly agreed to the indicators thus confirming that indeed organizational factors are significant in project implementation.

Findings on Socio-economic factors

This variable aimed at answering the research question “How do Socio-economic factors affect the implementation of Community based HIV/ AIDS projects by CBOs in Mombasa County?” It was assessed using three main indicators of level of education, economic status and provision of incentive packages. Measurement was on five point Likert scale and findings are presented in table 4.7.

Table 4.7: Descriptive statistics on Socio-economic factors

	N	Minimum	Maximum	Mean	Std. Deviation
The economic status	43	2.00	5.00	3.7209	.90831
Level of education	43	2.00	5.00	2.884	1.0999
Provision of incentive packages	43	2.00	5.00	3.4419	1.09767

Mixed results were found in this variable.

of education and incentive packages had a

Economic status was agreed to while the level

mean approaching 3 which represented neutral

in the Likert scale. The individual questions

are further presented in the table that follows.

Table 4.8: Frequency of responses on Socio-economic

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Level of education is likely to determine participation in CBO activities by an individual	0	24	4	10	5	43
The economic status of an individual is likely to influence their participation in CBOs	0	5	10	20	8	43
Provision of incentive packages is likely to influence implementation of CBO projects	0	10	14	9	10	43

The study revealed that socioeconomic factors specifically economic status and incentives affect the implementation of Human Immunodeficiency Virus projects by community based organizations. These findings are in line Kabwegyere and Migot-Adholla (1981) who argue that socio-economic factors such as rural or urban residence, sex, age, marital status, income, religion and family size influence participation. They argue that if the score on each of these variables is low then participation is reduced and in that context, development becomes insignificant. The findings also agree with Chowdhury(2004) who argued that a majority of people

participate in projects because of anticipated economic benefits and/or because of social status. He observed that a poor socio-economic background in terms of occupation and level of income influences the extent of participation in projects. The study negates Chowdhury(2004) who observed that people's level of education influences their participation in projects. This study revealed that the level of education is not significant predictor of implementation of projects

Findings on Government Involvement

Part of the study's objective was to establish how level of government involvement influences implementation of Community

based HIV/AIDS projects in Mombasa County. This variable was measured using a two point Likert scale on one indicator

(participation) and a five point Likert scale on oversight. Findings are presented in the tables below.

Table 4.9 Descriptive statistics the level of Government Involvement

	N	Minimum	Maximum	Mean	Std. Deviation
Government participation	43	1.00	2.00	1.6744	.47414
Oversight by the government	43	1.00	5.00	3.1860	1.36723

The mean and standard deviation of participation shows a “yes” for government participation while that of oversight showed greater than 3 thus tending to agree. The findings are further illustrated in tables 4.10 and 4.11 below.

Table 4.10: It is important to have government involved in CBO activities

	Frequency	Percent	Valid Percent	Cumulative Percent
No	14	32.6	32.6	32.6
Yes	29	67.4	67.4	100.0
Total	43	100.0	100.0	

It was evident from the findings that a majority of the respondents 67.4 %, agreed that it was important for the government to be involved in implementation of community based HIV projects. Only 32.6% were not in favour of government involvement.

Table 4.11: Oversight by the government enhances implementation of projects by the CBOs

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Disagree	4	9.3	9.3	9.3
Disagree	14	32.6	32.6	41.9
Neutral	5	11.6	11.6	53.5
Agree	10	23.3	23.3	76.7
Strongly Agree	10	23.3	23.3	100.0
Total	43	100.0	100.0	

However in the question that sought to find out if Government oversight was likely to enhance implementation of such projects, a majority 32.6% disagreed, while those who agreed and strongly agreed stood at 23.3%. A number of respondents 11.6% were neutral on the question, whereas there was a significant number, 9.3%. This study also confirmed the existence of a significant relationship between government support and implementation of projects. Similar findings were reported by Mansuri & Rao (2004) who observed that historical, political and social analysis of the country is critical in addition to the usual economic analysis to carefully assess whether the government has capacity to support community-based development in a manner consistent with both upward commitment and downward accountability. There should be commitment by the country to a cultural change in the institutional environment, which has to become more participatory, responsible and transparent, with downward accountability.

