

**Influences on
International Non-Governmental Organizations'
Implementation of Equity Principles
in HIV/AIDS Work in Kenya:
A Case Study**

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ABSTRACT

There are growing calls for the involvement of multiple agencies to address health inequities. Many international non-governmental organizations (INGOs) working in health and development mention equity principles in their vision statements, missions, or strategic directions, and many authors view equity, including focusing on vulnerable populations, as an important role for these INGOs. However, there is a lack of in-depth empirical research on what influences INGOs' implementation of equity principles in their work. The present study helps to fill this gap by using a case study to examine INGOs' implementation of equity principles in their HIV/AIDS initiatives.

In this case study, I focused on HIV/AIDS initiatives in Kenya to illustrate the nature of the implementation gap between the intent of INGOs to ensure equity in their work and actual practice, and to examine the various influences that affected the implementation of INGOs' equity principles. I used HIV/AIDS as the exemplar because of the global epidemic of HIV/AIDS and the resulting large monetary investments made by donors to Southern countries and INGOs to address the disease.

I conducted an in-depth case study of an INGO operating in Kenya. The research questions were: "What is the nature of the implementation gap between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice? What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work? How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?"

The case study design employed multiple methods including document reviews, interviews with staff of the INGO in Kenya, as well as its Northern INGO counterparts in

Canada and the U.S., interviews with partners and clients of the INGO in Kenya, and participant observation with staff of the INGO in Kenya.

I found that many players (e.g. Southern country government and the Northern donors) from different levels (e.g. in-country as well as Northern donor countries) shape INGOs' implementation of equity principles in their HIV/AIDS work. Influences from donors include donor agendas and the focus of donor funding, as well as donor country policies. Influences from the Southern country government include government priorities and legislation. These influence INGOs' implementation of equity principles in their HIV/AIDS work, and in some cases can outright contradict equity principles. However, since INGOs are often reliant on donor funding and need Southern governments' permissions to work in-country, INGOs work within a system that is characterized by asymmetrical interdependence. They have to find a middle ground for implementing equity principles in their HIV/AIDS work. Hence, these influences help give rise to an implementation gap between what INGOs intend to accomplish in implementing equity principles in HIV/AIDS work and actual practice.

Implications for policy and practice include the need to: increase awareness of the roles various players have in implementing equity and the need for ongoing collaboration to achieve equity aims; continue work in capacity building on equity for INGO staff and its partners; and develop and refine tools for measuring and monitoring the implementation of equity. The present research clearly shows the significant role that INGOs play in equity, and the importance of understanding the multiple players and levels that influence INGOs' implementation of equity principles in HIV/AIDS. The research can help INGOs, Southern country governments, and donors to better understand the system within which INGOs work

in implementing equity principles, as multiple organizations continue to try to address health inequities around the globe.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome
CHW	community health worker
CSO	civil society organization
GLUK	Great Lakes University of Kisumu
HIV	Human Immunodeficiency Virus
IDU	injecting drug users
INGO	international non-governmental organization
KEMRI	Kenya Medical Research Institute
KNASP	Kenyan National AIDS Strategic Plan
MARPs	most-at-risk populations
MoTS	modes of transmission study
MOU	memorandum of understanding
MSM	men who have sex with men
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
SNGO	southern non-governmental organization
STI	sexually transmitted infection

1 Chapter 1: Introduction and Literature Review

1.1 Summary Statement of the Problem

“We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security” [1, p. 1].

Inequities in health are defined as inequalities that are unjust, unfair, and unacceptable, yet avoidable [2]. Inequities in health care access and outcomes are growing within and between countries [3, 4]. Addressing health inequities is clearly on the global agenda. Concerns over growing inequities were a major stimulus for the World Health Organization’s Commission on Social Determinants of Health [4], and the importance of addressing inequities was reaffirmed in the 2011 Rio Political Declaration on Social Determinants of Health [1].

Many international non-governmental organizations (INGOs) cite equity as a goal in their visions, missions, and strategic directions. Common approaches to achieve this goal include focusing on vulnerable populations (e.g. people living in poverty and women and girls) and empowering communities. Some authors argue that INGOs play a critical role in addressing health inequities, through their close relationships with communities and their work with the most vulnerable [5-7].

In this study, HIV/AIDS initiatives are used as the exemplar to understand how an INGO implements its equity principles and what influences this implementation. Addressing HIV/AIDS is one of the Millennium Development Goals (MDGs) [8], reflecting its immense human toll. World-wide, approximately 34 million people were HIV positive in 2011 [9, p. 8]. Sub-Saharan Africa has been the hardest hit with 23.5 million people living with HIV and 1.8 million new infections reported in 2011 [9, p. 14]. In 2009, almost \$16 billion (U.S.

dollars) was spent in response to the HIV/AIDS epidemic globally; in Southern¹ countries, including those in sub-Saharan Africa, 88% of resources for HIV/AIDS came from “international funding”, particularly from bilateral (Northern country government) donors [10, p. 145]. These investments illustrate the enormity of the problem and the efforts of the international community to address the epidemic.

This thesis uses an in-depth case study to examine INGOs’ implementation of equity principles in HIV/AIDS initiatives and the influences on INGOs’ implementation of these equity principles.

1.2 Literature Review

1.2.1 Inequities in HIV/AIDS

The terms equity and equality are not interchangeable. Inequalities in health acknowledge differences between groups, but do not offer a value judgment on the fairness of these differences [2]. On the other hand, inequities in health form a subset of inequalities that are unjust, unfair, unacceptable and avoidable [2]. Inequities can be examined in terms of access to health care, health outcomes, and the underlying determinants of health that influence these.

Inequities in health are evident in many diseases, including HIV/AIDS. Countries in sub-Saharan Africa typically have a generalized HIV/AIDS epidemic, which means that HIV/AIDS is not limited to certain subgroups, and is transmitted in the general population [11]. But even with a generalized epidemic, certain groups are more vulnerable and at higher risk for HIV/AIDS due to upstream determinants of health that increase their social and political vulnerability.

¹ This thesis will use the term Southern country to denote developing countries, and Northern country to describe developed countries.

The prevalence of HIV/AIDS in sub-Saharan Africa among people aged 15 to 49 is 4.9% [12, p. 8]. This overall percentage hides the fact that there are large inequalities between groups in terms of HIV prevalence, as well as inequalities between groups in terms of behaviours to prevent HIV/AIDS and access to treatment and prevention for HIV/AIDS.

In terms of prevalence, in sub-Saharan Africa in 2009, the majority (approximately 60%) of people 15 years of age and older who were HIV positive were women [10, p. 25]. Prevalence of HIV by income and education group does not follow a typical gradient, but generally in the past, higher income and higher educated groups had a higher prevalence of HIV in sub-Saharan Africa. Yet, a 2008 systematic review found that more recent studies in sub-Saharan Africa showed people with lower levels of education had a higher prevalence of HIV than those with high levels of education [13].

Certain groups, including men who have sex with men, sex workers, and injecting drug users, also have a higher prevalence of HIV than other groups [10]. A 2012 UNAIDS report cites data from 50 countries that showed female sex workers are 13.5 times more likely to become infected than other women [9, p. 36]. The same UNAIDS document reported that injecting drug users are 22 times more likely to become infected with HIV and men who have sex with men are 13 times more likely to have HIV than the general population [9, p. 36].

Examining differences in HIV prevalence alone is not sufficient, as some groups, such as those with higher incomes, are more likely to be the first to access anti-retroviral therapy (ARVT) programs [14], for example. Therefore, to understand inequities in HIV/AIDS, it is critical that inequalities in prevalence and behaviours, as well as access to prevention and treatment, be examined in the broader context of structural determinants of health.

For certain populations, such as females and men who have sex with men, biological reasons can increase vulnerability to HIV. However, this vulnerability is exacerbated by broader upstream determinants of health. The challenges that certain groups face in accessing care, treatment, and prevention services for HIV/AIDS are typically “socially determined” [15, p. 6], and these barriers from upstream determinants lead to inequities in access and ultimately health status and outcomes. For example, multiple upstream determinants of health make women more vulnerable to being exposed to HIV infection than (heterosexual) men. Culturally, women can have a lower status than men, which makes it hard for them to negotiate condom use for protection from infection. Sexual violence towards women increases risk of infection. Males can also limit females’ access to health care services, including prevention and treatment services. Laws in many countries limit women’s rights to inherit and to own property, and females are often financially dependent on males. Due to poverty, females are sometimes forced to exchange sex for food or money. More generally, females are more likely to have limited education and less knowledge about HIV/AIDS. In addition, women and girls are primarily responsible for taking care of their families. Thus, if family members are infected, girls may have to leave school to take care of the sick, or find employment to replace any income lost from sick family members. People living in poverty and people with lower levels of education often live in conditions that facilitate the spread of HIV/AIDS. People infected by HIV/AIDS are less likely to be able to maintain livelihoods for themselves and their families due to disease, which in turn perpetuates the cycle of poverty [10, 16-25].

Most-at-risk populations², including men who have sex with men, injecting drug users, and sex workers, have increased risk for HIV/AIDS because of these upstream determinants of health. Many countries in sub-Saharan Africa criminalize high risk behaviours, including sex work, injecting drug use, and homosexuality [10]. In 2010, non-governmental organizations reported to UNAIDS (as part of regular reporting) that 55% of countries in sub-Saharan Africa had legislation, regulations, or policies in place that challenged the ability of key high risk populations to access services for HIV/AIDS [10]. Yet, criminalization is not effective in reducing rates of HIV/AIDS; instead, these most-at-risk populations are often pushed underground because of their behaviours, and may not access and use prevention, care or treatment services for fear of discrimination, stigma, violence, and/or legal reprisal [10, 19, 26-31].

Other groups also are less likely to have access to HIV/AIDS prevention and treatment services [32]. This includes people living in rural areas, people living in poverty, and those with lower education levels. Consequently, they are less likely to be knowledgeable about their risk of HIV/AIDS and its modes of transmission, and less likely to protect themselves by using condoms [20]. Even if people living in poverty are able to access anti-retroviral therapy (ARVT), access to the drugs alone is not sufficient. Reviews of the literature have shown that access to adequate nutrition is also important while on ARVT [33, 34], and this may be a challenge for those living in poverty, even if they are able to access ARVT.

Inequities in HIV/AIDS are produced by structural determinants; certain groups of people are more vulnerable to HIV infection and/or lack access to treatment and prevention

² I use the term “most-at-risk population” throughout this thesis as this was the term used during data collection, and the term used in various Kenyan documents (e.g. INGO, government). However, UNAIDS has recently released updated terminology that encourages the use of the term “key populations” instead of “most-at-risk populations”, to discourage stigmatization [11].

due to upstream determinants of health that could be changed, including gender and cultural norms, poverty, lack of education, and unsupportive legal structures [10, 19, 20, 35-40]. Focusing on reducing inequities through addressing these upstream determinants of health for vulnerable populations is critical to addressing the HIV/AIDS epidemic. Yet the majority of funding for HIV/AIDS is targeted at treatment and care [10].

1.2.2 Addressing Inequities in HIV/AIDS

Addressing health inequities is an important and challenging area for action for many players; as Marmot and Friel stated: “Putting these inequities in health right is a matter of social justice” [41, p. 1095]. Working towards equity in health includes focusing on those vulnerable groups who have poorer health as a result of structural determinants [42-44] by “removing obstacles” [45, p. 181], including addressing structural determinants as noted above. This will help to “close the gap” [46, p. 6] by shifting health outcomes amongst those on the bottom end of the gradient up towards those on the highest end of the gradient [46, p. 6]. In addition, improving the health across the population as a whole is important [41, 47] through mechanisms such as universal policies. However, universal policies, including universal access to health care, should also employ an equity lens. Universality does not entail providing equal resources across all geographies or groups. Rather, some may need more resources to address particular needs or circumstances [48].

Much of the current focus in HIV/AIDS is on achieving universal access to care, treatment and prevention for HIV/AIDS, as outlined in the 2006 Political Declaration on HIV/AIDS from the United Nations General Assembly [49]. Universal access means “all people should be able to have access to information and services [and] scaling up towards universal access should be equitable, accessible, affordable, comprehensive, and sustainable”

[50, p. 3]. However, there are insufficient resources to achieve universal access in HIV/AIDS care, treatment, and prevention, including a lack of funding, health human resources, infrastructure, and supplies in many countries in sub-Saharan Africa [26]: “With the rapid scale-up of international assistance to prevention and treatment programmes, including antiretroviral therapy, HIV incidence and mortality have declined. Yet progress is not uniform” [51, p. 3]. If universal access to care, treatment, and prevention for HIV/AIDS is the goal, but it is not immediately achievable, important questions arise such as those posed by Gruskin and Tarantola: “Who should benefit from services first, second or last; what levels of prevention, care and support should be provided to each affected population; and who, as a result, may benefit less or later from the highest attainable standard of services[?]” [52, p. 4167]. This is why it is critical to look more closely at inequities in HIV/AIDS – to examine which populations have a higher prevalence of HIV or have access issues in prevention, treatment and care due to increased social vulnerability from upstream determinants of health. Hence, even within a generalized epidemic, where the course of action is to try to reach everyone, resource limitations mean that typically those who receive services are those who are easiest to reach – for instance, people in urban areas, people with higher incomes, and people with higher levels of education. Furthermore, while access issues are important, their impact may be short-term or limited if underlying structural determinants of health are ignored. Focusing on particular vulnerable groups with prevention, care and treatment services, as well as addressing the underlying upstream determinants of health that are increasing their social and political vulnerability, will better address key drivers of inequities in HIV/AIDS.

Working on eliminating health inequities requires addressing the structural determinants of health [44, 53-56]. Poverty, low levels of education, and poor employment

prospects, along with lack of access to clean water, proper sanitation, adequate housing, and access to health care, results in health inequities. A person's ability to engage in personal behaviours that are beneficial to health is limited by these upstream determinants [2].

Inequities are pervasive and non-random, resulting from the overall social and environmental structures (including economic policy that perpetuates poverty, cultural norms or policies and legislation that marginalize certain groups) that have led to these inequities [57-59].

Hence, action on inequities should include addressing these structural determinants of health that cause health inequities, including changing systems that create unfair and unjust differences between groups [60].

1.2.3 The Significance of INGOs in Health and Development

With the magnitude of the HIV/AIDS epidemic and the reality of resource constraints in Southern countries, it is no wonder that INGOs are playing a key role working in HIV/AIDS. No single definition exists for non-governmental organizations, which can be challenging when examining and comparing the available data and literature on NGOs³ [61]. However, common definition elements of an NGO include: a formal, independent structure that is not-for-profit, voluntary, and has goals for the betterment of society [61-67]. NGOs vary widely; they work in many sectors (e.g. environment, agriculture, health, education, religion) and have different scopes and geographic coverage (e.g. membership-based NGOs; Southern NGOs —those from, and working in, Southern countries; international NGOs [64]). International NGOs working in health and development are a subset of NGOs that typically have: wide geographic coverage using a structured system of offices that are located in both Northern and Southern countries; large amounts of resources and influence;

³ As a result, I use the term “NGO” to represent non-governmental organizations more broadly. I only use the term INGO when the literature specifies INGO, or when speaking directly about my findings of the case INGO.

and been in operation for a long time [7, 62, 63, 68]. These organizations typically have broad development aims that include improving the overall health of people in Southern countries through such areas as providing health services, addressing determinants of health (e.g. water and sanitation), and/or providing humanitarian aid [62, 64]. Examples of INGOs active in sub-Saharan Africa include: AMREF, Care, Oxfam, World Vision, Médecins Sans Frontières, Save the Children, and Plan [7, 62-64, 68].

The number of NGOs around the world, as well as INGOs specifically, has increased substantially over the past few decades. The Union of International Associations estimated that the number of active INGOs worldwide increased from 9,396 in 1981 to 23,071 in 2011 (see Table 1). This includes INGOs working in all sectors (not just health and development) and membership-based organizations.

Table 1: Increase in International Non-Governmental Organizations, Select Years, 1981-2011

Year	Number of International NGOs
1981	9,396
1991	16,113
2001	18,323
2011	23,071

Reference: Union of International Associations, 2011 [69]. Data include only active INGOs, categories A-G⁴.

While specific data on health-focused NGOs were not readily available, given the increasing amounts of funding for HIV/AIDS in the past two decades (described next), one would expect that the number of NGOs focused on health, and in particular HIV/AIDS, would also have increased dramatically over the past three decades.

⁴ Categories A-G include “Federations of international organizations; universal membership organizations; intercontinental membership organizations; regionally defined membership organizations; organizations emanating from places, persons, or other bodies; organizations having a special form; and internationally-oriented national organizations” [69].

In addition to an increase in numbers of NGOs, according to the UN Population Fund, funding to NGOs from donor countries for population activities⁵ (including HIV/AIDS work) increased from \$816 million in 1999 to \$4.6 billion in 2009 [70, p. 19]. Donors entrust NGOs with a large proportion of the resources for implementation of HIV/AIDS interventions. The United Nations Population Fund reported that in 2009 in sub-Saharan Africa, 44% of donor country aid for population activities (including HIV/AIDS work) was channeled via NGOs, with the remaining funding through bilateral (34%) and multilateral (23%) channels [70, p. 20]. This reliance by donor countries on the NGO channel illustrates the important contribution that NGOs make to the health and development of Southern countries, including their work in HIV/AIDS.

Several factors help explain why the number of NGOs has increased, and why significant amounts of funding for health and development in Southern countries have been flowing through these NGOs. Many authors point to the change in development theories in recent years, in particular the shift towards neo-liberalism that began in the 1980s [61, 64, 71, 72]. Neo-liberalism emphasizes economic growth, the liberalization of markets [71], and increased privatization [63], in an effort to decrease both costs and government's provision of services [73]. The World Bank and the International Monetary Fund implemented Structural Adjustment Programmes in the early 1980s [74] for poorer countries to receive loans, including countries in sub-Saharan Africa [61, 71]. Poor countries were required to decrease the role of the state [7] in providing essential services such as health and education. The civil service shrank, as did wages for government workers who remained [75]. The diminishing state role also resulted in an increased number of NGOs, more public and private

⁵ Population activities include: sexually transmitted diseases (STI) and HIV/AIDS activities; family planning; and reproductive health services.

funding for NGOs [76], and a greater role for NGOs to fill in the resulting gaps [7, 72]. Other suggested reasons provided for the increase in number and influence of NGOs included the increase in democracies around the world that has opened the door for more civil society participation, and an increase in global communication, information, and transport technology that allowed people and ideas to flow more easily between countries [5, 7, 62, 64, 77].

Other postulated reasons for the increase in number and influence of NGOs in the past few decades relate more directly to NGOs' roles in equity-related work. This includes a change in post-colonial development theory that moved from a focus on solely material development to a broader perspective that includes participation and empowerment at the local level, areas viewed as strengths of NGOs [62]. This was coupled with increased attention on governance, which included democratization of states as well as a focus on a strong civil society, a free press, and augmented human rights [62]. Authors also cite a heightened awareness of global issues (such as global poverty), citizens' distrust of their national governments to solve these issues, and donors' reliance on INGOs to deliver essential services in fragile states [5, 7, 61, 62, 64, 77].

For these reasons, donors have increasingly been relying on NGOs to deliver initiatives in Southern countries, including HIV/AIDS initiatives. As Homen (2010) noted:

“Often praised for their commitment, flexibility, close contact with the grassroots, and ability to reach the poor, women, and other marginalized groups, NGOs/CSOs [civil society organizations] have become the darlings of donors and the UN system” [78, p. vii].

In addition, as this quote illustrates, NGOs' role in addressing inequities among vulnerable groups was one of the reasons behind an increased channeling of funds to NGOs from donors, which will be discussed next.

1.2.4 Literature Search Strategy

I conducted a search of the literature on NGOs and equity. Databases that were searched included: Medline, Web of Science, and PAIS. In addition, I reviewed reference lists from articles and books. For grey literature, I also searched relevant websites including Overseas Development Institute, Equinet, and International Development Research Centre. I focused in particular on articles from 1990 to 2012, since equity as a principle came more to the forefront in the 1990s and 2000s, and this time period better reflects the current equity context within which INGOs are working.

For the first search on INGOs' role in equity, I used the terms non-governmental organization in conjunction with equity, equality, social justice, human rights, gender mainstreaming, pro-poor, people living with HIV, and greater involvement of people living with HIV (see section 1.2.4.1). For the second search to understand potential influences (including other players such as donors and governments) on INGOs' implementation of equity principles in their HIV/AIDS work, I used the terms donors, government, community, vulnerable population, and equity (see section 1.2.4.2). Additional details on the search strategy can be found in Appendix A.

1.2.4.1 INGOs' Role in Equity

Many of the articles I found from the first literature search strategy were theoretical or commentaries on NGOs, and not empirical research. In addition, many did not specifically address equity per se, but focused on the context in which health and development NGOs work, with some reference to their work with vulnerable populations. Hence, for inclusion criteria for this section of the review, I included articles that were empirical, theoretical, or commentaries. Articles had to be focused on NGOs working in a Southern country or

countries, and include information either directly on the role of NGOs in equity or provide information that contributed to understanding the organizational context within which an NGO might be implementing its equity principles.

The Commission on the Social Determinants of Health called for action and outlined the importance of coherent and joined-up efforts by a variety of players, from government to civil society, to address inequities [53, 79]. The need for action by multiple players was reconfirmed in the 2011 Rio Political Declaration on Social Determinants of Health; addressing health equity was described as a “shared responsibility [that] requires the engagement of all sectors of government, of all segments of society, and of all members of the international community” [1, p. 1]. Hence, addressing inequities is not limited to a government role.

An identified role for NGOs, including in HIV/AIDS, is addressing inequities, such as reaching people living in poverty or other vulnerable groups [5, 6, 68, 73, 80-84]. Two of the main ways that NGOs implement their mandates, including their equity mandate in HIV/AIDS work, are through service delivery and advocacy [61, 62, 64]. Service delivery by NGOs can help to fill short-term needs for vulnerable groups, often filling gaps that are the result of cuts to government services as a result of neo-liberalism [61, 64].

However, many authors argue that there are serious challenges, particularly from an equity perspective, to an NGO having a service delivery-focused mandate. Concerns are noted from some, including Malhotra, Lewis and Kanji, that delivering these services are governments’ responsibility, and that NGOs are acting as substitutes for governments in the provision of essential services [64, 71]. NGO services are often viewed as providing only short-term solutions through service provision, and not focusing on addressing upstream determinants [71]; questions arise regarding the ability of NGOs to scale up these services,

including in HIV/AIDS, to the level necessary to sustain essential services over the long-term and ultimately address inequities on a broad scale [61, 64, 68, 71, 73, 80, 85]. It is felt by some that only governments and international institutions can mobilize the resources needed to make large-scale changes such as poverty eradication, and NGOs working in health and development should focus instead on advocacy [71, 86]. Hence, NGOs face tensions in terms of deciding whether to offer essential services that the government should be offering (but is not) or advocating for government's role in this work [7].

NGOs' role in advocacy is considered an important means to influence other players' agendas, such as governments and donors, in equity-related areas. This is recognized as contributing to broader and longer-term sustainable change to address inequities, compared with the short-term solutions of service delivery, counteracting NGOs' perceived closeness to governments and donors [7, 61, 64, 87, 88]. NGOs are viewed as being in a position to advocate to government and global institutions, as well as educate the public, about the importance of committing to a focus on equity within and between countries, including monitoring governments to fulfill their commitments related to equity [71, 89]. Engaging and empowering vulnerable groups (who are the focus of efforts to decrease inequities) is identified in the literature as a central action to address inequities in health [48, 55, 56, 90-92]. The Commission on the Social Determinants of Health argued that empowerment of groups, including communities, was key to ensuring their inclusion in making decisions that affect their own health [53, 93]. An equity tool, the Global Equity Gauge Alliance, included community empowerment as one of its three main pillars for action on equity (along with assessment and monitoring and advocacy), through encouraging vulnerable populations to be actively involved to speak on their own behalf, identify their priority areas, and influence policy-makers [94]. Capacity building with various groups, including working with

community members to empower them to be able to advocate to governments for improved services, is another aspect of advocacy deemed important for NGOs in their work on equity [64, 71].

Despite NGOs' role in equity, including in HIV/AIDS work, inequities remain. While achieving equity is not only the responsibility of INGOs working in HIV/AIDS, an implementation gap exists between the intent of INGOs to ensure equity in its HIV/AIDS work and actual practice. This implementation gap is identified in general terms in the NGO literature, in particular referencing issues of continuing or deepening poverty in sub-Saharan Africa, despite the increased number and influence of NGOs working in health and development [78, 95].

One of the contextual reasons for the implementation gap may be due to multiple accountabilities that INGOs have to address. Lewis noted that INGOs have multiple internal accountabilities (to their staff, and their boards) and externally (to donors, country governments, and beneficiaries) [61]. Najam outlined that donors provide much of the resources for NGOs work, country governments provide the legal space in which NGOs operate, communities are the beneficiaries of NGOs services and have expectations regarding these services, while NGOs have their own strategic directions on which to implement and report [96]. However, while formal mechanisms are in place for accountability to donors (via reporting requirements) and country governments (through registration as an organization and permission to continue to conduct work in the country), there are minimal formal mechanisms for accountability to the actual communities where NGOs work [61, 96], particularly since INGOs are not membership-based organizations [7].

It has been argued that reliance on donor funding and close relationships with governments can lead an NGO to focus on the needs of the donors and country government

at the expense of beneficiaries. Issues are raised about the lack of independence of the NGO if it is funded by donors and working closely with governments [61, 64]; if an NGO is spending its time delivering services, is dependent on donors for funding, and is working closely with donors and governments, it is argued that the NGO's advocacy agenda on behalf of the community will be limited [97]. The NGO's advocacy work can be limited if the NGO fears repercussions, including losing funding from donors [7, 61, 64, 82, 96-98]. If NGOs act as a substitute for government in service delivery, this perpetuates neo-liberalism [72], making it difficult to shift this paradigm amongst all players, including advocating for government responsibility in providing essential services in education and health [71]. This can challenge an NGO's autonomy in addressing their own agenda (including an equity agenda) since the NGO has to ensure it aligns with donors' and the government's agenda [7, 61, 64, 82, 96-98]. Hence, questions arise about how accountable NGOs really are to the most vulnerable, and if NGOs really can legitimately represent (through advocacy efforts) or address the needs of these groups [7, 61, 64, 82, 96-98]. As Lindenberg and Bryant noted: "[INGOs] are taking up the cause on behalf of the poor, but cannot claim to be elected representatives of the poor" [7, p. 211]; NGOs are not elected bodies, and beneficiaries have little power to hold NGOs accountable [61, 98].

Regardless of these challenges, many health and development INGOs have identified equity as one of their areas of focus, and declare their intention to address inequities (including gender inequities and poverty) through their organizations' strategic documents. I conducted an Internet search of the websites of international offices of six major INGOs (Care, Oxfam, World Vision, AMREF, Red Cross, and Plan) to examine references to equity in their organizations' visions, missions, or strategic directions. These INGOs outlined their mandate to work with marginalized or vulnerable groups including children, those living in

poverty, women and girls. They identified overarching equity-related values of non-discrimination, social justice, human rights, and/or equality, or cited equity directly, in their missions, visions, or strategic directions. This intent of INGOs to address inequities is confirmed in the literature — for example, a book by Lindenberg and Bryant, based on group discussions, interviews with staff from many INGOs, and structured questionnaires, identified that poverty is increasingly a focus of INGOs working in development:

“Poverty reduction is more frequently, and eloquently, their stated goal in mission statements, on their Web sites, in their annual reports, and in their advocacy and development documents” [7, p. 101-102].

However, INGOs work in a complex environment with multiple players, including donors, the country government, other NGOs, and the community, who can influence INGOs’ implementation of their equity principles in its HIV/AIDS work. My research examines these influences from various players.

1.2.4.2 Influences on INGOs’ Implementation of Equity Principles

For the second part of my literature search, to find previous research that has been conducted on the potential influences on INGOs’ implementation of equity principles, I included articles that met the following eligibility requirements: they were empirical, focused on NGOs working in a Southern country or countries, focused on NGOs’ implementation of equity principles, and included results on influences (external or internal to the organization, as well as challenges or facilitators) on an NGO’s implementation of equity principles. Only five studies met these inclusion criteria [99-103]. (See Appendix B for a summary chart for the literature search findings from this section).

Four out of five of the studies focused specifically on a gender dimension of equity [99-102], while one study by Smith focused on poverty [103]. Each study included multiple NGOs, with Desai [102] and Wendoh and Wallace [101] examining local NGOs, and

Tiessen [99, 100] and Smith [103] a mixture of INGOs and local NGOs. One of the Tiessen studies [100] and the study by Smith [103] included HIV/AIDS as one of the areas of focus in the research.

I found a number of common findings across these studies. Most of the results from these studies focused on internal influences from the INGO and NGO staff; influences were limited for other players, including donors and Southern governments. Amongst the studies focused on gender mainstreaming, the two Tiessen studies found that Southern countries' cultural norms challenged gender equality, in particular within the NGOs but also within communities, limiting commitment to equity [99, 100]. One of the Tiessen studies [100], the study by Desai [102], and the study by Wendoh and Wallace [101] also found that changing cultural attitudes and behaviours takes time; gender training was a typical tool used to address gender attitudes and behaviours and increase gender capacity amongst staff, but training was not sufficient to shift staff's long-standing attitudes and behaviours and lead to action. While many NGOs may have formally committed to the idea of equity gender mainstreaming, one of the Tiessen studies [100] and the study by Desai [102] found that NGO interventions at the community level tended to address immediate needs and not the underlying determinants of health. The other Tiessen study [99] and the study by Desai [102] noted that NGOs' data collection for their interventions did not adequately monitor gender equity, instead focusing on access (e.g. counting the number of women and men participating in programs) (if at all), but not equity of outcomes or shifts in underlying determinants of health that influence equity.

Along with these studies on gender mainstreaming [99-102], the study on poverty programs by Smith (2004) [103] found that NGOs felt Northern countries and donors drove the equity agenda, limiting ownership by NGO staff and the community. Smith (2004) also

found that despite the rhetoric of the importance of community participation in poverty programming, those living in poverty had limited involvement in selecting priorities for interventions [103].

There were limited findings on influences from Southern governments on NGO's implementation of equity. Wendoh and Wallace (2005) found that Southern governments tended to resist work on gender equality, due to beliefs that it was a donor driven concept and not suitable for their Southern country's cultural reality [101].

1.3 Gaps in the Literature

While equity is clearly an area of great interest, and NGOs play an important role in equity, only limited empirical research has been conducted to understand the influences from multiple players on an INGO's implementation of its equity principles. The research to date has shown that NGOs face multiple influences in implementation of their equity principles that challenge moving from strategy to action. While these studies provide important information, methodologies did not typically include data collection from multiple players (e.g. government, donors, other NGOs, community), and none included data from INGO staff in Northern countries along with data from staff from the same INGO working in Southern countries. Also, the previous studies focused exclusively on NGOs' implementation of gender mainstreaming or poverty, rather than a broader equity focus.

My research builds on this previous research by examining the INGO itself (in Kenya as well as two Northern offices), as well as multiple players that have the potential to influence equity, including donors and the Southern country government. My research also expands previous research that has been done by studying equity more broadly, beyond only gender or poverty. The next section outlines the research questions for my case study.

1.4 Research Questions

This study addressed these research questions:

What is the nature of the implementation gap between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice?

What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work?

How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?

1.5 Kenya as the Setting for the Case Study

The primary setting for the research was Kenya, a country with a high prevalence of HIV/AIDS, long-standing health inequities, and a large number of NGOs. While the number of INGOs continues to grow in Kenya and elsewhere in sub-Saharan Africa, the inequities in health in HIV/AIDS remain. Hence, Kenya provided a setting to understand the implementation gap between the intent of organizations to ensure equity in their HIV/AIDS work, and actual practice.

1.5.1 HIV/AIDS Prevalence and Inequities in Kenya

Kenya has a high prevalence of HIV/AIDS at 6.3%, with approximately 1.5 million people living with HIV in 2009 [10]. But there are inequalities in Kenya in the distribution of HIV prevalence, access to care, and HIV knowledge and behaviours. Table 2 presents an overview of these data. Data for this section were mined from the most recently available key reports on HIV/AIDS from the Kenyan government, and includes data they report to the United Nations on the indicators for the United Nations General Assembly Special Session on HIV/AIDS [104-106]. These are the most comprehensive and recent reports available that cover Kenya (compared to individual studies with limited populations or that focus only on specific geographies within Kenya).

Table 2: Inequalities in HIV/AIDS Prevalence, Incidence, Access to Care, Knowledge and Behaviour by Various Population Groups in Kenya

	HIV Prevalence [▲] [104, p. 215, 217, 106, p. 20] or Incidence ^{▲▲} [105, p. 14]	Access to Care: % of pregnant women aged 15-49 receiving HIV counseling during antenatal care [104, p. 193]	Knowledge: % men aged 15-49 reporting comprehensive knowledge of AIDS [104, p. 178]	Knowledge: % women aged 15-49 reporting comprehensive knowledge of AIDS [104, p. 177]	Behaviour: % men aged 15-49 reporting having ever been tested for HIV and received results [104, p. 192]	Behaviour: % women aged 15-49 reporting having ever been tested for HIV and received results [104, p. 192]
Kenya Overall	6.3% [▲]					
Sex						
Male (ages 15 to 49)	4.3% [▲]		55.8%		40.4%	
Females (ages 15 to 49)	8.0% [▲]	61.2%		48.7%		56.5%
Most-at-risk Populations						
Sex workers	29.3% [▲]					
Men who have sex with men	18.2% [▲] 67/1,000 ^{▲▲}					
Injecting drug users (IDUs)	60.4% [▲] 256/1,000 ^{▲▲}					
Prison population	126/1,000 ^{▲▲}					
Partners of IDUs	78/1,000 ^{▲▲}					
Provinces						
Nairobi	7.0% [▲]	88.9%	76.6%	66.7%	57.3%	73.8%
Central	4.6% [▲]	66.9%	63.9%	57.8%	35.7%	56.7%
Coast	4.2% [▲]	56.9%	52.9%	43.3%	43.6%	65.5%
Eastern	3.5% [▲]	57.1%	48.3%	46.3%	29.4%	51.2%
Nyanza	13.9% [▲]	65.0%	62.9%	54.8%	52.4%	61.3%
Rift Valley	4.7% [▲]	57.7%	53.7%	43.5%	38.8%	52.4%
Western	6.6% [▲]	65.6%	45.3%	45.8%	34.7%	53.7%
North Eastern	0.9% [▲]	14.0%	12.5%	5.1%	17.1%	23.5%
Residence						

	HIV Prevalence[▲] [104, p. 215, 217, 106, p. 20] or Incidence^{▲▲} [105, p. 14]	Access to Care: % of pregnant women aged 15-49 receiving HIV counseling during antenatal care [104, p. 193]	Knowledge: % men aged 15-49 reporting comprehensive knowledge of AIDS [104, p. 178]	Knowledge: % women aged 15-49 reporting comprehensive knowledge of AIDS [104, p. 177]	Behaviour: % men aged 15-49 reporting having ever been tested for HIV and received results [104, p. 192]	Behaviour: % women aged 15-49 reporting having ever been tested for HIV and received results [104, p. 192]
Rural	6.0% [▲]	57.1%	50.9%	44.2%	35.3%	52.0%
Urban	7.2% [▲]	77.6%	69.5%	62.0%	54.6%	69.9%
Education						
No education	5.7% [▲]	25.0%	14.8%	14.2%	19.3%	38.3%
Primary incomplete	6.5% [▲]	57.0%	37.8%	37.5%	24.8%	49.2%
Primary Complete	8.0% [▲]	65.1%	54.8%	51.3%	38.6%	61.5%
Secondary+	5.1% [▲]	79.7%	70.5%	65.5%	52.4%	63.8%
Income						
Poorest Quintile	4.6% [▲]		37.3%	26.5%	22.0%	44.5%
Second	6.8% [▲]		46.7%	44.7%	34.1%	51.1%
Middle	5.6% [▲]		56.9%	48.3%	35.3%	53.3%
Fourth	6.6% [▲]		54.5%	50.3%	41.1%	55.8%
Richest Quintile	7.2% [▲]		71.1%	64.5%	56.0%	70.6%

Table Notes: [▲]Prevalence; ^{▲▲}Incidence. Incidence is based on modeled estimates for 2006 conducted in conjunction the UNAIDS Reference Group on Estimates, Modeling and Projects, updating the work done by Gouws et al. (2006) [105, 107]. Missing data indicates data not available or not applicable.

In terms of prevalence, females are more likely to be infected by HIV than males [104]. As discussed above, females have an increased biological vulnerability to HIV; social-cultural conditions further increase their vulnerability. A number of Kenyan government documents recognize the challenges that females face that increase this vulnerability. For example, women's economic dependence on men increases their reliance on men [106]. Women may lack power to negotiate condom use, including with their husbands [108], and may feel unable to refuse sex even if their husband is having sex with other women [106]. These documents also report the occurrence and acceptance of sexual violence towards females as issues [105, 106]. In addition, certain cultural practices, such as wife inheritance and genital cutting, increase females' vulnerability to HIV [106].

Geographic inequalities also exist in Kenya, with Nyanza province having the highest percentage of people who are HIV positive and North Eastern province having the lowest percentage [104]. A number of reasons are posited for this higher prevalence. One is that, while male circumcision has been found to decrease vulnerability to HIV infection, it is not a cultural practice of Luo men, a tribe largely located in Nyanza province [105]. Wife inheritance, "widow cleansing", polygamous relationships, and "sex for fish" [105, p. 31] are other socio-cultural practices in Nyanza that have been identified as increasing vulnerability for HIV particularly in this province. When a man is appointed to take economic and social responsibility for a widow, this is wife inheritance [109]. "Widow cleansing" can be part of wife inheritance, where a widow takes part in sexual rites for the purposes of "cleansing" to integrate her back into the community [109]. "Sex for fish" (or jaboya) is a "transactional sex relationship" between the men who fish and the women who buy these fish to process and sell [110, p. 10]. In addition, while poverty and gender inequalities are issues throughout Kenya, the Kenyan *Modes of Transmission Analysis* (2009) report highlights the high levels

of poverty and rural women's low status as reasons for higher HIV prevalence in Nyanza province [105]. These social-cultural practices and structural conditions increase certain groups' vulnerabilities to HIV/AIDS.