Haider (2009) has same findings and suggested that government involvement contributes to the success of community approaches, dampen resistance and lead to support for such activities and linking community-based projects to government policies and institutions can extend the reach of such projects and their sustainability. Risks of government involvement on the other hand are Community-based projects may become a part of government bureaucracy rather than an innovative and participatory community approach and government interference in decision making process may undermine community empowerment.

4.4.4 Findings on Community participation

This variable aimed at answering the research question “How do community participation affect the implementation of Community based HIV/ AIDS projects by CBOs in Mombasa County?” It was assessed using three indicators of; Community needs assessment, Training for stakeholders, and Community meetings. A five point Likert scale was used 1 representing strongly disagree and

5 for strongly agree. Findings are presented below;

Table 4.12: Descriptive statistics on Community participation

	N	Minimum	Maximum	Mean	Std. Deviation
Community needs assessment	43	2.00	5.00	4.1628	1.19384
Training for stakeholders	43	2.00	5.00	4.1628	.84319
Community meetings	43	2.00	5.00	3.9535	1.19430

Looking at the means it can generally be concluded that most of the indicators were agreed to. The standard deviations also suggest that there are more agreements among the respondents over the factors. The above findings are cemented with the specific variables shown in the table that follows

Table 4.13 Frequency of responses on Community Participation

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
The CBO conducted a community needs assessment prior to implementation of their project	0	9	0	9	25	43
The CBO conducts trainings for various stakeholders in the community.	0	0	24	4	15	43
The CBO holds meetings with the community	0	9	4	10	20	43

The study revealed that Community participation affect the implementation of Human Immunodeficiency Virus projects by community based organizations. This agrees with Cernea & Ayse,(1997) who said that several decades of development funding have demonstrated the failures of the ‘top-down’ approach to reach and benefit the rural poor. This realization has led to the adoption of the ‘bottom-up’ approach to development. The findings contradict that of Rahmato (1991) who said that limited community participation in the implementation and management of projects means that the

projects have few chances of sustainability and Lack of reliable data on effective community participation in projects constitutes a major constraint to policy-makers, planners and managers. This frequently leads to incorrect assessment of the needs of people hence, making it difficult for governments and development agencies to properly measure progress achieved by projects in improving livelihoods of communities. This often leads to poor performance of the projects and eventual failure (Karki, 2001).

The findings agree with that of Mansuri & Rao, (2004) who indicated that community based initiatives is the active involvement of the members of a defined community in at

least some aspects of project design and implementation. These authors also added that the success of participatory projects may also be affected by how well heterogeneity is managed, by what resources and strategies are used to bring communities together and how effectively differences are debated (Mansuri & Rao 2004).

4.5 KMO and Bartlett's Test

The KMO measures the sampling adequacy which should be greater than 0.5 for a satisfactory factor analysis to proceed and in order to draw valid conclusions. Table 4.14 shows that the KMO measure is 0.553 and therefore satisfactory. From the same table, we can see that the Bartlett's test is significant. That is, its associated probability is less than 0.5.

Table 4.14 KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.553
Bartlett's Test of Sphericity	Approx. Chi-Square	844.217
	Df	78
	Sig.	.000

4.6 Communalities

The table of communalities shows how much of the variance in each variable has been accounted for by the extracted factors. For example over 96% of the variance in “The

CBO conducts community needs assessment prior to implementation of the projects “while only 44.7% of the variance in “*Level of education is likely to determine participation in CBO activities by an individual*” is accounted for.

Table 4.15 Communalities

	Initial	Extraction
Knowledge in project management influences implementation of community based HIV projects	1.000	.864
Training in Leadership and governance is likely to influence HIV project implementation by CBOs	1.000	.828
Members of the CBO have adequate financial management knowhow for successful project implementation.	1.000	.654
Do the officials, volunteers and members have the necessary HIV/AIDS skills to do their duties well?	1.000	.756
The organization prepares work plans for implementation of identified intervention activities and carries out M& E of during implementation	1.000	.593
Level of education is likely to determine participation in CBO activities by an individual	1.000	.447
The economic status of an individual is likely to influence their participation in CBOs	1.000	.829
Provision of incentive packages is likely to influence implementation of CBO projects	1.000	.915
Is it important to have government involved in CBO activities	1.000	.867
Oversight by the government enhances implementation of projects by the CBOs	1.000	.759
The CBO conducts community needs assessment prior to implementation of the projects	1.000	.960
The CBO conducts training for stakeholders in the community	1.000	.854
The CBO holds meetings with the community in regard to the activities they are implementing	1.000	.955

Extraction Method: Principal Component Analysis.

4.7 Total Variance Explained

Table 4.16 shows all the factors extractable from the analysis along with their eigenvalues, the percent of variance attributable to each factor, and the cumulative variance of the factor and previous factors. The first factor accounts for 27.449% of the variance, the

second 27.189%, the third accounts 16.420% while the fourth factor accounts for 8.032%, a total of 79.090% of the total variance. All the remaining each control only small amounts of variance and are not significant but between them account for the remaining 20.910%.

Table 4.16 Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.568	27.449	27.449	3.568	27.449	27.449	3.523	27.103	27.103
2	3.535	27.189	54.638	3.535	27.189	54.638	2.962	22.782	49.885
3	2.135	16.420	71.058	2.135	16.420	71.058	2.549	19.611	69.496
4	1.044	8.032	79.090	1.044	8.032	79.090	1.247	9.593	79.090
5	.825	6.343	85.433						
6	.601	4.621	90.054						
7	.428	3.290	93.344						
8	.377	2.901	96.244						
9	.263	2.026	98.271						
10	.122	.941	99.212						
11	.089	.688	99.900						
12	.011	.088	99.988						
13	.002	.012	100.000						

Extraction Method: Principal Component Analysis.

4.8 Scree plot

Figure 4.3 below shows that the curve begins to flatten between factors 4 and 5, factor 5 has

an Eigen value less than 1 so only four factors have been retained. This is consistent with Kaiser's Rule

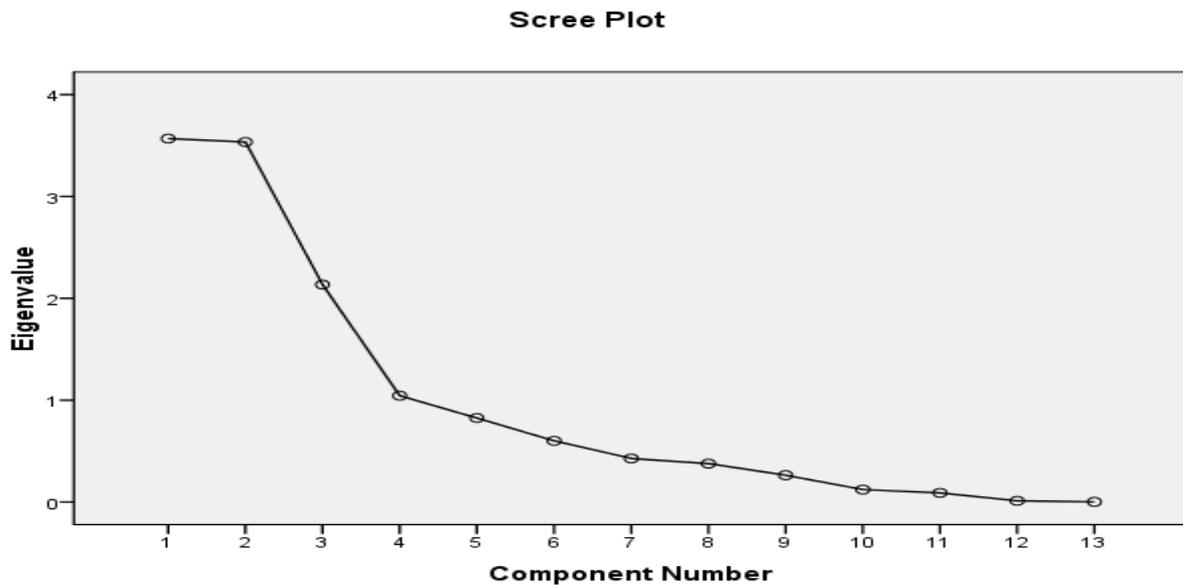


Figure 4.3: Scree Plot

4.9 Component Matrix^a

The component matrix shows the loadings that each variable has on each factor. The results are presented in table 4.17 below.