Income, education, and whether one lives in urban or rural areas are key determinants of health that influence access to services for HIV/AIDS, as well as behaviours that can help prevent HIV/AIDS. For example, people with higher incomes are more likely to have the resources to finish their education, which can lead to higher incomes. People with higher incomes are more likely to be able to pay for access to needed health services. And people living in urban areas often have better access to health care services. Kenya is a low income country and a high percentage of people living in poverty – in 2005, 43.4% were living on less than \$1.25 a day, and 67.2% were living below \$2 a day [111, p. 70]. Primary school completion rates in Kenya vary from 40% for those in the poorest quintile to 76% of those in the richest [111, p. 98]. Data on HIV/AIDS prevalence by income and education in Kenya are more complex. Those with completed primary education have the highest prevalence of HIV in Kenya, followed by primary incomplete and no education, while those with secondary or more have the lowest prevalence. People living in urban areas have a higher prevalence of HIV than those living in rural areas. By income, the highest prevalence is the richest quintile, followed by the second poorest quintile [104]. However, inequalities in prevalence are not the only factor to examine; it is important to examine inequalities in behaviours and knowledge, as well as access to prevention and treatment. People living in urban areas, those with higher incomes and those with higher levels of education are more likely to have knowledge about HIV and to report behaviours that may facilitate prevention and treatment compared with those in rural areas, those with lower incomes, and those with lower levels of education [104]. For example, women and men living in urban areas, with

higher levels of education, and with higher levels of income are more likely to report having comprehensive knowledge of AIDS and having been tested for HIV and received their results [104]. Hence, living in poverty, having low levels of education, and living in rural areas can increase vulnerability to HIV/AIDS in terms of lack of knowledge, preventative behaviours, and access to services. Living in poverty can also lead to more risky sexual behaviours, including informal or formal sex work, in order to provide for one's family [106, 108].

Most-at-risk populations (including sex workers and their clients, men who have sex with men and prisoners, and injecting drug users) are large contributors to new infections [105]. These groups have an increased vulnerability due to social and political conditions [112], as these behaviours are illegal and could result in punishment [108]. The Kenyan government's HIV/AIDS strategy outlines the challenges faced in providing prevention, care and treatment services to the most-at-risk populations given the social intolerance towards and criminalization of these groups, and subsequent stigma and marginalization they experience [108]. This makes it difficult for these groups to access prevention, treatment, or care. As identified in the Kenyan government's HIV/AIDS strategy, "many service providers find it difficult to provide non-stigmatising services to clients perceived to be practising illegal behaviour" [108, p. 6]. In addition, men who have sex with men face violence (sexual and physical) given their illegal and marginalized behaviours [106]. Sex workers face increased vulnerability to HIV given their increased risk to sexual violence and the early age that they start sex work [105, 106]. There has been a religious and cultural resistance to making any changes to legislation to legalize the behaviours of these groups [108]. As noted in the national strategy, given this cultural and legal context, Kenya faces challenges in prioritizing programs for these populations, including "reluctance to prioritise

interventions and services aimed at [these marginalized groups], even among professional planners and policy-makers” [108, p. 6].

1.5.2 Increase in INGOs in Kenya

There are a large number of NGOs working in Kenya, including an increasingly large number of international NGOs. According to Kenya’s NGOs Coordination Board, the number of registered INGOs increased from 58 in 1978, to 134 in 1988, and to 204 in 1996 [113, p. 8]. The latest survey data (2009) shows a further increase with 367 INGOs listed [114, p. 25]. While this data includes all INGOs regardless of sector, this same survey indicated that the highest percentage worked in HIV/AIDS (12%), followed by the education sector (11%) [114, p. 30]. Administrative records of both national and international NGOs working in all sectors, published out of the University of Nairobi, showed an increase from 836 NGOs in 1997 to 4,099 in 2005 [115]. Reasons suggested for the increase mirror those identified earlier in discussion of INGOs globally: an increase in demand for HIV services that cannot be met with Kenyan government health services and increases in international donor funding to NGOs for HIV/AIDS [113, 115].

1.6 Researcher’s Background

My philosophical stance as a researcher is as a constructivist. Hence, I believe that “knowledge is constructed rather than discovered” [121, p. 99], and I acknowledge subjectivity as “an essential element of understanding” [121, p. 45]. I therefore believe it is important to outline my background and assumptions since this influenced the choice of equity as my topic of my dissertation and the interpretation of the results.

In terms of my background, I worked in population health for many years prior to starting my PhD, including as Director of the Canadian Population Health Initiative at the Canadian Institute for Health Information. I believe that to improve the population’s health,

interventions should focus both on improving the overall health of all people, as well as focus on improving health inequities among different groups [59, 116-118]. While I have also worked at the provincial level in health care and on individual lifestyle change programs, I am acutely aware that by intervening downstream, such as focusing only on individual health behaviours or health care, the root causes of inequities are not being systematically addressed, including the more upstream determinants of health such as gender, education, income, and other structural determinants that influence health inequities.

I feel that equity is a matter of social justice, that everyone has a right to good health, and there is a global obligation to address inequities in a systematic way. Finally, in terms of the choice to study INGOs, I have worked at the senior level for health NGOs in Canada, and know the multiple challenges that these organizations face, including lack of funding and limitations to advocacy. I also believe that NGOs provide a critical role in civil society throughout the world, and should be important players in achieving equity aims.

Another important aspect of my background is my status as an outsider in Kenya. I am a white, middle-class female from Canada who has no prior experience working in Africa. The ways in which my philosophical stance and background may have influenced this research are addressed in the discussion chapter.

1.7 Overview of the Dissertation

This dissertation contains four chapters, plus appendices; the focus of each chapter is outlined below. This first chapter summarizes the problem and outlines the significance of equity in health as an area for research and action. An overview of inequities in HIV/AIDS is provided to illustrate why HIV/AIDS is used as an exemplar for a study on inequities. The section also examines the increase in numbers of NGOs, the role that INGOs play in

delivering on an equity agenda, and the influences on INGOs' work in equity. Past research results on the multiple influences that INGOs face when implementing their equity principles are then outlined. The chapter examines gaps in the literature, and closes with a description of my study setting, and my research questions.

In Chapter 2, I describe the methods for the study, a case study of an INGO working in Kenya in HIV/AIDS. I present: how the case study was selected, the various data collection methods used (interviews, document analysis, and participant observation), and my ethics considerations. I finish this chapter with a description of the analysis approach taken and steps for data verification and preliminary dissemination of the results.

Findings are presented in Chapter 3. I begin with the case description of the INGO, outlining its governance structure, the Kenyan office's work in HIV/AIDS, and how the INGO approached equity in its work as per its strategic documents. I then provide an overview of the participants and documents from the data collection. This section includes the timelines for data collection and details on the number of participants involved in the participant observation and interviews, as well as the documents analyzed. I then outline the donors' and Kenyan government's approaches to equity, as noted in their formal documentation. This is followed by a section highlighting the interdependence of players working on HIV/AIDS in Kenya (namely the INGO, the Kenyan government, and donors). I conclude this chapter by reporting on how the interdependence amongst players influenced the INGO's implementation of equity in its HIV/AIDS work. This includes how the INGO aligned its work with these other players, as well as how the INGO influenced these other players in terms of equity in HIV/AIDS.

In the final chapter, Chapter 4, I present the main themes that arose from the data, including the context of asymmetrical interdependence within which the INGO implemented

its equity agenda. The influences from the other players, including donor funding and priorities, and the Kenyan government priorities and legislation, meant that the INGO privileged particular vulnerable populations over others to avoid potential repercussions. The INGO aligned with the system, but also pushed back its equity agenda with donors and government through: collecting and providing evidence, getting involved in government structures, and networking with other NGOs to provide a strength in numbers approach. This chapter also includes a discussion on strengths and limitations of the research, potential areas for future research, and the implications of the research for the field of population health.

The appendices include more details of my literature search and findings, copies of ethics approvals, consent forms, interview guides, and other forms used in the research study.

2 Chapter 2: Study Methods

2.1 Overview of the Case Study

I conducted a nested case study with a major INGO working in development and health [119]. The purpose was to explore the nature and mechanisms of multiple influences on an INGO's implementation of equity principles in its HIV/AIDS work [120] using multiple methods [121, 122]. A nested case study addresses "how...the subunit connect[s] with other subunits and the whole" [119, p. 152]⁶.

While the two most referenced books on case studies are those by Stake [121] and Yin [123], these authors have very different philosophical approaches to qualitative research and case studies, with Stake being a constructivist and Yin a positivist [124]. Given my philosophical stance, I primarily followed the approach of Stake, including acknowledging the background I brought as a researcher [121, 122]. Where appropriate, I incorporated some aspects of Yin's approach, in particular conducting a literature search prior to the field work, as well as developing propositions and general interview questions prior to entering the field. Stake does not encourage an extensive literature review or the development of propositions *a priori*, while Yin does.

2.2 Selection of the INGO for the Case Study

I employed purposive sampling [122, 125] to decide on the case study location in Kenya. In particular, given the location of my Kenyan-based thesis committee member and the high prevalence of HIV/AIDS in Nyanza province, I sought to find an INGO that had HIV/AIDS programs underway in Kisumu in Nyanza province. Based on the common definitional elements for an INGO (as outlined in section 1.2.3), the eligibility criteria I used

⁶ In addition to the case study, originally, I had a secondary data analysis component to my research. However, there was insufficient information on equity to include in the analysis. (See Appendix C for more information).

to determine if the organization was an INGO were that the organization: worked in many different countries (with offices in Northern and Southern countries), had been in operation for a long period of time, and had significant resources and influence [7, 62, 63, 68].

Additional eligibility criteria for the case selection of the INGO included:

- Equity identified as a principle or value, as reflected in its statement of mission, vision or core strategies
- Funded by a variety of donors and sources
- Conducted HIV/AIDS work in Kisumu, Kenya, and had a Northern office in Canada, the U.S., or the United Kingdom

I identified eligible INGOs using several strategies. I spoke to international experts in the field of HIV/AIDS and searched on the Internet. For each INGO identified, to determine eligibility, I reviewed their websites for: their vision, mission, and core strategies to see if equity was identified; their office locations to see if they worked in Kenya and had an office in Canada; and their projects to determine if any of these projects in Kenya were HIV/AIDS related. Twenty-two INGOs were deemed eligible, or potentially eligible (if I could not find sufficient information on the websites). I then sent preliminary emails to the contact email identified on the website to the Canadian offices of these INGOs in the spring of 2008 to ascertain if they met the criteria of having HIV/AIDS projects in Kisumu and if they might be interested in learning more about my project. Fourteen of these were screened out as they did not meet the criteria of having HIV/AIDS projects in the Kisumu area in Kenya. Five did not respond to my contact attempts, leaving three INGOs that were eligible. Prior to my February and March 2009 trip to meet with these three potential INGOs, my Kenyan thesis committee member suggested three additional INGOs for consideration. I confirmed eligibility for these additional INGOs. I emailed either the Kenyan-based senior head of the INGO or the person in charge of HIV/AIDS from these six eligible organizations a few weeks prior to my trip. Four responded and agreed to meet with me. However, only two

meetings took place. The other two organizations cancelled their meetings with me and we were unable to reschedule due to my limited time in Kenya.

Both INGOs I met with indicated their willingness to take part in the research. I made the final selection of the case INGO based on the opportunity to participate as a volunteer within the organization during the data collection period.

The case INGO that was chosen had offices in six sub-Saharan countries (including a Kenyan office) and in 12 Northern countries. The INGO office in Kenya as well as two Northern offices of the INGO (Canada and the U.S.) were selected. Their respective staff and programs related to HIV/AIDS formed the boundaries [122] of this nested case. Details about the case INGO were gathered during the field work and the case description is outlined in the results section (Chapter 3). As the case INGO is anonymous, throughout this thesis it will be referred to as the INGO.

2.3 Data Collection

Data collection required securing key contacts within each organization. Within the INGO in Kenya, I had a key senior contact person whom I originally met with in 2009 to discuss my study. This individual, along with another Kenyan INGO staff who oversaw the HIV/AIDS projects, met with me on a regular basis and answered questions, provided documents, and provided suggestions for internal and external interviews. I had one key contact in the INGO in Canada and another in the INGO in the U.S. who both assisted me in the data collection in their respective countries by providing me with documents, and in the case of the U.S., facilitating additional interviews.

The case study employed multiple methods including participant observation, interviews, and document analysis, allowing for rich, in-depth data, as well as data triangulation [121]. I collected data on the INGO's operations in Kenya (for three months:

from end of February 2010 to end of May 2010) as well as with the INGO’s Canadian and U.S. offices (in June and July 2010). The research started in Kenya with: participant observation with INGO staff; interviews with INGO staff, external partners (including staff from donor organizations, Kenyan government, and other NGOs), and INGO clients; and document analysis. Following this, interviews and document analysis took place in Canada and the United States.

Table 3 outlines the data collection methods by country.

Table 3: Case Study Methods by Country

	Kenya	Canada	United States
Participant Observation	✓	X	X
Internal Interviews (INGO Staff)	✓	✓	✓
External Interviews (Partners of the INGO)	✓	X	X
Client Interviews	✓	X	X
Document Analysis	✓	✓	✓

2.3.1 Participant Observation in Kenya

While I considered a range of roles for participant observation (e.g. from an observer to a complete member), I decided on and played the role of an “active” member [126, p. 50]. Therefore, I participated as a volunteer in the INGO while collecting data. I took part in day-to-day activities and conducted work assigned to me, including writing a synthesis report based on numerous INGO project evaluations, providing comments on draft proposals for HIV/AIDS funding, writing a journal article on aid effectiveness based on the organization’s work, and reviewing a conference presentation and article on the INGO’s community-level work. This provided me with an opportunity to see the inner workings of the INGO, while at the same time offering the INGO the benefit of having a volunteer staff person. However, since I was also conducting research, was a foreigner, and was only volunteering for a limited time, I was not a “complete” member [126, p. 67]. While I volunteered part-time

(approximately half-time) with the INGO in Kenya for a period of three months, I was in the office almost every working day during that period.

Employees at the INGO office in Kenya were eligible to take part in the participant observation component of my research if they worked for the INGO in an overarching capacity (e.g. senior management, evaluation) or specifically on HIV/AIDS projects. Following my entry into the INGO, I informally met many staff (through introductions, attending meetings, or by virtue of my volunteer work at the INGO) and discussed my research and its purpose, one-on-one, as the opportunity arose. Then, the manager in charge of the HIV/AIDS area emailed a communiqué to the heads of all of the HIV/AIDS projects to outline: the purpose of my research, that it has passed ethics, and that I had approval from the INGO to conduct data collection with them. The communiqué stated that I would be speaking with them or their staff about participating in the project if they were willing to take part. (See Appendix H for this communiqué). I then met individually with staff from all of the HIV/AIDS projects, as well as other relevant staff, including senior managers and evaluators involved in HIV/AIDS work, to discuss my research and provide them with participant observation information forms for their review. I asked them to review the forms, ask any questions, and then, if they were willing to take part, to sign the consent form.

I went on field visits with staff to see several projects in action. I had informal conversations with staff specifically about my research and conversations with staff about specific projects I was assisting with. I wrote field notes [122] about my daily work in the INGO. I developed an observational protocol to assist with note-taking in the field [121], including descriptive notes and my reflections [122] (see Appendix J). In these field notes, I identified documents I should locate and noted potential interviewees. The field notes captured information about the overall context of the INGO and its partners, as well as

observations regarding how equity is thought of and operationalized on a day-to-day basis. I used this information to formulate follow-up questions for my key contacts.

2.3.2 Interviews

I developed an open-ended interview guide for each set of interviews: internal INGO staff in Kenya, internal INGO staff in the U.S. and Canada, external partners, and clients. The questions for the external and internal interviewees asked how they viewed equity, how the organization viewed equity, challenges faced and influences experienced in operationalizing equity in HIV/AIDS initiatives. At the end of each interview, I asked participants to identify key documents they thought I should review.

Prior to conducting interviews with three senior staff in the INGO in Kenya, I asked them to complete an equity form (see Appendix I), which provided information on how the INGO defined equity, the organization's principles and frameworks on equity, any codes that the INGO had signed on to that reflected equity, and how the INGO assessed equity. This data was used to guide probes during my interviews, and was included in data analysis.

Client interviews focused on understanding the clients' involvement and perceptions of the INGO's HIV/AIDS programming, including any advice they had previously provided to the INGO on the HIV/AIDS project with which they were involved, what the INGO had done to help the client be involved in the program, and what the INGO could do to encourage more clients to access the program. (See Appendix I for the interview guides).

2.3.2.1 Pilot Testing of Interview Guides

The draft interview guides, interviewee background form, and equity form were pilot tested with three individuals prior to my arrival in Kenya. These individuals all had experience working with NGOs, HIV/AIDS, and vulnerable populations. Their experiences included work with Aboriginal populations in Canada, pastoral communities in Tanzania,

and women in Southeast Asia. The changes suggested were minor, and were incorporated into the final versions.

2.3.2.2 Eligibility Criteria for Interviews

Table 4 outlines the eligibility criteria that I used for each set of interviews.

Table 4: Eligibility Criteria by Interview Group

Interviewee Type	Eligibility Criteria
Internal Interviews - INGO Staff in Kenya	The staff person: -had been employed for more than three months at the INGO (to ensure that they had sufficient knowledge of the issues) -was currently working (i.e. not on leave) -was currently involved with the development, delivery, or evaluation of HIV/AIDS initiatives, or involved in the INGO's work across projects including HIV/AIDS (e.g. senior management, communication, evaluation).
External Interviews (Partners of the INGO)	The external interviewees: -had a relationship with the INGO Kenya office in their HIV/AIDS work through their organization, if this relationship had been in place for over six months
Client Interviews	The client: -was a current or past client of one of INGO's HIV/AIDS programs -was 18 years of age or older, was capable of providing informed consent, -had been a client for more than six months (to adequately answer the questions)
INGO Interviews in Canada and the U.S.	Same as for the INGO Staff in Kenya

2.3.2.3 Interviews with Kenyan INGO Staff and External Partners

Following approximately six weeks of participant observation, I started to conduct interviews with employees working in the INGO in Kenya, from junior to senior professional staff located in Nairobi as well as in field offices in other areas of Kenya. I sought to interview staff from each of the HIV/AIDS projects underway at the INGO, and both senior managers and junior project staff, seeking maximum variation [125].

External interviews were held in Kenya with people familiar with the INGO Kenya office who were not INGO employees. This included Kenyan government staff, donors, and staff of other NGOs that were partners with the case INGO. For all external staff, I recruited based on suggestions from my Kenyan committee member and my key contacts in the INGO to ensure maximum variation [125]. For interviews with Kenyan government staff, I selected representatives from the two major Kenyan government structures that focused on HIV/AIDS at the district and federal level (the National AIDS Control Council and the National AIDS and STI Control Programme). For interviews with donor staff, I selected interviewees from two large Northern government donors that provided funding to the case INGO's HIV/AIDS projects. For staff from partner NGOs, I purposefully selected representatives from two Kenyan-based NGOs that worked in partnership with the case INGO in HIV/AIDS.

I digitally recorded the interviews (if the interviewee consented to this). Following each interview, I wrote field notes using a contact summary form that I developed based on Miles and Huberman (1994) [125]. This form captured my thoughts on the interviews, key points that arose in the interviews, critical findings, and any suggestions for follow-up (e.g. other people to interview, documents to access, additional probes that I might use in future interviews). See the contact form in Appendix J.

2.3.2.4 Client Interviews

Interviews with clients of the INGO's HIV/AIDS programs were also conducted. I spoke to my key contacts in the INGO to find out which of the INGO's HIV/AIDS projects might be considered for inclusion for client interviews. The INGO had seven projects underway on HIV/AIDS. Two of these projects were not eligible: one project was just starting and the other was in the final reporting phase. Hence, neither of these projects had

clients to interview. Two different projects were selected for inclusion based on maximum variation in terms of services offered and geography [125]. I then spoke with the managers of these two HIV/AIDS projects, and they agreed that we could approach their clients to take part. One project was an anti-retroviral therapy project embedded within an integrated INGO health facility, and the other project focused on capacity building and granting funding for civil society organizations working in HIV/AIDS.

I hired a Kenyan research assistant to conduct the client interviews; I did not take part in the interviews. I oriented her to the project, trained her in qualitative interviewing including the use of probes, and discussed the contact forms that she had to complete as part of the field notes. Prior to the start of the interviews, the research assistant translated all of the relevant documents, including information form, consent form, and interview guide into Kiswahili. I then had these translations verified by one of the INGO staff and my Kenyan-based dissertation committee member. Once final changes were made, I provided the research assistant with copies of English and Kiswahili versions of all of documents for the client interviews.

We recruited clients in-person through the INGO program. An INGO staff person asked the client if they were willing and interested to hear more about the research. If yes, the research assistant then approached them to discuss the research and their potential interest in being interviewed. (See Appendix G for the recruitment scripts). For the anti-retroviral therapy project embedded within an integrated INGO health facility, the research assistant interviewed a mix of clients from different components of the project. For both projects, the research assistant interviewed a mix of males and females.

After each interview, the research assistant completed the interview contact form. After the research assistant had interviewed clients from the first project (about half of the

interviews), I met with her. She debriefed me about her experience and provided me with suggestions for clarifying and probing in the next set of interviews. I reviewed the transcripts and provided her with feedback on additional probes or areas for improving the quality of the next set of interviews.

2.3.2.5 Interviews with INGO Canada and U.S. Staff

Interviews were also conducted with staff from the Canada and the U.S. INGO offices following my return from data collection in Kenya. Given the small number of staff in these offices, I interviewed all staff that fit the eligibility criteria outlined in Table 4.

As with the other interviews, I digitally recorded the interviews (if the interviewee consented to this) and wrote field notes following each interview based on the contact summary form from Appendix J.

I determined that I had conducted a sufficient number of interviews for this research based on a couple factors. In the case of the Northern offices of the INGO, all eligible Canadian and U.S. staff were interviewed. For the other interview groups, I sought maximum variation [125], and did not conduct further interviews once data saturation was reached.

2.3.3 Documents

I used documents to examine what was formally written about the INGO's implementation of equity principles in its HIV/AIDS work and influences, and to substantiate and supplement data from participant observation and interviews [123]. I gathered documents over the duration of the data collection period in Kenya, and then at the Canadian and U.S. offices. I accessed these documents with permission from the INGO through my key contacts in each country or via the Internet. Documents of interest included those relevant to the case, including project materials for HIV/AIDS initiatives underway and

conducted in the past (e.g. project files), evaluations of projects, annual reports, minutes of pertinent meetings (e.g. senior management team minutes), requests for proposals from donors, responses to these requests for proposals from the INGO, and government and donor strategies that might influence the INGO. Documents were included for review if they were relevant to HIV/AIDS (e.g. strategies or project-related information) and/or equity at the donor, government, INGO, or community level.

I developed a document summary form (based on a form developed by Miles and Huberman's (1994) [125]) to make notations on the relevance and key points from the documents. This form included the document's name, its significance, and a summary of the document (see Appendix J).

2.4 Use of Preliminary Propositions in Tool Development and Data Collection

Prior to the start of data collection, and based on the literature review conducted for my research proposal, I developed six general proposition statements to guide the initial data collection and interview questions. These preliminary propositions focused on the various players identified in the literature review (donors, country government, other partner NGOs, people living with HIV/AIDS) that might influence the INGO in implementing its equity principles in its HIV/AIDS work. For example, proposition #2 focused on the donor level:

“Donors’ agendas and priorities influence an INGO’s implementation of its equity principles in its HIV/AIDS work. If equity is not explicitly on the agenda of the donor, the focus on equity in the initiatives that an INGO implements will be limited. Donors’ monitoring and evaluation requirements, with a focus on efficiency over equity, also negatively influence an INGO’s implementation of its equity principles in its HIV/AIDS work.”

(See Appendix D for the complete list of these preliminary propositions). These propositions were used to develop initial interview questions and to guide the data collected during the participant observation and document collection. A list of the propositions were included in

the interview contact form, the document form, and the participant form as areas for me to consider during data collection, in particular as a framework to continually consider the different players that influence equity (e.g. Kenyan government, donors, community, other NGOs). Given the nascent nature of the propositions, I posed them only as initial guiding ideas and did not limit my data collection to these propositions.

2.5 Ethics

This project followed the guidelines of the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* [127]. Prior to recruitment and data collection, the Health Sciences and Science Research Ethics Board at the University of Ottawa [128] assessed and approved the case study. The ethics committees at the Great Lakes University in Kisumu and the Kenya Medical Research Institute (KEMRI) also assessed and approved the case study research. (See Appendix F for the ethics approvals).

A two-stage consent process was followed – first with the organization, and then with individual participants. The organizational and individual information and consent forms are provided in Appendix G.

Organizational consent. I sought consent from the key contact person in the Kenyan, Canadian, and American INGO offices. This consent included support for the data collection methods including interviews, document review, and, in the case of Kenya, participant observation. In the consent forms, I indicated that the INGO name would remain anonymous in the research write-up but indicated that it might be possible for someone familiar with NGOs to identify the INGO in the write-ups. As well, the INGO's name had to be identified to those other organizations taking part in interviews. Hence, the INGO's organizational anonymity was not guaranteed.

Organizational consent forms were also signed by a senior representative of each external organization that had staff participating in interviews. These organizations were also not identified by name. However, consent forms outlined that their organization's relationship to the INGO (e.g. as a donor or as an NGO partner of the INGO) would be stated in the thesis and other published materials.

Participant consent. Following receipt of organizational consent, I sought free and informed consent from participants (e.g. interviewees and people being observed) using a clear and concise consent form that participants were required to sign. The script and consent form outlined potential harms and benefits of the research. To address individual anonymity, papers and reports developed from the research used pseudonyms and did not include unnecessary details that might lead others to uncover someone's identity. Participants were asked if they were willing to be quoted. They also had an opportunity, at the end of the interview, to identify if there were any portions of what they had said in the interview that they did not want to be quoted on.

I identified that a possibility still existed, given the close-knit nature of INGOs, that people might be able to identify individuals in the final thesis or articles. This risk was outlined in the consent form, including the concern that funders might take issue with what the interviewee said, or that their employer might penalize the interviewee for what they said. I informed participants of these risks and the measures that I took to limit these risks. I also provided INGO and external staff with the opportunity to review the transcripts from their interviews.

Client risk was deemed higher than that for other interviewees. Potential risks included: feeling uncomfortable discussing challenges with the INGO and/or fearing that they might lose access to programs if they identified challenges; concern they would have

been asked to disclose their HIV status; and peer pressure or a sense of coercion to take part in the research (since they received services from the INGO and received a travel honorarium for participating in the research). To minimize these risks, as part of the organizational consent form, the senior Kenya staff person who signed on behalf of the organization committed to “ensuring that there are no negative consequences for clients who participate in the research, regardless of what clients report[ed]”. Clients were not asked to disclose their HIV status, and if they did disclose in the course of the interview, this was removed from the transcript.

Additional information. For interviews with the Kenyan INGO and its partners, as well as the INGO’s Northern offices, I conducted interviews in English, which was the working language of the INGO and its partners in Kenya, Canada, and the United States. To minimize disruption and to respect the interviewee’s time, I held these interviews at a time and place convenient for the interviewee, which was typically at their office. Clients were offered the opportunity to be interviewed in Kiswahili, but most chose to speak in English, using occasional phrases in Kiswahili that were then translated into English by the research assistant during the transcription process. Clients were provided with a small travel honorarium based on the INGO’s typical travel honorarium amount.

Data storage. During the field work in Kenya, I stored the data in a secure location (locked cabinet) at my residence. Once I returned home, I stored the Kenyan data as well as the data from Canada and the United States in a secure location (locked cabinet) at my home. I stored electronic materials on my laptop with password protection. Upon completion, verification, and member checking of the transcripts, I erased all tape recordings. Once data analysis was complete, I stored all raw and analyzed data on a password-protected storage device, and deleted the data (including NVivo files, transcripts, back-up files) from my computer. All

paper and electronic documents were moved and stored in a locked cabinet at the office of Nancy Edwards at the University of Ottawa in Ottawa, Canada to be held for five years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. consent forms) will be shredded and data on the memory stick will be deleted.

2.6 Analyses

For the first step in the analysis, I immersed myself in the data. I typed my handwritten field notes daily for three months, and wrote reflective notes. I hired staff to transcribe the tape-recorded interviews verbatim, which I subsequently verified by listening to the interview and comparing it with the transcript. For interviews that were not digitally recorded, I typed up my interview notes. As I did this, I also made notes about key salient points arising from the data. As I read documents in the field, I noted these in participant observation forms and as part of my reflections. What I read was helpful to contextualize interview data, to provide thick descriptions, and to reflect on potential areas for further exploration.

At this preliminary stage, I developed thick descriptions of various components needed for the case studies, including details (e.g. funder, objectives, start and end date, target groups, location, activities, budget and staffing) of each of the INGO's HIV/AIDS programs. While field work was still underway, I developed early descriptive visual displays as per Miles and Huberman [125] to visually represent the multiple players influencing the INGO's implementation of its equity principles in its seven HIV/AIDS programs.

Following the field work, I entered all interviews, the three equity forms, and a few key documents into NVivo 9 [129] to assist with the initial coding of the data. Using Auerbach and Silverstein's process (2003), I conducted first-level coding which entailed identifying "relevant text" based on one of my three research questions and coding these

segments of texts into “repeated ideas” [130, p. 36-37]. I proceeded with this coding without a pre-structured coding framework. I coded based on player (e.g. donor, Kenyan government, INGO Kenyan staff, clients, and Northern INGO staff), so if “repeated ideas” were common across more than one player, each group was coded separately. I developed a matrix that examined coded categories of responses to particular interview questions⁷ by interviewee group to examine patterns in the data and look for differences in responses between groups. I also coded information about my entry into the INGO and other relevant context. In vivo coding [131] was used in some cases, as appropriate. To ensure comprehensive first-level coding, I also coded the interview data by assigning a code for each interview question, called “structural coding” [131, p. 84], given that these interview questions were developed to answer the research questions. I coded participant observation and document data via hard copy, highlighting relevant text as it pertained to the relevant codes.

The results from these first-level coding practices were then used to develop matrices to further understand the data. I developed descriptive matrices as per Miles and Huberman (1994) [125] to further understand the data that resulted from my first-level coding practices. Table 5 outlines the matrices developed at this stage.

Table 5: Matrices Developed following First-Level Coding

Type of Matrix	Content of Matrix
“Thematic conceptual matrices” [125, p. 131]	I developed a matrix that used full quotes from the data to compare and contrast challenges and facilitators that were cited as influencing equity by level. -rows: donors, Kenyan government, community, and INGO -columns: interview responses from internal Kenyan staff, external

⁷ **For INGO staff in Kenya and Northern countries, donors and government:** what does equity mean to your organization; what does equity mean to you; awareness of codes; describe or characterize the INGO’s progress in achieving equity principles

For clients: what do you like about the program/being involved in the program; what could the INGO do to have more people use the program?

Type of Matrix	Content of Matrix
	<p>Kenyan staff, and Northern INGO staff interviews as well as participant observation</p> <p>I developed a separate matrix for data from the documents. -rows: influences (similar to those in the interview and participant observation matrix) -columns: donors, Kenyan government, and INGO</p> <p>The purpose of these matrices was to start to identify patterns in the data and consolidate the codes into a smaller number of categories based on their inter-relationships.</p> <p>In addition, I developed a matrix comparing different vulnerable groups for HIV/AIDS. -rows: influences on equity from different players (donors, Kenyan government, Northern INGO, and the Kenyan INGO) -columns: females, men who have sex with men, sex workers, and people living in poverty</p> <p>This matrix identified the influences that challenged and facilitated equity implementation by particular groups (e.g. whether or not there was identification of vulnerable group as a priority, whether or not legal frameworks were supportive of implementing equity with that vulnerable group).</p>
<p>“Checklist matrix” [125, p. 109]</p>	<p>Based on the above matrix, I developed checklist matrices that examined: -rows: different vulnerable groups by -columns: different influences (e.g. legal, consensus documents, cultural, evidence)</p> <p>The purpose was to illustrate whether these influences were supportive or hindering equity work towards each vulnerable group. These matrices were done for the Kenya country level and the Northern (donor) country level.</p>

For second-level coding, I reviewed and grouped repeating ideas into categories of data based on their commonalities, and wrote descriptions of how these categories were connected to each other [130]. I then reviewed across these categories of data to understand how they could be further organized into (an even smaller number of) common categories. At this stage, I also developed various drafts of “networks” [125, p. 93] (analytical visual

representations) [122] to illustrate the relationship between common categories as a basis for an emergent conceptual framework.

Moving from descriptive to interpretive during third-level coding, I developed overall themes arising from the case study. I wrote the integrated storyline based on the interrelated nature of these themes, and I went back and forth between the raw data and the themes arising to ensure coherence. I continued to further develop and refine the themes. Throughout all stages of the analysis process, I discussed and reviewed the repeating ideas, categories, themes and integrated storylines with my co-supervisors.

In addition, to develop my case description, I coded data that would help me to add to my thick description of the case, including information on the INGO and specific programs. I developed a matrix of the various HIV/AIDS programs with columns identifying each project's start and end dates, target groups, activities, locations, partners, donors, budget, staff, and contact information. I reviewed documents and identified relevant information for inclusion in the case description, either following up with my key contacts or searching on the web for missing information. Based on this information, I organized and wrote the case description.

2.7 Data Verification and Preliminary Dissemination

I verified the data at two stages – raw data verification through member checking of interviews, and preliminary analysis verification through presentations and review of a summary of early results. In terms of raw data verification, all interviewees in Kenya and North America (apart from the client interviews) were offered the opportunity to member check their interviews and provide any feedback from this review. Following my verification of the transcript, I sent the transcript to the interviewee for any comments. I gave them two

weeks to respond and informed them that if I did not hear from them by this deadline, I would assume that the transcript was accurate.

In February 2011, following data collection in Canada and the U.S. and further data analysis, I returned to Kenya to ensure that the preliminary analysis was on the right track at this stage in the research. I made a presentation of these preliminary analyses (based primarily on my first level coding) to staff to ensure my findings were comprehensive, and to ask a few clarification questions from my analysis to date. For example, I asked about the development and ownership of the government's HIV/AIDS strategy, as my data showed mixed responses. All Kenyan-based INGO staff were invited to attend this presentation; 12 attended. Of those in attendance, five people had taken part directly in this research. Those present generally agreed with my findings. Responses also indicated that saturation of the topic had been reached, as very few new ideas arose.

At the same time, I also emailed a written summary of the preliminary findings to all staff who had taken part in the research in Kenya, the U.S. and Canada, and staff had the opportunity to review and comment on the written version of the preliminary findings. (See Appendix L for a copy of this summary). No issues were raised about the summary, either in person or by email. A number of staff commented that they felt that the summary represented the INGO's situation.

A list of my preliminary dissemination activities to date is outlined in Appendix E. My future planned knowledge translation activities will include publication of the thesis results in peer reviewed journals and presentation at conferences.

3 Chapter 3: Results

3.1 INGO Case Study Description⁸

This case study description outlines the history and background of the INGO, including its governance. The scope of the INGO's work, and its equity principles in HIV/AIDS work, are summarized.

The INGO was formed in the 1950s in Eastern Africa. Its original focus was providing health care services to people in hard to reach areas. The INGO's Strategic Plan (2007-2017) notes that since 2000, it has moved from a focus only on service delivery to one of building capacity, conducting research on its programs, and advocacy. This was based on a growing recognition that a service delivery approach alone was not sufficient to produce lasting changes in health. The INGO's advocacy role focuses on health human resource shortages and the need for strengthening the health system.

3.1.1 Overall Governance

The INGO is currently made up of its headquarters office, 12 National offices in Northern countries in Europe and North America, and six Country offices located in sub-Saharan Africa. National offices mainly focus on fundraising, technical support to the country offices' programs, and raising Northern countries' awareness about African health issues. Country offices implement projects and services in health, and work on influencing related country-level practices and policies, such as advocating for the use of community health workers to strengthen the health system.

The overall Board of Directors approves the INGO's strategic plan and policies. The U.S. and Canada offices each have their own Executive Directors and Board of Directors.

⁸ The case study description was developed using data collected from participant observation, interviews, and documents. To help to maintain the anonymity of the case INGO, references to document names and page numbers are not cited.

While these National offices are affiliates of the INGO, they are separate entities in their own Northern countries. For example, the U.S. National office produces its own annual report and financial statements, independent from the overall INGO. The Country offices (in sub-Saharan Africa) are structured differently than the National offices (in Northern countries). For example, the Kenyan office has a Country Director and Advisory Council that helps to set priorities within the Kenyan context, identifies potential opportunities, and provides oversight for the Kenyan office's projects. The Kenyan office develops its strategic plan and workplan according to the overall INGO strategic plan, ensuring it is aligned with the government health sector strategy plan and policies.

The INGO also has an International Forum, made up of the INGO Board Chair and representatives from the INGO's National offices, which meets on a regular basis. During my data collection period, this forum had initiated governance reforms to improve integration across headquarters and the National offices, including having one overall INGO strategy, plan, budget, evaluation framework, brand, and governance structure.

As per its annual report in 2010, the overall budget expended by the INGO in fiscal year 2008-2009 was approximately \$75 million, of which almost \$25 million was allocated to the Kenyan office. Thirty-eight per cent (almost \$29 million) of the overall 2008-2009 budget for the INGO was for HIV/AIDS work. Annual reports do not detail sources of funding, but my participant observation, interviews and document reviews indicated that the majority of funding (over 80% and closer to 90%) is restricted – that is, it comes from responding to requests for proposals, and therefore has to be spent within specific project parameters. The INGO headquarters receives some unrestricted funding that is not tied to

specific projects, from two Northern country governments⁹. The INGO also fundraises from individuals through its Northern offices. The Kenyan Country office funds its project work by responding to requests for project proposals, typically from Northern country governments, such as the U.S., United Kingdom, and Sweden, as well as some private foundations and companies (e.g. pharmaceutical companies).

3.1.2 INGO's Kenyan Office and its Work in HIV/AIDS

The Kenyan office has four departments, covering clinical services, water and sanitation, maternal and child health, and HIV/AIDS. Approximately 200 staff are employed, making it the largest country office in the overall organization. Most of these staff are located in Nairobi, with smaller offices located in other parts of Kenya where projects are based. For example, one of the larger HIV/AIDS projects had offices in multiple provinces (with approximately two to six staff in each office).

The INGO was running seven HIV/AIDS projects in Kenya during my three-month data collection period. These were in various stages of the project cycle. One was just starting and was hiring staff; one was complete and in the report-writing stage; the others were at intermediate stages of implementation. Some of the projects were very small, involving two or three staff, while others were quite large (one project had approximately 50 staff and accounted for about 40% of the INGO's total Kenyan budget). Some projects were based in one locale while others were operational in several provinces or across countries. Some of the projects focused on intermediary organizations (e.g. capacity building of civil society organizations) while others provided direct health services to community members.

⁹ The exact amount of this unrestricted funding is not outlined in the annual reports.

It is mainly Northern country government (Sweden, United Kingdom, the United States) that fund the Kenyan INGO's HIV/AIDS projects; a private donor funded one HIV/AIDS project that had just finished. The INGO was seeking funding for other planned projects on HIV/AIDS, and during my data collection period, it responded to a few requests for proposals from HIV/AIDS donors.

One project aimed to improve HIV data collection in Kenya while the remaining six projects focused on reducing the risk of HIV infection or on providing care and treatment for those with HIV/AIDS. Activities included: providing medical services; improving access to anti-retroviral therapy and HIV testing and counseling; and building capacity of health workers in areas such as ARVT adherence, home-based care, prevention of mother to child transmission, and stigma reduction. Some projects included building capacity of civil society organizations to provide linkages between the community and the health care system. Many projects provided infrastructure, including bicycles for community health workers to reach community members.