Table 4.17 Component Matrix^a

	Component			
	1	2	3	4
Knowledge in project management influences implementation of community based HIV projects	.646	.569	-.319	
Training in Leadership and governance is likely to influence HIV project implementation by CBOs		.832		
Members of the CBO have adequate financial management knowhow for successful project implementation.	.317	.637	-.370	
Do the officials, volunteers and members have the necessary HIV/AIDS skills to do their duties well?	.525	.679		
The organization prepares work plans for implementation of identified intervention activities and carries out M& E of during implementation	.361	.650		
Level of education is likely to determine participation in CBO activities by an individual		-.583		
The economic status of an individual is likely to influence their participation in CBOs	-.361	.403	.661	.315

Provision of incentive packages is likely to influence implementation of CBO projects	.324	.394	-.804
Is it important to have government involved in CBO activities	.519	-.693	
Oversight by the government enhances implementation of projects by the CBOs	.740	.345	
The CBO conducts community needs assessment prior to implementation of the projects	.800	-.558	
The CBO conducts training for stakeholders in the community	.498	.713	.303
The CBO holds meetings with the community in regard to the activities they are implementing	.788	-.506	

Extraction Method: Principal Component Analysis.a. 4 components extracted.

4.10 Rotated Component Matrix^a

The component matrix above was rotated for clarity that is so as to get a more clear and differentiated factor loading.

Table 4.18 Rotated Component Matrix^a

	Component			
	1	2	3	4
Knowledge in project management influences implementation of community based HIV projects	.851		.305	
Training in Leadership and governance is likely to influence HIV project implementation by CBOs	.829		-.372	
Members of the CBO have adequate financial management knowhow for successful project implementation.	.748			
Do the officials, volunteers and members have the necessary HIV/AIDS skills to do their duties well?	.839			
The organization prepares work plans for implementation of identified intervention activities and carries out M& E of during implementation	.720			
Level of education is likely to determine participation in CBO activities by an individual	-.530	.405		
The economic status of an individual is likely to influence their participation in CBOs				-.888

Provision of incentive packages is likely to influence implementation of CBO projects		.936
Is it important to have government involved in CBO activities	.857	
Oversight by the government enhances implementation of projects by the CBOs	.742	.415
The CBO conducts community needs assessment prior to implementation of the projects	.747	.613
The CBO conducts training for stakeholders in the community	.830	-.391
The CBO holds meetings with the community in regard to the activities they are implementing	.903	.371

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 5 iterations.

Variables concerned with Organizational factors are heavily loaded on factor 1, while those concerned with Community participation are heavily loaded on factor 2; Factor 3 was loaded on to by variables related socio-economic, the remaining variables concerning government support and incentive were loaded

on factor 4. These factors can be used as variables for further analysis. The 13 variables were reduced to four major factors using the Kaiser's Rule and the scree test. These rotated factors account for 79.090% of the covariance among the variables.

SUMMARY, CONCLUSION AND

RECOMMENDATIONS

Summary of findings

This study was conducted with the aim of identifying Factors affecting implementation of Human Immunodeficiency Virus projects by community based organizations in Mombasa County. A total of 52 questionnaires

were distributed and these form the basis the finding. Principal Component Analysis, subsequent rotation (Varimax) was applied. Many correlations were in excess of 0.30 and both KMO and Bartlett's tests produced criteria that supported the application of PCA. Communalities varied from 0.960 to 0.447. Applying Kaiser's Rule and the scree test, thirteen variables were reduced to four major

factors. Following rotation, factor one was loaded on six items that reflected Organizational factors and accounted for 27.449% of the variance and it was revealed that Organizational factors play an important role in implementation of Human Immunodeficiency Virus projects by community based organizations. Factor two was loaded on five items one that reflected Community participation and accounted for 27.189% of variance. The study revealed that Community participation affect the implementation of Human Immunodeficiency Virus projects by community based organizations. The third factor was loaded on seven items, accounted for 16.420% of the variance; this factor was referred to as socio-economic factors. The study revealed that socioeconomic factors affect the implementation of Human Immunodeficiency Virus projects by community based organizations. The fourth factor was loaded on two items, accounted for 8.032% of variance and was labeled government support and incentive. This study

also confirmed the existence of a significant relationship between government support and implementation of projects. These rotated factors account for 79.090% of the covariance among the variables