3.1.3 Equity and the INGO

Overall, the INGO outlined three strategies in its strategic plan for the period 2007 to 2017: partnering with communities to improve health, capacity building for communities, and policy and research on health systems. While equity was not explicitly listed as one of the three strategic foci, there were repeated references to equity in the strategic plan. Equity was mentioned in the section on core values and principles with particular reference to gender equity, pro-poor and non-discriminatory approaches, empowered communities, and health as a human right. These represented five of the twelve principles for the organization. All five illustrate the importance that the INGO places on ensuring equity amongst different

groups, as well as the central role of empowered and engaged communities in health. The language expressing its core values and principles was assertive and progressive, positioning these principles in relation to relevant international conventions and agreements.

Components of equity were also outlined in the INGO's corporate HIV/AIDS strategy (2006-2010). The overall goal of the strategy was to reach universal access in HIV/AIDS interventions (including care, treatment, and prevention). Vulnerable groups, namely people living in poverty in rural and urban areas, were specifically identified, as were children and youth. This strategy had five implementation principles, of which two were equity-related. The HIV strategy reflected equity principles similar to those outlined in the overall INGO strategy. One equity-related principle focused on poverty, gender inequities, and stigma as key areas to focus on in the HIV strategy. The other equity-related principle noted "balanc(ing) human rights" and public health as significant components in intervening in HIV/AIDS.

Nevertheless, the strategic actions focused on individual health behaviours, as well as providing health care services, including behaviour change strategies and individual testing. A more upstream human rights orientation was missing, such as addressing cultural and legislative barriers affecting most-at-risk populations. Sex workers and intravenous drug users were only briefly mentioned, and men who have sex with men were not identified at all. In terms of action to move HIV/AIDS work forward, community engagement, capacity building, and collecting evidence on what works were the key actions outlined in the HIV strategy.

Many of the INGO's community projects modeled their work on the Kenyan government's Community Strategy, which was developed as a way to implement the Kenya Essential Package for Health at the community level. The Essential Package for Health

formed part of the Kenyan government's National Health Sector Strategic Plan 2005-2010 [132], and outlined six levels of service. These ranged from the community itself (Level 1), to dispensaries in the community (Level 2), and health centres (Level 3). Levels 4, 5 and 6 represent the hospitals at the primary, secondary, and tertiary levels. The Kenya Essential Package for Health represents a shift in emphasis from a focus on the formal system at higher levels (e.g. levels 4 through 6), to a focus at the community level (linking levels 1 and 2) by providing people living in poverty in Kenya with basic health services. As the document describes:

“Level 1, the community level, is the foundation of the service delivery priorities, because it allows the community to define its own priorities so as to develop ownership and commitment to health services. Communities will be empowered with information and skills. Only in this way can real change towards healthy lifestyles be achieved” (p. xii).

Hence, as this quote describes, the Community Strategy represents an explicit orientation of empowerment at the community level by having the community identify its priorities and increasing the capacity of communities. In terms of practicalities, the Community Strategy includes identifying and training one voluntary community health worker per 20 households in a community. These community health workers promote health amongst community members by educating them on prevention, by treating minor health issues and referring community members to health facilities for treatment, among other duties. A community health extension worker, who is a paid and trained medical professional in nursing or public health, supervises the community health workers. A Community Health Committee, consisting of community members and the community health extension worker, oversees the work at the community level, and identifies priorities for the community, plans interventions, and monitors results. This is the structure for a community unit, which consists of approximately 1,000 households or 5,000 people [133]. While the Kenyan government

identifies a number of priority “service activities and requirements” (including HIV), the community also identifies its priorities. The Community Strategy aligns with an equity approach, but resourcing the Strategy’s implementation is an issue. As the Kenyan government does not have adequate resources to implement the Community Strategy throughout Kenya, I learned through participant observation that the government relies on NGOs, who secure funding from external donors, for implementation. The case INGO had some HIV/AIDS projects that implemented components of the Community Strategy through various mechanisms. For instance, the INGO: trained community health workers to provide HIV prevention and referral information for community members; built capacity of local civil society organizations to provide home based care and support groups for people living with HIV; and linked the community (Level 1) with health service facilities (Level 2) through formal structures.

3.2 Description of Participants and Documents

3.2.1 Overview of Data Collection Timelines

Table 6 provides an overview of the timelines for data collection in Kenya, Canada, and the U.S.

Table 6: Overview of Data Collection Timelines

Kenya	
Document Collection	February 2010 – May 2010
Participant Observation	March 2010 – May 2010
Internal Interviews (INGO Staff in Kenya)	April 2010 – May 2010
External Interviews (Partners of the INGO in Kenya)	April 2010 – May 2010
Client interviews	April 2010 – May 2010
Canada and the U.S.	
INGO Interviews	June – July 2010
Document Collection	June – July 2010

3.2.2 *Participant Observation in Kenya*

Ten staff who worked for the INGO agreed to take part in participant observation. Two were senior managers overseeing HIV/AIDS work and one worked on evaluation of projects including HIV/AIDS. The remaining staff worked for one of the INGO's HIV/AIDS projects: one staff each for three of the INGO's HIV/AIDS projects, and four staff from the largest HIV/AIDS project. Nine of these participants were located in the Nairobi office, and one was located in Eastern Kenya. Six were male, and four were female.

In my volunteer role at the INGO, I generally spent full days in the office, or on field visits, five days a week. The participant observation arose from day-to-day informal interactions in the office and working jointly with staff on projects. In the case of one of the staff who was located in Eastern Kenya, my participant observation occurred mainly during a two-day project field visit. In addition, two of the participants were also my key contacts for ongoing project issues, so I had regular meetings with them to pose questions and seek clarification about my observations, and to discuss the projects I was volunteering on.

3.2.3 *Interviews in Kenya*

Table 7 outlines the number of interviews conducted by type of interviewee, as well as the sex and location of the interviewees.

Table 7: Summary of Interviews Conducted

Interviewee Type	Number of interviews conducted	Sex	Interviewee's Location
Internal Interviews (INGO Staff in Kenya)	16	8 males 8 females	14 Nairobi 2 Western province
External Interviews (Partners of the INGO)	8	5 males 3 females	5 Nairobi 2 Western province 1 Nyanza province
Client Interviews	10	5 males 5 females	6 Nairobi 4 Western province

Interviewee Type	Number of interviews conducted	Sex	Interviewee's Location
INGO Interviews in Canada and the U.S.	7	4 males 3 females	1 Canada 6 U.S.
Total	41 interviews		

In Kenya, 16 interviews were conducted with internal INGO staff. Fourteen of these staff were based in Nairobi, and two in Western province. Nine agreed to have their interviews digitally recorded; seven agreed to only having notes taken. The interviews lasted on average 64 minutes (varying from 32 to 120 minutes).

In addition to internal INGO interviews, eight external interviews were also conducted in Kenya— two with donors; four with government staff; and two with partner Southern NGOs. Six of these external interviewees agreed to have their interviews digitally recorded, although one of these could not be recorded as security refused to allow recording devices inside the building. Two agreed to only having notes taken. The external interviews were 30 to 75 minutes in length, averaging 47 minutes.

Ten interviews were conducted with clients of the INGO's HIV/AIDS projects – six with an anti-retroviral therapy project embedded within an integrated INGO health facility and four with a capacity-building and grant-making project. All of the clients agreed to have their interviews digitally recorded, but due to a technical challenge, one of the interviews was not digitally recorded and notes were taken instead. The client interviews lasted 23 minutes on average (varying from 17 to 34 minutes).

3.2.4 Interviews in Canada and the United States

I conducted one interview in Canada and six in the United States with staff from the INGO offices. I spent one afternoon at the Canadian office (although I had made an initial visit a year earlier to discuss the project), and I was in the U.S. office over a three-day

period. The interviews averaged 47 minutes (ranging from 37 to 60 minutes). All interviews were conducted in English; six were conducted in person. One U.S. interview was done by telephone a couple of weeks following the in-person visit, as the staff person was in Kenya when I was on site at the U.S. office. All of the interviewees agreed to have their interviews digitally recorded. The Canadian staff person worked on proposal writing and technical support for projects in Kenya and other Southern countries, including HIV/AIDS projects. The U.S. interviewees included senior staff, as well as project, finance, and communication staff who worked with Southern country offices, including the Kenyan office, on various projects including HIV/AIDS.

3.2.5 Documents

I gathered approximately 120 eligible documents in Kenya, and seven each in the U.S. and Canada. Of the Kenyan documents, 88 were INGO documents and included senior management minutes, overall equity-related guidelines for the INGO, case studies, human resource information, strategic plans, governance information, project meeting materials, responses to requests for proposals, and project reports (including evaluations, needs assessments, monthly and annual reports, implementation plans, brochures, and training information). Twenty-two documents were Kenyan government documents, including strategic plans, governance information, operating plans and frameworks, and evaluation, data and indicator documents. Ten were donor documents, which included strategic plans and requests for proposals. Documents provided by the Canadian office included proposals, newsletters and annual reports. The U.S. office provided an annual report, program information, a newspaper article, a request for proposal, and governance policies. The majority of these documents covered the time period of 2006 to 2010, while a few were from

as early as 2003. In addition to the documents gathered during the data collection period, I searched for documents from 2011 and 2012 that were available publicly on the Internet to assist in filling in gaps in information as I finalized the write-up of the case and the dissertation.

3.3 Donors' and Kenyan Government's Explicit Identification of Equity

Many interviewees identified that other players' explicit identification of equity helped facilitate the INGO in its implementation of equity principles in HIV/AIDS. In my review of documents, I confirmed that equity was explicitly identified as a principle in many of the donors' and Kenyan government's recent documents.

Amongst donors, the level of emphasis on equity varied somewhat. I reviewed strategic documents on HIV/AIDS strategies from three Northern country donors (Sweden, United Kingdom, United States) who were the major funders of the HIV/AIDS work for the INGO. These were fairly high-level documents outlining the overall strategy for HIV/AIDS in Southern countries. The United States President's Emergency Plan for AIDS Relief (PEPFAR) had the least emphasis on equity in its HIV/AIDS strategy amongst these three donors [134]. PEPFAR's strategy for HIV/AIDS (2010-2014) did not specifically identify equity in its goals, but made a few references to gender equity regarding the need for services to be gender equitable and to mainstream gender in programs: "PEPFAR is working to implement women-centered care, and to ensure that its services are gender equitable. Its programs address the particular vulnerabilities faced by women and girls, especially those who are impacted by gender-based violence" (p. 5). Brief mentions were made of the need to be "responsive to the *public health needs* of marginalized communities" (p. 5, emphasis added), and address stigma that these groups face. There was limited mention of people living in poverty. The UK government's Department for International Development's

HIV/AIDS strategy (2004) [135] also did not specifically identify equity as a goal, although women, youth, people living in poverty, and most-at-risk populations were identified as priority groups. The plan also had a section on human rights, and outlined the challenges that women, sex workers, and men who have sex with men face in HIV/AIDS epidemics in Southern countries. The Swedish International Development Cooperation Agency (SIDA) had a stronger emphasis on equity in its 2008 HIV/AIDS international policy [136]. SIDA's HIV/AIDS strategy, including its emphasis on equity, aligns with the goals of their overall global development work – to help those living in poverty to better the conditions in which they live, and the ultimate objective of “contribut(ing) to equitable and sustainable global development” (p. 8). Human rights and gender equality were identified as major foci of SIDA's HIV/AIDS policy; the human rights section included identifying challenges for most-at-risk populations, women, and youth.

In both donor documents and interviews, gender equity was a consistent domain of focus.

“We have a special focus when it comes to equity. This is on gender” (#607, donor).

“Equity comes mostly under the ambit of gender at [donor organization] — when you hear of equity at [donor organization], you are also likely to hear about gender” (#606, donor).

Delivering services to people living in poverty was another focus:

“When it comes to health programs, from where I sit in [my donor organization], the biggest lens is for geographic targeting. I'll ask myself in terms of the poverty map in Kenya—where is the poorest area of the poorest groups in a certain area. So once I have that, the second question is about delivering services at that level...At [my donor organization], I am interested in geography, and targeting by...equity issues like poverty and gender” (#606, donor).

Some donor countries had a broader lens, beyond service delivery, to that of human rights that included people living in poverty as well as most-at-risk populations (MARPs):

“Pro-poor is linked closely with human rights. [Our] overall objective is to contribute to the ability of people, including those living in poverty, to take care of their own lives...In terms of MARPs—there are legal issues, but we need to find creative ways to work with these groups, especially LGBTI [lesbian, gay, bi-sexual, transgender, intersex], especially from the human rights perspective” (#607, donor).

Interviewees noted the contrasting viewpoints of donors—for some, equity was more central to their work, including a human rights focus. Generally, European donors were viewed as being more “equity conscious” than U.S. donors (#400, government staff), and certain countries within Europe were viewed as having a particularly strong equity focus. As one country donor said about another:

“Swedish SIDA is more interested in equity issues—in gender equity—than we are; they are more socialist than we are. They use a human rights approach. SIDA tends to be more equity focused, more gender focused” (#606, donor).

The political leanings of the donor country seemed to influence the level of interest in equity.

In the Kenyan government, equity was a key principle repeatedly cited across the spectrum of planning documents, covering HIV/AIDS specifically and health generally. These documents, released in 2008 and 2009, were identified by interviewees and in participant observation. These strategic and planning documents were health-focused, including the National Health Sector Strategic Plan of Kenya II [132], and the Kenyan National AIDS Strategic Plan [108], as well as overarching economic and political documents, including Vision 2030 [137] (the overall development plan for Kenya) and the draft Constitution for Kenya [138].

Many internal and external interviewees identified that Kenya’s new Constitution (which was in draft form at the time of data collection) had a major equity focus. The new Constitution made reference to “human dignity, equity, social justice, equality, human rights, non-discrimination and protection of the marginalised” [138] in the sections outlining values and principles. Both internal and external interviewees agreed that the Constitution brought

the issue of equity, and in particular equity among tribes, to the forefront. One tribe was viewed as having received more resources and land than many other tribes in Kenya, and this had boiled over, one year prior to my data collection, in post-election violence.

“At the moment, and maybe from most of the post-election violence and from whatever is happening in our country right now even the constitution, a lot of focus is on more equitable distribution [of]...the national cake” (#59, internal staff).

“Like the current discussion on the draft constitution — it has a section on human rights, so issues of equity can be discussed. The draft constitution goes out for discussion and then goes for referendum. There is an opportunity to discuss equity in a general sense, not just in terms of HIV/AIDS. This is an opportunity to discuss equity at a very strategic level—to have equity coming up at different levels—like to discuss equity in terms of land. Issues of land—it is a very central issue and it’s also influenced by a lot of cultural issues—so we can also be tackling issues of equity there—they are on the table. We can tackle issues elsewhere so to me that’s the biggest opportunity there currently. The constitution is an opportunity people can use to discuss equity” (#606, donor).

Hence, the formulation of the new Constitution offered a forum for Kenyans to debate issues of equity more broadly and to discuss ways to move forward. These issues included human rights and in particular the equitable distribution of resources and land amongst Kenyans tribal groups.

Another Kenyan government document that many external and internal interviewees identified as pivotal to equity, Vision 2030, focused on gender and poverty. Vision 2030, which began in 2008, followed from the Kenyan Economic Recovery Strategy for Wealth and Employment Creation (the “Kenyan equivalent of the poverty reduction strategy papers”¹⁰) [132, p. 5]. Vision 2030 had three pillars, including a social pillar that “seeks to build a just and cohesive society with social equity in a clean and secure environment” [137, p. 1]. These overarching government documents clearly identified equity as a pivotal

¹⁰ In 1999, the World Bank and International Monetary Fund introduced Poverty Reduction Strategy Papers (PRSPs) “as a new framework to enhance domestic accountability for poverty reduction reform efforts; a means to enhance the coordination of development assistance between governments and development partners; and a precondition or access to debt relief and concessional financing from both institutions’ HIPC Initiative [The Enhanced Heavily Indebted Poor Countries Initiative]” [139].

principle for Kenya to: improve its overall governance of the country, implement its long-term development plans to move from a low-income country to a middle-income country, and achieve its goal to reduce poverty and address its other social issues.

Specific to health, the National Health Sector Strategic Plan (NHSSP II) (2005-2010) also had an equity focus, starting with its vision (“An efficient and high quality health care system that is accessible, equitable, and affordable for every Kenyan”) [132, p. 10], and one of six policy objectives to achieve this vision (“increase equitable access to health services” (p. 10)). In terms of HIV/AIDS, the Kenyan National AIDS Strategic Plan (KNASP III) [105] clearly outlined the need to focus on populations most at risk of HIV transmission, including men who have sex with men, injecting drug users, and sex workers. KNASP III identified the need for health services targeting vulnerable and marginalized populations. It also called for addressing underlying social determinants, in particular for people living in poverty, as well as women and girls. For instance, the plan stated that: “Equity and rights-focused approaches require that interventions promote social inclusion” [108, p. 8].

3.4 Interdependence of Players Working on HIV/AIDS in Kenya

In this section, I focus specifically on the relationship amongst the different players working in HIV/AIDS in Kenya to provide the context of interdependence, prior to examining the influences on the INGO’s implementation of its equity principles.

The INGO was one player in HIV/AIDS in Kenya, working interdependently with donors and the Kenyan government. This interdependence was reflected through their mutual reliance on each others’ roles in working towards a common goal of responding to and addressing the HIV/AIDS epidemic in Kenya. The major role of the donors was the provision of funding, while the Kenyan government coordinated the overall country response

to HIV/AIDS, and the INGO implemented programs at the community level. Each needed the others to move towards their goal.

Like the INGO, the Kenyan government relied on donors for the majority of their funding for work in HIV/AIDS [108]. Government staff noted their reliance on donor funding:

“We can comfortably say that 80 percent of all resources for HIV and AIDS programming [in Kenya] comes from external sources” (#603, government staff).

Data from documents supported this. For example, in 2009, the Kenyan government reported to UNAIDS that approximately \$687 million was spent on HIV/AIDS [10, p. 236]. However, only 14.2% of this expenditure was funded by domestic public funds. The remaining funds came from donors, including bilateral, Global Fund, United Nations, multilateral, and other international sources. These numbers were fairly consistent from 2007-2009, with only 13.7% (2007) and 11.2% (2008) of funding for HIV/AIDS coming from domestic sources [10, p. 236]. Similarly, INGO staff noted their reliance on donor funding for projects: *“We [the INGO] depend on donor funds” (#44, internal staff)*. This reliance on project funding meant that the INGO was funded on a project-by-project basis by a multiplicity of donors and had to continually try to access project funding by responding to donors’ requests for proposals.

The role of the Kenyan government was to coordinate the overall response to HIV/AIDS in Kenya. Specifically, the National AIDS Control Council (NACC) oversaw implementation of the overall country action plan on HIV/AIDS (the Kenyan National AIDS Strategic Plan III [108]) and the resultant monitoring and evaluation system (the National Monitoring and Evaluation Framework [140]). The government’s National AIDS and STI Control Program (NAS COP) coordinated the health sector response: *“[NAS COP] is the*

main organization coordinating what we call the health sector response to HIV” (#400, government staff). The Kenyan government’s role was to coordinate the work of various players, including the donors and the INGO, in their HIV/AIDS work. Internal and external interviewees identified that the INGO was one player helping to implement this overall response to HIV/AIDS:

“The [INGO] helps us to contribute to the overall national response to HIV together with other partners” (#400, government staff).

The contribution from the INGO was to work in the communities to implement the Kenyan HIV/AIDS strategy. Many INGO staff and donor interviewees noted that donors counted on the INGO to implement HIV/AIDS projects at the community level: *“[The INGO] is the one who implements” (#607, donor).* Some interviewees noted that the donors did not have the in-country expertise or the connections to the community that the INGO had:

“[The INGO] can identify problems [based on what] we have seen, and based on results we have had, we apply strategies that are effective... The donor identifies the larger issue and [the INGO] contextualizes this based on its experience...” (#44, internal staff).

As this quote illustrates, the INGO was viewed as having the knowledge and experience at the community level to implement donors’ visions within the community context. The Kenyan government also relied on the INGO for its knowledge, experience, and connections to the community. The Kenyan government was working towards providing services at the community level with a community empowerment approach as an active component, as illustrated in the Community Strategy discussed above [141]. However, even though the Kenyan government technically had links in all communities, many interviewees, and in particular those external to the INGO, noted that the INGO filled in gaps in government services that were due to fiscal constraints and inadequate human resources: *“[The*

INGO] ...is trying to fill the gap left by the government of Kenya” (#607, donor). This included the INGO implementing programs at the community level:

“[The INGO] was a pioneer in that community [on prevention of mother to child transmission]. They were pioneers in several communities, in several districts when they went there. Because the government hadn’t done much [in terms of service provision]” (#401, partner NGO).

While only specifically identified by one interviewee, some of these gaps that the INGO was addressing may have resulted from the neo-liberal agenda, and Structural Adjustment Programmes, from the early 1980s:

“The neo-liberal agenda failed. [The INGO] fills in the gaps of government. [Where] IMF and World Bank – other bilateral damage was inflicted. [The INGO] provided a bandage for the wounds” (#23, internal staff).

The INGO further addressed gaps in service by building health facilities for the purpose of eventually handing these over to the government: *“We [the INGO] have built facilities that we have handed over to the government” (#23, internal staff).* One of the projects I examined as part of the case study was an integrated health facility, which included HIV/AIDS components, that was run by the INGO, and the INGO was looking to hand this facility over to the government (#3, participant observation, March 29th, 2010). The case INGO is not the only INGO that filled this service gap – 1998 data cited in the 2005 National Health Sector Strategic Plan showed that 20% of the over 4,600 health facilities in Kenya were owned by NGOs or faith-based organizations, 51% were owned by the Kenyan government, and the remaining 29% by private for-profit organizations [132, p. 3-4]. The case INGO clearly played a key role in the delivery of health care in Kenya, since in this same Kenyan government document, the INGO was named as one of “the most important private health care providers in Kenya”.

Perhaps not surprisingly, given the donors' and Kenyan government's reliance on the INGO to implement services at the community level, the INGO was also viewed by the donors and government staff I interviewed as having a strong reputation in working with communities:

“[The INGO] traditionally has been very strong working with communities...they have a track record working in communities...They've had that history [of] working, reaching down to the very remotest parts of the country” (#400, government staff).

Many internal and external interviewees felt that this positive reputation was because the INGO was based in Kenya, had a long history of working with communities, and had positive relationships with donors, the Kenyan government, and the community:

“The relationship between [the government department] and [the INGO] has been there for a long time...We realized that [the INGO] has been involved for a very long time in provision of health service to communities. And the fact that the heaviest burden of disease in this country is within the decentralized structure, at the community level, we took cognizance of some of the good practices that [the INGO] has brought on board through their widespread activities, throughout Africa, and decided to work very closely with them – particularly in areas where they had community structures that have been providing services to communities” (#603, government staff).

“[The INGO] has a comparative advantage [with] other NGOs because [the INGO] is seen as Kenyan based even though they have an international infrastructure – they are seen as very much rooted in Kenya” (#606, donor).

Due to the INGO's long history with providing services to communities, the Kenyan government and donors trusted the INGO and relied on the INGO to conduct work where there were gaps – delivering services and working with communities.

Hence, the Kenyan government, donors, and the INGO each had specific roles that were necessary to address the HIV/AIDS epidemic in Kenya – with the donors providing a substantial amount of funding, the Kenyan government coordinating the overall response for HIV/AIDS work, and the INGO implementing programs in the communities. Each player

needed the others, and therefore these players were mutually reliant – that is, they were dependent on each other if they wished to meet their HIV/AIDS goals.

This interdependence among the donors, Kenyan government, and INGO was also formally outlined in both global and Kenyan-specific documents. These documents provided formal commitments that outlined the importance of alignment amongst the players in terms of priorities and monitoring (although the documents did not outline formal mechanisms for repercussions if this alignment did not occur). One such external, global document was the Paris Declaration [142], which identifies principles for coordination amongst Southern governments and Northern governments and other donors involved in development aid, including but not specific to HIV/AIDS:

“The Paris Declaration dealt with issues in terms of harmonizing, etc. This helped to clearly identify the division of labour” (#606, donor).

However, this document focused on multilateral and bilateral donors and Southern country governments, and not INGOs. It did provide a starting point for alignment amongst players as donors committed to align with country priorities when providing aid, and also use common indicators to measure progress.

Another formal global commitment that reflected the interdependence amongst the players was the Action Framework for HIV/AIDS. The “Three Ones” key principles by UNAIDS outlined three principles of coordination for all players involved in a “country-level HIV/AIDS response”. These principles were:

- *“One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.*
- *One National AIDS Coordinating Authority, with a broad based multi-sector mandate.*
- *One agreed country level Monitoring and Evaluation System”[143, p. 1].*

The various players in Kenya, including the donors and the INGO, were encouraged to align to the Kenyan National AIDS Strategic Plan III [108], which was the HIV/AIDS Action Framework for Kenya. This expectation was based in the global commitments identified above, and reinforced by donors and the Kenyan government.

“All players in this country, including [the INGO] have to subscribe to the strategic plan, because that is the blueprint for HIV programming. Within the strategic plan, we have a results’ matrix, which indicates very clearly what results the country requires” (#603, government staff).

“Donors want to know ‘how are you fitting in with the government strategies and documents’. So the donor requires this. So KNASP—the donors are not in the country or not at a level to be able to know much, but the best way of doing things, they look at government documents” (#44, internal staff).

As part of the commitment and operationalization of the “Three Ones”, all of the players were also expected to use the Kenyan monitoring and evaluation system—the National Monitoring and Evaluation Framework [140]—to report in a common way:

“We also have now a common monitoring and evaluation system, and everybody has to report...into that system using the tools and reporting format that we have agreed on” (#603, government staff).

The INGO ensured that the HIV/AIDS data they collected aligned with this evaluation framework: *“Most people are collecting information from the government tools that exist” (#16, internal staff).* As the evaluation framework changed, the INGO made changes to re-align with this document:

“I am realigning our [INGO’s] indicators according to this document [National HIV and AIDS Monitoring and Evaluation and Research Framework, 2009, NACC]” (#44, internal staff).

The indicators that the INGO reported on, and asked civil society organizations that it funded to report on, aligned with those required by the Kenyan government. Hence, there were

certain structures and requirements arising from the Three Ones key principles that fostered alignment in HIV/AIDS work amongst the INGO, donors and government.

An additional document where interdependence amongst these players was outlined and formally acknowledged was the Kenyan Health Sector Wide Approach – Code of Conduct [144]. This document identified the formal roles and commitments that the players have signed on to align and integrate their work – including the Development Partners (i.e. donors), the Government of Kenya, and Implementing Partners (i.e. NGOs) in health. Principles for this code included that the Kenyan government will provide the leadership in setting the agenda. The other players are expected to “align [with and]...support” this agenda. More formal legislation was also in the planning phases during the data collection in Kenya in 2010:

“We don’t have a mechanism of enforcing...government policies within international NGOs. But we now have a draft legislation...which is actually going to hold everybody accountable...to what we have within our strategic plan...It will mean that [donors and NGOs] have to subscribe one hundred percent to the national priorities as contained in the strategic plan and the national plan of operation...So you don’t come into Kenya with prescriptions. You come to Kenya to work within the priority areas in the country. So that will help us in alignment and harmonization of donor activities in the country” (#603, government staff).

The purpose of this legislation was to provide a formal mechanism requiring organizations working in Kenya to align their work to the government strategies and documents, as opposed to pushing their own agenda.

Formal interdependence amongst players was also illustrated through INGO representation on Kenyan government committees at both national and local levels. Many external and internal interviewees identified that the INGO was a key member on a number of these committees. These committees were viewed in particular by internal staff as playing an important role in helping to align the INGO’s work with that of the government, as well

as opportunities for the INGO to provide advice and information to the government. The importance of the INGO's role in these committees to ensure alignment was also noted in project documents. Strategies and work were discussed at these committees to improve coordination and avoid duplication.

“Working with NACC and working with AIDS Committees in localities where we work helps a lot. The key is integrating with national activities in government areas – we complement, we supplement government activities. That way the government respects the community, we have the government's respect, that way there will be no difficulty. We support each other and have the support of each other. This works well when [the INGO] sits on various committees too, we integrate with the government, so it becomes easy” (#124, internal staff).

“One of the key things [we do] as [the INGO] is to support the health district stakeholders forum, which facilitates key health actors, including the Ministry of Health, to come together and discuss what is going on. So you are able to know what your partner is doing” (#16, internal staff).

In recent years, it appears that expectations to align the work of country government, donors, and other players, including INGOs working in Southern countries, have increased. Much of this change seems to have arisen from the need to better coordinate aid, and to reduce duplication and increase cooperation among players, including in their HIV/AIDS work. These requirements are being increasingly enshrined in global documents, such as the Paris Declaration and the Three Ones Principles, as well as more formally in-country through agreements, legislation, and committee structures.

3.5 How the INGO Implemented Equity Principles in its HIV/AIDS Work

Many interviewees noted the INGO implemented its equity principles in its HIV/AIDS work by focusing its programs on vulnerable groups. The other major equity focus of the INGO's projects in HIV/AIDS that was identified by interviewees was empowering communities to strengthen health systems.

3.5.1 Focusing on the Geographically Remote and Poor Communities

The INGO implemented its equity principles in its HIV/AIDS work by focusing on population groups where the INGO was viewed as having a positive and long-standing reputation: geographically remote populations and people living in poverty. Addressing equity through a focus on these groups was viewed as ingrained in the INGO's work.

The INGO had provided health care access to people living in remote areas for decades. The original mission of the INGO, which dated back to the 1950s, made direct reference to gaps in accessible health services to those in remote areas:

“The [INGO’s] vision [facilitates equity] because the INGO was founded by people who believed that communities lacked access to health care and the INGO set off to meet some of those needs” (#23, internal staff).

Many staff mentioned that the INGO's work continued in these geographically distant regions, citing this as an important contribution of the INGO to improve health equity:

“One thing [the INGO] does fairly well, or makes a good intent to, is working in the furthest regions. We’ve done fairly well on that historically...” (#205, Northern INGO staff).

Many external partners and clients echoed this view:

“[The INGO] has had that history of working, reaching down to the very remotest parts of the country...if you were to look at equity in terms of access to service, universal access, making sure as much as possible even those who do not have access to health facilities get the service, then I think that is what the INGO is doing” (#400, government staff).

“We have many organizations [in Kenya] working to uplift the community. Many of them should come on the ground the way [the INGO] has. Because if you look around, you will see that international NGOs, many of them [are] now concentrated maybe in Nairobi and other areas, but [the INGO] is going all over the place and it is assisting” (#508, client).

These perceptions were confirmed through participant observation and document review, where I found that the majority of the INGO's HIV/AIDS projects were located outside of

Nairobi (apart from a project in a Nairobi slum) in many small and poor communities throughout the country.

Many interviewees also saw working with people living in poverty as a historical focus for the INGO: “[The INGO] has always focused on...the poor population” (#2, *internal staff*). One of the INGO’s 12 “core values and beliefs” was “pro-poor”:

“[The INGO] identifies priorities and allocates resources on a pro-poor basis, giving priority to people and communities that we believe to be the most vulnerable” (INGO Strategy 2007-2017).

Many interviewees noted that working in areas with high levels of poverty was a purposeful strategy for the INGO to implement its equity principles in its HIV/AIDS work:

“[The INGO] targets the poor, we are at the community level and that’s where the poor are. The principle [of pro-poor] is already established; you’ll find us [in the slums] and in rural areas where the poor are – that’s a deliberate strategy” (#44, internal staff).

“The INGO they try to make...at least the poor have access to the basic HIV/AIDS care prevention and support packages” (#16, internal staff).

This focus on people living in poverty at the community level ranged from the INGO working on prevention of mother to child transmission (PMTCT) of HIV/AIDS in rural communities to providing health care services in an urban slum.

3.5.2 Focusing on Gender

Interviewees also identified that the INGO implemented its equity principles in its HIV/AIDS work by focusing on gender. Staff frequently equated equity with gender equity: *“In my perception, equity is more seen as male and female” (#85, internal staff)*. Perhaps this was because gender was an area where increasingly more and more HIV/AIDS projects were focusing, and many donors were targeting. However, unlike their work with

geographically remote populations, gender equity had not been the original historical focus of the INGO.

The INGO's focus on women and girls was due to their vulnerability for HIV/AIDS as a result of challenges accessing services, lower income, lower levels of education, and cultural practices such as disinheritance (#50, internal staff).

“Women and girls are not able to...have access to reproductive health services which is very crucial” (#46, internal staff).

“Attitudes in Kenya, for example, amongst most communities the boy child is viewed as more of a child than the girl child – so when the family makes a decision on who gets an education, if the family doesn't have enough money, they opt to educate the boy because they see the boy as more superior to the girl” (#607, donor).

Many of the interviewees mentioned male involvement, the need to include males in HIV/AIDS projects and services, as an important area of work for the INGO. This was confirmed via my participant observation:

“In regard to the male gender, we deliberately target male involvement when it comes to PMTCT [prevention of mother to child transmission] programming, particularly for couple counseling and testing” (#44, internal staff).

Staff within the INGO had identified that getting men onside was critical to achieve gender equity, stating that focusing programs on women without simultaneously educating men would not result in change:

“So we needed to involve men, so early on, NGOs targeted men and women because they knew women didn't have the right to decide the number of babies they had, so what was the use of educating her if she didn't have the ability to choose, so NGOs needed to ensure both men and women understood the benefits. Male engagement follows the same principles. People had learned from family planning that males should know their HIV status (#41, internal staff).

Many interviewees expressed that gender equity would never be reached without having men included in HIV/AIDS interventions, as men were often the household member with the decision-making power with regards to prevention and treatment. Ensuring male

involvement in HIV/AIDS programs was discussed in many of the INGO project planning meetings I attended. The importance of involving men in the INGO's HIV/AIDS projects was also identified by a couple of clients: "*We must involve (men)*" (#507, client).

Interviewees' identification of the importance of gender equity for the INGO's implementation of its equity principles in HIV/AIDS matched the strategic documents for the INGO that outlined gender equity as an organizational value. A few Kenyan staff mentioned the work being done on gender mainstreaming, including the INGO strategy, and development of a Kenyan-specific taskforce on gender mainstreaming:

"[The INGO] as an organization has a gender mainstreaming policy, so we're in the process of trying to localize it to the Kenyan situation" (#16, internal staff).

The taskforce and gender document were viewed as specific tools to help with implementation of gender equity in the INGO's interventions. The internal INGO Gender Mainstreaming document from headquarters was readily available to staff in the Kenyan and Northern offices, and most staff I interviewed had seen a copy.

It was noted by a number of interviewees that the INGO had made strides in gender equity through its HIV/AIDS work: "*I think generally we are making progress towards the promotion of gender equity*" (#59, internal staff). Much of the INGO's approach to addressing gender inequities involved empowerment, which is discussed next.

3.5.3 Empowering Communities and Beneficiaries to Strengthen Health Systems

Empowerment was identified by a number of staff of the INGO as an important approach that the INGO used to implement equity in its HIV/AIDS work. The ultimate goal of empowerment, according to the INGO staff I interviewed, was to enable community members to advocate for their community's health needs on their own behalf and increase

their involvement in making health decisions. Interviewees noted that targeted communities had high levels of poverty and/or were located in rural and remote areas. This interviewee summarized the importance of community empowerment to the INGO and its link to equity:

“[The INGO’s] main mission in our strategy in Africa is to empower...communities, the least empowered of them [to achieve] an equitable health status, which entails...teaching, training in health promotion, disease prevention, and providing the health systems and the human resources for health and everything that’s involved in health systems, the med[ications], the devices, equitable access – all the areas that fall under health systems strengthening, in an equitable manner in those communities. So that’s also giving them a voice....and giving them training about demanding the equity and achieving the equity” (#204, Northern INGO staff).

As this quote illustrates, empowerment entailed more than service provision. It was evident from document reviews and my field visits to some of the INGO’s HIV/AIDS projects that the Kenyan Community Strategy was front and centre in many of the projects. For example, the INGO’s empowerment approach built capacity of community organizations and community members to ensure they had the necessary knowledge and expertise to provide services and advocate on behalf of the community, and linked the community with government structures to ensure community participation in planning fora and on formal committees.

In one large HIV/AIDS project, the INGO provided trainings for civil society organizations to build their organizational capacity. These trainings included capacity building on how to attain funding (e.g. proposal writing), how to address governance issues, and how to network with government and other partners:

“They [the INGO] generate a lot of knowledge for us...They have a lot of trainings they offer, and those trainings are building our capacity, both individually and as an organization. Because now I know how to write a report, something that I did not know. Now I know how to write a proposal...When we go for meetings, we interact with people from other organizations, and also network. Through the networking, we get contacts for other donor organizations”(#508, client).

In addition, I found through interviews, participant observation, and documents that civil society organization members, community health workers, local health staff and community members had received technical training to help deliver basic health services in the community (#22, internal staff), including providing first aid and health information.

“Community health workers are very central to what [the INGO] does. Basically, these are people providing the link between the community and the formal health system” (#202, Northern INGO staff).

“We train one or two CSO [civil society organization] members who we call trainer of trainers, who are then able to train their members on these health services. And it’s basically health services that can be given at the community level. So they’ve been able to identify danger signs, give first aid, give health talks, which is very important. To be able to understand, for example, when it comes to adherence to ARVs, why it is important. So that they are able to also impart that knowledge to the community (#16, internal staff).

Many of the clients interviewed concurred that capacity was built through training on health information for them to use individually and/or to share with community members.

Individually, capacity building included providing education on HIV/AIDS topics including adherence to ARVT and safe deliveries:

“I got educated on [ARVT] adherence” (#505, client).

“There is information that we get from the trainings, for example PMTCT. That is where we get the information then we give it out to people...I also took the information to my wife and when she delivered, she gave birth safely” (#502, client).

Clients used this knowledge to help other community members by providing health education and health services as part of their work with their civil society organization.

“Every Friday we do door-to-door involving youth. We teach them about HIV management and prevention and the reduction of stigma in the village” (#503, client).

“Sometimes I do visit door-to-door to...clients and some of them are still in denial [of their HIV status]. So I visit them, talk to them, slowly by slowly, then they catch up with the situation [of accepting HIV status]” (#501, client).

Clients identified capacity building as the primary assistance the INGO provided. A few clients also mentioned intangible benefits from their involvement with the INGO projects—those who volunteered in their communities (through funding from the INGO to their civil service organization) identified community recognition as an important reward for their work: *“What I get out of it? Let me say pride. I feel very accepted by the community”* (#509, client). I witnessed this pride first hand while on field visits to the projects.

A number of interviewees also noted that the INGO built capacity with civil society organizations on issues of gender mainstreaming, human rights, and legal training, so these organizations could assist in empowering women and girls in advocating for their rights:

“We train civil society organizations in gender mainstreaming in HIV/AIDS interventions – and at the same time, we train civil society organizations on what we call paralegal issues and these will come in to protect widows and orphans in terms of property inheritance and widow inheritance” (#50, internal staff).

A few clients identified a number of ways that the INGO was working on gender empowerment through its HIV/AIDS projects.

“We are normally taught gender issues” (#507, client).

“When we are writing proposals, they encourage gender mainstreaming in our activities. Gender mainstreaming is very important, something that [the INGO] encourages” (#508, client).

“Leadership structures...it should include both [men and women] ... in distribution of services, [our civil society organizations] should not just be an organization where beneficiaries are just men” (#509, client).

As these clients identified, working on gender included training civil society organizations on gender issues (e.g. human rights training to assist women with property inheritance issues), encouraging these organizations to mainstream gender in projects, and requiring them to ensure inclusion of both men and women in the leadership of their organizations and in who they reached with services.

The INGO also worked closely with cultural custodians (e.g. through chief's *barazas*¹¹ and councils) on issues of culture, to increase their understanding of gender issues and the benefits of empowering women by changing cultural practices that perpetuate inequities:

“Talking about [gender] in barazas and other forums so that they can advocate for the rights of women” (#59, internal staff).

Training these community leaders in gender equity was viewed by a number of INGO staff as critical to the INGO's work on gender empowerment, as this was aimed at shifting structural conditions, including culture.

The INGO also worked to empower communities by: providing formal linkages between the community and the Kenyan government through formal committees, getting civil society organizations involved with inputting information into government processes, and implementing the Community Strategy. Many staff viewed linking community with the Kenyan government as a positive influence on equity at the community level. Many interviewees noted that this was because these linkages offered structures and resources to bridge the gap between the government health services (Level 2 and above) and the community (Level 1). This gave the community members a voice at government tables and provided a way for them to make their needs known to the government.

“One of the things that [the INGO] has been doing is ensuring that civil society organizations and health facilities have got close linkages. One of the ways we are doing this is through initiating meetings between the two or other committees at that level” (#16, internal staff).

“Many of the communities we work with have formed health committees. They are able to reach out to the health managers, the ministries, and demand for services. For me, that's a sign of success [in equity]” (#46, internal staff).

¹¹ Chief's *barazas* are meetings with chiefs and assistant chiefs of communities.

Some interviewees also noted that the INGO had been successful in linking the community groups with other formal government planning fora such as the Annual Operational Plan for the National Health Sector Strategic Plan and the Joint Annual AIDS Review.

“The fact that the civil society organizations are able to participate in these [Joint Annual AIDS Review and Annual Operational Plan] is a sign that the INGO has built [the civil society organizations’] capacity to be able to articulate what it is they want and they can even be listed by the Ministry of Health officials, who a few years ago would have thought – ‘these community groups, what are they telling us? What do they know about health?’” (#46, internal staff)

This linking function was viewed by the INGO as key to implementing equity in its HIV/AIDS work.

As part of community empowerment, many interviewees also identified that the INGO implemented equity in its HIV/AIDS work through providing services at the community level, either directly as a service provider, or by providing funding and capacity building to civil society organizations to provide these services. These services, which were also identified in documentation and which I saw in field visits, ranged from basic health services, to access to ARVT, to prevention education. Clients who were interviewed shared a similar perspective and identified specific types of services that the INGO provided that they as clients benefited from. This included access to ARVT and other medicines, voluntary testing and counseling, support groups for people living with HIV/AIDS, and access to hospital services. Many clients also identified that community members received information and education on HIV/AIDS (e.g. prevention and management of HIV/AIDS and the importance of adherence to ARVT) including through door-to-door outreach from community health workers trained by the INGO projects.

A few interviewees noted how the INGO was integrating health care services with upstream determinants of health to further address equity in its HIV/AIDS programs. This

included working with communities on income generating activities (such as farm inputs) and increasing access to water and nutrition.

“Many communities do not have access to water and basic hygiene information... [the INGO] is able to work to help them receive this” (#46, internal staff).

“The [INGO’s Project X] has given us a challenge that the people we [as a CSO] service, they should be involved in an income generating activity” (#509, client).

Income generating activities were a focus of one large HIV/AIDS project and were viewed as a means to economically empower women. It was felt that this helped to address power inequities between women and men:

“The civil society organizations that we fund also promote access to productive sources of income to the vulnerable women. Most women don’t have access to productive income—they rely on their husband for income and hence are vulnerable to the men because of economic inequality. We empower such women with IGAs [income generating activities]. If you go to Western [province], you get a number of IGA programs for widows and orphaned children i.e., dairy cow rearing and other IGAs established for women” (#44, internal staff).

When clients were asked how the INGO could improve the projects with which they were involved, they made several suggestions. These included augmenting projects to address the broader determinants of health by doing more work to address poverty; giving out more microfinance loans; and providing nutrition, toilets, and access to potable water.

3.5.4 Working with Other Groups

While people living in poverty, geographically remote, and women and girls were the groups predominantly identified by the INGO staff in terms of its focus for equity, a few of the HIV/AIDS projects also worked with other groups. One project that worked with other countries around the Lake Victoria Basin focused on populations that were vulnerable to HIV/AIDS due to mobility, namely fishers, plantation workers, and university students, through capacity building of civil society organizations working with these populations.

Another population of focus for one particular INGO project was orphaned and vulnerable children (OVC), who were provided with services including support and care. In addition to focusing on populations identified in previous sections, the largest HIV/AIDS project also funded some civil society organizations to reach out to other vulnerable populations, including fishers, as well as marginalized populations including sex workers and prisoners. This project had also had some success in funding a civil society organization to reach out to men who have sex with men. However, their work with marginalized populations focused particularly on a public health approach, such as providing prevention services and encouraging behaviour change, versus a human rights approach that might have included trying to change legislation to promote equity.

3.6 Further Opportunities for the INGO to Implement Equity

The INGO had clearly been working to move its equity principles forward in its HIV/AIDS work, including focusing on particular vulnerable populations in delivering programs and employing a community empowerment approach. However, some INGO staff still identified that equity as an overall principle was vague, and the INGO's focus on equity was largely project-by-project. Some interviewees, in particular senior staff, identified that there were more opportunities to further link the INGO's principles of equity to implementation and evaluation across the INGO's projects.

“I think it’s an assumption that since we have a value there in the corporate strategic plan for example, and since we have senior staff that have several years of experience elsewhere before or even within [the INGO], that they would translate [equity] into everyday actions. I think it’s a bit too much. And even for me, I want to admit the whole issue of equity I think [needs] to be unpacked, so that people understand” (#3, internal staff).

Some staff viewed equity as nebulous and felt that, for the INGO to further transform equity principles into action, equity needed to be “unpacked”.

“It’s not that we have unpacked [equity] so that we have specific strategies...We do it on a program-to-program, project-to-project basis” (#2, internal staff).

As this quote indicates, specific equity strategies had not been developed across the INGO; rather, implementation of equity principles tended to be dependent on the purpose and scope of specific projects, based on the donors’ requirements, which was likely due to the INGO’s reliance on donor funding.

To address equity more strategically, interviewees identified that staff needed to understand both what equity entailed (since it was felt to be vague) and why it was an important principle for the INGO to implement given multiple priorities. This seemed to involve a need to increase INGO staff’s understanding of equity as a principle to ensure that equity was considered on an ongoing basis.

“How do you know if you are doing equity...I don’t think there’s a clear understanding of what equity is...” (#205, Northern INGO staff).

“There is no coherent document that outlines [INGO’s] views and perceptions of equity, what this is” (#23, internal staff).

Internal staff were not alone in identifying this – external interviewees also noted this abstract nature of equity:

“To most people equity is a very abstract thing, you know, it’s like this, ‘Ah, those human rights people, oh yeah, those people’. It’s still an evolving concept. Then generally I think the whole realm of social science in HIV is still very evolving so people have not appreciated the role of social science in medicine and public health. I think the moment you start talking of language around rights based approaches, gender mainstreaming, equity, you lose people, so that’s the context that we are working in, this is something that we are seeing” (#400, government staff).

Equity as a term was not necessarily well understood, perhaps due to the belief by a few interviewees that Northern country donors were driving the equity agenda based on their conceptualization of equity. As one interviewee noted:

“Everyone is moving on equity because this is all Western driven, the labels are Western, they are part of donor conditionalities” (#124, internal staff).

Yet, while a few argued that equity was based on donors' agenda, equity as a principle was viewed throughout the Kenyan government and INGO documents, as identified earlier.

When asked what facilitated or challenged the implementation of equity principles in the INGO's HIV/AIDS work, internal interviewees argued that linking the principles of equity to action required senior management leadership. Consistent with the organization's principles of equity, some of the interviewees I asked, in particular at the more junior staff level, indicated that senior managers typically supported the principles of equity:

"I see a positive push by the NGO management and even staff [towards equity] (#46, internal staff).

On the other hand, senior management felt they could do more with peers to strengthen their support of equity as a principle to facilitate implementation.

"There is an interest...among all the senior management team that [equity is] important, but...I wouldn't say that they are very strong ambassadors" (#2, internal staff).

"If the leadership is showing commitment to gender or to equity principles, and that then will be translated in the vision, mission because the leadership would drive vision, and the mission and the values...we are about 10 senior management team members, so I think maybe about four out of 10 who probably are fully committed" (#1, internal staff).

In addition to the matter of senior management leadership, a few staff identified the need to increase staff's understanding of the significance of equity to the INGO, and the value that working on equity brings to the organization in achieving its mission.

"What maybe I really do wonder is whether we have done enough as in [to] sensitize our staff to those [equity] values. The instruction we get is that whenever we have meetings we should sort of create awareness about the INGO's strategic vision and therefore that implies the values. But I'm not sure whether we do that diligently" (#3, internal staff).

"I think if staff were more aware of what equity is, then they would maybe address it more consciously. I would say it's not something we really think about....it's not part

of our institutional language. So you can say that I don't think staff have the formal capacity to understand and address equity issues" (#16, internal staff).

"We are a very dynamic organization of staff coming in and staff going out and so on, so the people who have probably been here longer like myself [are] probably more grounded in types of understandings of that value [of equity] of the organization... We hope we'll reach a critical mass of staff who have, who believe, or who are committed to these [equity] principles" (#1, internal staff).

To help increase this capacity, many staff identified the need for concrete tools and guides to assist in operationalizing equity principles across projects.

"I think that's probably the biggest challenge [to equity]; staff capacity...not understanding equity... Once you have the tools, it becomes easier now in the situation where you don't have, necessarily, specific tools, then it's in the staff's responsibility to ensure that we have a sufficient equity focus and be implemented in order to ensure a higher level of equity, at that time. Then, staff capacity becomes an issue" (#2, internal staff).

"If there are guidelines, that would help...like steps of what needs to be done to ensure equity...that would be very, very useful" (#85, internal staff).

"There is no how-to-do manual... We don't have a how-to-do formal procedures on how to mainstream equity into our project implementation" (#3, internal staff).

"[In addition to] the intention to promote equity...you need structure, to raise awareness, to develop capacity, to develop plans in terms of programming and staffing" (#22, internal staff).

While the INGO had developed some tools for equity implementation, including a gender mainstreaming tool and a draft mainstreaming policy for people with disabilities, these tools focused on particular populations. Perhaps this was why staff still requested more tools on mainstreaming equity into their work, beyond tools that had been developed for specific populations. While most were aware of the INGO's gender and disability tools, some interviewees questioned what the next steps for the documents were, including the need to ensure they were used in project planning and implementation.

In addition, some interviewees identified the need for measurement strategies to understand if progress was being made by the INGO to achieve equity. Staff noted that

process and output data were disaggregated by sex, but not by other important variables such as income level, disability status, or most-at-risk populations. There was no evidence of disaggregation beyond sex in the evaluation documents I reviewed. In addition, no standardized mechanism was in place in the INGO to assess its overall progress towards meeting its equity principles.

“If there’s no equity index or any guidance...then it’s a challenge. Not that the organization is not interested in it, but I think if there was some gauge, some measurement, then it would be better” (#85, internal staff).

A number of staff agreed that measuring the INGO’s overall progress towards achieving equity would be important:

“I think what would be helpful...how can we make sure that we are sufficient, specifically when we talk about equity, that we have the two or three indicators that we can use. I think that would be useful” (#2, internal staff).

However, one interviewee noted that given the abstract nature of equity, measurement of equity was difficult:

“There are nebulous areas where there aren’t clear indicators, like equity – there are no reliable tools. ...I am not sure how many people in our organization have experience in measuring equity” (#205, Northern INGO staff)

This nebulous nature of equity overall, as well as its measurement, was identified as a limiting factor for the INGO in its implementation of a more strategic approach to equity principles for HIV/AIDS.

3.7 Shaped by Interdependence: External Influences on the INGO’s Equity Implementation in HIV/AIDS

Given the interdependencies among the INGO, government, and donors, the INGO’s implementation of equity principles in its HIV/AIDS work was heavily shaped by these players. The INGO aligned its implementation of equity principles in its HIV/AIDS work to the agendas of the donors and Kenyan government based on what was deemed acceptable by

these other players (as evidenced by donor funding, legal frameworks and socio-cultural values). The INGO implemented initiatives and focused on certain populations based on this alignment.

3.7.1 Aligning with Priorities of Donors and Kenyan Government

Many INGO staff identified that working with the Kenyan government, including adhering to its priorities and policies, was key to the success of the INGO in implementing equity in its HIV/AIDS work.

“You’ll not hear the Ministry of Health saying that [the INGO] is implementing a project that doesn’t adhere to its rules and regulations or policies or guidelines... You need the government to be fully behind an initiative, and if they are not behind it, you find that it’s very difficult” (#16, internal staff).

“The projects [that the INGO works on] are in line with national policy, which is why [the INGO] has lived long and has been able to adjust. It doesn’t stand for values that are not accepted by the government....[The INGO] has tried not to be in conflict with government values, and that’s why it is a good relationship. Things we stand for are the things that the government stands for” (#124, internal staff).

“In most of the countries that we work in, we don’t go rogue and do our own programming. It’s actually informed by what the Ministry of Health’s focus is for the five, 10 year period, what they think are the most important issues to be covered within the country. We want to contribute to it, not work against them” (#300, Northern INGO staff).

As noted above, one way that the INGO implemented equity in its HIV/AIDS work was through community empowerment, aligning with the Kenyan government’s Community Strategy.

“The intention [of the approach of the Community Strategy] is to build the capacity of communities to assess, analyze, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country’s socio-economic development. The second major intended impact of the approach is that the communities will thereby be empowered to demand their rights to seek accountability from the formal [health] system for the efficiency and effectiveness of health and other services...The goal of reducing health inequities can only be achieved effectively by involving the population in decisions and in the

mobilization and allocation of resources, and thereby promoting community ownership and control in the context in which they live their lives” [141, p. 2, 4].

The government viewed empowerment of communities as key to reducing health inequities.

Government staff whom I interviewed confirmed the Kenyan government’s commitment to the Community Strategy:

“And, and I think our interest is, not to simply have community members as recipients of services and goods, our interest is to empower them, so that they make decisions, they help us in decision-making and sustainability of those programs. Because, given the fact that lots of programs we have are donor driven or donor-funded; one day the donors will go away. And unless these are owned by communities, they will cease to exist in this country, and therefore we will not be able to deal with HIV and AIDS. So an area of interest to us is empowerment, so that empowerment of communities to take part in decision-making and promote sustainability of programming, even in the absence of support that is external” (#603, government staff).

Hence, the INGO’s community empowerment approach, including implementing elements of the Community Strategy, aligned with the Kenyan government’s priorities.

The INGO’s work in gender empowerment in its HIV/AIDS programs aligned with donor agendas on equity, as gender equity was an area of priority for donors and an explicit funding condition of some donors. A few interviewees identified donors as the impetus for the INGO’s focus on gender equity:

“In Kenya, we weren’t looking at an equity lens until donors came in and said ‘Women have rights too and they need to have equal chances’...Now most programs look at gender issues” (#50, internal staff).

The INGO’s focus on gender equity also aligned with the Kenyan government’s equity work, including the government’s collection of HIV/AIDS data by sex. The Kenyan government required that the INGO (and all NGOs and civil society organizations working in HIV/AIDS) complete a quarterly program report on activities, and all data had to be reported for males and females separately (e.g. number of people trained, number receiving food and nutrition support). Internal interviewees also identified disaggregation of data by sex as the primary

way that equity was measured by the INGO: “*In our reporting, we make sure that our data is disaggregated by gender*” (#33, internal staff). Civil society organization clients funded by the INGO were also required to report data disaggregated by males and females as part of their civil society organizations’ activities:

“[The INGO] wants to see the management of organizations. Is it dominated by men alone, or is it inclusive? Are ladies represented?” (#508, client).

The formal collection of disaggregated data by sex illustrated how the donors’ and Kenyan government’s priority of gender equity filtered to the INGO, and down into the community.

Hence, two of the major ways that the INGO implemented equity in its HIV/AIDS work were through community empowerment and through a gender equity focus, which were priority areas for the donors and the Kenyan government. The INGO’s work in HIV/AIDS was aligned with these priorities.

3.7.2 Aligning with Donor Funding: “He Who Pays the Piper Calls the Tune”

The primary way that donors’ influenced the INGO’s implementation of equity in its HIV/AIDS work was through funding requirements. The majority of interviewees agreed:

“He who pays the piper calls the tune” (#400 – government staff and #124 – internal staff).

As the INGO was reliant on donor funding, and had to respond to donors’ proposals for funding, what donors asked for in their requests for proposals had a strong influence on the extent to which equity was a focus in the INGO’s HIV/AIDS programs:

“At the end of the day, [the donor] is only concerned with what’s in the proposal [in terms of whether or not equity is a focus]” (#205, Northern INGO staff).

Interviewees noted that the INGO had to respond to the proposal objectives as outlined by the donor, and the INGO staff often did not feel that they had a lot of flexibility in terms of inserting their own ideas and principles. If the donor’s request for proposal for an HIV/AIDS

project was not oriented towards equity, a few interviewees stated that equity was subsequently not emphasized by the INGO.

“Because the other thing that has to be kept in the forefront, is that the RFA [request for applications] has very specific outputs. And it is only those outputs that you are allowed to respond to, in response to that RFA. And so, for example, if there isn’t anything in there about equity, and then you put specific programmatic things around, you’re going to add that, you are not responsive to the RFA. And you are automatically denied” (#201, Northern INGO staff).

“It’s more to align ourselves to what the proposals say, rather than to insist that ‘these are our values and our principles, so we must focus on that’....I think it’s really more the donor driven agenda as in trying to get the funding and satisfying the requirements of the funding...Why struggle to suggest something in the proposal when, first of all, the instructions for doing the proposal are very rigid. You are told exactly then how to write each paragraph and what to say, what targets to meet... my take is that often the proposal, the requirements, and the format is pretty rigid. You can only write this on that, and you might not be allowed to do a lot of experimentation. But indeed sometimes they say suggest other innovative ideas. And if equity is one of them, it might fit. Or if a disadvantaged region of the country or communities or groups are, then that’s when you might have scope” (#3, internal staff).

The INGO staff often felt limited by donor’s requirements as outlined in requests for proposals. This rigidity is perhaps not surprising, given the INGO’s reliance on donor funding. Yet it also meant that some staff felt that there was limited opportunity to fully realize the INGO’s equity principles in the projects, if this was not already in the donor’s proposal, given the focus and terms of the funding of the donor’s requests for proposals.

However, for the most part, INGO staff felt that many donors facilitated the INGO’s implementation of equity in HIV/AIDS, since equity was often a focus of donor funding.

This translated into requests for proposals on HIV/AIDS that had an equity focus.

“I’d say that donors facilitate [equity] more than anything else. I mean, after all, their funds come from them, but also...the donors are coming from countries where equity probably is more advanced. To them, it’s also of key interest that we demonstrate that whatever we’re implementing [in HIV/AIDS] is addressing equity, that it is basically making the lives of communities better. So, donors actually facilitate [equity]” (#1, internal staff).

Donors had particular political ideologies and values that defined what they wanted to focus on, and fund, in terms of HIV/AIDS programs. Donors' requests for proposals were based on the priorities and agenda of its Northern country first and foremost.

“As a development agency [from Northern country], we have our global policy that guides the overall development. This comes from external research, evidence, and our experience in development work in countries” (#607, donor).

As identified above, given the different political ideologies and values of donors, donors were not homogenous, and many interviewees noted that certain donors, in particular those from European countries, were more likely to include an equity focus in their requests for proposals for HIV/AIDS projects.

“The proposals [for funding of HIV/AIDS initiatives] originating from Europe tend to embrace equity in this broader sense as in pro-poor, explicitly, as compared to... the American” (#3, internal staff).

On the other hand, the U.S. was identified as one donor that, in the past, had deliberately excluded certain projects that facilitated equity. The HIV/AIDS funding under the United States' Bush administration had caveats that some interviewees felt negatively affected equity, including the focus on abstinence-only projects, taking family planning off the agenda:

“We've had a long period where [for U.S.'s PEPFAR funding] family planning has been off the agenda...which doesn't help in any way, because the well off people — they are always getting access to family planning, the ones that are well-educated and know what to do. The poor people with less education, with poorer access, they are then the ones that are marginalized in this case, right? So, some donors, because of their policy, are limiting the ability to have a proper equity, or fully, fully focus on equity...and some are very supportive” (#2, internal staff).

This same senior staff person noted that donors' priorities, and what is subsequently included (or excluded) as priorities in requests for proposals, changed depending on the donor country's political climate:

“USA, especially PEPFAR...that moves with the wind depending on who is in power and the government system” (#2, internal staff).

The U.S. was viewed as recently having shifted to increasing its focus on equity under the Obama administration, and following the move to the Global Health Initiative from PEPFAR.

“Increasingly, even the American proposals you see that they want that you target the most vulnerable in society” (#3, internal staff).

This shift was identified in interviews, and verified in participant observation and in my review of proposals for new HIV/AIDS projects, in which the U.S. recently added equity as one of their focus areas.

Because donors’ requests for proposals reflected their Northern country’s political ideologies and values, a few interviewees, both externally and internally, acknowledged that donors had the potential to override what Kenya had identified as priorities, by prescribing projects in requests for proposals:

“So you might find that if a [donor] doesn’t really care about gender or maybe with MARPs or anything else, it’s very difficult for us...Those are decisions made already in Washington. It’s very difficult for us to say, ‘No, we have a gap addressing girls in school’ [or] ‘you need some equity element to that’. They’ll tell you ‘No, but it’s not in our plans so we won’t do it.’ So again, I think that is sort of the background in which we are working” (#400, government staff).

Even with the formal mechanisms identified in the section on interdependence to encourage alignment of donor funding with Kenyan government priorities in HIV/AIDS, equity elements of HIV/AIDS programs were particularly susceptible to donor influence.

“There are some [donors] that look at what they need to get out of [funding a project on HIV/AIDS in Kenya] and they give their resources to that. The [government] doesn’t control resources...The best we can do as [government agency] is to provide the best guidance, and say, ‘Okay, fine. This is the minimum package, this is the policy, this is what you need to do, this is how you get consent, this is how it happens’....We can try and tell them, ‘Okay fine, I think you need to work in this particular region’, but we are not always successful to tell them that we need to work

in this particular region, because the mechanisms that these partners and the donors have...we may not have total control for that” (#400, government staff).

Hence, donors had the ability to direct local implementation decisions that influenced equity.

This included decisions on whether vulnerable groups, including those in certain remote geographic areas, were a focus for HIV/AIDS interventions.

The other way that interviewees identified that donors influenced the INGO in terms of implementing equity principles in its HIV/AIDS work was the duration of funding provided by donors to the INGO. Project funding was typically short-term (between three and five years), which was not viewed as conducive to implementing equity:

“Donors’ cycles are insufficient for addressing equity issues... Donors just want to provide services” (#41, internal staff).

Providing short-term services may address immediate needs, but it is inadequate to shift structural determinants, including cultural changes. These short-term agendas were often a result of the Northern country’s political cycle of four or five years, but making a difference in terms of equity, including empowering communities, can take many years (#201, Northern government staff).

“If you would have a program that would last, let’s say six years, then it would be more meaningful in terms of [equity] outcomes, ‘cause we’re really based on outputs, ‘cause it’s really – it’s changing perceptions and building that capacity that we have been building” (#85, internal staff).

Hence, a disconnect existed between the donors’ needs (a focus on short-term outputs to illustrate to their constituents that they have made progress) and development needs (which would include long-term equity outcomes) that could restrict progress towards the INGO’s implementation of equity principles in HIV/AIDS work.

3.7.3 *Aligning with Kenyan Government's Legislation and Donor Countries' Policies*

The Kenyan government and donors also shaped the INGO's implementation of its equity principles in terms of where the INGO *did not* focus. Senior managers noted that the INGO did not advocate for legislation changes to address human rights for most-at-risk populations, including men who have sex with men and sex workers.

The INGO had an excellent reputation as previously outlined, built on its history of work in the communities and its positive relationships with donors and the Kenyan government. But to maintain this reputation, the INGO avoided advocating on issues that would be perceived as controversial or out of step with Kenyan legislation.

“So we push for the whole area of equity and address vulnerability and marginalization as much as we can, especially in the areas that are not political controversial” (#2, internal staff).

Senior management staff of the Kenyan INGO said in interviews and in participant observation that if these parameters were not respected, the INGO risked a number of consequences that would have a direct and deleterious impact on their work in the country. These included being banned from Kenya if it was to implement its equity principles through advocating for certain controversial changes in legislation, such as legislation to legalize homosexuality:

“If you want, as an organization, to go out and advocate for legalization of homosexuality, then you would be in trouble... Well, if we did, it would have serious consequences for us; or it could have... I mean in the most extreme cases, we would be deregistered as an NGO, right, and not be allowed in the country. That would be on the extreme, but you know, it could be more control [over] what we're doing, lobbying donors for not giving us money, us in our ability to do policy influence in our other areas... and, [the INGO] wouldn't go that way because it has never been the way we have been working, trying to be confrontational” (#2, internal staff).

For this reason, the INGO chose to be non-confrontational. Rather, it worked within the system to avoid potential repercussions. For example, in Kenya, homosexuality, sex work,

and drug use are illegal. Advocating for legislation change to legalize homosexuality or sex work, or provide harm reduction services to injecting drug users, was viewed as contentious given legal frameworks and socio-cultural norms in Kenya. As one partner NGO interviewee noted, in order to maintain positive relationships with the Kenyan government, many NGOs avoided advocating for changes to legislation in these highly contentious areas.

“[Some NGOs] are looking at their relationship with the government and they realize that issues of homosexuality are criminalized in this country and so they realize that to maintain a good relations[hip] with the government, they don’t want to be talking about [legalization]. Sex work again is criminalized and therefore organizations are cautious to look at [legalization]” (#602, partner NGO).

The case INGO was one of these NGOs that worked within the Kenyan legal framework to maintain these relationships:

“So we try and find ways of working within the present legal framework [of the country], whether we agree to it or not” (#2, internal staff).

From an equity perspective, working within the legal framework limited the programming and advocacy approaches that the INGO could take with most-at-risk populations, including men who have sex with men and sex workers. As one interviewee explained in speaking about one of Kenya’s neighbouring countries:

“It means we can’t make statements on the issue [of legalizing homosexuality]. And we did not make statements about Uganda—the penalties [death penalty] for being gay, the legislation that was pending recently. And...that’s because the countries in which we work, it’s illegal. So, we try to be very neutral as an organization and I regret that” (#204, Northern INGO staff).

The INGO stayed out of advocating for controversial issues, instead opting to remain “neutral” to continue working closely with the Southern country governments. The quote above from a Northern INGO staff member also highlights the challenge when legal frameworks in Southern countries contradict equity values of Northern donor countries. As a Kenyan INGO staff member noted:

“You will have some of the offices that...would try and push issues that are difficult for us to address, again homosexuality. Some of the national [Northern] offices will say, “You must fight for [legalizing homosexuality]”. [Interviewer: And how does that play out?] “We will say what we can do [in Kenya] and what we can’t do, so they have not pushed us on areas where we just can’t implement it. So they [National Northern offices] might have a strong desire, but so far they have listened to us and then agreed to disagree, when we have said, ‘We can’t move on that’ ” (#2, internal staff).

This illustrates the tension between the Northern INGO and Kenyan INGO staff who had different perceptions about how equity could be implemented and the risks involved. While the Northern INGO staff may have sought to advocate on these issues, the Kenyan INGO continued to align with the work of the Kenyan government to maintain positive relationships, avoid negative repercussions, and continue its work.

There were contradictory directives within Kenya as well. While the Kenyan government identified the importance of working with most-at-risk populations in the Kenyan National AIDS Strategic Plan III (KNASP), there was incongruence between these statements and the legislation Kenya has in place. This challenge was directly acknowledged in the KNASP:

“A series of difficult legal issues arise from attempts to programme more directly for the MARPs (sex workers, IDUs, MSM), and to take these programmes to scale. Sex work, homosexuality and drug use are all illegal in Kenya. Programmes have been working with all these groups for many years, but under constraints. There is a need to come up with policies that will facilitate scaling up access to services by the different groups clustered under the term MARPs” [108].

A few interviewees indicated that the Kenyan government and the case INGO focused on public health advocacy, as outlined in the KNASP, including reaching vulnerable groups with health services. Another tactic would have been to advocate for equity through an overall human rights approach, including advocating for changes in legal frameworks for most-at-risk populations. However, it was felt that the Kenyan government focused on a public health approach, which included health care access, rather than a human rights

approach that would involve addressing human rights issues for most-at-risk populations by changing legislation. As one interviewee explained:

“There is the public health [approach] which is what the KNASP looks at. Then there is the human rights approach, which is what some organizations want to look at... The KNASP is really talking about prevention and care for these populations [which is a public health approach], but we have some organizations also that are going into...issues of legislation like having them not criminalized [which is a human rights approach]” (#602, partner NGO).

Hence, while providing health services to various groups, including most-at-risk populations, would fall under what was deemed acceptable under the KNASP and permissible within the legislative framework in Kenya, the INGO did not move beyond this to focus on a more human rights approach given potential repercussions.

Donor country’s policies could also influence the INGO in its implementation of equity principles. There was an instance cited where the donor country’s policies had the potential to negatively influence the INGO’s implementation of its equity principles in its HIV/AIDS work. In order to be eligible to receive U.S. funding, the INGO agreed to the U.S.’s policy forbidding its funding recipients to advocate for the legalization of sex work. By agreeing to this policy, the INGO could not advocate for any change to the legal framework in Kenya if the INGO wanted to receive funding from the U.S. One of the Northern INGO staff identified this as a limitation to the INGO’s right to advocate on issues that might influence equity:

“This type of thing [signing this agreement] can be a challenge though as what if we wanted to advocate for a change in law in the country we are working in? There was some contention since we had to have this policy if we wanted the grant, but we might want to support the legalization of prostitution at some point, so this encroaches on freedom of speech” (#200, Northern INGO staff).

The INGO had to align with this policy to receive the funding, but the INGO’s reliance on donor funding placed a limit on the potential advocacy levers that the INGO could use in

implementing its equity principles in its HIV/AIDS work.

Hence, legislation and policies from other players in the interdependent system within which the INGO worked influenced the INGO's advocacy work or the potential areas for the INGO's advocacy. In particular, the INGO was constrained in its human rights efforts.

3.7.4 The Kenyan Government: Moving from Equity Principles to Action

As outlined above, the Kenyan government had equity as part of its overall strategies, including Vision 2030 and the Constitution, and in its HIV/AIDS strategy. However, many interviewees within the INGO, as well as donors and government staff, did not view the Kenyan government as championing equity in action in HIV/AIDS, beyond this documented support for equity. When I asked Kenyan government staff how their government approached equity in HIV/AIDS, there was a mixed response. The two interviewees at the national level identified that equity was not a major focus for the government:

“...I wouldn't say we have a formal policy on equity, but we try as much as possible...that it becomes a guiding principle in our documents so we say okay, our interventions [in HIV/AIDS] should be cost effective, it should be scaled up rapidly, and then there should be an equity element; but it's not something that we pursue very, very consciously. That's the unfortunate scenario because we tend to be so busy delivering services where it's easy to deliver services, so we tend to go for the low-hanging fruits... So I don't think I would be very, very confident to tell you that we have very, very specific strategy to ensure equity...we don't have either the time or the capacity or the resources sometimes to invest in fairly longer term approaches that are more equitable...I think equity is...very down low in the priority list because it's an emergency element, we need to cut down the HIV infections, we need to know where they are coming from and you need to work, move, so that's how we do that” (#400, government staff).

“For us, because we are dealing with a national disaster [of HIV/AIDS], disasters know no gender, they know no ethnic group. So for us, we are actually committed to universal access to services and goods for all people who need it in this country. And that is contained in all our strategic plans. So for us everybody should access goods and services, because we have universal access targets that this country must meet” (#603, government staff).

Despite formal documents outlining equity and a focus on vulnerable populations in HIV/AIDS, these senior level national government interviewees felt that, given the scope of the HIV/AIDS epidemic in Kenya, the principle of equity was not the main consideration in their work. Interestingly, these government interviewees described addressing HIV as an emergency, and discussed a focus on universal access to ARVs. Yet, as these quotes illustrate, they did not view efforts to improve accessibility overall as addressing equity. Other external partner interviewees also felt that, while equity was outlined in government documents, in reality, when it came to implementation, equity in HIV/AIDS was not always a priority for the Kenyan government, perhaps due to multiple priorities.

“We [the Southern NGO working with the INGO on an HIV/AIDS project] come with our own objectives, country [governments] come with objectives and priorities...I am not saying they [country government] don't embrace equity, but the extent is not great” (#401, partner NGO).

“My take is not to expect the government to raise the issue of equity” (#606, donor).

On the other hand, when I asked the two local government staff I interviewed about how the Kenyan government approached equity in HIV/AIDS, they identified their work in engaging the community, and working with particular vulnerable groups such as women and most-at-risk populations. Hence, while the Kenyan government clearly outlined equity as one of its principles in a number of its key strategic and HIV/AIDS documents, government staff had mixed opinions about whether or not equity was a priority in the implementation of its HIV/AIDS work. This difference in viewpoint may be due to the level of the interviewees with whom I spoke. Several senior federal level staff were faced with showing progress towards addressing the overall HIV/AIDS epidemic in Kenya through universal access, while local level staff were working on the ground with vulnerable and marginalized groups.

3.8 How the INGO Influenced Other Players on Equity

The interdependent relationship of the INGO with its donors and the Kenyan government meant that the INGO aligned its implementation of equity principles to the views of these other players, but in turn the INGO also influenced the Kenyan government and the donors. It did this through three approaches: documenting best practices through their program research, actively contributing on the Kenyan government's committees, and partnering with other NGOs.

A major strength of the INGO, as identified by internal and external interviewees, was the program research it conducted when implementing projects on the ground, including sharing its experience from implementing equity principles in its HIV/AIDS work:

“We [donors] learn from them [INGO] in terms of their experiences – they are the ones who implement, and they are very good at documenting their experiences. From their experience, this brings evidence – so as partners working with them, this can inform our way of thinking and working – so for us it is a two way [influence on equity]. We support them to generate knowledge and we give them tried and tested principles, then they in turn create more knowledge” (#607, donor).

Donors and the Kenyan government then used the lessons learned from evidence gathered from programs at the community level in an iterative way. This evidence was used to influence programs as well as policies:

“[The INGO has] direct experience [at the community level] and I think more importantly that we [the Kenyan government] would use experiences from [the INGO], direct experiences, to inform policy. So it is a circle that never ends, [the INGO] has that community level service delivery, we learn lessons from it, the lessons flow from that and sort of feed into policy and other partners can take in to account, so there is that cycle, so [the INGO] is part of that cycle, the quality improvement cycle that we talk about, so that [the government] doesn't just write policies that are out of context, but they are embedded in direct experience from the field” (#400, government staff).

An example of the Kenyan government being influenced by the INGO in terms of implementing equity principles was the Kenya-wide uptake of an organizational capacity

building tool, which included a gender equity component that had been developed and implemented at the community level by the INGO in one of its HIV/AIDS programs:

“We [government] have now taken some of the very good practices that the INGO has been running over the years to come up with a national model for capacity building which has now been agreed on by all partners. And we are looking forward to rolling this throughout the country with the INGO providing quality assurance” (#603, government staff).

From a more general perspective, a few internal interviewees identified that the INGO had influenced the government in terms of the government’s understanding of the importance of working with particular populations to address inequities:

“We [INGO] position ourselves to generate evidence that these inequalities exist, these problems are there and they need to be addressed and then advocate using that evidence to get the government to start thinking about some of these remote communities and so on. And I think we have succeeded in a certain way in a sense the government is now starting to look at those marginal communities in its programs” (#1, internal staff).

Despite some success, a few internal and external interviewees identified that the INGO could do more to influence the government and donors on equity in HIV/AIDS given the evidence the INGO collected:

“Our [INGO] knowledge sharing [about equity] has not been very good. This is an area that needs strengthening” (#124, internal staff).

One external staff member noted that the INGO was in a position to lead on the issue of equity—with donors and governments—based on the evidence that the INGO had gained from projects, as well as the INGO staff’s in-depth knowledge of communities where the INGO had worked:

“In terms of issues of equity/gender—[the INGO] has been given an open door to influence—so they have a big opportunity. They have to base it on some evidence...[The INGO] has a lot they can mine from past and present work that can have an influence on equity issues at the national level if they want to...If [the INGO] has issues for the national level – like IGA [income generating activities] at the grassroots level, projects about income support, good documented issues of governance, human rights, people demanding some basic services...they could use

this to influence the government...If [the INGO] looks at gender and equity issues, the results of this – the government will be a very good audience for these issues (#606, donor).

In conjunction with providing evidence to the Kenyan government and donors, the INGO also used existing government structures to promote its equity principles within the Kenyan government, including actively participating on various government committees at the local and national level:

“[The INGO] is a very strong partner at all levels — national all the way to the district level. We are a very strong partner, vocal partner. We participate in, I think, quite a huge number of fora at all levels” (#16, internal staff).

INGO representatives sat on government committees that focused on particular vulnerable populations (a working group on injecting drug users and one on gender) as well as committees focused on issues of human rights and community empowerment. By participating in these committees, many of the internal interviewees noted that the INGO was able to have some influence on government policies and strategies, including equity:

“When we sit on these sub-committees, we are able to articulate and advocate for ways of working that we think are most appropriate for the communities we work with in terms of accessing HIV and AIDS services. So we champion the cause, so to speak, of the communities that we work at the various subcommittees and committees” (#46, internal staff).

The sub-committees were identified as a mechanism for the INGO to bring their equity agenda forward, including focusing on marginalized communities. The INGO had also influenced the Kenyan government’s equity work through government consultations.

“The documents [Kenya National AIDS Strategic Plan and Vision 2030] are produced with the participation of civil society like [the INGO]. We take into them our narratives on equity...It is an iterative process – the government comes up with these documents and we see what works and what doesn’t work – this is interactive, iterative, there is an influence both ways. It is like a flowing river” (#23, internal staff).

“We participated quite actively in the review of this document, the Kenyan National [AIDS] Strategic Plan, especially the community pillar...Previously, the strategic plan that was there was not very clear on some of the equity issues but we’ve been able to

actively ensure that some of the issues of concern are included in the strategic plan” (#46, internal staff).

Consultations on the development of the Kenyan National AIDS Strategic Plan offered the INGO an opportunity to incrementally influence the equity agenda in a sanctioned way. Through participation on committees and in other government consultation processes, the INGO was also able to work within the system to influence the Kenyan government, including its equity principles. However, interviewees offered few specific examples of what resulted from this participation with regards to equity, and I found no documentation that assessed this.