Conclusion

The level of implementation of Human Immunodeficiency Virus projects by community based organizations is related to a variety of factors. Organizational factors of play a fundamental role in implementation of projects; it was found that project management, leadership and governance, financial management, Technical capacity and finally Monitoring and evaluation are significant indicators of implementation community protects. Community participation such as through conducting community needs assessment, training for stakeholders' community and holding meetings with the community had a significant influence in implementation community protects. The socio-economic factors as indicated by; Level of education, economic status and incentive packages has a significant influence in

implementation community protects. Government support and assistance is also found to be a key factor as the community has been assisted by incentives and oversight.

Recommendations

1. This study realized important findings that have effect on the implementation of Human Immunodeficiency Virus projects by community based organizations. Based on this it is recommended there is need for CBO to liaise with local leaders and raise public awareness on the roles that CBOs do.
2. There should be more emphasis put on organizational factors like project management, financial management etc for successful implementation of projects.
3. People with a higher level of education need to take initiative and actively participate in management and implementation of community based HIV projects to enhance implementation of such projects.
4. There should be more involvement of communities as well as PLHIV so as to have

tailor made projects that are responsive to needs of the community and PLHIV

5. Further research need to be done on the impact of Government policies on the implementation of Human Immunodeficiency Virus projects.

REFERENCES

African Medical Research Foundation (2004), *HIV and AIDS needs assessment*, Lake Victoria Basin Region, AMREF. Nairobi, Kenya

Asian Productivity Organization (APO) (2002). *Participatory Project Cycle Management (PPCM): A Planning Method for Community Development*.

AMPATH. n.d. "Home-based Counseling and Testing." [www.ampathkenya.org/our-programs/communicable-diseases/home-based-counseling-and-testing-\(hct\)/](http://www.ampathkenya.org/our-programs/communicable-diseases/home-based-counseling-and-testing-(hct)/)

Bill & Melinda Gates Foundation, (2009) *Managing HIV Prevention from the Ground Up: Avahan's Experience with Peer Led Outreach at Scale in India*. New Delhi:.

Blackman, R (2003) *Project Cycle Management*. Tearfund. Teddington, England.

Blankenship, K, M, Biradavolu M,R, Jena, A & Dhugana ,N(2010). *Challenging the stigmatization of female sex workers through a community-led structural intervention: learning from a case study of a female sex worker intervention in Andhra Pradesh, India. AIDS Care*

Busza, J. & Schunter, B. (2001). *From competition to community: participatory learning and action among young, debt-bonded Vietnamese sex workers in Cambodia*. Reproductive Health Matters

Centers for Disease Control and Prevention. (1997) *Community-based human immunodeficiency virus (HIV) prevention projects* (Announcement 704). Atlanta, GA:

Cernea, M.M, & Ayse, K (1997). *Social Assessment for Better Development: Case Studies in Runia and Central Asia*. The International Bank for Reconstruction and Development. The World Bank. Washington DC.

Chandrasekaran, Padma, Dallabetta, G, Loo, V, Rao, S, Gayle, H, & Alexander, A, (2006). *Containing HIV/AIDS in India: The Unfinished Agenda*. The Lancet Infectious Diseases

Creswel, J.W. (2012). *Educational Research: Planning, Conducting and Evaluating Qualitative and Quantitative Research*. 4th edition. Boston: Pearson Education, Inc.

Coulton C. Using community-level indicators of children's well-being in comprehensive community initiatives. In: Connell J, Kubisch A, Schorr L, Weiss C, eds. *New Approaches to Evaluating Community Initiatives*. Washington DC: The Aspen Institute; 1995

Deininger, K & Liu Y. (2009) *Economic and Social Impacts of Self-Help Groups in India*.: World Bank. Washington DC.

Fernández, M, Brown, G.S, Gay, C.L, Mattson, T.L., Bital, E, & Kelly, J.A. (2003). *Applying ESID principles to HIV prevention research*. American Journal of Community Psychology

Gay, L.R. (1992) *Educational research: Competences for analysis and application*. Charles E. Mairill publishing company. Bell & Howell company. Columbus, Toronto, London.