Finally, the INGO worked with other NGOs to partner on projects to move equity principles forward, based on their common goals: *“We [INGO and other NGOs] have the same goals [in terms of equity]” (#23, internal staff).* Equity was an area of focus for most NGOs in Kenya: *“I still haven’t come across an NGO that doesn’t consider equity issues” (#124, internal staff).* Partnering took the form of formal networks and stakeholder fora, as well as development of joint proposals based on various NGOs’ comparative advantages.

Many interviewees noted that a network of health NGOs offered a mechanism to collaborate in advocating for equity-related issues. This formal network had worked on areas such as health systems strengthening at the community level and promoting civil society’s capacity to monitor the Kenyan government health budget. One external interviewee explained this work and its relationship to equity:

“I have personally...attended workshops and seminars sponsored by [the network] working in partnership with [the INGO]...to promote civil society capacity to...monitor spending of finances so that we can hold government accountable. If communities cannot access health and yet there is money allocated to [health], I think that is one way of promoting access to health...and minding people who are perhaps from the lower bracket of income because they are not able to access health...how much of that [budget] is addressing...the needs of women, how much is it addressing...people living with HIV, how much is that going to...pastoralist

communities, are we reaching out to marginalized communities?” (#602, partner NGO).

Interviewees identified that this network was a way to provide increased legitimacy to the NGOs’ interactions with the Kenyan government, through strength in numbers.

The INGO also sat with other NGOs on many stakeholder fora at the district level, usually organized by the government, to network, plan and coordinate projects as well as discuss lessons learned. Some of the internal INGO staff identified equity as a one of the topics discussed at these fora, given the focus of equity by many of the NGOs.

“We have the Regional Development Partners Forum where we discuss several issues. We discuss what we do as [the INGO], what [another INGO] does, we share our core values with them, we bring gender equity issues out... we discuss lessons learned, achievements, we look at it together, so we can inform our interventions here. For example, if they tried a certain thing and it didn’t work for them, then we shouldn’t put our feet into it. We would have trained chiefs [on gender] but we didn’t since they [the other INGO] had already, and they can also make use of what we’ve done” (#50, internal staff).

Discussions related to equity at these fora included gender mainstreaming, avoiding duplication of initiatives, ensuring the “*equitable distribution of resources*” (#59, internal staff) in communities for HIV/AIDS initiatives, and learning from each other’s successes and challenges.

One staff person argued that more work could be done to leverage the comparative advantage of other NGOs:

“If the NGO could tap into [other NGOs’] various comparative advantages and join forces probably the voice [for equity] would be, their ability to influence policy and practice at the government level would be greater (#46, internal staff).

This interviewee noted that these combined efforts could provide even more of a voice for equity to influence government’s policy and practice.

Partnering with other NGOs allowed the INGO to coordinate with these other NGOs and increase their ability to advocate on equity issues through a network of NGOs, benefiting from strength in numbers.

3.9 Conclusion

This chapter detailed the results of my research based on interviews, participant observation, and document analysis. It showed the dynamic interplay amongst various players working on HIV/AIDS in Kenya, and the influences on the case INGO's implementation of its equity principles. The final chapter integrates these findings by outlining the main themes arising from the data, examines these within the broader literature, and discusses their implications.

4 Chapter 4: Discussion and Conclusion

4.1 Main Themes Arising from Study

The main themes that arose from the study were: the asymmetrical interdependence amongst the players working in HIV/AIDS in Kenya; the privileging of particular vulnerable populations in the INGO's implementation of equity in HIV/AIDS; and the INGO's two main approaches to balance its equity commitment with the context within which it worked – aligning with the system as well as pushing back incrementally on the donors and the Kenyan government to influence these organizations' equity agendas.

4.1.1 Asymmetrical Interdependence

In the previous chapter, the interdependence amongst the donors, the Kenyan government, and the INGO as they worked on HIV/AIDS in Kenya was outlined. I found that this interdependence was asymmetrical, as the INGO did not have equal power to the Kenyan government or to the donors in implementing its equity principles. This asymmetry arose, first, because the INGO relied on donors for its funding. In addition to reliance on donor funding, previous literature has shown there is also competition for donor funding amongst NGOs [145, 146], likely augmented by the large (and increasing) number of NGOs working in Kenya [113-115]. Second, the INGO also needed the Kenyan government's support to operate in Kenya, and the Kenyan government oversaw the overall strategy and coordination of HIV/AIDS in Kenya. The term "asymmetrical interdependence" has been used in the literature in the examination of relationships between nations [147]. Critical to this asymmetrical interdependence is the notion of power: "asymmetrical interdependence is a basis for power: potential power accrues to the less dependent actor in a relationship" [147,

p. 37]. Much of the discussion about power in the NGO literature focuses on the reliance of NGOs on donor funding, and the resulting “overt” influence [148, p. 6] that the donor has on the NGO [149]. Dimensions of power include having control over financial resources as well as political authority, leading to the ability to assert a level of dominance over other players, including the ability to set the agenda [150-154]. This reflects what I found in my research, namely the power from the donors (financial resources) and government (political authority). In my research, many interviewees noted how donors “*still drive how organizations operate*” (#300, Northern INGO staff), and potential repercussions from the government were a consideration in implementation of equity principles. Many authors speak about the multiple accountabilities that NGOs face [7, 61, 97, 103, 155, 156], and the resulting challenges from this “unbalanced accountability” [61, p. 376] where, due to asymmetry amongst players, an NGO tends to focus on the priorities and accountabilities to its donors and country government over the NGO’s beneficiaries or its own principles [61, 96]. However, this previous work examined NGO governance, including NGO accountability, partnerships, or donor aid, and did not focus on equity. That asymmetrical interdependence influences the INGOs’ implementation of equity principles raises a unique contradiction. Inequities arise because of power differentials: “All societies have social hierarchies in which economic and social resources, including power and prestige, are distributed unequally. The unequal distribution of resources affects people’s freedom to lead lives they have reason to value, which in turn has a power effect on health and its distribution in society” [57, p. 1154]. Hence, INGOs are working on addressing inequities within a system where they have less power, and more at stake, than other players. The context of asymmetrical interdependence means that there are multiple influences from these players on

INGOs' implementation of equity principles. This creates an implementation gap between the intent of INGOs to ensure equity in their HIV/AIDS work and actual practice.

The Kenyan government and donors' explicit recognition of equity as a principle in various strategic documents was recognized as a facilitator for the case INGO's implementation of its equity principles. However, some donors emphasized equity more than others, and the equity strategies outlined by donors and the Kenyan government did not always align with the operationalization of these principles. Because of the interdependence amongst the players in this system, the INGO could not simply focus on its own agenda, but had to take other players into account when planning and implementing its equity principles in its HIV/AIDS work. I found that the INGO faced a number of system influences from donors and the Kenyan government as a result of this asymmetrical interdependence, and aligned its implementation of equity principles accordingly. Other authors have recognized the importance of aligning equity work, particularly with the priorities of the government. The importance of players, including NGOs, aligning their actions on social determinants of health with country governments was identified as a priority strategy in the WHO discussion paper for the World Conference on Social Determinants of Health [157]. Another WHO document on equity and urban health identified aligning with government priorities at a national and local level as a criteria for selecting interventions to address equity [158]. In this case study, the INGO was heavily reliant on donor funding and thus had to align its work with the donors' requests for proposals, while needing to maintain its organizational status within Kenya and trying to be true to its equity agenda. Other authors have identified that donors decide on the focus of their funding, often based on their own priorities and needs [7, 145, 146, 159], although much of this past work had not focused on equity per se. In the present study, donors' requests for proposals were based on donors' priorities, which were

decided by the Northern country, and could change based on who was in political power in that Northern country. There was also evidence in the literature that donor-driven agendas change over time [156], often depending on political ideology of elected governments in donor countries such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) which focused on abstinence under the Bush administration, but not under the Obama Administration [160-162]. My case study found that funding from donors was usually short-term. This challenged the INGO's implementation of its equity principles, given that addressing inequities, and the structural determinants of health, can take a long time. The challenges with short-term donor funding have also been identified in the NGO literature [101, 163].

4.1.2 Privileging of Particular Vulnerable Populations in Equity Implementation

Senior INGO staff in particular stated that, to maintain positive relationships with the government, the case INGO could not implement equity in its programs in a way that challenged existing Kenyan laws involving behaviours that were considered a criminal offense (e.g. advocating for legalization of homosexuality), or it would risk losing its reputation or even its status as an INGO in Kenya. An illustration of the potential deleterious influence of a Southern country government on INGOs' implementation of equity principles is Ethiopia's legislation that prohibited foreign NGOs from working in areas of human rights, gender equality, and ethnic equality [164, 165].

The case INGO made a choice to maintain positive relationships with the Kenyan government rather than take a confrontational approach to equity. Hence, the INGO privileged particular vulnerable populations based on its reputation, its history, the priorities of the Kenyan government and the donors, and what was deemed less controversial and in

keeping with Kenya's legal framework. Hence, people living in poverty, people living in geographically remote areas, and gender inequities were primary foci for the INGO's implementation of equity principles in its HIV/AIDS work. These populations also benefited from a more upstream structural approach by the INGO, where it went beyond downstream issues of health care access and behaviour change in its programs to include addressing structural determinants of health (e.g. working with cultural custodians to shift cultures around gender; working on income generating projects). However, other vulnerable populations, including men who have sex with men, sex workers, and injecting drug users, were less privileged by the INGO. The work the INGO did with these populations tended to take an approach that focused on behaviour change and access to health services. A more upstream human rights orientation, including advocating for changing legislation to address the structures that were perpetuating inequities, was missing for these populations. Hence, this choice limited the programming and advocacy approaches that the INGO took to address equity.

4.1.3 Aligning with the System and Pushing Back

However, even though the interdependence was asymmetrical, with the donors and the Kenyan government having more power, this did not mean that the INGO had no influence to move its equity agenda forward in its HIV/AIDS work. Literature identifies that power amongst players in the aid field is complex [154], and not "simple, discreet, and unidirectional" [148, p. 8], which is illustrated by the current case INGO and its demonstration of agency. The case INGO used two main approaches to try to balance its equity commitment with the asymmetrical interdependent context in which it worked, by both aligning with the system and pushing back on the system. In terms of aligning with the system, the INGO focused its implementation of equity principles in its HIV/AIDS work by

continuing in areas where it had a historical reputation as well as by working within the realm of what was supported by the donors and the Kenyan government, as noted above. Many equity tools, global strategies on equity, and key authors working in equity have identified common elements to address inequities that are congruent with the work of the case INGO that I studied (e.g. community empowerment and focusing on vulnerable populations) [42-46, 48, 53, 55, 56, 90-94]. However, this previous work did not examine how the system within which INGOs work, including the context of asymmetrical interdependence, may influence INGOs' focus on particular elements of equity principles in their HIV/AIDS work.

The case INGO had a positive historical reputation in working with people living in remote areas and people living in poverty. This aligned with the system, since donors and the Kenyan government had supported the INGO's work in these areas – areas where the INGO had worked since its early days. Other literature supports this, arguing that NGOs are strongly influenced by the discourse in place at the time of their formation [166]. In addition, the case INGO aligned its work to ensure that its implementation of equity principles in HIV/AIDS was in accord with those of its key partners, including with what the donors and government identified as priorities, what the donors supported financially, and what the government and donors supported from a legal standpoint. Rather than implement its agenda independently, the INGO ensured its congruence with these priorities of the other key players, implementing its equity principles while mitigating risks. For example, the Kenyan government supported the INGO's work in community empowerment, as this was key to the government's Community Strategy.

The INGO's work on gender (including gender mainstreaming, its focus on women and girls in its HIV/AIDS projects, and data disaggregation by sex) was another area where

the INGO aligned its work to build on donors' and the Kenyan government's priorities in the area of gender equity. Previous research on NGOs' implementation of gender mainstreaming has found that donors have driven the gender mainstreaming agenda [99-102]. In my research, donors also played a key role in putting gender on the agenda. As one interviewee noted, equity as a whole may be a donor-driven concept: "*everyone is moving on equity because this is all Western driven, the labels are Western, they are part of donor conditionalities*" (#124, internal staff). However, while previous research has also identified that NGOs had limited ownership of gender mainstreaming, and tended to focus on community's immediate needs versus shifting underlying determinants [100-102], the case INGO I examined did embrace gender mainstreaming in its community interventions through addressing structural determinants, including trying to shift cultural practices and working with chief *barazas*. However, challenges still remained within the case INGO, as identified by previous research, in limiting data collection related to equity to disaggregation by sex [100-102]. For accountability and to learn from previous work, governments, NGOs and other institutions need to measure inequities in health across various groups to monitor progress in access to health care, health status and health outcomes over time. This allows an equity assessment of actions taken, to ensure that inequities are not worsening as a result of interventions, and to make adjustments based on results [2, 44, 45, 48, 53-56, 92-94, 167-169].

As particular development approaches become popular, and others fall out of vogue, this information is imparted to NGOs via funding conditionalities and other means [166]. NGOs are not passive recipients of these changing discourses [166]. Similarly, I found the case INGO was not simply implementing only the donors' or Kenyan government's agenda in its own work. The INGO also pushed back on the system to implement equity principles in

its HIV/AIDS work, influencing the donors and the government, benefitting from the INGO's own reputation and strengths. Yet, as noted above, the INGO chose to do this incrementally, maintaining its reputation within the Kenyan system. In the literature, one equity tool, the Equity Gauge, identified that building coalitions with other organizations, as well as taking part in government-led committees and participating in the development of government strategic documents, are important advocacy strategies to influence equity changes in policies [94]. I found that the case INGO participated in these types of strategies. The INGO worked within government structures, and advocated for change in an incremental way, as opposed to advocating from outside of these structures in a more confrontational manner. Staff of the INGO identified that they used existing government structures to promote the INGO's equity principles by actively participating on local and national government committees and government consultations. On the other hand, interviewees also identified these structures as playing a significant role in helping the INGO to *align its work with the Kenyan government's work*, indicating that these structures influenced the INGO's equity agenda as well. In addition, few specific examples emerged with regards to how the INGO was able to use these government structures specifically to further advance its equity agenda, and no documentation was found that assessed the effectiveness of these structures as a strategy for the INGO to influence the government's equity agenda.

The INGO documented best practices and provided donors and the Kenyan government with evidence based on its work with communities. This helped the INGO to demonstrate what worked in terms of implementing equity in HIV/AIDS (in particular with vulnerable populations it privileged including working with women and girls, people living in poverty and people living in geographically remote areas), and further highlighted the

importance of addressing equity in HIV/AIDS work with these groups in particular. The INGO developed, implemented, and evaluated tools, models, and training methods that supported an equity approach. These could be shared with donors and the Kenyan government, and could subsequently be built on and disseminated to other communities. On the other hand, it could be argued that the INGO only collected evidence on programs that were focused on donor priorities (given the reliance on donor funding), and government structures would reflect government priorities. Hence, these may continue to perpetuate a privileging of certain vulnerable populations that have been the focus of equity work in HIV/AIDS.

The INGO also worked with other NGOs in joint processes, including involvement in formal network and stakeholder fora. The formal network provided an opportunity to have strength in numbers when advocating to the government on particular issues that may have an equity focus. Stakeholder fora were a mechanism to share what works and to learn from one another.

In these ways, the INGO moved the equity agenda forward incrementally, based on its reputation and working within the system, while avoiding potentially negative repercussions that might result from pushing too fast or working outside the system. Other authors have identified that, while NGOs' advocacy to improve health equity can be confrontational, working within the system for "incremental changes" is another tactic that can be used [47]. While there is limited research on the decisions made by INGOs in terms of their strategies for advocacy [170], a number of typologies of government and NGO relationships have been put forth over the years [171-175]. Similar to the idea of "asymmetrical interdependence" discussed above, power and dependency are common variables in these typologies [171-175]. Some of these typologies view advocacy as limited

to confrontational and independent organizations [174, 175], while others view advocacy as a function that can occur under different types of relationships between NGOs and the government [173]. One of the typologies recognizes the policy influencing approach called “advising”, which involves cooperation with the government using evidence-based work, reflecting the context of the case INGO [176, p. 2]. However, these typologies focus only on the NGO-government relationship, and do not recognize the complex nature of the system within which an INGO works in a Southern country – that is, the relationships with multiple players, including donors. These typologies are typically theoretically based, and not specific to a given theme such as equity. Hence, my research adds to this work by providing an empirical case examining how an INGO advocated for principles of equity while working with the system, and provides new understandings about the tripartite relationship amongst the INGO, the country government, and donors, and not just the NGO-government relationship.

4.2 Limitations and Strengths of the Research

4.2.1 Limitations

In terms of limitations, from a methodological point of view, I may be critiqued for not being completely true to Stake’s [121] philosophy for my case study, as I used some components from Yin [123] (e.g. in the development of *a priori* propositions). However, while Yin and Stake have very different philosophical approaches, I addressed this by clearly outlining the aspects of Yin I used in my research, and why I did so. As a constructivist, Stake’s approach aligned best with my epistemological assumptions, and I attempted throughout this dissertation to ensure that my approach was clear, including openly outlining my background as a researcher, employing participant observation to help develop a deeper

understanding of the context, and using the voice of the participants throughout this research [122]. I also relied on many other qualitative approaches during the analysis, as I found neither Yin nor Stake particularly useful in addressing how best to analyze the data. I identified other methodologists who informed my analytic approach.

Another limitation of this research was the amount of data I was able to collect on each of the seven HIV/AIDS projects that the INGO was working on. My research was more heavily weighted towards the largest HIV/AIDS project in terms of the number of people I interviewed, the number of documents I collected, and the number of people involved in the participant observation. This particular project (as described earlier) had about 50 staff and accounted for about two-fifths of this INGO's total Kenyan budget. This particular project also represented a large portion of the budget and staffing of the INGO in Kenya, and therefore my results may reflect this project more so than the INGO's other HIV/AIDS projects. This project was funded by two European government donors, whom interviewees noted were more likely to be equity-oriented than other donors; hence, in terms of transferability of the results from this case study, they may apply more to projects funded by donors who have a more specific focus on equity. The INGO's other projects had more of a focus on specific populations. For example, one of these smaller projects targeted orphaned and vulnerable children, while another worked with other East African countries to target common mobile populations, including fishers, plantation workers, and university students. Other HIV/AIDS projects were smaller in terms of number of staff. In addition, one project was just starting up and one was just finishing up which limited data collection from these particular projects. To help to ensure that all seven projects had some representation in this research, I interviewed one or more INGO staff who had knowledge of each of the INGO's HIV/AIDS projects. In addition, one or more INGO staff who had knowledge of each of the

INGO's HIV/AIDS projects were involved in the participant observation. Documents were also collected from each of the seven projects. While I collected data on all seven HIV/AIDS projects, I did not have enough data for each project to do a comparison across these seven projects, but I collected enough data to understand the critical issues facing the INGO in implementing its equity principles in its HIV/AIDS work.

The number of individuals who consented to participant observation could also be viewed as a methodological limitation to transferability of the results, if it was felt that I was not able to collect data from across a range of perspectives and projects within the INGO. I encountered some difficulty from potential participants in the INGO in their understanding of the nature of participant observation, and hence I was only able to conduct participant observation with 10 people. However, I did have contact with well over 100 people over the course of the three months of data collection in Kenya. The idea of taking part in an interview as a research method was more easily understood by people, and it was less challenging to have people agree to an interview than to participant observation. In addition, in the way I designed my participant observation, I had only accounted for internal people taking part, and I had not considered meetings where external people were also attending. Hence, I was not able to conduct participant observation in meetings where external people attended. If I had designed the research to include external players in the participant observation, this may have provided further opportunity for response variability, including the ability to conduct further data triangulation for external partners (between their documents, interviews, and actual observation). Nevertheless, it would have been challenging to get participant observation consent prior to meetings with external people.

Finally, the fact that I developed preliminary propositions (see Appendix D) to guide the research prior to data collection, yet did not use these specific propositions as the focus

for my analysis and presentation of results, could be viewed as a limitation. However, the propositions I developed were nascent, given the limited literature in this area, and as I collected data, it became clear that the propositions were far from sufficient. For example, I had failed to include in the propositions the idea that not only could an INGO's implementation of equity principles be influenced by different players, but also that the INGO could push back on the donors and the Kenyan government to influence their equity agendas. As another example, I found (as I collected data) that examining communities' influence on the INGO's implementation of its equity principles, as opposed to limiting this to people living with HIV/AIDS, was a more useful and relevant scope. As discussed in the methods section, I used the propositions to help frame parts of my data collection tools, but I did not use the propositions as a starting point for analysis. I focused on the different players outlined in the propositions (donors, Kenyan government, community, other NGOs) and their potential influences, but I did not limit my data collection or analysis to these preliminary propositions. Hence, I viewed the propositions as guiding ideas while ensuring I was not constrained by them during data collection or analysis.

4.2.2 Strengths

This case study of an INGO was original in that it looked at the INGO office in Kenya as well as its Northern counterparts in the U.S. and Canada. This research provided in-depth, rich qualitative information from multiple sources and used multiple methods to understand the influences on an INGO implementing equity in its HIV/AIDS work. Participant observation allowed for an in-depth understanding of the INGO's internal as well as inter-organizational influences on implementing its equity principles in its HIV/AIDS work. Interviews with: INGO staff (from junior to senior levels and across multiple

HIV/AIDS programs), two Northern offices of the INGO, external Kenyan staff partners, and clients, provided multiple perspectives. Documents helped to provide initial background information and, along with participant observation, assisted in confirming or disconfirming what I learned through interviews.

4.2.2.1 Rigour

To enhance the rigour of the study, I addressed issues of credibility, confirmability and auditability [122, 125, 177]. To augment credibility, I employed member checking, developed a thick description of the case, spent time in the field, and outlined my stance. Member checking included asking internal and external interviewees to review their transcriptions for accuracy, as well as presenting preliminary analysis of the data to ensure these early findings reflected their experiences. I developed a thick description of the case through collecting data from multiple sources, and attempting to fill information gaps by asking questions of my key contacts and collecting further documents. I also staged my data collection (starting with participant observation) to allow for time to understand the context prior to conducting interviews. I spent three months collecting data and volunteering with the INGO. Participant observation takes time, and is therefore costly. However, there was the possibility that, given I am a white western female who had previously never lived in Kenya, participants' responses would be influenced. Spending time in the field helped to offset this by ensuring that I gained a positive rapport with staff of the INGO, limited social desirability responses, and collected data from a number of perspectives [178]. The INGO staff brought me to meetings with external partners and on field visits to communities, which helped me to understand the day-to-day program work and develop trust with participants. Given the knowledge of the case and its context that I attained through time I spent at the INGO and the contributions I made to the INGO's work through editing and writing, I found that the

staff and external partners were quite open with me in the interviews and during participant observation, discussing both facilitators as well as challenges in the INGO's implementation of its equity work. In the dissertation, I clearly outlined the background that I brought to this study.

To address confirmability, I digitally recorded interviews (where interviewees agreed) and had internal INGO and external staff member check their interviews to ensure accuracy. I sought feedback from informants through presentation of preliminary data results to help to verify the early analysis I had done. To enhance both confirmability and credibility of the data, I used *triangulation of methods* and *triangulation of data sources* [179]. In terms of *triangulation of methods*, I compared the data collected from the three different methods (interviews, participant observation, and document analysis). Documents provided information on what is formally written, participant observation allowed for collection of data on the day-to-day workings of the INGO including context, and interviews resulted in more focused data on equity implementation and its influences. This helped to build a stronger case (where data from all three methods were aligned) or to identify discrepancies between data sources (where data from the three methods were incongruent). *Triangulation of data sources* was done for interviews and documents. Interviews were conducted with Kenyan INGO staff, Northern INGO staff, external staff, and clients. Different types of documents were reviewed (e.g. minutes, overall strategies, evaluation reports), and documents from various sources were also included (from the INGO, donors, and Kenyan government). Triangulation of data sources ensured that multiple perspectives within a method were explored to examine congruent or competing findings amongst different players—INGO staff, Northern Kenyan staff, clients, and external staff [125].

For auditability, I kept an audit trail of the research, including transcripts, copies of the documents, and field notes. Interview guides and various data collection forms are included in Appendix I. In the methods section, I outlined my sampling strategy and the analysis plan that I undertook to develop the themes from the data. I worked closely with my co-supervisors during the development of the research, data collection, analysis, and write-up, and they offered different insights on interpretations for consideration [125].

4.3 Implications of Researcher's Background

As I stated in the first chapter when discussing my background, I am a white, middle-class female from Canada. Prior to my first visit in 2009 to meet with INGOs for case selection, I had never previously been to Kenya, or anywhere in Africa. I did not speak Kiswahili or any of the local languages of Kenya. However, I had spent over a year familiarizing myself with Kenya and its context, including health structures, prior to my first visit.

While I was in Kenya, some people expressed the opinion that researchers from Northern countries come into Kenya and get the information they need and leave without giving anything back to the Kenyan community. I hoped to address some of these concerns by: living in a local neighbourhood during my participant observation (and not in an expatriate community); volunteering my time with the INGO before, during, and after data collection; and returning to Kenya to present my preliminary results to staff. I also learned about the INGO so that I could better assist them through my volunteer work. About half way through my three months, one of the senior staff said to me that he felt I had a strong understanding of the INGO and knew it well. One of my thesis committee members is Kenyan, which also assisted my understanding of the Kenyan context and helped to link me with various contacts. I hired a Kenyan research assistant to conduct interviews with

community members in case language was an issue. Language rarely was an issue for me during data collection, as all Kenyan INGO staff, and most of the community members I met with during field visits, spoke English (if they did not, someone translated for me). There were a number of silences in the data that may have resulted from my being a foreigner. For example, I did not hear or see much in the interviews, participant observations, or in most of the documents about major issues of corruption, post-election violence in Kenya, or tribal conflict, and their relationship to equity. I also did not probe specifically on these issues. However, I found that the people I interviewed, whether within the INGO or from other organizations, were frank with me in the interviews, including providing criticisms about the INGO, the Kenyan government, and the donors in terms of challenges and facilitators to implementing equity in HIV/AIDS initiatives. By conducting participant observation and document analysis, I had an opportunity to collect a wide range of information from multiple perspectives.

4.4 Transferability

The case INGO has many characteristics that were typical of other INGOs, including a wide geographic coverage with offices in both Northern and Southern countries and a long history of operations [7, 62, 63, 68]. The case INGO was viewed by the donors and the Kenyan government as playing a key role in implementing initiatives in the community, often where the government had left a gap, which is also a typical characteristic of INGOs as noted in the literature [61, 64], as is a reliance on Northern country donor funding [148, 149]. Given this, it is expected that many of the research results from this study would be transferable to INGOs with similar characteristics. Transferable findings include: the implementation gap that exists between the intent of the INGO to implement equity and actual practice; the multiple players including donors and the country government that

influence implementation of equity principles through their priorities, funding, policies, and legislation; and the context of asymmetrical interdependence that INGOs' face when they are reliant on donor funding and trying to work closely with country governments. While I chose the topic of HIV/AIDS as a focus for the case study, it is likely that many of the findings would also be applicable to INGOs working on other development issues, including other diseases for which there are inequities and multi-player involvement (e.g. government and donors). While most of the data collection took place in Kenya (as well as Canada and the U.S.), many of these findings are also likely transferable to other Southern countries where INGOs work, where health inequities remain an issue, and where Northern country donor funding is provided to INGOs working in other Southern countries.

In addition, I increased the potential transferability of my research results by: describing the sampling in detail, developing a thick description of the case and the results so that the reader can decide where the results might be transferable, identifying in my conclusions limitations to the research and how results might be further tested, and outlining challenges to the transferability of the results [125].

However, these findings are likely less transferable to INGOs who are not reliant on country donor funding and/or choose to play a more contentious advocacy role versus a service delivery and capacity building role. It is anticipated that INGOs with more flexible funding arrangements would also have less constraints in implementing equity principles in their HIV/AIDS work. As one Northern INGO staff noted during an interview, organizations with a high percentage of unrestricted funding could focus more on advocacy or other priority issues that are important to the INGO, since they are less reliant on the donor (#300, Northern NGO staff). In addition, given that the focus of the research was on INGOs that

work in both Northern and Southern countries, the results may not be fully transferable to INGOs that are primarily Northern-country based.

4.5 Future Research

Limited research has been conducted examining influences on INGOs' implementation of its equity principles in HIV/AIDS work. Research should continue to focus on various organizations' implementation of equity, and the context within which equity principles are being implemented, including challenges and facilitators to this implementation by various players.

One gap in the research is to understand how the different nature and mandate of various NGOs affects their implementation of equity principles, and whether these NGOs face similar or differing influences when implementing these equity principles. For example, the present research examined an INGO that is particularly focused on service provision, capacity development and training. Advocacy INGOs might have a different approach to implementing equity, and may be faced with different influences on their implementation of equity principles. Different players may also influence advocacy INGOs. For example, these INGOs may seek other sources of funding (e.g. from individuals' donations) so they are less reliant on Northern country government donor funding. They therefore may have more flexibility in implementing equity in their work, if they are less restricted in aligning their equity work with Northern country donors. Also, NGOs that are not international and are based only in a Southern or Northern country may face fewer influencers in implementation of their equity work, if they do not have to balance the needs of Northern country donors and the Southern country government. Case studies examining these different types of organizations would help to build an understanding of influences on these organizations and

how they might differ depending on the types of NGOs. Comparative case studies could examine how these NGOs implement equity in their work, what influences they face in implementing their equity principles, and how these influences are similar or different from the case INGO in the present study.

The current research did not address all potential levels of influence that the INGO may face in implementing its equity principles in HIV/AIDS. In particular, the present study did not comprehensively examine the larger global context beyond the Northern INGO staff and Northern country donors. The global context has the potential to strongly influence the country government and donors' equity work in particular, which may in turn influence the INGO's implementation of equity. This includes the role of global institutions (e.g. the World Bank and the United Nations) and their initiatives. Further research should investigate this broader global context of organizations and their initiatives and their potential influence on an INGO's implementation of equity principles. A key research question that builds upon the current research is, "How have global initiatives, such as Structural Adjustment Programs and Poverty Reduction Strategy Papers, influenced the INGO's (and/or other organizations') implementation of equity principles?" Other global initiatives might include the Commission on the Social Determinants of Health or declarations from the United Nations that have key equity implications.

The present study did not include all types of donors that may influence INGOs' implementation of equity, as it focused on Northern country donors that currently funded the case INGO's HIV/AIDS work. The influences on INGOs' implementation of equity principles from large private donors (e.g. Bill and Melinda Gates Foundation, pharmaceutical companies) may also differ and should be further explored. NGOs receiving funding largely from private individual donors would also be an interesting case to explore, given differing

accountabilities. For example, it could be the case that private organizations such as pharmaceutical companies put less of a focus on equity and upstream determinants of health as a value, and instead focus on downstream determinants such as health care and drugs. Further research would need to be conducted to assess whether or not the type of donor influences INGOs' implementation of equity principles in varying ways.

Finally, this research found that the case INGO's implementation of its equity principles was not only influenced by donors and the Kenyan government, but that the INGO also found ways to work within the system to influence donors and the Kenyan government. Future research could further examine particular cases where NGOs have been successful in influencing donors and Southern country governments in equity to better understand what strategies work and under which circumstances.

4.6 Contributions to Population Health and Implications of this Research

Addressing health inequities is an integral part of population health, and equity is the primary focus of the present research. As I stated at the start of this dissertation, there have been many calls for action on health inequities (including from the WHO Commission on the Social Determinants of Health and the subsequent Rio Political Declaration on Social Determinants of Health) and acknowledgements that governments cannot do this alone [1, 4]. Yet there has been a focus on government players in the discourse on equity, perhaps since they have access to the policy levers to better address inequities. However, INGOs working in Southern countries play a large role in providing services given their number and funding levels, and hence can play a large role in addressing inequities. Issues of governance, including the importance of outlining the various roles and responsibilities of different players, are identified in a general fashion in some documents [51]. But, to be successful, it is critical to understand the organizational context within which organizations work, as well

as the challenges and facilitators they face, when trying to address inequities. This study helps to contribute to this understanding by revealing the tripartite relationships that INGOs work within in their implementation of equity principles in their HIV/AIDS work. These players (e.g. Southern country government and the Northern donors) from different levels (e.g. in-country as well as Northern donor countries) shape INGOs' implementation of equity principles in their HIV/AIDS work. Influences from donors include donor agendas and the focus of donor funding, as well as donor country policies. Influences from the Southern country government include government priorities and legislation. These influence INGOs' implementation of equity principles in their HIV/AIDS work, and in some cases can outright contradict equity principles. However, since INGOs are often reliant on donor funding and need the Southern government's permission to work in-country, they work within a system that is characterized by asymmetrical interdependence. Hence, they have to find a middle ground for implementation of equity principles in their HIV/AIDS work. Thus, these influences help give rise to an implementation gap between what INGOs intend to accomplish in implementing equity principles in HIV/AIDS work, and actual practice.

Beyond the key focus on equity, this research also makes a contribution to population health by providing an interdisciplinary approach to the topic. My research addresses one of the diseases of poverty – HIV/AIDS – which affects people in lower income countries more than those in rich countries [180]. In addition, a population health approach examines issues within a broader context, beyond the individual (or the individual organization). This dissertation has examined the influences on equity implementation from multiple players, and the research is embedded in the larger context beyond that of the INGO.

A number of important implications arise from this research for policy and practice, including the need to: increase awareness of the roles of various players in implementing

equity and the need for ongoing collaboration to achieve equity aims; continue work in capacity building on equity for INGO staff and its partners; and develop and refine tools for measuring and monitoring the implementation of equity.

4.6.1 Awareness of Roles and Need for Ongoing Collaboration

This research helped to increase our understanding of the various influences on the case INGO in implementing equity in its HIV/AIDS work. Staff from Southern INGO offices, Northern INGO offices, Southern governments, and donors will find this research useful to understand these influences and the role that their organization might play in challenging or facilitating the implementation of equity. The case study showed that INGOs play a critical role in implementing equity in HIV/AIDS work. There is a lack of models to help assist INGOs in understanding how they might implement equity principles in their work, whether it be HIV/AIDS work or work in another area. Based on equity tools, global action documents on equity, and key authors focusing on the equity discourse over the past decade, many common elements can be identified as key to addressing health inequities, although these are not INGO-specific. These key elements to addressing health inequities include:

- identifying equity as a priority in the organization (particularly in strategic documents) [54, 93, 167, 181, 182],
- intervening on structural determinants of health [2, 44, 53-56],
- focusing on vulnerable populations [42-45],
- employing an equity lens in universal programming [41, 47, 48],
- empowering and engaging the community [48, 53, 55, 56, 90-94], and
- ensuring monitoring and evaluation of equity [2, 44, 45, 48, 53-56, 92-94, 167-169].

The current research helps to build on these general elements to help move towards a model for INGOs' implementation of equity principles by examining how INGOs implement equity and how and what influences this implementation.

The research also offers information on opportunities to continue to push for implementation of equity principles, both internally as well as with external partners, while recognizing the potential risks involved. INGOs with research-based mandates are in a position to lead on the issue of equity, including pushing donors and governments, through their collective evidence-base gathered from projects as well as the knowledge they gain from working directly with communities. This includes examining areas where NGOs have successfully influenced donors and Southern country governments (through involvement on government committees and structures, by using evidence, and working with networks of other NGOs) to advance the equity agenda, even within the current system. Both internal and external interviewees identified opportunities wherein the case INGO could do more to provide evidence on equity in HIV/AIDS to further move the agenda forward.

In addition, INGOs will want to consider the context of asymmetrical interdependence when planning, implementing, and measuring progress toward implementing their equity principles. This will include examining where INGOs may be privileging certain vulnerable populations in their equity work (given the context of asymmetrical interdependence), and determining how they can ensure that other vulnerable populations are also being addressed through equity work. Also, INGOs need to consider their equity agenda and how it is being influenced by others given the context of asymmetrical interdependence - if INGOs are building only on their reputation and history (i.e. working with vulnerable populations they have always worked with), and adding additional areas of equity only when they align with what donors or the country government is bringing to the table, this can be very limiting to INGOs' equity agendas. Emerging vulnerable populations, or the most vulnerable of the vulnerable, may be left behind by all of the players when this happens.

Donors and governments can use this research to increase awareness of and better understand how their policies and strategies influence (and possibly contradict) an INGO's implementation of equity, and consider how to facilitate working together within the system to continue to address equity in HIV/AIDS work. This may include broadly examining their own policies and strategies to assess their potential impact, either positively or negatively, on INGOs' implementation of equity principles. This research illustrated how ongoing collaboration amongst players is needed to facilitate the implementation of equity principles in HIV/AIDS work, as INGOs are not working on equity in isolation.

4.6.2 Continued Work in Capacity Building on Equity

This research showed that equity as a principle is outlined in many strategic documents by various players, but equity is still somewhat of a nebulous term. This research can assist organizational staff in considering how best to continue to implement equity principles in their work. While there was a general awareness of equity, there was a lack of clear understanding of how to operationalize equity beyond a project-by-project basis to a more strategic, overall approach for the INGO. Potential opportunities to build this strategic capacity that were identified in the present research include:

- Ensuring commitment among senior leaders in the INGO to the value of equity, given the significance of senior leadership in facilitating implementation of equity principles
- Increasing staff's understanding of the significance of equity to the INGO, and the importance of equity in reaching the INGO's overall mission
- Building on this commitment and understanding of equity to ensure an equity lens as part of overall strategic planning for the INGO
- Providing ongoing capacity building for all staff at all levels to engage them in equity. This includes capacity building with senior leaders and new staff as well as other players (e.g. government staff at various levels) to engage them in understanding the value of equity, what equity entails, and how to best operationalize equity throughout the work of the INGO.
- Developing guidelines or a checklist for equity to assist in mainstreaming equity in everyday work

- Providing already-developed equity-related guidelines (e.g. gender mainstreaming documents) to new staff as part of their orientation package
- Providing ongoing support to ensure organizational guidelines that do address equity or particular vulnerable populations become “*living documents*” (#300, *Internal staff*), including identifying a contact person for any follow-up

4.6.3 Developing and Refining Practical Tools for Measuring and Monitoring the Implementation of Equity

This research identified a perceived lack of practical measurement and monitoring tools for the implementation of equity. Data collection tools focused primarily on inputs and process level data on males and females only, and overall equity was viewed as difficult to measure. Continued work should be done at the INGO, government, and donor levels to assess how best to practically capture progress in meeting principles of equity in their projects, including key indicators (beyond disaggregation by sex) and qualitative data as appropriate. This would help organizations in their implementation of equity by helping to understand what is working and what is not.

In addition, INGOs, as well as donors and country governments, should assess how best to evaluate how they are doing overall in meeting their strategic values or principles of equity. Developing and implementing metrics to understand their overall impact in addressing inequities (as well as challenges and facilitators), as identified in their strategic documents, may assist organizations to move beyond a project-by-project approach to equity.