Gebre Selassie Beyene G, Lulseged K, & Kebede T (2002). *The potential of community-based organizations in HIV/AIDS prevention and social support activities in Ethiopia*. Abstracts of the AIDS Conference, Barcelona.

Gruber, J. & Caffrey, M. (2005). *HIV/AIDS and community conflict in Nigeria: implications and challenges*. Social Science and Medicine

Haider, H. (2009) . *Community-based Approaches to Peacebuilding in Conflict-affected and Fragile Contexts*. Geneva: International Development Department, University of Birmingham

Hailu, Y.M. (2002), *The importance of organizing support for care group givers of persons living with AIDS (PLWA) and orphaned children*. International Conference on AIDS, Barcelona.

Hogle, J.A (ed). (2002). *What Happened in Uganda?: Declining HIV Prevalence, Behavior Change, and the National Response*. USAID. Washington DC,

Karki, M (2001). *Institutional and Socio-Economic Factors and Enabling Policies for Non-Timber Forest Products-Based Development in North East India*. Paper presented in the Pre-Identification Workshop

for NTFP-led development in NE India, organized in IFAD, Rome

Kelly, J. A., Heckman, T. G., Stevenson, L. Y., Williams, P. N., Ertl, T., Hays, R. B., Leonard, N.R., O'Donnell, L., Terry, M. A., Sogolow, E. D., & Neumann, M. S. (2000). Transfer of research-based HIV prevention interventions to community service providers: Fidelity and adaptation. *AIDS Education and Prevention*

Kenya Gazette, Legal Notice No. 170 of 1999

Kenya National AIDS Control Council (2005) *Kenya National AIDS strategic plan 2009/10-2012/13: delivering on universal access to services*. Nairobi, Kenya

Kenya National Bureau of Statistics (2009), *Census Report*, Nairobi, Kenya

Knipe, A, Van der Walt, G, Van Niekerk, D, Burger, D and Nell, K. (2010). *Project management for Success*. 6th impression. Sandton: Heinemann Publishers (Pty) Ltd.

Kothari, C.R. (2003); *Research Methodology; Methods and Techniques*. 2nd ed. New Age Int. Publishers, New Delhi

Lassner, K. (2010) *Guide to effective governance*. Management Sciences for Health and USAID

Lever R., (2008) [ref 20/11/12]: Available at <http://suite101.com/article/project-initiation-starting-in-the-right-way-a87438>.

Mansuri, G & Rao, V. (2004) *Community-Based and –Driven Development: A Critical*

Review. The World Bank Researcher Observer. 19(1). The international Bank for Reconstruction and Development/ World Bank.

Martin, P & Tate, K. (2001) *Getting Started in Project Management*. New York: John Wiley & Sons, Inc

Maskey V, Gebremedhin T.G, Dalton TJ (2003) *A Survey Analysis of Participation in a Community Forest Management in Nepal*.

Merzel, C. & D'Afflitti, J. (2003) *Reconsidering community-based health promotion: promise, performance, and potential*. American Journal of Public Health

Ministry of Medical Services and Ministry of Public Health and Sanitation (2012) *Position Paper: Implementation of the Constitution in the Health Sector*. (Kenya).

Minkler M, Thompson M, Bell J, & Rose, K (2001), Contributions to community involvement to organizational-level empowerment: the federal Healthy Start experience. *Health Educ Behav*.

Mouton, J. (2001), *How to succeed in your Master's and Doctoral Studies: South African Guide and Resource Book*. Pretoria: J.L van Schaik.