While a number of health equity tools exist, particularly tools developed in Northern countries [183-185], these tend to focus on assessing where and why inequities exist, planning how to address these, and monitoring the implementation of policies or programs to address inequities. While these are useful planning and monitoring tools, their main use tends to be for governments to assess potential programs or policies or to evaluate government interventions [186]. While communities and other organizations (including NGOs) are

identified as key stakeholders in most of these tools [183], the tools do not tend to address organizational context more broadly amongst these organizations. While many tools assess some contextual factors, such as the context of decision-making including “general governance, political context and social context” [187, p. 5], inter-organizational dynamics are not specifically mentioned. For example, very few of these tools identify issues of power, including asymmetry of interdependence amongst organizations trying to address inequities. Two international tools can be a starting point to address these issues, as their audience includes NGOs and they include aspects of inter-organizational context. The Urban HEART (Urban Health Equity Assessment and Response Tool) from the World Health Organization [188] includes governance as one of its indicators, although governance is focused mostly on people’s rights and inclusion as opposed to governance between organizations. The tool also offers criteria for prioritizing interventions for equity that includes the importance of alignment with, and political support from, governments (as identified above). The Equity Gauge from the Global Equity Gauge Alliance (GEGA) is the most comprehensive tool in covering these inter-organizational dynamics. It provides a section of questions to help examine the context, including government support and the influence of other players such as donors to “improve... understanding of the background forces that support and undermine health equity” [94, p. 10]. The findings from my dissertation will be useful to help augment these tools, and to assist in providing considerations for the inter-organizational dynamics present amongst players that may influence an organization’s implementation of equity principles.

4.7 Conclusion

Global efforts have called for action to address inequities and health, and argue that action on inequities is not limited to governments, but includes multiple players, including

civil society and the global community [1, p. 1, 53, 79]. Given this commitment to reducing inequities, it is important to look at the role that various organizations play, including INGOs, to continue to find the best ways for INGOs to address inequities, and to examine and address any challenges that these organizations face when trying to implement equity principles.

Limited research has been conducted to understand the influences on INGOs' implementation of equity. The present research clearly shows the significant role that INGOs play in equity, and the importance of understanding the multiple players and levels that influence an INGO's implementation of equity principles in HIV/AIDS. However, a gap exists between the intent of INGOs' implementation of equity principles and actual practice due to multiple influences from various players, including donors and country governments.

This research study adds to the literature by examining the tripartite relationship amongst INGOs, Southern country governments, and donors, which adds depth to understanding the context within which INGOs are implementing their equity principles. This research can help INGOs, Southern country governments, and donors to better understand that implementation of equity has to consider the system within which the INGO works, and the players that influence it. The elucidation of these various influences may assist these players when they are contemplating partnerships on equity issues in HIV/AIDS or other areas. The research illustrates how ongoing collaboration amongst the various players is important to continue to work towards equity goals in HIV/AIDS. Future research should continue to examine these influences, including examining NGOs with different mandates, as well as influences from global structures and initiatives.

4.8 Statement of Contributions

For this dissertation, I (Elizabeth Dyke) led the work, including development of the thesis proposal, ethics approval, development of data collection tools, recruitment of participants, data collection, data analysis and interpretation, and write-up of the thesis. I was supervised by my thesis committee, including my co-supervisors (Dr. Nancy Edwards and Dr. Ian McDowell) and my other committee members (Dr. Stephen Brown and Dr. Richard Muga). I met with my co-supervisors on a monthly basis, and they provided ongoing overall guidance of the project from inception to completion. My other committee members provided guidance at various points throughout the process. Dr. Muga also facilitated my work in Kenya.

I hired a research assistant in Kenya to conduct interviews with the clients and transcribe these interviews. The research assistant translated the client interview guides and consent forms, and another person in the INGO reviewed these for accuracy. Dr. Muga also reviewed these. Three transcriptionists were hired to transcribe the various interviews. Numerous people within the INGO and in Kenya assisted me throughout the research process by providing documents, helping me understand the context for the research, and participating in the research.

5 Appendices

5.1 Appendix A: Literature Search Strategy

Databases searched (based on meeting with librarian in 2008):

- **Medline** (University of Ottawa Books@Ovid, University of Ottawa Full Text Journals@Ovid, Journal Abstracts & Tables of Contents, AMED (Allied and Complementary Medicine) 1985 to July 2012, Embase Classic+Embase 1947 to 2012 July 16, Ovid Healthstar 1999 to June 2012, Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1946 to Present, Mental Measurements Yearbook 1st to 19th Yearbooks January 2012, PsycINFO 1806 to July Week 2 2012, Index to Foreign Legal Periodicals 1985 to May 2012, EBM Reviews - Cochrane Database of Systematic Reviews 2005 to June 2012, EBM Reviews - ACP Journal Club 1991 to June 2012, EBM Reviews - Database of Abstracts of Reviews of Effects 2nd Quarter 2012, EBM Reviews - Cochrane Central Register of Controlled Trials June 2012, EBM Reviews - Cochrane Methodology Register 3rd Quarter 2012, EBM Reviews - Health Technology Assessment 3rd Quarter 2012, EBM Reviews - NHS Economic Evaluation Database 2nd Quarter 2012, Ovid Healthstar 1966 to 1998, Ovid OLDMEDLINE(R) 1946 to 1965, Ovid MEDLINE(R) Daily Update July 16, 2012)
- **Web of Science:** Science Citation Index Expanded (SCI-EXPANDED) --1899-present; Social Sciences Citation Index (SSCI) --1898-present; Arts & Humanities Citation Index (A&HCI) --1975-present; Conference Proceedings Citation Index-Science (CPCI-S) --1990-present; Conference Proceedings Citation Index- Social Science & Humanities (CPCI-SSH) --1990-present
- **PAIS:** (originally the Public Affairs Information Service) - PAIS International (1997 and on) and PAIS Archive (1915-1976)

I focused on research on NGOs and equity to understand NGOs' implementation of equity principles – in particular – what influenced an INGO's implementation of equity principles.

Last search completed week of July 16-18, 2012

1. NGO OR nongovernmental organi*ation OR non-governmental organi*ation
2. Equity
3. equality
4. Social justice
5. Human rights
6. Gender mainstreaming
7. Pro-poor OR propoor
8. "People Living With HIV" OR "People Living with AIDS" OR "Greater Involvement of People Living with" (HIV/AIDS)" OR PLWHA OR PLHIV OR GIPA
9. 1 and 2
10. 1 and 3
11. 1 and 4

12. 1 and 5
13. 1 and 6
14. 1 and 7
15. 1 and 8

I searched for research on equity and NGOs involving other players to assess if any research has been done on the influence of other players on an NGO's implementation of its equity principles (e.g. donors, government, community).

Terms Used:

1. NGO OR nongovernmental organi*ation OR non-governmental organi*ation
2. Donor OR funder OR aid agenc*
3. Government
4. Community
5. "Implement* equity"
6. Equity
7. Equit* [TI]
8. 1 and 5
9. 1, 2 and 6
10. 1, 3 and 6
11. 1, 4 and 6
12. vulnerable population
13. 1 and 12

For the above searches, I reviewed reference lists from articles and books.

I also searched relevant websites including Overseas Development Institute (ODI), Equinet, and IDRC (I was only able to access IDRC's website until May 2010 given that it was a secure website for people receiving grants from IDRC).

The search also included reviewing relevant readings from courses at the University of Ottawa (Political Science 4170: "The Politics of Foreign Aid", Population Health 8910: "Scientific Paradigms in Population Health"; Population Health 8930: "Population Health Interventions"; Nursing 6115: "The Design of Multiple Interventions for Community Health"; Population Health 8900: "Globalization and Health Equity". I also reviewed suggested documents from key informants and discussed possible literature sources/accessing available literature at relevant conferences (e.g. AIDS Conference in Mexico City in August 2008, Canadian Conference on International Health in 2008, 2009 and 2010, the Canadian Population Health Association Conferences in 2008, 2009, 2010, 2011 and 2012, and the Canadian International Development Agency (CIDA) International Cooperation conference in November 2008). I also am a member of a number of relevant listserves (e.g. PAHO equity) where I also kept up to date on articles relevant to equity over the course of my PhD.

5.2 Appendix B: Summary Chart of Key Literature on Influences on Implementation of an NGO's Equity Principles

Author, reference number, date, location	Objective of the research	Methods	Findings	Limitations
Tiessen (2004) [99] Malawi	-examine the challenges that NGOs and INGOs face in implementing gender mainstreaming into practice, and the resulting gap between having a strategy and actual implementation	-document review -participant observation (for 13 months in an umbrella organization) -20 semi-structured interviews with staff from 10 different environmental NGOs and INGOs -a questionnaire of 32 NGOs with staff responsible for gender mainstreaming	-This study found challenges to gender mainstreaming including inequities in hiring practices in the NGOs because of cultural norms of gender roles in Malawi, staff capacity issues in understanding gender mainstreaming, and views by many staff that gender equality is a Western or donor-driven agenda. -While many staff had attended gender trainings, the motivation for staff to attend these was also raised as a concern, given the high per diems paid for attending these workshops. -The study results showed that the NGOs tended to continue to implement gender programmes to males and females based on traditional norms of labour division (e.g. gardening for females and enterprise for males). -Few instances of disaggregating data by sex occurred. -Mainstreaming gender was viewed as something that was done at the community level, and not something that had to be considered internally in the NGO as part of staff's examination of their own attitudes and behaviours.	-limited information provided on how data analyzed
Tiessen (2005) [100] Malawi	-examine the challenges that NGOs and INGOs face in implementing gender mainstreaming into practice, and the resulting gap between having a strategy and actual implementation -This study included a section	-document review -in-depth interviews (17 community members as well as 20 INGO and NGO staff from 10 poverty and environmental development organizations)	-This research found some resistance to examining gender inequalities within the organization given a lack of commitment at the individual and organizational level to work on gender inequalities. -While gender mainstreaming was included in NGOs' strategies, a common belief was that this was a Western notion that did not apply to the Malawi context, which challenged moving gender mainstreaming from strategy into action. -Increasing the number of female staff and having gender training workshops for staff were insufficient to shift long-held gender attitudes and behaviours amongst staff. -Individual and organization attitudes and behaviour changes were slow to take place. -Training workshops did not result in translation of information	-limited information provided on how data analyzed

Author, reference number, date, location	Objective of the research	Methods	Findings	Limitations
	of results on NGOs' response to gender mainstreaming in HIV/AIDS interventions.		into action, and the information was not disseminated with other members of the NGO. -While staff identified that they would like to increase community capacity to address cultural issues that increased females' vulnerability to HIV/AIDS, the focus of interventions at the community level tended to be on increasing the number of women participating in projects, and monitoring was limited to counting males and females. While increased participation in projects may help to address females' immediate needs, it does not shift underlying determinants that are responsible for gender inequalities.	
Desai, 2005 [102] Mumbai	-to examine how gender inequality was addressed in these NGOs, and how NGOs changed in terms of operations due to changing economic and political climates	-surveyed 67 grassroot NGOs in 1995-1996, and 40 of these again in 2003	-The study found that, over time, gender mainstreaming and associated language had been adopted by many NGOs, yet not institutionalized within the NGOs. -This increased commitment to gender mainstreaming seemed to be driven by donor agendas, based on where funding was focused. -Yet NGOs had limited comprehension of how to address gender inequalities including the broader underlying structural determinants. -Changing attitudes and behaviours on gender took time, resources and commitment, and required more than training staff on gender. -Data collection from interventions focused only on counting the number of females participating.	-limited information provided on the nature of the survey including sampling, validation, and analysis; based on the results section it appears that both qualitative and quantitative questions were asked
Wendoh and Wallace (2005) [101] -four sub-Saharan countries (Zambia, Rwanda, Uganda, and	-study of local African NGOs examined organization and community resistance to gender equality		-The study found NGO staff had limited ownership of the issue of gender equality, as well as limited understanding of what it entails. -It was felt that gender equality was an agenda that was prescribed from those in power. Donor influence was identified – that gender equality was on the agenda as a condition for funding without considerations for the community context. -Gender mainstreaming was viewed as being a one size fits all approach that donors expected to be implemented in a very short time frame given short funding cycles.	-limited details about sample, methods or analysis were outlined, except that data collection included NGOs, government officials, and communities.

Author, reference number, date, location	Objective of the research	Methods	Findings	Limitations
Gambia)			<p>-The research also outlined Southern governments’ resistance to gender inequality, due to concerns of cultural inappropriateness, the perceived threat to males, and challenges in implementation given that these issues did not reflect community realities.</p> <p>-Staff working in NGOs shared cultural norms with the communities that they worked in, and these deep-rooted practices and beliefs were often contradictory to a Northern gender equality agenda.</p> <p>-Short workshops on gender were one method used to increase capacity among staff, but were insufficient as a method given the time and effort it takes to change long-held attitudes and behaviours.</p> <p>-In addition, the question of motivation—that people attended gender training workshops for the per diem —was also raised as a challenge.</p> <p>-A small number of NGOs had some success at the community level in addressing gender inequalities by starting with local male leadership to sensitize key community leaders and illustrate the value of gender equality.</p>	
Smith (2004) [103] sub-Saharan Africa	-influences on governance decisions made by NGOs in sub-Saharan Africa working on poverty initiatives	-case studies of 10 NGOs -Major governance decisions varied across the 10 NGOs, but included such decisions as whether or not to scale up and whether or not to shift ownership of a program to another group or to the community. -Cases focused on poverty programs that have had positive results based on the criteria of having: a rigorous published	<p>-The research found that the donor was the major influencer in these key decisions made by the NGOs.</p> <p>-Donors’ focus on ensuring sustainability of programming as quickly as possible (considered by donors to mean no longer requiring funding from the donor) was a key focus for the donors of INGOs, but not for local NGOs. This was a challenge for INGOs, since this focus on a narrow definition of sustainability can lead INGOs to choose interventions that may, at first blush, seem “sustainable” at earlier phases, potentially resulting in diminished results on reducing poverty.</p> <p>-The study also found that, while community participation was discussed as an important component of programming, people living in poverty had limited involvement in priority selection for programs.</p>	-limited information was provided on how the case studies were chosen, and data analysis was not described.

Author, reference number, date, location	Objective of the research	Methods	Findings	Limitations
		evaluation, been identified by experts, or won a major development prize.		

5.3 Appendix C: Description of Secondary Data Analysis

To complement the primary data collection, I also initially accessed qualitative data from the study “Strengthening Nurses’ Capacity in HIV Policy Development in sub-Saharan Africa and the Caribbean” [189], given its focus on HIV/AIDS in sub-Saharan Africa. One of the co-principal investigators from this project is also my thesis co-supervisor (Nancy Edwards). This project used a generic qualitative approach. Researchers conducted interviews and focus groups with NGOs, donor agencies, nurses, and others to understand the “interface among health system priorities, capacity-building, and policy innovation”, including assessing how “international funding agencies and national HIV/AIDS management strategies influence workplace policies and nursing strategies” [189, p. 13]. I used this secondary data to assist me in preparing for my primary data collection, by furthering my understanding of the Kenyan health system and the context of HIV/AIDS in Kenya, including challenges faced. I had initially intended to use this data to help me to address my research questions by examining, “Is equity identified as an issue by NGOs working in HIV/AIDS in Kenya? If so, how is the issue of equity discussed?” While I reviewed the Kenyan-based interviews and focus groups prior to my primary data collection, equity was only mentioned on occasion, and typically not as it related to NGOs. I therefore did not have sufficient data from the secondary data for further analysis.

5.4 Appendix D: Original Preliminary Propositions from Thesis Proposal

- **Proposition 1:** There is a chasm (or “implementation gap”) between the intent of INGOs to ensure equity in their HIV/AIDS work (as outlined in their own mission/vision/principles) and actual practice. Influences at the global, country, and local level affect an INGO’s implementation of its equity principles in its HIV/AIDS work.
- **Proposition 2:** Donors’ agendas and priorities influence an INGO’s implementation of its equity principles in its HIV/AIDS work. If equity is not explicitly on the agenda of the donor, the focus on equity in the initiatives that an INGO implements will be limited. Donors’ monitoring and evaluation requirements, with a focus on efficiency over equity, also negatively influence an INGO’s implementation of its equity principles in its HIV/AIDS work.
- **Proposition 3:** The extent of the Southern country government’s (where the INGO is working) commitment to equity principles, via such mechanisms as legal support for people living with HIV/AIDS, influences an INGO’s implementation of its equity principles in its HIV/AIDS work.
- **Proposition 4:** Lack of coordination and competition between INGOs and between the INGO and SNGOs has a negative influence on achieving equity aims.
- **Proposition 5:** Involving people living with HIV/AIDS (PLWHA) positively influences an INGO to focus on equity, as people living with HIV/AIDS are living the experiences of inequities and will therefore encourage the INGO to focus on equity.
- **Proposition 6:** The multiple accountabilities at multiple levels that an INGO working in HIV/AIDS faces influences an INGO’s implementation of its equity aims. Because of reliance on donor funding, an INGO’s work in equity will be influenced more by donors than other factors, such as clients and the INGO’s own equity principles.

5.5 Appendix E: Dissemination Activities

A number of dissemination activities have taken place over the course of this work, both for academic purposes as well as dissemination to the INGO itself.

Presentation of Data to Senior Management at INGO Kenyan Office

Gyorfi-Dyke, Elizabeth. (2010). International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study. Presentation to two senior management staff at the INGO Kenyan office, May 20, 2010.

Presentation of Data to Staff at INGO Kenyan Office and Headquarters

Dyke, Elizabeth. (2011). International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work In Kenya: A Multi-Level Case Study. Presentation at the INGO Kenya, February 7, 2011.

Paper Summarizing Findings to Date to Key Informants at INGO Kenyan, U.S., and Canadian Offices

Dyke, Elizabeth. (2011). International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study. Paper emailed February 3, 2011.

Conference Presentations

Dyke, Elizabeth. (2011). International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study. Presentation at the Canadian Public Health Association (CPHA) Conference, Montreal, June 19-22, 2011.

Gyorfi-Dyke, Elizabeth. (2010). International Non-Governmental Organizations'

Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study. Presentation at the Canadian Society for International Health (CSIH) Canadian Conference on Global Health, Ottawa, October 31-November 3, 2010.

Gyorfi-Dyke, Elizabeth. (2009). Vertical “vs.” Horizontal Funding. Presentation at the Multiple Interventions Programs Invitational Symposia Series: 3rd Annual Symposium, Ottawa, ON, August 28, 2009.

For the following appendices, please note: My last name changed in the fall of 2010, following data collection. Hence, for the most part, my name appears on forms as “Elizabeth Gyorfi-Dyke”, yet it is now “Elizabeth Dyke”.

5.6 Appendix F: Organizational Agreements with Great Lakes University of Kisumu and Ethics Approval Certificates

Memorandum of Understanding with Great Lakes University of Kisumu and the University of Ottawa

The University of Ottawa has a Memorandum of Understanding (MOU) with Great Lakes University of Kisumu (formerly called the Tropical Institute for Community Health and Development). While this agreement was signed in December 2005, and was to last three years in duration, the updated MOU was being drafted and had not yet been re-signed. Please see attached.

AGREEMENT
between the
UNIVERSITY OF OTTAWA
and the
TROPICAL INSTITUTE FOR COMMUNITY HEALTH AND DEVELOPMENT
UNIVERSITÉ LIBRE DES PAYS DES GRANDS LACS

CONSIDERING:

1. That the *University of Ottawa*, Canada, and the *Tropical Institute for Community Health and Development, Université Libre des Pays des Grands Lacs*, Kenya, have areas of common interest and similar academic goals in teaching;
2. That both institutions are interested in establishing links to strengthen this area of common interest;

IN ACCORDANCE WITH THE FOREGOING it has been decided to establish a collaborative Agreement between the two institutions who, therefore, agree to the following:

CLAUSES

- First:** To develop academic links establishing first an exchange of information between the two universities with regard to programs and course offerings.
- Second:** To promote the exchange of professors and, in some cases, research personnel between the two institutions in order to allow faculty members from one institution to teach and, in certain cases, carry out research at the other university during a certain period of time.
- Third:** The two institutions will offer to exchange faculty and students the same services as those of their own faculty and students, providing academic services and accepting the course work completed at the host university as equivalent to their own within the limits of existing regulations in each university. This agreement is open to undergraduate and graduate students of the Faculty of Health Sciences of the University of Ottawa and the undergraduate and graduate students of the Tropical Institute for Community Health and Development, Université Libre des Pays des Grands Lacs. Students will pay tuition and general fees at their home university; they will be exempted from paying tuition and general fees at the host university.
- Fourth:** In order to carry out this collaborative Agreement, both universities will name liaison persons to establish a concrete exchange program in accordance with the regulations and economic limitations of each institution and will supervise the implementation of the exchange.

At the University of Ottawa, these persons will be Professor Gisèle Carroll, Vice-Dean Academic/Secretary of the Faculty of Health Sciences with respect to academic matters and the Manager, International Exchange Program, International Office, with respect to administrative matters.

At the Tropical Institute for Community Health and Development, Université Libre des Pays des Grands Lacs, these persons will be Dr. Dan Kaseje, Director and Professor, Faculty Development and Internationalization Activities with respect to academic matters and the Deputy Director, Academic Affairs/Liasion Officer, with respect to administrative matters.

Both institutions will exchange a maximum of eight undergraduate or graduate students for one academic year (two semesters) or for one semester. Students from both institutions will be allowed to take part in the exchange for one academic year (two semesters) or for one semester.

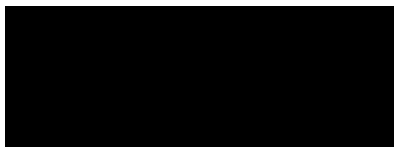
Tropical Institute for Community Health and Development, Université Libre des Pays des Grands Lacs students must subscribe to the compulsory University Health Insurance Plan (UHIP) upon arrival at the University of Ottawa. University of Ottawa students must obtain additional insurance coverage while studying at the Tropical Institute for Community Health and Development, Université Libre des Pays des Grands Lacs.

Fifth: The present Agreement can be modified through mutual written agreement between the two Parties, at the request of either.

Sixth: The present Agreement will take effect at the date of signature by both parties and will have a duration of three years, renewable automatically for a similar period, if neither party notifies the other of a desire to terminate the Agreement at least six months prior to the concluding date.

IN WITNESS WHEREOF, the institutions have caused this Agreement to be executed in duplicate copies in English with each of the copies being equally authentic, signed by their duly authorized representatives.

University of Ottawa



**President and Vice-Chancellor
Dr. Gilles G. Patry**

Dec. 14, 2005
Date

**Tropical Institute for Community
Health and Development,
Université Libre des Pays des
Grands Lacs**



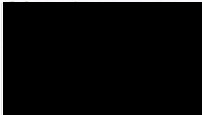
**Director ✓
Dr. Dan Kaseje**

Dec. 20, 2005
Date



GREAT LAKES UNIVERSITY OF KISUMU (GLUK)

5th March 2009

Elizabeth Gyorfi-Dyke,


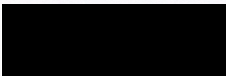
Dear Ms. Gyorfi-Dyke,

RE: ADMISSION AS PHD STUDENT UNDER GLUK – UNIVERSITY OF OTTAWA MOU

I am writing to inform you that, following your application, you have been admitted to the university to undertake studies leading to the degree of Doctor of Philosophy (PHD) beginning 1st September, 2009.

The initial period of admission is two years, and the applicable fees under the MOU shall apply.

May I take this opportunity to wish you every success in your studies.

Yours faithfully


Prof. Owino Ojong'o
Deputy Vice Chancellor, Academic Affairs

CC. Dean of Student.

P.O. Box 2224 40100, Kisumu, Kenya, Off Tom Mboya Drive, Milimani, Tel Number 057 2023972 / 2024871, Fax: 057 2024577,
E-mail adminkisumu@tichinafrica.org, academics@tichinafrica.org, Website: www.gluk.ac.ke, www.tichinafrica.org

Nairobi Campus, Lenana Road Wood Avenue junction, Opposite Len Wood Apartments
P. O. Box 60827 - 00200, City Square, Nairobi, Tel: 254 - 20 - 3876804, E-mail: tichnbi@wananchi.com, tichnbi@yahoo.com



**GREAT LAKES UNIVERSITY OF KISUMU
(GLUK)**

P. O. Box: 2224-40100 KISUMU, Tel: 254-057-2023972,
Cell. 0722-683813

Email:

adminkisumu@tichinafrica.org, vcoffice@tichinafrica.org

**Certificate of Approval of Research Proposal
GLUK Ethical Review Board (GERB)
Ref. No. GERB/010/09**

Date of Notification Monday, July 20th 2009

Study Protocol: Non-Clinical

Title: INTERNATIONAL NON-GOVERNMENTAL ORGANIZATION'S IMPLEMENTATION OF EQUITY PRINCIPLES IN HIV/AIDS WORK: A MULTI-LEVEL CASE STUDY

Investigator Elizabeth Gyorfi-Dyke (PhD Candidate)

Supervisors Dr. Richard Muga (Kenya)
Dr. Nancy Edwards (Canada)
Dr. Ian McDowell (Canada)

Approval Date: Friday, August 28, 2009

Approval Expiration Date: First week of March 2011

Type of Review: Minimum Quorum of Board

This is to inform you that your study proposal has been reviewed by the GLUK Ethics Review Board and approved on the basis of its status, purpose, methodology and strict adherence to possible ethical concerns of the participants in the study.

The study is also understood to be a sub-project of the ongoing "Interface among Health Systems Priorities, Capacity-Building and Policy Innovations in Sub-Saharan Africa and the Caribbean."

Note that any changes to the proposal could alter the status of the research and should you prefer to make any change whatsoever to the protocol, you should seek a fresh analysis and approval.

Signed

3rd Sep '09

Dr. Benard Abong'o (CHAIR, GERB)

Date: Friday, August 28, 2009



KENYA MEDICAL RESEARCH INSTITUTE

P. O. Box 54840 - 00200 NAIROBI, Kenya
Tel: (254) (020) 2722541, 2713349, 0722-205901, 0733-400003; Fax: (254) (020) 2720030
Email: kemri-hq@nairobi.mimcom.net; director @ kemri. org; website: www.kemri.org

KEMRI/RES/7/3/1

October 16, 2009,

**TO: ELIZABETH GYORFI-DYKE (PRINCIPAL INVESTIGATOR)
UNIVERSITY OF OTTAWA**

**THROUGH: DR. DAN KASEJE,
THE VICE CHANCELLOR,
GREAT LAKES UNIVERSITY OF KISUMU (GLUK)**

**RE: NON-SSC PROTOCOL NO. 168 (INITIAL SUBMISSION):
INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS'
IMPLEMENTATION OF EQUITY PRINCIPLES IN HIV/AIDS WORK IN
KENYA. PI: ()**

This is to inform you that during the 170th meeting of KEMRI/National Ethics Review Committee held on Tuesday 6th October 2009, the above study was reviewed.

The Committee notes that the aim of the study is to understand what influences International Non-governmental Organizations (INGOs) implementation of equity principles in their HIV/AIDS work and commends you for this timely and useful study.

Due consideration has been given to ethical issues and the study is hereby granted approval for implementation effective this **16th day of October 2009**, for a period of twelve (12) months.

Please note that authorization to conduct this study will automatically expire on **Friday, 15th October 2010**. If you plan to continue with data collection or analysis beyond this date, please submit an application for continuing approval to the ERC Secretariat by **Friday, 3rd September 2010**.

You are required to submit any amendments to this protocol and other information pertinent to human participation in this study to the ERC prior to initiation. You may embark on the study.

Yours sincerely,



**R. C. KITHINJI,
FOR: SECRETARY,
KEMRI/NATIONAL ETHICS REVIEW COMMITTEE**



Université d'Ottawa **University of Ottawa**
Service de subventions de recherche et déontologie Research Grants and Ethics Services

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Nancy	Edwards	Health Sciences / Nursingy	Supervisor
Elizabeth	Gyorfi-Dyke	Health Sciences / Others	Student Researcher

File Number: H05-09-11

Type of Project: Secondary use of data

Title: International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work: A Multi-Level Case Study

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/23/2009	06/22/2010	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A



Université d'Ottawa **University of Ottawa**
Service de subventions de recherche et déontologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.



Germain Zongo
Assistant Director, Ethics (Interim)
For Dr. Daniel Lagarec, Chair of the Health Sciences and Sciences REB



Université d'Ottawa **University of Ottawa**
Service de subventions de recherche et déontologie Research Grants and Ethics Services

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Nancy	Edwards	Health Sciences / Nursingy	Supervisor
Elizabeth	Gyorfi-Dyke	Health Sciences / Others	Student Researcher

File Number: H06-09-04

Type of Project: PhD Thesis

Title: International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work: A Multi-Level Case Study

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/26/2009	06/25/2010	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A



Université d'Ottawa **University of Ottawa**
Service de subventions de recherche et déontologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.



Germain Zongo
Assistant Director, Ethics (Interim)
For Dr. Daniel Lagarec, Chair of the Health Sciences and Sciences REB

2

550, rue Cumberland 550 Cumberland Street
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5841 • Téléc./Fax (613) 562-5338
<http://www.rges.uottawa.ca> <http://www.ssr.uottawa.ca>

5.7 Appendix G: Request for Organizational Permission, and Individual Information and Consent Forms

Request for Organizational Permission for Participation in the Study

[This form was also signed by the Case INGO in the U.S. and Canada].

Dear XXX:

We are writing to request permission from [CASE INGO] in Kenya for staff at your organization to participate in a research study entitled, *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*.

The purpose of this study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

The specific research questions of this study are:

- What is the nature of the “implementation gap” between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice?
- What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work?
- How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?

What will your organization be asked to do?

[CASE INGO] in Kenya will be asked to participate in the following activities:

1. To act as a case study for the research project. The case study would involve participant observation, interviews, and document reviews with [CASE INGO] in Kenya.
2. Facilitate access for Elizabeth Gyorfi-Dyke to observe day-to-day activities in [CASE INGO] in Kenya for a period of 3 months. Elizabeth would observe day-to-day activities at [CASE INGO] in Kenya that relate to equity and HIV/AIDS (e.g. understanding the context of [CASE INGO] in Kenya, how equity is envisioned, and the various influences on work in equity). This would be achieved by Elizabeth volunteering with [CASE INGO] in Kenya half-time. Free and informed consent from [CASE INGO] in Kenya office staff (in Nairobi and regional offices as applicable) would be obtained prior to commencing the participant observation.
3. Facilitate access to staff and volunteers to be interviewed (if they consent) about equity and what might influence the implementation of equity aims in [CASE INGO] in Kenya's HIV/AIDS work. This includes allowing staff to take part in interviews during work hours as part of their workday.
4. Assist with identification of people who work with/are familiar with [CASE INGO] in Kenya who are not employees (e.g. Kenyan government staff, [CASE INGO] Headquarters staff, funders, and staff of other INGOs or Southern NGOs that are partners with [CASE INGO] in Kenya) so that Elizabeth can conduct interviews to understand the

various influences at multiple levels (e.g. government level, funder level) that affect equity implementation in HIV/AIDS work. [CASE INGO] in Kenya would be asked to send letters out on Elizabeth's behalf to potential participants. If they do not respond after 2 weeks, [CASE INGO] in Kenya would be asked to send out another follow-up letter.

5. Assist with identification of, and facilitate access to, relevant key documents, in particular documents that outline how [CASE INGO] in Kenya conceptualizes equity in principle and documents that identify how this plays out in practice including information on influences on implementation of equity aims. This includes assigning a contact person for Elizabeth who would ensure non-public documents do not contain confidential information and that documents are anonymized as needed (e.g. names deleted on electronic copies or blacked out on hard copies). For documents that are not in the public domain, Elizabeth will seek permission from [CASE INGO] in Kenya to a) access the document, b) copy any portions of the document if applicable, and c) cite specific text from the document in Elizabeth's thesis/publications if applicable. For this, Elizabeth will have a release form that [CASE INGO] in Kenya would need to sign indicating that Elizabeth has been given this permission.
6. Assist with identification of clients of your HIV/AIDS programs so that Elizabeth can set up interviews (to be conducted via a trained research assistant that Elizabeth will hire) to understand their experiences with equity in [CASE INGO] in Kenya's HIV/AIDS programming. This would entail having an [CASE INGO] in Kenyan staff person ask clients of [CASE INGO] in Kenya's HIV/AIDS programs if they would be willing/interested in hearing more about the research (using a short script provided by Elizabeth). If the client is willing to hear more, the hired research assistant will then approach them to discuss the research and their potential interest/answer their questions. [CASE INGO] in Kenya agrees that Elizabeth/the research assistant will not disclose to [CASE INGO] in Kenya which clients chose, or did not choose, to take part. [CASE INGO] in Kenya also commits to ensuring that there are no negative consequences for clients that participate in the research, regardless of what clients report.
7. People being interviewed will not be asked to disclose their HIV/AIDS status in this research. However, if HIV status is disclosed or if emotional distress about HIV status of self or a family member is a concern, a referral will be made to an appropriate individual or agency in the community. [CASE INGO] in Kenya will be asked to assist Elizabeth with the development of a list of referrals for services for HIV/AIDS, including information on costs.
8. Assist with identification of one of your Northern "sister" organizations (e.g. [CASE INGO] Canada) that [CASE INGO] in Kenya has some connection to via its HIV/AIDS work. Elizabeth would then approach this organization to conduct interviews and document analysis with them following the Kenyan-based research.

Are there any risks from participating?

Minimum risk is expected for [CASE INGO] in Kenya staff participating in this study. Participants' decisions as to whether or not to participate in the study will not have any positive or negative repercussions for them. Please note that individuals may refuse to answer any of the questions asked during the interviews, can withdraw their quotes and comments, may ask Elizabeth to not take notes and/or leave the room during participant observation, and may choose to withdraw from the study at any time. Participant observation and interviews will be conducted during normal working hours. Care will be taken to

minimize disruption in the workplace. Participants will be informed that [CASE INGO] in Kenya has given permission for staff to participate, but only anonymized findings of the study will be shared with the organization.

While [CASE INGO] in Kenya's name will not be used in the research writeups, the anonymity of [CASE INGO] in Kenya as an organization cannot be guaranteed given the close-knit nature of the NGO community. As a result, there may be a concern that negative findings (e.g. any challenges identified regarding HIV/AIDS work in [CASE INGO] in Kenya) might result in negative repercussions (e.g. from funders). However, the intent of the research is to understand what influences [CASE INGO] in Kenya's implementation of equity in HIV/AIDS work, and [CASE INGO] in Kenya will have access to the final aggregated findings, which can be used to learn from and/or make changes to HIV/AIDS work as part of ongoing learning and improvement.

Are answers from our organization confidential?

The organization cannot be fully anonymous. Responses from individual participants will be kept confidential and will be used only for the purpose of the study. Anonymity of participants will be protected by not recording names with responses or identifying individuals. A unique code number will be assigned to participants for audiotapes and transcripts. Aggregate results will be published so individual identity will not be revealed in any reports or publications. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from other members of the organization or funders. However, as above, precautions will be taken to limit these risks.

What are the benefits from participating in this research?

This research will help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. This research may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs, including [CASE INGO] in Kenya, to better achieve their equity aims.

Compensation: There will be no monetary compensation for participation in the study. Costs associated with the research will be paid for by Elizabeth.

Voluntary Participation: Staff will be under no obligation to participate. If they choose to participate, they may withdraw from the study at any time and /or refuse to answer any questions.

Permission: We require a letter of permission from your organization to participate in this study.

If you have any questions or concerns, you can contact:

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health,
University of Ottawa

Telephone: Kenya: XXXXXXXX
Canada: +1-XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of
Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community
Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXX@XXXXX or XXXX@XXXXX

This study has received ethics approval from the University of Ottawa Research Ethics
Board and KEMRI.

If you have any questions or concerns regarding the ethical conduct of this study, you may
contact:

Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland
Street, Room 159, Ottawa, ON K1N 6N5

Tel.: +1-(613) 562-5841

Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-
00200, Nairobi, Kenya

Tel: (020) 2722541

Email: info@kemri.org



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Diplôme en recherche sur
les services et les politiques
en matière de santé
Certificat en évaluation et
gestion du risque en santé
des populations

University of Ottawa
Faculty of Graduate and
Postdoctoral Studies

PhD in Population Health
Diploma in Health Services
and Policy Research
Certificate in Population
Health Risk Assessment
and Management

1 rue Stewart, pièce 300
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Tel.: 613.562.5691
Fax: 613.562.5659
E-mail: pop@uOttawa.ca

www.uOttawa.ca

Organizational Permission for Participation in the Study [[CASE INGO] in Kenya]

[CASE INGO] in Kenya agrees to participate in the project *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*. This research is being conducted by Elizabeth Gyorfi-Dyke (PhD Candidate, University of Ottawa), under the supervision of Professors Nancy Edwards (University of Ottawa), Ian McDowell (University of Ottawa) and Richard Muga (Great Lakes University of Kisumu).

The purpose of this study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work.

Your participation will consist of the following:

- 1) To act as a case study for the research project. The case study would involve participant observation, interviews, and document reviews with [CASE INGO] in Kenya.
- 2) Facilitate access for Elizabeth Gyorfi-Dyke to observe day-to-day activities in [CASE INGO] in Kenya for a period of 3 months. Elizabeth would observe day-to-day activities at [CASE INGO] in Kenya that relate to equity and HIV/AIDS (e.g. understanding the context of [CASE INGO] in Kenya, how equity is envisioned, and the various influences on work in equity). This would be achieved by Elizabeth volunteering with [CASE INGO] in Kenya half-time. Free and informed consent from [CASE INGO] in Kenya office staff (in Nairobi and regional offices as applicable) would be obtained prior to commencing the participant observation.
- 3) Facilitate access to staff and volunteers to be interviewed (if they consent) about equity and what might influence the implementation of equity aims in [CASE INGO] in Kenya's HIV/AIDS work. This includes allowing staff to take part in interviews during work hours as part of their workday.
- 4) Assist with identification of people who work with/are familiar with [CASE INGO] in Kenya who are not employees (e.g. Kenyan government staff, [CASE INGO] Headquarters staff, funders, and staff of other INGOs or Southern NGOs that are partners with [CASE INGO] in Kenya) so that Elizabeth can conduct interviews to understand the various influences at multiple levels (e.g. government level, funder level) that affect equity implementation in HIV/AIDS work. [CASE INGO] in Kenya would be asked to send letters out on Elizabeth's behalf to potential participants. If they do not

respond after 2 weeks, [CASE INGO] in Kenya would be asked to send out another follow-up letter.