Mugenda, O.M & Mugenda, A.G. (2003), *Research Methods, Quantitative & Qualitative Approaches*, African Centre For Technology Studies, ACTS press, Nairobi, Kenya

- NACO (2006), *National AIDS Control Programme Phase III (2007–2012): Strategy and Implementation Plan*. New Delhi: NACO.
- National AIDS/ STI Control Program (2011) *Guidelines for Antiretroviral Therapy in Kenya*. 4th Edition. Nairobi: NASCOP
- Nzau-Muteta, G, Nzeyimana, J & N'guessan. (2005) *Community development support project in the Kayes and Koulikoro Regions (PADEC)*. Mali: Department of Social Development Central and West Region.
- Oso, Y. & Onen, D. (2008), *A general guide to writing research proposal and Report. A hand book of beginning Researchers*. Nairobi, Jomo Kenyatta Foundation
- Pandey, B & Okazaki, K. (2005), *Community Based Disaster Management: Empowering communities to cope with disaster risks*. Japan. United Nations Centre for Regional Development.
- Patel, M. B. & Morris, P.G. W (1999), *Guide to the Project Management Body of Knowledge, Centre for Research in the Management of Projects*, University of Manchester, UK,
- Pieterse, M. (2001). *Critical success factors in information technology projects*. Johannesburg: Rand Afrikaans University.
- Project Management Institute. (2004). *A guide to the project management body of knowledge*. 4th edition. USA: Project Management Institute Inc.
- Sabine, L & Everitt, B.S (2004). *A Handbook of Statistical Analyses Using SPSS*. Chapman & Hall/CRC Press LLC. Boca Raton, Florida.
- Steckler, A, Israel, B, Dawson L, & Eng E. (1993) Theme issue: community health development: an anthology of the works of Guy Steuart. *Health Educ Q*.
- Quinlan, C. (2011) *Business Research Methods*. United Kingdom: Cengage Learning EMEA.
- Ravhura, T.I. (2010) *The impact of management on the sustainability of community development projects in Mutale Local Municipality*, Limpopo Province.
- Richman, L. (2012). *Improving your project management skills*. 2nd edition. USA: American Management Association.
- SMARTE.org. (2010). *Community Involvement*
- UNAIDS (2002) *Report on the Global HIV/AIDS Epidemic*. UNAIDS, Geneva,.
- USAID/Kenya. (2012) *“USAID mothers2mothers program giving babies a healthy start to life.”* kenya.usaid.gov/success-story/1270.
- Van Deventer, I & Kruger, A.G.(2009). *An educator's guide to school management skills*. Sixth impression. Pretoria: Van Schaik publishers.

Victor A.J, & Bakare, Y (2004). *Rural Livelihood Benefits from Participation in the Taungya Agroforestry System in Ondo State, Nigeria*. Small-Scale Forest Economics, Manage. Policy

Wafula, Sam & Meschack Ndirangu. (2009) . *Building Community Capacity in HIV/AIDS Response: The Case of Maanisha Project*. AMREF Case Studies. Nairobi: AMREF.

Weiss, CH (1995) .Nothing as practical as good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families. In: Connell J, Kubisch A, Schorr L, Weiss C, eds. *New Approaches to Evaluating*

Community Initiatives: Concepts, Methods and Contexts. Washington, DC: Aspen Institute;

Westland J.(2006) The project management lifecycle; *A complete step-by-step methodology for initiating, planning, executing & closing project successfully*

Wideman R.M. (2000). *First principles of project Management*. Revision 16, 00-11-03. AEW Services : Vancouver, BC.