- 5) Assist with identification of, and facilitate access to, relevant key documents, in particular documents that outline how [CASE INGO] in Kenya conceptualizes equity in principle and documents that identify how this plays out in practice including information on influences on implementation of equity aims. This includes assigning a contact person for Elizabeth who would ensure non-public documents do not contain confidential information and that documents are anonymized as needed (e.g. names deleted on electronic copies or blacked out on hard copies). For documents that are not in the public domain, Elizabeth will seek permission from [CASE INGO] in Kenya to a) access the document, b) copy any portions of the document if applicable, and c) cite specific text from the document in Elizabeth's thesis/publications if applicable. For this, Elizabeth will have a release form that [CASE INGO] in Kenya would need to sign indicating that Elizabeth has been given this permission.
- 6) Assist with identification of clients of your HIV/AIDS programs so that Elizabeth can set up interviews (to be conducted via a trained research assistant that Elizabeth will hire) to understand their experiences with equity in [CASE INGO] in Kenya's HIV/AIDS programming. This would entail having an [CASE INGO] in Kenyan staff person ask clients of [CASE INGO] in Kenya's HIV/AIDS programs if they would be willing/interested in hearing more about the research (using a short script provided by Elizabeth). If the client is willing to hear more, the hired research assistant will then approach them to discuss the research and their potential interest/answer their questions. [CASE INGO] in Kenya agrees that Elizabeth/the research assistant will not disclose to [CASE INGO] in Kenya which clients chose, or did not choose, to take part. [CASE INGO] in Kenya also commits to ensuring that there are no negative consequences for clients that participate in the research, regardless of what clients report.
- 7) People being interviewed will not be asked to disclose their HIV/AIDS status in this research. However, if HIV status is disclosed or if emotional distress about HIV status of self or a family member is a concern, a referral will be made to an appropriate individual or agency in the community. [CASE INGO] in Kenya will be asked to assist Elizabeth with the development of a list of referrals for services for HIV/AIDS, including information on costs.
- 8) Assist with identification of one of your Northern "sister" organizations (e.g. [CASE INGO] Canada) that [CASE INGO] in Kenya has some connection to via its HIV/AIDS work. Elizabeth would then approach this organization to conduct interviews and document analysis with them following the Kenyan-based research.

**Signature of Senior
Administrator:**

**Name of Senior
Administrator:**

Organizational Name:

Contact Details:

Date:



uOttawa

L'Université canadienne
Canada's university

Université d'Ottawa
Faculté des études
supérieures et
postdoctorales

Doctorat en santé des
populations
Diplôme en recherche sur
les services et les politiques
en matière de santé
Certificat en évaluation et
gestion du risque en santé
des populations

University of Ottawa
Faculty of Graduate and
Postdoctoral Studies

PhD in Population Health
Diploma in Health Services
and Policy Research
Certificate in Population
Health Risk Assessment
and Management

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Tel.: 613.562.5691
Fax: 613.562.5659
E-mail: pop@uOttawa.ca

www.uOttawa.ca

Information Form - People Working at [CASE INGO] in Kenya (Interviews)

Title of the study: *International Non-Governmental
Organizations' Implementation of Equity Principles in
HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of
Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXX

Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of
Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of
Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great
Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXXX@XXXXXX or XXXX@XXXXXX

Invitation to Participate: You are invited to participate in the
abovementioned research study conducted by Elizabeth Gyorfi-
Dyke, under the supervision of Professors Nancy Edwards, Ian
McDowell and Richard Muga. Funding assistance has been
provided by the Social Sciences and Humanities Research
Council and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand
what influences international non-governmental organizations'
(INGOs) implementation of equity principles in their HIV/AIDS
work. The research looks at how [CASE INGO] in Kenya deals
with equity issues, such as addressing poverty and gender, when
doing work in HIV/AIDS, and what factors influence this work.

Participation: You are being asked to participate in an interview
lasting approximately 1 hour in which you will be asked

questions about how [CASE INGO] in Kenya approaches equity in HIV/AIDS programming and some specific questions on particular factors that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims. You will be asked to complete a short form prior to the interview that will ask some basic questions such as your title and how long you have been at the organization. You may also be asked to complete another short form that asks specific questions about how [CASE INGO] in Kenya focuses on equity in its HIV/AIDS work. [CASE INGO] in Kenya has agreed as an organization to participate in this study, and is aware that interviews will be conducted during normal working hours.

Risks: Your participation in this study will entail that you describe your thoughts about equity in HIV/AIDS in [CASE INGO] in Kenya. Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. You have been advised to say only what you are comfortable saying, and you know that you may withdraw from the study at any time. You will not be asked about whether or not you are HIV positive. If you disclose your HIV status or are concerned about your HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the interview will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. However, as above, precautions will be taken to limit these risks. Following the interview, you will have the opportunity to review your transcript.

Conservation of data: The data collected, including audio recordings of the interview, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once the interview is complete and has been transcribed, verified by Elizabeth and checked by you, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data from the interview will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

If you have any questions about the study, you may contact the researcher or her thesis supervisors.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

Tel.: +1-(613) 562-5841

Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-00200, Nairobi, Kenya

Tel: (020) 2722541

Email: info@kemri.org



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Consent Form - People Working at [CASE INGO] in Kenya (Interviews)

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXX
Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXXX@XXXXXX or XXXX@XXXXXX

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Elizabeth Gyorfi-Dyke, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Sciences and Humanities Research Council and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

Participation: You are being asked to participate in an interview lasting approximately 1 hour in which you will be asked questions about how [CASE INGO] in Kenya approaches equity

in HIV/AIDS programming and some specific questions on particular factors that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims. You will be asked to complete a short form prior to the interview that will ask some basic questions such as your title and how long you have been at the organization. You may also be asked to complete another short form that asks specific questions about how [CASE INGO] in Kenya focuses on equity in its HIV/AIDS work. [CASE INGO] in Kenya has agreed as an organization to participate in this study, and is aware that interviews will be conducted during normal working hours.

Risks: Your participation in this study will entail that you describe your thoughts about equity in HIV/AIDS in [CASE INGO] in Kenya. Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. You have been advised to say only what you are comfortable saying, and you know that you may withdraw from the study at any time. You will not be asked about whether or not you are HIV positive. If you disclose your HIV status or are concerned about your HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the interview will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. However, as above, precautions will be taken to limit these risks. Following the interview, you will have the opportunity to review your transcript.

Conservation of data: The data collected, including audio recordings of the interview, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once the interview is complete and has been transcribed, verified by Elizabeth and checked by you, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data from the interview will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

If you have any questions about the study, you may contact the researcher or her thesis supervisors.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

Tel.: +1-(613) 562-5841

Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-00200, Nairobi, Kenya

Tel: (020) 2722541

Email: info@kemri.org

Acceptance: You, _____, agree to participate in the above research study conducted by Elizabeth Gyorfi-Dyke of the Institute of Population Health, University of Ottawa, whose research is under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga.

- a) You agree to allow your interview to be audio-taped: ___Yes ___No
If you do not agree to allow your interview to be audio-taped, you agree to allow the interviewer to take notes: _____ Yes _____ No

- b) You agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal your identity. _____
You do not wish to be quoted at all. _____
- c) You would like to review your transcript once it is complete. It will be sent to your email at the following email address _____. You understand that the transcript will be password protected and the password will be sent in a separate email. You will have two weeks to review the transcript and provide any comments by email.

You would like to review your transcript once it is complete. However, you do not wish this to be sent by email. Instead, you prefer that it is sent:

(please indicate the means and other relevant information such as address). You will have two weeks to review the transcript and provide any comments to Elizabeth. _____

- d) If you choose to withdraw, you agree that all data gathered from you may continue to be used in the study. _____
If you choose to withdraw, you request that all data gathered from you be given to you for you to dispose of. _____
If you choose to withdraw, you request that all data gathered from you be shredded/deleted. _____

There are two copies of the consent form, one of which is yours to keep.

Participant's signature: _____ Date: _____

Communiqué Provided by Senior Contact at Case INGO via email to Managers

Communiqué

By way of this email, I would like to introduce you to Elizabeth Gyorfi-Dyke, who is a PhD Candidate (in population health) from the University of Ottawa in Canada. She has been at CASE INGO in Kenya for 2 weeks, and she will be here until May 21st, 2010.

While Elizabeth is here, she is working on a few projects for CASE INGO in Kenya. She is also doing data collection here at CASE INGO in Kenya for her PhD. CASE INGO in Kenya has agreed to take part in this research, and her research project has passed the necessary ethics boards in Canada and Kenya. One of Elizabeth's PhD committee members is Professor Richard Muga from Great Lakes University in Kisumu.

Over the next short while, Elizabeth may be speaking to you and your staff about participating in her research project. Individuals can decide if they are willing to take part in the research, and will be asked to read and sign consent forms if they agree.

More details about the research are below:

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how CASE INGO in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

Data collection: Elizabeth will be conducting interviews, looking at various documents, and collecting data via participant observation for her research.

Benefits of the Research: It is hoped that the research will help investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Elizabeth's contact information is:

Kenya mobile: XXXXXXXX

Email: XXXXXX@XXXXX

She is located across the hall from Dr. XXX's office.



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Request for Organizational Permission [People Working Outside [CASE INGO] in Kenya (Other NGOs, Government etc.)] to have Staff Participate in the Study

Dear (name of senior administrator):

We are writing to request permission from _____ (name of organization) for staff in your organization to participate in a research study entitled, *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*.

The purpose of this study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

The specific research questions of this study are:

- What is the nature of the "implementation gap" between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice?
- What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work?
- How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?

What will staff at your organization be asked to do?

If your organization agrees to participate in the study, staff would be asked, if they consent, to take part in a one hour interview during their workday. The interview would focus on questions about your organization's work with [CASE INGO] in Kenya in HIV/AIDS and particular factors, such as external factors, that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims, based on their experience.

Are there any risks from participating?

Minimum risk is expected for staff participating in this study. Participants' decisions as to whether or not to participate in the study will not have any positive or negative repercussions

for them. Please note that individuals may refuse to answer any of the questions asked during the interviews, can withdraw their quotes and comments, and may choose to withdraw from the study at any time. Interviews will be conducted during normal working hours. Participants will be informed that your organization has given permission for staff to participate.

Are answers from our organization confidential?

Your organization's name will not be identified in the research write-ups. While your organization will not be identified by name in the research write-up, the relationship of your organization to [CASE INGO] in Kenya will be stated (e.g. funder, partner), and given the close-knit nature of the community, this may increase the risk of anonymity failure for the organization. The risk of organizational anonymity failure may include a concern that comments will result in a negative reaction from other organizations, such as from the NGO community.

Responses from individual participants will be kept confidential and will be used only for the purpose of the study. Your organization will not be told which participants chose to take part in the study. Anonymity of participants will be protected by not recording names with responses or identifying individuals. A unique code number will be assigned to participants for audiotapes and transcripts. Aggregate results will be published so individual identity will not be revealed in any reports or publications. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from the NGO community. However, as above, precautions will be taken to limit these risks.

What are the benefits from participating in this research?

This research will help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. This research may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs and their partners to better achieve their equity aims. Your organization will receive an executive summary of the research results.

Compensation: There will be no monetary compensation for participation in the study.

Voluntary Participation: Staff will be under no obligation to participate. If they choose to participate, they may withdraw from the study at any time and /or refuse to answer any questions.

Permission: We require a letter of permission from your organization to participate in this study.

If you have any questions or concerns, you can contact:

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health,
University of Ottawa

Telephone: Kenya: XXXXXXXXX
Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of
Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community
Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: +011-XXX-XXXXXXXXXX

Email: XXXXXX@XXXXXX or XXXX@XXXXXX

This study has received ethics approval from the University of Ottawa Research Ethics
Board and KEMRI.

If you have any questions or concerns regarding the ethical conduct of this study, you may
contact:

Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland
Street, Room 159, Ottawa, ON K1N 6N5

Tel.: +1-(613) 562-5841

Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-
00200, Nairobi, Kenya

Tel: (020) 2722541

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Fax: 613.562.5659
E-mail: pop@uOttawa.ca

www.uOttawa.ca

Organizational Permission [People Working Outside [CASE INGO] in Kenya (Other NGOs, Government etc.)] to have Staff Participate in the Study

Our organization agrees to participate in the project *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*. This research is being conducted by Elizabeth Gyorfi-Dyke (PhD Candidate, University of Ottawa), under the supervision of Professors Nancy Edwards (University of Ottawa), Ian McDowell (University of Ottawa) and Richard Muga (Great Lakes University of Kisumu).

The purpose of this study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work.

As outlined above, staff will be asked to take part in a one hour interview, if they consent, during their workday. The interview would focus on questions about your organization's work with [CASE INGO] in Kenya in HIV/AIDS and particular factors, such as external factors, that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims, based on their experience.

**Signature of Senior
Administrator:**

**Name of Senior
Administrator:**

Organizational Name:

Contact Details:

Date:

Key Informant Recruitment for those outside [CASE INGO] in Kenya (Other NGOs, government etc.): Telephone script for individuals whose names/contact details are in public domain

May I please speak to _____?

Hello, my name is Elizabeth Gyorfi-Dyke. I am a PhD Candidate at the University of Ottawa in Canada, conducting my research in Kenya with [CASE INGO] in Kenya. This purpose of the research study “International Non-Governmental Organizations’ Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study” is to understand what influences international non-governmental organizations’ (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work, including external influences from other sources such as government and other NGOs.

Do you have a few minutes to talk?

IF NO (no time to talk now):

Is there a better time I might be able to call you back? (When: _____)

Or can I send you some information by mail/email/fax?

IF YES, collect the following information:

Would you prefer to receive the information by mail/email/fax?

Circle one: Mail Email Fax

Telephone: _____

Address: _____

Email: _____

Fax: _____

IF YES can talk now, continue: Your name was available from the publicly available list _____ (source indicated here). We would like to interview you to learn about your perspectives about what influences NGOs implementation of equity principles in their HIV/AIDS work.

The interview will take approximately one hour and would be done at a place and time that is convenient for you. With your permission, the interviews would be audiorecorded, or else the interviewer would take notes.

Would you be interested in participating?

IF YES, interested in participating:

I would like to share the information sheet and consent form with you prior to this interview date.

Would you prefer to receive it by mail, email, or fax?

Circle one: Mail Email Fax

Telephone: _____

Address: _____

Email: _____

Fax: _____

After you have had a chance to read the information and consent form I will call you back or email you to set up a date and time that we could schedule the interview. Would this be all right?

We really appreciate your interest in our study. I will send you the information today. Thank you very much for your time.

IF NO, do not want more information/are not interested: Thank you very much for your time.



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Information Form for Interviews - People Working Outside [CASE INGO] in Kenya (Other NGOs, Government etc.)

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXXX

Canada: +XXX-XXX-XXXX

Email: XXXXXXX@XXXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXXX@XXXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXXX@XXXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXXXX@XXXXXX or XXXX@XXXXXX

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Elizabeth Gyorfi-Dyke, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work, including external influences from other sources such as government and other NGOs.

Participation: You are being asked to participate in an interview lasting approximately 1 hour in which you will be asked questions about your organization's work with [CASE INGO] in Kenya in HIV/AIDS and particular factors, such as external factors, that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims. You will be asked to complete a short form prior to the interview that will ask some basic questions such as your title and how long you have been at your organization.

Risks: Your participation in this study will entail that you describe your thoughts about what factors, including the role of your organization, might influence an organization such as [CASE INGO] in Kenya to achieve its equity aims in HIV/AIDS. Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. You have been advised to say only what you are comfortable saying, and you know that you may withdraw from the study at any time. You will not be asked about whether or not you are HIV positive. If you disclose your HIV status or are concerned about your HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the interview will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. Although your name was provided to the researchers by [CASE INGO] in Kenya, the researchers will not reveal to [CASE INGO] in Kenya whether you participated in this study. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. While your organization will not be identified by name in the research write-up, the relationship of your organization to [CASE INGO] in

Kenya will be stated (e.g. funder, partner), and again given the close-knit nature of the community, this may increase the risk of anonymity failure. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from members of the NGO community. However, as above, precautions will be taken to limit these risks. You will have the opportunity to review your interview transcript.

Conservation of data: The data collected, including audio recordings of the interview, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once the interview is complete and has been transcribed, verified by Elizabeth and checked by you, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data from the interview will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

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Certificate in Population
Health Risk Assessment
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Consent Form for Interviews - People Working Outside [CASE INGO] in Kenya (Other NGOs, Donors, Government etc.)

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXX
Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXXX@XXXXXX or XXXX@XXXXXX

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Elizabeth Gyorfi-Dyke, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work,

including external influences from other sources such as government and other NGOs.

Participation: You are being asked to participate in an interview lasting approximately 1 hour in which you will be asked questions about your organization's work with [CASE INGO] in Kenya in HIV/AIDS and particular factors, such as external factors, that may or may not influence [CASE INGO] in Kenya's ability to achieve its equity aims. You will be asked to complete a short form prior to the interview that will ask some basic questions such as your title and how long you have been at your organization.

Risks: Your participation in this study will entail that you describe your thoughts about what factors, including the role of your organization, might influence an organization such as [CASE INGO] in Kenya to achieve its equity aims in HIV/AIDS. Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. You have been advised to say only what you are comfortable saying, and you know that you may withdraw from the study at any time. You will not be asked about whether or not you are HIV positive. If you disclose your HIV status or are concerned about your HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the interview will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. Although your name was provided to the researchers by [CASE INGO] in Kenya, the researchers will not reveal to [CASE INGO] in Kenya whether you participated in this study. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as an organization cannot be fully anonymous, increasing the likelihood

that participant anonymity may also be at risk. While your organization will not be identified by name in the research write-up, the relationship of your organization to [CASE INGO] in Kenya will be stated (e.g. funder, partner), and again given the close-knit nature of the community, this may increase the risk of anonymity failure. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from members of the NGO community. However, as above, precautions will be taken to limit these risks. You will have the opportunity to review your interview transcript.

Conservation of data: The data collected, including audio recordings of the interview, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once the interview is complete and has been transcribed, verified by Elizabeth and checked by you, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data from the interview will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

If you have any questions about the study, you may contact the researcher or her thesis supervisors.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

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Tel: (020) 2722541

Email: info@kemri.org

Acceptance: You, _____, agree to participate in the above research study conducted by Elizabeth Gyorf-Dyke of the Institute of Population Health, University

of Ottawa, whose research is under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga.

- a) You agree to allow your interview to be audio-taped: ___Yes ___No
If you do not agree to allow your interview to be audio-taped, you agree to allow the interviewer to take notes: _____ Yes _____ No
- b) You agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal your identity. _____
You do not wish to be quoted at all. _____
- c) You would like to review your transcript once it is complete. It will be sent to your email at the following email address _____. You understand that the transcript will be password protected and the password will be sent in a separate email. You will have two weeks to review the transcript and provide any comments by email.

You would like to review your transcript once it is complete. However, you do not wish this to be sent by email. Instead, you prefer that it is sent:

(please indicate the means and other relevant information such as address). You will have two weeks to review the transcript and provide any comments to Elizabeth. _____

- d) If you choose to withdraw, you agree that all data gathered from you may continue to be used in the study. _____
If you choose to withdraw, you request that all data gathered from you be given to you for you to dispose of. _____
If you choose to withdraw, you request that all data gathered from you be shredded/deleted. _____

There are two copies of the consent form, one of which is yours to keep.

Participant's signature: _____ Date: _____

Script for Potential Participants for Key Informant Interviews (Clients)

[Clients will be approached in person by an [CASE INGO] staff person. This [CASE INGO] staff person will read this prepared script to see if the client has any interest in speaking to the research assistant in more detail about the research.]

Script:

Researchers from the University of Ottawa in Canada are conducting a study with [CASE INGO] in Kenya on their HIV/AIDS programs. They are looking for clients who might be willing to take part in the research. They are asking you if you would be willing to take part in an interview that would last about one hour. Your participation is entirely voluntary. If you wish to learn more about the research, please speak to the research assistant (*points to the research assistant*).



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Information Form for Interviews with Clients

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXXX

Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Research Assistant: Laura Muthoni

Telephone Kenya: XXXXXXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: drmuga@yahoo.com or r.muga@gluk.ac.ke

Invitation to take part in the research study: You are invited to participate in the above research study that Elizabeth Gyorfi-Dyke is conducting, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Why is this research study being done? Many organizations in Kenya are working on programs for HIV/AIDS. Many of these organizations also work on reaching people who are at risk, such as people who are living in poverty and girls/women. [CASE INGO] in Kenya is one of these organizations. The reason for this study is to try to understand what things make it easier or

harder for [CASE INGO] in Kenya to work on issues such as poverty and gender when doing work in HIV/AIDS.

What do I need to do? You are being asked to participate in an interview lasting about 1 hour. The interview can take place at a time and place easiest for you. If you need to travel to take part in the interview, your travel costs will be paid. You will be asked questions about your experiences with [CASE INGO] in Kenya's HIV/AIDS programs, including what you like about them and what would make them better.

What are the risks and possible discomforts from being in this research study? You will be asked about your thoughts about [CASE INGO] in Kenya's HIV/AIDS programs. There are a few possible risks that you face for agreeing to take part in this research. You may feel that it is hard to talk about some of the things we talk about, since you are a client of [CASE INGO] in Kenya. You may be worried that by talking about this that you may lose access to the programs at [CASE INGO] in Kenya. The research is looking at what you like about the programs and also what you think could be better. Only say what you are comfortable saying, and you may withdraw from the study at any time.

You will not be asked about whether or not you are HIV positive. If you disclose your HIV status or are concerned about your HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community.

It is up to you to decide if you want to take part in the study. Whether or not you decide to take part will have no affect on the programs or services you get from [CASE INGO] in Kenya.

What are the possible benefits from being in this research study? Your participation in this study will not have a direct benefit to you; however, it will give you the chance to help researchers and organizations understand how to better reach people who are at risk for HIV/AIDS, such as people living in poverty or girls/women.

If you take part in this research study, how will your privacy be protected? All information you provide during the interview will be kept confidential. The information from the interview will be used only for the purpose of the study. The content of the interview will only be discussed with people on the research team. Your name will not be recorded with your responses. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Only grouped results will be used in publications (books, articles, the thesis) so your identity will be kept private. Publications from the research will use fake names (pseudonyms) and will not include unnecessary details that may lead people to uncover your identity. The publications will include quotes, but any identifying information that is not important to the research will be taken out or changed so the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. Although your name was provided to the researchers by [CASE INGO] in Kenya, the researchers will not reveal to [CASE INGO] in Kenya whether you participated in this study. However, while

all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final publications. This risk is increased since the organization's name ([CASE INGO]) cannot be fully anonymous, increasing the likelihood that people may be able to identify individuals in the final publications. This risk may include a concern that comments will result in a negative reaction from others, such as from members of the organization. However, as above, the researchers will take care to limit these risks.

What will be done with the data? The interview will be translated into English for the researcher. The information collected, including audio recordings of the interview, the translation, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be stored in a secure location (locked cabinet) in Kenya. Electronic materials will be stored on Elizabeth's laptop that can only be accessed by a password known only to Elizabeth. Once the interview is complete and has been transcribed, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators, the translator, and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Do you have to participate? What should you do if you want to stop taking part in the study? It is up to you to decide if you want to take part in the study. Whether or not you decide to take part will have no affect on the programs or services you get from [CASE INGO] in Kenya.

If you choose to take part, you can drop out from the study at any time and/or refuse to answer any questions, and this will have no affect on the programs or services you get from [CASE INGO] in Kenya. If you choose to drop out, you may agree that all information you have given until that point may continue to be used in the study. Or you may decide to take all information relating to you, in which case all information from the interview will be given to you for you to dispose of (or, if you prefer, the information can be destroyed for you, that is shredded/deleted). If you drop out, you will still be paid for any travel costs for the research.

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Consent Form for Interviews with Clients

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Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXXX

Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXXX

Research Assistant: Laura Muthoni

Telephone Kenya: XXXXXXXXX

Thesis Supervisors:

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Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: drmuga@yahoo.com or r.muga@gluk.ac.ke

Invitation to take part in the research study: You are invited to participate in the above research study that Elizabeth Gyorfi-Dyke is conducting, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Why is this research study being done? Many organizations in Kenya are working on programs for HIV/AIDS. Many of these organizations also work on reaching people who are at risk, such as people who are living in poverty and girls/women. [CASE INGO] in Kenya is one of these organizations. The reason for this study is to try to understand what things make it easier or

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What do I need to do? You are being asked to participate in an interview lasting about 1 hour. The interview can take place at a time and place easiest for you. If you need to travel to take part in the interview, your travel costs will be paid. You will be asked questions about your experiences with [CASE INGO] in Kenya's HIV/AIDS programs, including what you like about them and what would make them better.

What are the risks and possible discomforts from being in this research study? You will be asked about your thoughts about [CASE INGO] in Kenya's HIV/AIDS programs. There are a few possible risks that you face for agreeing to take part in this research. You may feel that it is hard to talk about some of the things we talk about, since you are a client of [CASE INGO] in Kenya. You may be worried that by talking about this that you may lose access to the programs at [CASE INGO] in Kenya. The research is looking at what you like about the programs and also what you think could be better. Only say what you are comfortable saying, and you may withdraw from the study at any time.

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If you take part in this research study, how will your privacy be protected? All information you provide during the interview will be kept confidential. The information from the interview will be used only for the purpose of the study. The content of the interview will only be discussed with people on the research team. Your name will not be recorded with your responses. A unique code number will be assigned to you to identify your audiotaped interview and interview transcript. Only grouped results will be used in publications (books, articles, the thesis) so your identity will be kept private. Publications from the research will use fake names (pseudonyms) and will not include unnecessary details that may lead people to uncover your identity. The publications will include quotes, but any identifying information that is not important to the research will be taken out or changed so the quote could not be used to identify you. You understand that at the end of the interview, you will be asked if there are any portions of what you have said that you do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. Although your name was provided to the researchers by [CASE INGO] in Kenya, the researchers will not reveal to [CASE INGO] in Kenya whether you participated in this study. However, while

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What will be done with the data? The interview will be translated into English for the researcher. The information collected, including audio recordings of the interview, the translation, transcripts of the interview, hand-written and electronic notes taken during the interview, and completed forms will be stored in a secure location (locked cabinet) in Kenya. Electronic materials will be stored on Elizabeth's laptop that can only be accessed by a password known only to Elizabeth. Once the interview is complete and has been transcribed, the digital recording will be erased. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. transcripts) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators, the translator, and the audiotape transcriber will have access to the data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Do you have to participate? What should you do if you want to stop taking part in the study? It is up to you to decide if you want to take part in the study. Whether or not you decide to take part will have no affect on the programs or services you get from [CASE INGO] in Kenya.

If you choose to take part, you can drop out from the study at any time and/or refuse to answer any questions, and this will have no affect on the programs or services you get from [CASE INGO] in Kenya. If you choose to drop out, you may agree that all information you have given until that point may continue to be used in the study. Or you may decide to take all information relating to you, in which case all information from the interview will be given to you for you to dispose of (or, if you prefer, the information can be destroyed for you, that is shredded/deleted). If you drop out, you will still be paid for any travel costs for the research.

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Acceptance: You, _____, agree to take part in the above research study conducted by Elizabeth Gyorfi-Dyke of the Institute of Population Health, University of Ottawa, whose research is under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga.

- a) You agree to allow your interview to be audio-taped: ____Yes ____No
If you do not agree to allow your interviews to be audio-taped, you agree to allow the interviewer to take notes: ____ Yes ____ No
- b) You agree to be quoted but all information that might identify you won't be included or will be changed so that the quote won't identify you. _____
You do not wish to be quoted at all. _____
- c) If you choose to drop out, you agree that all information gathered from you may continue to be used in the study. _____
If you choose to withdraw, you request that all information gathered from you be given to you for you to dispose of. _____
If you choose to drop out, you request that all information gathered from you be destroyed (shredded/deleted). _____

There are two copies of the consent form, one of which is yours to keep.

Participant's signature: _____ Date: _____

Université d'Ottawa
Faculté des études
supérieures et
postdoctorales

Doctorat en santé des
populations
Diplôme en recherche sur
les services et les politiques
en matière de santé
Certificat en évaluation et
gestion du risque en santé
des populations

University of Ottawa
Faculty of Graduate and
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and Policy Research
Certificate in Population
Health Risk Assessment
and Management

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Information Form - Participant Observation

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorf-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa

Telephone: Kenya: XXXXXXXXX

Canada: +XXX-XXX-XXXX

Email: XXXXXXX@XXXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXXX@XXXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine

Telephone: +XXX-XXX-XXXX ext. XXXX

Email: XXXXXXX@XXXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu

Telephone: XXX-XXXXXXXXXX

Email: XXXXXXX@XXXXXXX or XXXXXX@XXXXXX

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Elizabeth Gyorf-Dyke, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

Participation: Elizabeth Gyorf-Dyke will be volunteering with [CASE INGO] in Kenya for a period of approximately three months. During this time, she will be a participant observer –

that is, she will participate in the day-to-day activities of [CASE INGO] in Kenya while observing the day-to-day work. This will entail taking notes on what she observes. Over this three month period, you may be observed during your daily work interactions, as Elizabeth seeks to understand how [CASE INGO] in Kenya deals with issues of equity in HIV/AIDS, and what factors influence this work. Elizabeth will observe a number of staff members working at [CASE INGO] in Kenya. A period of observation will last about four hours. [CASE INGO] in Kenya has agreed as an organization to participate in this research, and is aware that these observations will be conducted during normal working hours.

Risks: Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. If you agree to participate, the observations could make you feel self-conscious. You may ask Elizabeth to leave the area at any time for any reason or ask that something not be recorded. Issues that are outside the scope of the research (e.g. personal employment issues) will not be recorded, nor included in the research. You understand that although other participants who are taking part in the participant observation will be asked to respect the anonymity about who participated and confidentiality about what was said, this cannot be guaranteed.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You understand that while the researchers will protect your confidentiality and anonymity in how they use your responses, the nature of participant observation means that other participants may be present during the participant observation, and may feel they know who has participated in the research. You understand that you are asked to maintain confidentiality of what is said by others during the participant observation and anonymity about who participated. You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the participant observation will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be used to identify you in field notes taken during the participant observation. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as

an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from other members of the organization or funders. However, as above, precautions will be taken to limit these risks.

Conservation of data: The data collected, including hand-written and electronic notes taken during observation, will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. field notes) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators will have access to the anonymized data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

If you have any questions about the study, you may contact the researcher or her thesis supervisors.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

Tel.: +1-(613) 562-5841

Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-00200, Nairobi, Kenya

Tel: (020) 2722541

Email: info@kemri.org

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Consent Form - Participant Observation

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Researcher: Elizabeth Gyorfi-Dyke, PhD Candidate, Institute of Population Health, University of Ottawa
Telephone: Kenya: XXXXXXXX
Canada: +XXX-XXX-XXXX

Email: XXXXXX@XXXX

Thesis Supervisors:

Professor Nancy Edwards, Faculty of Health Sciences, School of Nursing, University of Ottawa
Telephone: +XXX-XXX-XXXX ext. XXXX
Email: XXXXXX@XXXX

Professor Ian McDowell, Faculty of Medicine, Department of Epidemiology and Community Medicine
Telephone: +XXX-XXX-XXXX ext. XXXX
Email: XXXXXX@XXXX

Professor Richard Otieno Muga, Deputy Vice-Chancellor, Great Lakes University of Kisumu
Telephone: XXX-XXXXXXXXXX
Email: XXXXX@XXXXX or XXXX@XXXXX

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Elizabeth Gyorfi-Dyke, under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga. Funding assistance has been provided by the Social Science and Humanities Research Foundation and the International Development Research Centre.

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how [CASE INGO] in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

Participation: Elizabeth Gyorfi-Dyke will be volunteering with [CASE INGO] in Kenya for a period of approximately three months. During this time, she will be a participant observer – that is, she will participate in the day-to-day activities of [CASE

INGO] in Kenya while observing the day-to-day work. This will entail taking notes on what she observes. Over this three month period, you may be observed during your daily work interactions, as Elizabeth seeks to understand how [CASE INGO] in Kenya deals with issues of equity in HIV/AIDS, and what factors influence this work. Elizabeth will observe a number of staff members working at [CASE INGO] in Kenya. A period of observation will last about four hours. [CASE INGO] in Kenya has agreed as an organization to participate in this research, and is aware that these observations will be conducted during normal working hours.

Risks: Minimum risk is expected from your participation in this study. Your decision as to whether or not to participate the study will not have any positive or negative repercussions for you. If you agree to participate, the observations could make you feel self-conscious. You may ask Elizabeth to leave the area at any time for any reason or ask that something not be recorded. Issues that are outside the scope of the research (e.g. personal employment issues) will not be recorded, nor included in the research. You understand that although other participants who are taking part in the participant observation will be asked to respect the anonymity about who participated and confidentiality about what was said, this cannot be guaranteed.

Benefits: Your participation in this study will not have a direct benefit to you; however, it will give you an opportunity to help researchers understand the issue of equity in HIV/AIDS in international non-governmental organizations. The information that you share may help the investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Confidentiality and anonymity: You understand that while the researchers will protect your confidentiality and anonymity in how they use your responses, the nature of participant observation means that other participants may be present during the participant observation, and may feel they know who has participated in the research. You understand that you are asked to maintain confidentiality of what is said by others during the participant observation and anonymity about who participated. You have received assurance from the researchers that any information you share will remain strictly confidential. You understand that the data will be used only for the purpose of the study and that your confidentiality will be protected. The content of the participant observation will only be discussed within the research team. Anonymity will be protected by not recording your name with your responses or identifying you in any way. A unique code number will be used to identify you in field notes taken during the participant observation. Aggregate results will be published so your identity will not be revealed in the dissertation or other publications. The dissertation and publications developed from the research will use pseudonyms and will not include unnecessary details that may lead people to uncover your identity. The research write-up (in the dissertation and articles) will include quotations, but any identifying information that is not integral to the research will be removed or changed so that the quote could not be used to identify you. However, while all precautions will be taken, there is still a chance, given the close-knit nature of the organization, that people may be able to identify individuals in the final dissertation or publications. This risk is also increased due to the fact that [CASE INGO] as

an organization cannot be fully anonymous, increasing the likelihood that participant anonymity may also be at risk. The risk of anonymity failure may include a concern that comments will result in a negative reaction from others, such as from other members of the organization or funders. However, as above, precautions will be taken to limit these risks.

Conservation of data: The data collected, including hand-written and electronic notes taken during observation, will be kept in a secure manner. During the field work in Kenya, the data will be stored in a secure location (locked cabinet). Electronic materials will be stored on Elizabeth's laptop with password protection. Once Elizabeth returns to Canada, the data will be stored in a secure location (locked cabinet). Upon completion of the data analysis, all raw and analyzed data will be stored at the office of Nancy Edwards for 5 years following publication of the thesis. At the end of five years, all confidential paper documents (e.g. field notes) will be shredded and all computer data files containing confidential information will be deleted. During this time, only the study investigators will have access to the anonymized data. Everyone who has access to the raw data will be asked to sign a confidentiality agreement.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can still withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, you may agree that all data gathered from you until that point may continue to be used in the study. Or you may decide to withdraw all data relating to you, in which case all data will be given to you to dispose of as you wish (or, if you prefer, the data can be shredded/deleted).

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Email: ethics@uottawa.ca

OR

National Ethical Review Committee, Kenya Medical Research Institute, P.O. Box 54840-00200, Nairobi, Kenya

Tel: (020) 2722541

Email: info@kemri.org

Acceptance: You, _____, agree to participate in the above research study conducted by Elizabeth Gyorfi-Dyke of the Institute of Population Health, University of Ottawa, whose research is under the supervision of Professors Nancy Edwards, Ian McDowell and Richard Muga.

- a) You agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal your identity. _____
You do not wish to be quoted at all. _____

b) If you choose to withdraw, you agree that all data gathered from you may continue to be used in the study. _____

If you choose to withdraw, you request that all data gathered from you be given to you for you to dispose of. _____

If you choose to withdraw, you request that all data gathered from you be shredded/deleted. _____

If you have any questions about the study, you may contact the researcher or her thesis supervisors.

There are two copies of the consent form, one of which is yours to keep.

Participant's signature: _____

Date: _____

5.8 Appendix H: Communiqué Provided by Senior Contact at Case INGO via email to Managers

Communiqué

By way of this email, I would like to introduce you to Elizabeth Gyorfi-Dyke, who is a PhD Candidate (in population health) from the University of Ottawa in Canada. She has been at CASE INGO in Kenya for 2 weeks, and she will be here until May 21st, 2010.

While Elizabeth is here, she is working on a few projects for CASE INGO in Kenya. She is also doing data collection here at CASE INGO in Kenya for her PhD. CASE INGO in Kenya has agreed to take part in this research, and her research project has passed the necessary ethics boards in Canada and Kenya. One of Elizabeth's PhD committee members is Professor Richard Muga from Great Lakes University in Kisumu.

Over the next short while, Elizabeth may be speaking to you and your staff about participating in her research project. Individuals can decide if they are willing to take part in the research, and will be asked to read and sign consent forms if they agree.

More details about the research are below:

Title of the study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

Purpose of the Study: The purpose of the study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The research looks at how CASE INGO in Kenya deals with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS, and what factors influence this work.

Data collection: Elizabeth will be conducting interviews, looking at various documents, and collecting data via participant observation for her research.

Benefits of the Research: It is hoped that the research will help investigators build theory on equity in HIV/AIDS, and increase our understanding of the various influences that affect INGOs in addressing equity in their HIV/AIDS work. Findings may assist INGOs to better achieve their equity aims.

Elizabeth's contact information is:

Kenya mobile: XXXXXXXX

Email: XXXXXX@XXXXX

She is located across the hall from Dr. XXX's office.

5.9 Appendix I: Data Collection Tools

Background Information from Interviewees

ID Code # _____

Background Information

Please complete this background information sheet prior to the interview that we have scheduled for: _____.

1. Your Title: _____

2. Short description of what your work entails:

3. How long have you been in this position? ___ months ___ years

4. How long have you been with this organization? ___ months ___ years

5a. Do you have previous work experience with other non-governmental organizations/international organizations?

Yes

No

5b. If yes, which organizations and for how long?

Organization: _____ Length of Time: ___ months ___ years

Organization: _____ Length of Time: ___ months ___ years

Organization: _____ Length of Time: ___ months ___ years

Organization: _____ Length of Time: ___ months ___ years

6. What is your disciplinary background? _____

Interview Questions for [CASE INGO] in Kenya

[Consent form will be provided ahead of time and discussed/signed prior to the interview].

[Participants will be asked to complete background information on paper document prior to the interview. I will note demographic information that I am aware of, such as name and organization name. I expect that organizational structure will be identified through the participant observation work in Kenya; if clarifications are needed, I will ask a senior staff person in the organization or the gatekeeper].

ID #: _____ **Organizational ID#:** _____

Record sex: _____

I am doing research on international non-governmental organizations working in HIV/AIDS. In particular, I am interested in learning how these organizations deal with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS. There is a lot of interest in how we might improve equity and reduce inequity but this is challenging for many organizations. We can learn both from what has worked and what has been challenging for these organizations. I would like to hear about both [CASE INGO] in Kenya's successes and challenges, as well as both internal and external factors that influence how [CASE INGO] in Kenya might implement its equity principles.

The interview will take approximately 1 hour. I will start by asking some general questions about how [CASE INGO] in Kenya approaches equity in HIV/AIDS programming, and then ask some specific questions on particular factors that may or may not influence [CASE INGO] in Kenya's ability to implement its equity principles.

Also, as I ask about [CASE INGO] in Kenya's work in HIV/AIDS, I am interested in work across the spectrum – from treatment and care, to prevention, and through more upstream interventions such as micro-finance programs.

When I use the word equity, what does it mean to you?

How explain equity to someone in your village? What word used Kiswahili or other language?

Usawa (oo-sa-wa) – fairness?