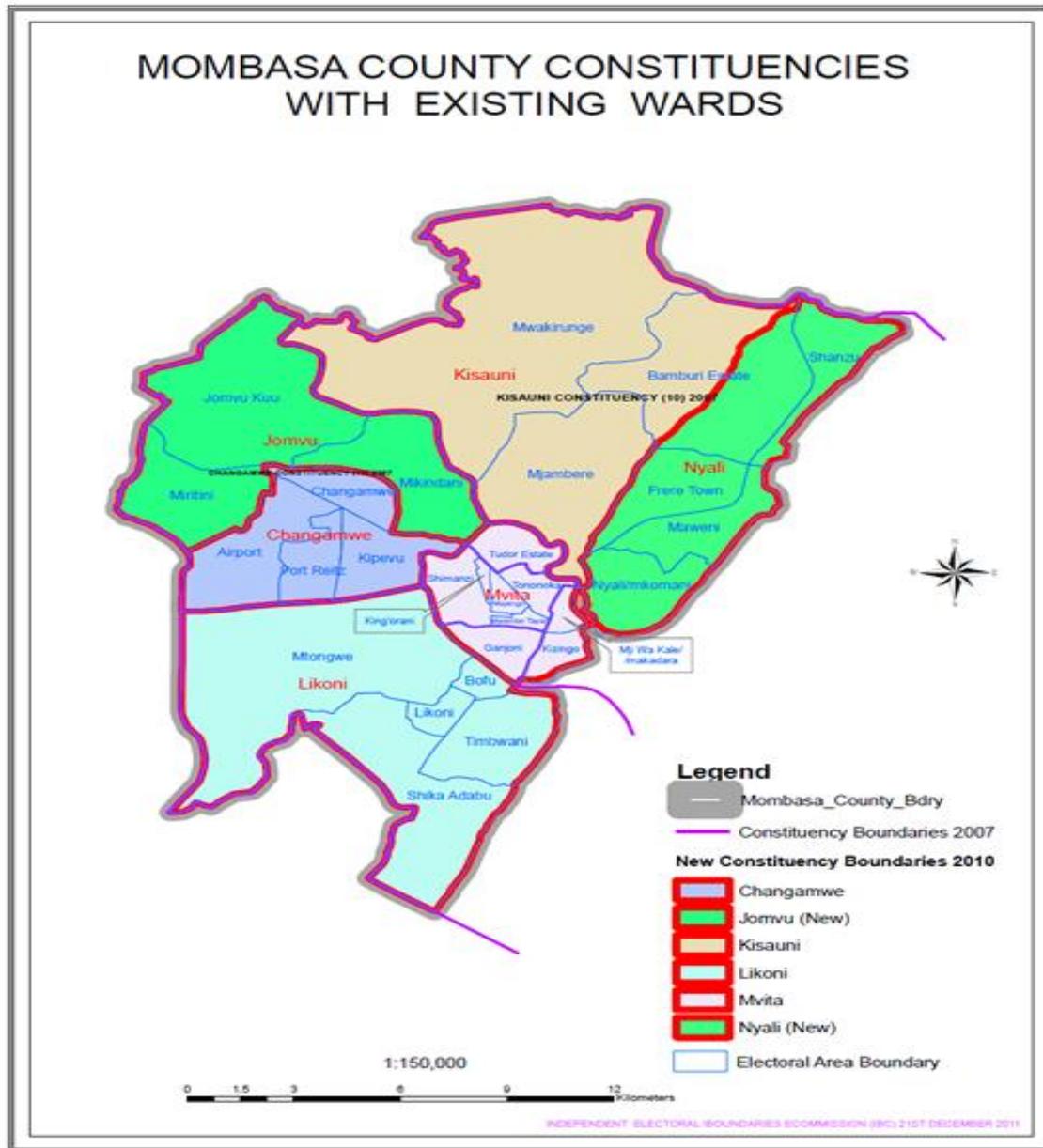
WHO/UNAIDS/UNICEF. (2011). *Global HIV/AIDS Response: Epidemic update and health sector progress towards universal access progress report*. www.unaids.org

APPENDIX I: LIST OF CBOS

S/No.	Name of Group	Year of Reg	Location
1	Jamii Bora CBO	2011	Bombolulu
2	Maganda Community Health Workers Development CBO	2011	Miritini
3	Vyemani Commuinty Unit	2011	Vyemani
4	Standing Firm CBO	2011	Kiembeni
5	Narcol CBO	2011	Miritini
6	Safe Heaven CBO	2011	Miritini
7	Mbungoni Community Initiative	2012	Kisauni
8	Okoa Timbwani	2012	Likoni
9	Zenith Community Project CBO	Tudor	2013
10	Bomu Rocina Orphans CBO	Port Reitz	2013
11	Smart Reasonable	Tononoka	2013

12	Kazi ni Sasa CBO	Tononoka	2013
13	Pamoja Tunaweza	Kisauni	2013
14	Digital Ten Network	Mvita	2013
15	Kingorani Initiative Muslim Youth CBO	Majengo	2013
16	Network for people Living with HIV	Likoni	2013
17	Inuka Support Group	Kisauni	2013
18	Lahuka Women Empowerment Project	Kisauni	2013
19	Solace Youth Development Group	Kisauni	2013

APPENDIX II: MAP OF MOMBASA COUNTY



Source: IEBC 2011