Urari – proportional/evenness

Uwiano – ratio/proportion

1. Two of the overall principles outlined by [CASE INGO] in Kenya are pro-poor and gender equity.
 - a) Please describe what the principle of pro-poor means to you.
 - b) Please describe what the principle of gender equity means to you.
 - c) How would you describe or characterize [CASE INGO] in Kenya's progress in achieving these principles?

- d) Please give me examples of how [CASE INGO] in Kenya has designed, implemented and/ or evaluated HIV/AIDS programs to address the principle of pro-poor. What about gender equity?
- e) What does [CASE INGO] in Kenya hope to achieve in the future with regards to pro-poor and gender equity principles in its HIV/AIDS work?

Probe: What are the main challenges in operationalizing these principles?

2. In what other ways does [CASE INGO] in Kenya approach the issue of equity and inequity in its HIV/AIDS work?

Probes:

-This could include a focus on vulnerable populations (e.g. low income, women, children, youth, sex workers, people with disabilities, intravenous drug users (IDU)).

[I will provide a definition of inequity to the interviewee asked for this, or if the individual's responses indicated that they were describing inequalities rather than inequities]. Inequities are differences between groups that are unjust and unfair – for example, in terms of gender inequities, women can be at increased vulnerability to HIV/AIDS given difficulties in negotiating condom use. HIV/AIDS programs with equity principles might try to address these issues.

3. What influences [CASE INGO] in Kenya's ability to implement its equity principles?

Probes:

-These influences could be internal (e.g. governance, policies) or external (e.g. donors). These can also be influences within Kenya and/or outside Kenya at a more global level.

4. There are some specific areas that I am interested in and want to explore in more detail.

- a) How do donor agendas and priorities influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probes:

-If the donor is not focused on equity as an issue, how does this influence your work in equity in HIV/AIDS? Has this been an issue for [CASE INGO] in Kenya?

-What about donors' monitoring and evaluation requirements? How do these influence your work in equity in HIV/AIDS?

- b) How do policies from the health ministry or National AIDS Control Council influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probes:

-In what ways? E.g. commitment to equity principles such as legal support for people living with HIV/AIDS

- c) How do partnerships or relationships between [CASE INGO] in Kenya and other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to implement its equity principles?

Probes:

-Tell me about any other ways that other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to achieve its equity aims.

d) How does working with the community (or People Living with HIV/AIDS (PLWHA)) influence [CASE INGO] in Kenya's ability to implement its equity principles?

Probes:

- Tell me about how [CASE INGO] in Kenya works on the ground with the community/People Living with HIV/AIDS (PLWHA).
- What are your organizational policies on involving the community and PLWHA?
- What kind of input does the community and PLWHAs provide into your HIV/AIDS work? What are the mechanisms for their input/how do they provide input/through what means?

e) We have talked about various organizations and stakeholders that may influence [CASE INGO] in Kenya in achieving its equity aims, including donors, the ministry, other NGOs, and the community/PLWHA. How do these multiple influences impact [CASE INGO] in Kenya's equity agenda?

Probes:

- How do these multiple accountabilities influence [CASE INGO] in Kenya's ability to implement its equity principles?
- Is there one particular group (e.g. donors) that influence [CASE INGO] in Kenya's work on equity more than any other? How (e.g. because of reliance on funding)?

5. I am also interested in the relationship between [CASE INGO] in Kenya and other [CASE INGO] offices, including [CASE INGO] Canada (or other National offices) and [CASE INGO] Headquarters, and the influences that these offices might have, either positively or negatively, on [CASE INGO] in Kenya implementing its equity principles.

- a) How does [CASE INGO] Headquarters influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?
- b) How do other [CASE INGO] offices in Northern Countries (National offices), e.g. [CASE INGO] Canada or [CASE INGO] UK, influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

6.

- a) Are there other aspects of equity in HIV/AIDS initiatives at [CASE INGO] in Kenya you want to describe?
- b) What other aspects of equity in HIV/AIDS initiatives at [CASE INGO] in Kenya are particularly challenging for the organization?

7. Wrap-up Questions

- a) Are there other **key contacts** who you think would be helpful to interview (within your organization or outside the organization)?
- b) Are there **key documents** that you think I should examine?
- c) Are there key events or meetings that you think I should attend to better understand these issues?

END: That is the end of the interview. Are there any portions of what you have said that you do not want to be quoted on? [If yes, record this on tape and in a written note by the

interviewer.]

OVERALL PROBES:

-How does this influence [CASE INGO] in Kenya's thinking about equity?

-Please give me an example.

-IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT DIRECTION OF INFLUENCE, ONE OR MORE OF THE FOLLOWING PROBES MAY BE USED:

-Please describe if this is a facilitator or a barrier. In what way?

-Please give me an example of how this has a positive influence on your organization's ability to achieve its equity aims.

-Please give me an example of how this has a negative influence on your organization's ability to achieve its equity aims.

-IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT LEVEL OF INFLUENCE, THE FOLLOWING PROBE MAY BE USED:

-Are these influences from a local level? Country level? Global level?

-FOR GREATER CLARITY/IF EQUITY ASPECT NOT CLEAR...

-How do you think this influences your work with... girls/women?... with people living in poverty?

Interview Questions for People Working Outside [CASE INGO] in Kenya (e.g. other NGOs, government)

[Consent form will be provided ahead of time and discussed/signed prior to the interview].

[Participants will be asked to complete background information on paper document prior to the interview. I will note demographic information that I am aware of, such as name and organization name].

ID #: _____ **Organizational ID#:** _____

Record sex: _____

I am doing research on international non-governmental organizations working in HIV/AIDS. In particular, I am interested in learning how these organizations deal with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS. There is a lot of interest in how we might improve equity and reduce inequity but this is challenging for many organizations. We can learn both from what has worked and what has been challenging for these organizations. I have been conducting research with [CASE INGO] in Kenya and I understand that [your organization] works with [CASE INGO] in Kenya on HIV/AIDS. I would like to talk to you about factors, such as external factors, that might influence how [CASE INGO] in Kenya might reach its equity goals.

The interview will take approximately 1 hour. I will start by asking some general questions about your work with [CASE INGO] in Kenya in HIV/AIDS, and then ask some specific questions on particular factors that may or may not influence [CASE INGO] in Kenya's ability to implement its equity principles.

Also, as I ask about work in HIV/AIDS, I am interested in work across the spectrum – from treatment and care, to prevention, and through more upstream interventions such as micro-finance programs.

When I use the word equity, what does it mean to you?

What does equity mean to your organization?

ALL: 1. What is your relationship with [CASE INGO] in Kenya in terms of HIV/AIDS work/programs?

ALL: 2. In terms of equity, two of the overall principles outlined by [CASE INGO] in Kenya are pro-poor and gender equity.

- a) How does your organization approach the issue of equity in your HIV/AIDS work?
- b) Do you work with [CASE INGO] in Kenya on issues of equity in HIV/AIDS, such as pro-poor and gender equity? If yes, please describe an example of this work.
- c) What are the main challenges in operationalizing equity principle in HIV/AIDS work?

3. In what other ways does your organization approach the issue of equity and inequity in its HIV/AIDS work?

Probes:

-This could include a focus on vulnerable populations (e.g. low income, women, children, youth, sex workers, people with disabilities, intravenous drug users (IDU)).

[I will provide a definition of inequity to the interviewee asked for this, or if the individual's responses indicated that they were describing inequalities rather than inequities]. Inequities are differences between groups that are unjust and unfair – for example, in terms of gender inequities, women can be at increased vulnerability to HIV/AIDS given difficulties in negotiating condom use. HIV/AIDS programs with equity principles might try to address some of these issues.

4. **ALL:** How does your organization influence [CASE INGO] in Kenya in terms of equity in their HIV/AIDS work?

Probe: These influences could be such factors as providing funding, partnering with [CASE INGO] in Kenya on HIV/AIDS work, policies that you put in to place (in the case of government). These can also be influences within Kenya and outside Kenya at a more global level.

5. There are some specific areas that I am interested in and want to explore in more detail. [Questions about NGOs will only be asked of NGOs, questions of government will only be asked by government, etc.]

- a) **DONORS:** How does your agenda and priorities as a donor influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probe: As a donor, is equity (e.g. pro-poor and gender equity) a major focus for you in HIV/AIDS programs? In what ways? Can you give me an example?

-What about your monitoring and evaluation requirements as a donor? What do you require as a donor for monitoring and evaluation?

- b) **GOVERNMENT:** How do policies from the health ministry or National AIDS Control Council influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probe: In what ways? E.g. commitment to equity principles such as legal support for people living with HIV/AIDS

- c) **OTHER NGOs:** How do partnerships or relationships between [CASE INGO] in Kenya and other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to implement its equity principles?

Probe: Tell me about any other ways that other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to achieve its equity principles in its HIV/AIDS work.

- ALL:** 6. Are there other aspects of equity in HIV/AIDS initiatives at [CASE INGO] in Kenya do you feel might be influenced by your organization?

Probe: This could be either positive or negative influences.

ALL: 7. Wrap-up Questions

- a) Are there other **key contacts** that you think would be helpful to interview (within your organization or outside the organization)?
- b) Are there **key documents** that you think I should examine?

END: That is the end of the interview. Are there any portions of what you have said that you do not want to be quoted on? [If yes, record this on tape and in a written note by the interviewer.]

OVERALL PROBES:

-Please give me an example.

-IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT DIRECTION OF INFLUENCE, ONE OR MORE OF THE FOLLOWING PROBES MAY BE USED:

-Please describe if this is a facilitator or a barrier. In what way?

-Please give me an example of how this has a positive influence on [CASE INGO] in Kenya's ability to achieve its equity principles.

-Please give me an example of how this has a negative influence on [CASE INGO] in Kenya's ability to achieve its equity principles.

-IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT LEVEL OF INFLUENCE, THE FOLLOWING PROBE MAY BE USED:

-Are these influences from a local level? Country level? Global level?

-FOR GREATER CLARITY/IF EQUITY ASPECT NOT CLEAR...

-How do you think this influences [CASE INGO] in Kenya's work with...girls/women?... with people living in poverty?

Equity Background Information

How does [CASE INGO] in Kenya define equity?

Does [CASE INGO] in Kenya's mission statement/organizational values include reference to equity or inequity?

- Yes
- No
- Don't Know

If yes, please explain.

Does [CASE INGO] in Kenya have guiding principles related to equity? (e.g. relationship to equality, vulnerable populations, populations at risk, determinants, social justice, human rights?)

- Yes
- No
- Don't Know

If yes, please explain.

Does [CASE INGO] in Kenya have an equity framework (e.g. that guides policies, governance, initiatives, staffing)?

- Yes
- No
- Don't Know

If yes, what does it include?

Does [CASE INGO] in Kenya use this framework?

- Yes
- No
- Don't Know

If yes, in what way?

Has [CASE INGO] in Kenya signed on to any codes of conducts or declarations that relate to equity or inequity? (e.g. The Code of Good Practice for NGOs Responding to HIV/AIDS, the NGO Code of Conduct for Health Systems Strengthening)

- Yes
- No
- Don't Know

If yes, please identify which codes/declarations.

Does [CASE INGO] in Kenya complete equity or inequity assessments as part of the regular program planning cycle (e.g. ongoing assessments/report cards examining whether principles of pro-poor and gender equity have been reached)?

- Yes
- No
- Don't Know

If yes, please describe this assessment process (e.g. frequency, what the process entails).

Thank you very much for your time.

Interview Questions for Clients of [CASE INGO] in Kenya's HIV/AIDS Programs

Program could = "initiative" (e.g. health centre)

ID #: _____

Record sex: _____

1. What HIV/AIDS programs from [CASE INGO] in Kenya are you involved in (or have been involved in in the past)?
2. Why did you decide to be involved in the program(s)?
3. Please describe the program(s) to me. [Probes: What is your role/involvement (e.g. CSO, CHW)? How often are you involved? What does being involved offer for you (or your community)? How long have you been involved in this program?]
4. Do you provide advice or input to [CASE INGO] in Kenya on this program(s)? If yes, how do they get your advice or input? What advice or input did you provide to them? What did [CASE INGO] in Kenya do about this advice? (Probes: e.g. have you provided advice on your involvement in the program? If yes, how do they get your advice or input? What advice or input did you provide to them? What did [CASE INGO] in Kenya do about this advice?)
5. What do you like about the program(s)/being involved in the program?
6. What does [CASE INGO] in Kenya do to help you be involved in the program (PROBE: e.g. incentives?)
7. What are some of the things that could be improved with the program(s)?
8. Please tell me about other suggestions you have for how [CASE INGO] in Kenya could improve this program(s).
9. What suggestions do you have to make the program more useful to you?
10. What could [CASE INGO] in Kenya do to have more people use the program?

[Probes may also include asking about specific policies that [CASE INGO] in Kenya has about their programs (e.g. internal policies on equity) to get the client's perspective on the extent that this is being achieved. These will be better understood following the participant observation phase].

END: That is the end of the interview. Are there any portions of what you have said that you do not want to be quoted on? [If yes, record this on tape and in a written note by the interviewer.]

Interview Questions for [CASE INGO] USA and Canada

[Consent form will be provided ahead of time and discussed/signed prior to the interview].

[Participants will be asked to complete background information on paper document prior to the interview. I will note demographic information that I am aware of, such as name and organization name].

ID #: _____ **Organizational ID#:** _____

Record sex: _____

I am doing research on international non-governmental organizations working in HIV/AIDS. In particular, I am interested in learning how these organizations deal with equity issues, such as addressing poverty and gender, when doing work in HIV/AIDS. There is a lot of interest in how we might improve equity and reduce inequity but this is challenging for many organizations. We can learn both from what has worked and what has been challenging for these organizations. I have been conducting research with [CASE INGO] in Kenya and I understand that [CASE INGO] USA/Canada works with [CASE INGO] in Kenya (or other [CASE INGO] Country offices) on HIV/AIDS. I would like to talk to you about factors, such as external factors, that might influence how [CASE INGO] in Kenya (or other [CASE INGO] Country offices) might reach its equity goals.

The interview will take approximately 1 hour. I will start by asking some general questions about your work with [CASE INGO] Country offices including Kenya in HIV/AIDS, and then ask some specific questions on particular factors that may or may not influence [CASE INGO] country offices' ability to implement its equity principles.

Also, as I ask about work in HIV/AIDS, I am interested in work across the spectrum – from treatment and care, to prevention, and through more upstream interventions such as micro-finance programs.

When I use the word equity, what does it mean to you?

What does equity mean to your organization?

ALL: 1. What is your relationship with [CASE INGO] in Kenya [or other Country offices] in terms of HIV/AIDS work/programs?

ALL: 2.

- d) How does your organization approach the issue of equity in your HIV/AIDS work?
- e) Do you work with [CASE INGO] in Kenya or other [CASE INGO] Country offices on issues of equity in HIV/AIDS, such as pro-poor and gender equity? If yes, please describe an example of this work.
- f) What are the main challenges in operationalizing equity principles in HIV/AIDS work?

PROBES:

5. In what other ways does your organization approach the issue of equity and inequity in its HIV/AIDS work?

Probes:

-This could include a focus on vulnerable populations (e.g. low income, women, children, youth, sex workers, people with disabilities, intravenous drug users (IDU)).

[I will provide a definition of inequity to the interviewee asked for this, or if the individual's responses indicated that they were describing inequalities rather than inequities]. Inequities are differences between groups that are unjust and unfair – for example, in terms of gender inequities, women can be at increased vulnerability to HIV/AIDS given difficulties in negotiating condom use. HIV/AIDS programs with equity principles might try to address some of these issues.

6. **ALL:** How does your organization influence [CASE INGO] in Kenya or other country offices in terms of equity in their HIV/AIDS work?

Probe: These influences could be such factors as providing funding, partnering with [CASE INGO] in Kenya on HIV/AIDS work, policies that you put in to place (in the case of government). These can also be influences within Kenya and outside Kenya at a more global level.

5. There are some specific areas that I am interested in and want to explore in more detail. [Questions about NGOs will only be asked of NGOs, questions of government will only be asked by government, etc.]

- a) DONORS:** How does the agenda and priorities as a donor influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probe: As a donor, is equity (e.g. pro-poor and gender equity) a major focus for you in HIV/AIDS programs? In what ways? Can you give me an example?

-What about your monitoring and evaluation requirements as a donor? What do you require as a donor for monitoring and evaluation?

- b) GOVERNMENT:** How does the health ministry or National AIDS Control Council influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

Probe: In what ways? E.g. policies, commitment to equity principles such as legal support for people living with HIV/AIDS

- c) OTHER NGOs:** How do partnerships or relationships between [CASE INGO] in Kenya and other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to implement its equity principles?

Probe: Tell me about any other ways that other INGOs or SNGOs influence [CASE INGO] in Kenya's ability to achieve its equity principles in its HIV/AIDS work.

PROBE: Churches/FBOs

e) We have talked about various organizations and stakeholders that may influence [CASE INGO] in Kenya in achieving its equity aims, including donors, the ministry, other NGOs, and the community. How do these multiple influences impact [CASE INGO] in Kenya's equity agenda?

Probes:

- How do these multiple accountabilities influence [CASE INGO] in Kenya's ability to implement its equity principles?
- Is there one particular group (e.g. donors) that influence [CASE INGO] in Kenya's work on equity more than any other? How (e.g. because of reliance on funding)?

5. I am also interested in the relationship between [CASE INGO] in Kenya and other [CASE INGO] offices, including [CASE INGO] Canada (or other National offices) and [CASE INGO] Headquarters, and the influences that these offices might have, either positively or negatively, on [CASE INGO] in Kenya implementing its equity principles.

- a) How does [CASE INGO] Headquarters influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?
- b) How do other [CASE INGO] offices in Northern Countries (National offices), e.g. [CASE INGO] Canada or [CASE INGO] UK, influence [CASE INGO] in Kenya's implementation of its equity principles in its HIV/AIDS work?

ALL: 6. Are there other aspects of equity in HIV/AIDS initiatives at [CASE INGO] in Kenya do you feel might be influenced by your organization?

Probe: This could be either positive or negative influences.

ALL: 7. Wrap-up Questions

- a) Are there other **key contacts** that you think would be helpful to interview (within your organization or outside the organization)?
- b) Are there **key documents** that you think I should examine?

END: That is the end of the interview. Are there any portions of what you have said that you do not want to be quoted on? [If yes, record this on tape and in a written note by the interviewer.]

OVERALL PROBES:

- Please give me an example.
- IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT DIRECTION OF INFLUENCE, ONE OR MORE OF THE FOLLOWING PROBES MAY BE USED:
 - Please describe if this is a facilitator or a barrier. In what way?
 - Please give me an example of how this has a positive influence on [CASE INGO] in Kenya's ability to achieve its equity principles.
 - Please give me an example of how this has a negative influence on [CASE INGO] in Kenya's ability to achieve its equity principles.

-IF INTERVIEWEE IDENTIFIES AN INFLUENCE, AND THERE IS SOME LACK OF CLARITY ABOUT LEVEL OF INFLUENCE, THE FOLLOWING PROBE MAY BE USED:

-Are these influences from a local level? Country level? Global level?

-FOR GREATER CLARITY/IF EQUITY ASPECT NOT CLEAR...

-How do you think this influences [CASE INGO] in Kenya's work with...girls/women?... with people living in poverty?

5.10 Appendix J: Data Summary Forms

Contact summary form – interviews

(Miles and Huberman, 1994, p. 51-54)

Date: _____
 Time of the Interview/Observation: _____
 Length of Interview/Observation: _____
 Location of interview/Observation: _____
 Participant ID#(s): _____
 Organizational ID #: _____

Comments on context of contact	
Summary of key information from each question (key points/relevant observations – e.g. back-up of the transcript) -Proposition 1: Equity gap/overall influences -Proposition 2: Donors’ agendas/priorities -Proposition 3: Southern country government’s commitment to equity -Proposition 4: Lack of coordination/competition between INGOs and SNGOs -Proposition 5: PLWHA -Proposition 6: Multiple accountabilities at multiple levels	
My reflections on the interview	
Main issues/themes/critical findings arising from this contact (potential interpretations)	
Any suggestions re: follow-up? -other people to interview	

-documents to access	
Comments on interview guide -additional probes? -issues/challenges with questions and suggested changes if applicable -new topics to include in questions?	

Observational Protocol (Creswell, 2007, p. 137)

Date:
Time of participant observation:
Length of Participant observation:
Location:
Other relevant context:

Who was present - pseudonyms (details in descriptive notes):

Link with propositions below as relevant:
-Proposition 1: Equity gap/overall influences
-Proposition 2: Donors' agendas/ priorities
-Proposition 3: Southern country government's commitment to equity
-Proposition 4: Lack of coordination/competition between INGOs and SNGOs
-Proposition 5: PLWHA
-Proposition 6: Multiple accountabilities at multiple levels

Descriptive notes (direct observations)	Descriptive notes (my participation/ role)	Reflective notes ("experiences, hunches, learnings")

Page ___ of ___

Descriptive notes (direct observations)	Descriptive notes (my participation/ role)	Reflective notes (“experiences, hunches, learnings”)

SKETCH OF PHYSICAL SET-UP:



Document summary form (revised March 10, 2010)

(Miles and Huberman, 1994, p. 54-55)

Document Number/classification:	
Date received:	
Date reviewed:	
Name/description of document:	
Event or contact, if applicable, that document is associated with:	
Significance/importance of document (why document selected including audit trail of selection and review of this document):	
Key Reflections:	
Summary of document (content): -Proposition 1: Equity gap/overall influences -Proposition 2: Donors' agendas/ priorities -Proposition 3: Southern country government's commitment to equity -Proposition 4: Lack of coordination/ competition between INGOs and SNGOs -Proposition 5: PLWHA -Proposition 6: Multiple accountabilities at multiple levels	
Key salient points (interpretation):	

Key links between document and contacts (if applicable):	
Notes to self (e.g. things to examine, other documents, probes)	

5.11 Appendix K: Confidentiality Agreements with Research Assistant and Transcriptionists

Title of the Study: *International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work in Kenya: A Multi-Level Case Study*

This research is being conducted by Elizabeth Gyorfi-Dyke (PhD Candidate, University of Ottawa), under the supervision of Professors Nancy Edwards (University of Ottawa), Ian McDowell (University of Ottawa) and Richard Muga (Great Lakes University of Kisumu).

The purpose of this study is to understand what influences international non-governmental organizations' (INGOs) implementation of equity principles in their HIV/AIDS work. The specific research questions of this study are:

- What is the nature of the “implementation gap” between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice?
- What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work?
- How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?

This research has received ethical approval from University of Ottawa (Canada), Great Lakes University of Kisumu (Kenya), and the Kenya Medical Research Institute (Kenya). Any person involved with Elizabeth Gyorfi-Dyke on this research project must agree to abide by the requirements of these ethics boards by signing a confidentiality agreement.

I, _____, acknowledge that Elizabeth Gyorfi-Dyke has explained the ethics requirements to me.

I, _____, acknowledge that I understand these requirements.

I, _____, agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or manner (e.g. talking with others, disks or memory sticks, tapes or audio files, transcripts, notes) with anyone other than the Researcher.
2. Keep all research information in any form or manner (e.g., disks or memory sticks, tapes or audio files, transcripts, notes) secure while they are in my possession.
3. After consulting with the Researcher(s), erase or destroy all research information in any form or manner regarding this research project that is not returnable to the Researcher(s) (e.g. information stored on computer hard drive).

Name of Research Assistant/Transcriber/Translator (please print): _____

Signature of Research

Assistant/Transcriber/Translator: _____

Date: _____

Signature of Researcher (Elizabeth Gyorfi-Dyke): _____

Date: _____

5.12 Appendix L: Draft Summary Report for Case INGO February 2011

International Non-Governmental Organizations' Implementation of Equity Principles in HIV/AIDS Work In Kenya: A Multi-Level Case Study

By Elizabeth Dyke, PhD Candidate, University of Ottawa, Canada

Preliminary Results for Discussion and Feedback – Draft Executive Summary

Objectives of the Research

HIV/AIDS is a major issue globally. One key group working on HIV/AIDS is international non-governmental organizations (INGOs). INGOs often focus on working with marginalized communities, low income people and girls/women. The objective of this study is to understand what influences INGOs' implementation of equity principles in their HIV/AIDS work.

Specifically, the research questions for my PhD research are:

- What is the nature of the implementation gap between the intent of an INGO to ensure equity in its HIV/AIDS work and actual practice?
- What characterizes multi-level influences that affect an INGO's implementation of equity principles in its HIV/AIDS work?
- How do multi-level influences affect an INGO's implementation of equity principles in its HIV/AIDS work?

Methods

An in-depth case study of an INGO working in Kenya (referred to throughout as The NGO), as well as its northern counterparts in Canada and the United States, was conducted. The case design employed mixed qualitative methods including documents, interviews, and participant observation in Kenya over a three month period. Forty-one interviews were conducted: 16 internal interviews with NGO staff in Kenya, 8 external interviews with government, funders, and partner NGOs in Kenya, and 10 client interviews from 2 HIV/AIDS projects in 2 different provinces in Kenya. In addition, 7 interviews were conducted with the 'sister' NGO in the U.S. and Canada. Documents from The NGO in the U.S. and Canada were also collected for analysis.

Results

Equity as a Construct

The NGO and Equity

Equity is a major theme in HIV/AIDS in Kenya. Equity is a focus or a theme in many documents in The NGO. This includes in the Headquarters Strategic Plan (where core values and beliefs include gender equity, pro-poor, non discrimination, and health as a human right). The Strategic Plan for The NGO Kenya also includes the issues of equity in health and gender equity.

The NGO has signed on to various codes of conduct that commit to aspects of equity. For example, the *NGO Code of Conduct for Health Systems Strengthening* commits The NGO to

“activities and programs (that)...foster equity” and the *Code of Good Practice for NGOs Responding to HIV/AIDS* includes organizational principles of access and equity as well as gender and human rights. The *Kenya Health Sector Wide Approach*, signed by The NGO Kenya, commits to “respect for human rights, equity...” and identifies mainstreaming of equity and gender.

Kenyan Government and Equity

Equity is also a major theme in Kenyan government documents. For example, Vision 2030 includes a focus on gender and poverty, and states that “The social pillar seeks to build a just and cohesive society with social equity in a clean and secure environment” (V2030, p. 1).

The new draft Constitution is also seen by some people I interviewed to be a forum for Kenyans to discuss and address equity, including human rights, issues of land, and cultural issues. According to a lawyer quoted in an August 23, 2010 newspaper article “The new Constitution, which will be promulgated this Friday, has been described as one ‘that will ensure equity for all Kenyans.’¹²

In terms of HIV/AIDS, the Kenyan National AIDS Strategic Plan (KNASP III) also includes quite a bit of wording focused on equity. For example: “Equity and rights-focused approaches require that interventions promote social inclusion”. Most-at-risk populations (MARPs), including men who have sex with men (MSM), intravenous drug users (IDU), and commercial sex workers (CSW), are clearly identified in KNASP III.

How is equity viewed?

Internal and external staff have varying definitions of equity. Equity tends to include the ideas of:

- Fairness
- Distribution, typically the distribution of resources (e.g. ensuring geographical equity in terms of fair distribution across geographies)
- A focus on gender, in particular women and girls. Male involvement was also identified as important.
- Empowering marginalized communities, including the Community Strategy
- Another population that is identified less often is people with disabilities
- MARPs (MSM, IDU, CSW) aren’t identified as much in equity discussion unless prompted

Equity is seen as being ingrained in the work of The NGO, since this work has been done since The NGO’s inception (e.g. Flying Doctors; working in rural and underserved communities).

How is equity operationalized in HIV/AIDS work?

Among internal and external people, there is a general awareness of equity (albeit with sometimes varying definitions), but not always a clear understanding of how to operationalize equity in everyday work.

¹² <http://www.capitalfm.co.ke/news/Kenyanews/New-Kenyan-law-ensures-equity,-says-Muite-9551.html>

– “I think if staff were more aware of what equity is, then they would maybe address it more consciously. I would say it’s not something we really think about.” (internal staff)

Equity is seen as abstract, fuzzy, and not measurable, leading to challenges in operationalization. Equity and other related constructs, such as human rights, are not unpacked.

– “I think the moment you start talking of language around rights based approaches, gender mainstreaming, equity, you lose people” (external)

Ideas on operationalization of equity include reaching both men and women, and ensuring disaggregation of data by sex (e.g. how many people were trained who were male versus female, how many staff at The NGO are male versus female, or how many beneficiaries are male versus female). Equity is seen as something that is ideal to work on, but it is not always a priority given the overall sense of emergency of HIV/AIDS in Kenya.

Multiple Influences

There are many challenges for an INGO implementing equity on the ground in their HIV/AIDS work. There are multiple influences that affect The NGO’s implementation of its equity principles in its HIV/AIDS work, including the Kenyan government, donors, the community, and other NGOs.

Influence from the Donor

“He who pays the piper calls the tune”

Donors strongly influence The NGO and the country government agenda given that they are the one’s providing the money. Both internal and external people identified that HIV/AIDS is fairly donor driven given that The NGO is responding to proposals. If the request for proposal does not have aspects of equity included, then the focus will not be on equity as The NGO is responding to the proposal objectives as outlined by the donor.

On the other hand, donors are also developing proposals following the Kenyan government priorities by following government strategies and documents (e.g. KNASP III).

Short-term Agendas and Sustainability

Donors also influence The NGO in terms of equity in HIV/AIDS work through short-term agendas. Building capacity in a community can take many years, and donors are often focused on short-term outputs as opposed to long-term equity outcomes. This is linked to issues of project sustainability.

Heterogeneity of Donors

Donors are not homogenous either - for some, equity is more central to their work. SIDA is seen as more focused on equity, including gender equity, than other funders. Generally, European donors are viewed as being more “equity conscious” than U.S. funders. U.S. funders tend to focus more on short-term outputs than some of their other counterparts. However, there is some indication that there is a slight shift to increase the focus on equity in

the U.S. under Obama (versus Bush) and with the move to the Global Health Initiative (GHI) from PEPFAR.

Flexibility and Influence of the NGO

It was also identified that some donor sources (e.g. unrestricted funding) can result in more flexibility for The NGO to focus on its own priorities, such as equity. How much flexibility and influence an NGO has depends on their power and reputation. The North American NGO offices identified that there are some organizations with lots of unrestricted funding, and that, as such, these NGOs could focus more on advocacy or other issues that were of interest to the NGO. However, The NGO is not as visible as some of the larger INGOs in North America, and therefore *“We can’t go out yet and dictate (to the donor)” (Northern NGO staff).*

Vertical versus Horizontal Funding

Vertical funding of programming is where the donor focuses on disease-specific aims (e.g. HIV/AIDS or malaria) while horizontal funding of programming is where the donor aims to improve health systems overall (Ooms, 2008) or look at the broader issues of poverty. There is much debate over vertical versus horizontal funding of programs in the literature, and the effectiveness (and challenges) of each. The focus has shifted over time from horizontal (e.g. primary care) to vertical, with the current focus on vertical financing (Perin and Attaran, 2003; Sanders, 2008). Vertical funding allows donors to be able to point to their funding as the cause of improvements (Brugha, 2007), and target diseases that are having a major impact on Southern countries. However, vertical funding also leads to lack of donor coordination (Easterly, 2007) and duplication; hence, there are often multiple projects with vertical foci that do not address larger cross-cutting horizontal issues such as the health system or poverty. These vertical programs may also not line up with Southern countries’ priorities. Vertical programming may also have negative influence on equity: *“Vertical programmes hinder the development of comprehensive approaches needed to tackle social inequity and the wider determinants of health – thereby negatively affecting the health development process” (Atun, 2008).*

The NGO Headquarters strategy document identifies issues related to vertical programming, including access and equity (p. 18). Also, one of the codes that The NGO has signed on to, the *NGO Code of Conduct for Health Systems Strengthening (2008)* states that *“NGOs recognize that vertical programs and selective approaches exacerbate inequities in health systems and ignore underlying determinants of health” (p. 8).*

In the research I conducted, people identified that donor priorities are often vertical over horizontal; there is a lack of focus on determinants of health among many donors (e.g. a focus on ARV adherence or VCT versus issues of lack of nutrition as a result of drought). There are other challenges that arise in disease-specific funding; for example, co-infection with HIV, Malaria and TB are not addressed.

- *“So you, if you have TB you go to one clinic, you line up for two hours. Then you have malaria, you go to another clinic and you line up for another two hours. And then if you have to go get your ARVs you have to go do that, line up. It’s a whole day*

process as opposed to just training one person, one clinic, who can look after all those issues”.

The NGO Influence on Donors

The NGO also has an influence on donors in terms of equity in HIV/AIDS. The NGO provides contextualization for the donor’s project, since the donor is less familiar with the context in country. The NGO has experience on the ground with the community. And finally, The NGO provides evaluation information through operations research – the evidence base - to the donors, and this can influence future projects, including aspects of equity.

Influence from the Country Government

Lip Service

The challenge of lip service to equity at the politician level, versus actual implementation, was identified as a barrier to equity: *“Usually at the policy level, it is not a big deal to get (politicians) to agree to issues like equity....Kenyan politicians are good at agreeing to things, but they don’t mean it. Their interest is to get money. So if you as a donor come with a long list including equity—you’ll find that (politicians) adopt things to suit the donor, but the question is - do they really believe in those things? The politicians will say “equity is good, this is fine”—but will they follow these? Most will not.” (external)*

Legal Framework

The country government’s legal framework also challenges equity, including MARPs. This was identified in interviews as well as in documents. The KNASP III identifies this challenge outright: *“A series of difficult legal issues arise from attempts to programme more directly for the MARPs (sex workers, IDUs, MSM), and to take these programmes to scale. Sex work, homosexuality and drug use are all illegal in Kenya. Programmes have been working with all these groups for many years, but under constraints” (KNASP).* The challenge in working with MARPs under this legal framework, as well as the challenges in moving to change the legal framework, were identified by both internal and external staff.

Political Equality Versus Equity

The notion of political equality versus equity was also identified. It is argued that politicians want resources divided equally across districts, rather than where there is more need. This was identified as an issue in HIV/AIDS as well as in other areas, including infrastructure: *“So from a government perspective, equity is not a major issue. Politics override.” (external)*

KNASP III

As mentioned above, KNASP III has a focus on equity, including gender and MARPs. How did this come about? There were mixed findings in terms of who was the major driver of the KNASP III, in particular vis-à-vis equity and values. While internal and external staff tend to agree that it was a participatory process, with many stakeholder involved including NACC, UNAIDS, and CSOs at regional and national levels, some say it was led by the Kenyan government while others say it there was significant external (Northern donor) influence.

–*“It is mainly donor driven. It did not come from the government. And indeed because you know KNASP is developed by multiple stakeholders including the donor community and so on and somebody had to fund the strategic planning, the revision, the strategy... and that way they can be setting the agenda, you can put in your agenda in the strategy so... that’s really the reality” (internal staff).*

In addition, the research found that there was donor funding of various NGOs to allow these NGOs to influence the KNASP agenda, including in the area of equity. Technical assistance was also provided by donors.

There was agreement that, regardless of who drove the process, government ownership of the strategy was essential: *“You need to have a good buy-in at NACC—so now you can say ‘this is your document’” (external).*

The reason KNASP III was developed earlier than originally intended is due to the changing evidence-based. The evidence base played a major role in KNASP III: *“This Strategic Plan comes a year early, following a synthesised review of KNASP II, which exposed emerging changes in the epidemic as evidenced by the Modes of Transmission Study (MoT) in 2008, and the Kenya AIDS Indicator Survey (KAIS) in 2007” (KNASP).* Hence, evidence also plays a role in whether or not equity is on the agenda.

“If we look at the KNASP—the donors participated somehow and supported financially—but also what influenced the KNASP was the Kenya Mode of Transmission Survey (KMoTS)” (internal staff).

Limitations on Advocacy

One of the interesting issues that was identified in this research was around advocacy for issues of equity, and the role that The NGO plays. It was found that advocacy for equity by The INGO can be limited by The NGO’s relationships with donors and the country government.

Advocacy can be focus on advocacy for equity in public health, such as encouraging equitable access to health. Many organizations, and many documents (e.g. KNASP III), focus on public health advocacy, including reaching vulnerable groups. Fewer organizations push this advocacy for equity to the next level of human rights, including advocating for changes in legal frameworks.

There are many tensions in terms of advocacy, and how and what is advocated for by The NGO is influenced by both Kenyan government and Western (donor) governments. The NGO focuses on advocacy for equity in public health, but does not move beyond this as it could have negative repercussions for The NGO. The NGO works within the government systems (Kenyan and Northern governments), rather than advocating for politically controversial reform such as changes to legal frameworks. For example, to receive U.S. funding, The NGO agreed to align with the U.S.’s policy on sex work, even though this means that The NGO cannot advocate for any change to the legal framework in Kenya if The NGO ever desired.

The NGO's Influence on the Kenyan Government

The NGO also has an influence on the Kenyan government in terms of equity, via participation in many committees e.g. NACC, by filling in gaps in programs and services where the government is not, and through public health advocacy.

Other INGOs/SNGOs as Influencers

For the most part, the influence of other INGOs or Southern NGOs on The NGO's implementation of its equity principles in HIV/AIDS was not identified as an issue. There were some coordination/duplication issues with other NGOs that were identified (e.g. other NGOs coming in to the same geographical area that The NGO is already working in and providing the same services). The "Three Ones" helps with coordination – new NGOs and/or new projects have to work within the government strategy. It was found that The NGO works closely with other organizations, and each learn from each other, including in the area of equity.

Influence of the Community

Empowerment and the Community Strategy

Working with the community, including the Community Strategy and use of Community Health Workers (CHWs), is viewed by staff as a positive influencer of equity, in particular closing the gap between the government and the community, and "giving people a voice". The importance of empowering marginalized communities and capacity building was identified as significant. Through empowerment, it is felt that this will help with sustainability of the programs. On the other hand, the Community Strategy relies heavily on community volunteers, who are often unpaid.

The NGOs Influence on Community re: Equity

The NGO also influences the community on issues of equity in HIV/AIDS by consulting with the community, trying to address community needs (as well as the donor and government requirements), and advocating for equity (e.g. gender equity) with chiefs and elders through engagement, communication, and capacity building.

Contextual Challenges to Equity in HIV/AIDS

There are a number of contextual challenges that have not been identified above that play a role in influencing equity in HIV/AIDS including:

- high poverty rates
- high community expectations/dependency/hand-out mentality (which can threaten community ownership of a program and sustainability)
- post-election violence

At a government level, some of these challenges are:

- (lack of) political will
- (lack of) infrastructure
- (lack of) resources e.g. sufficient number of female condoms for distribution

At a community level, challenges include:

- attitude and cultural practices, including comfort with the status quo (e.g. gender)
- lack of male involvement
- poor literacy and education levels in communities
- stigma/discrimination towards HIV/AIDS and MARPs

Internal to The NGO

There are also contextual challenges that are internal to The NGO.

Culture/Values

Staff at The NGO Kenya are members of the community, and hence culture and values can play a role in challenging issues of equity. There is the expectation though that regardless of the staff person's values and beliefs, services will be provided to clients: *“Personally you might not agree with MSMs but you will work to help them...when we talk and we discuss with staff, you know, they're like, ‘Yes, it's part of our job. We have to do it because of ABCD.’ They might not believe in it, but they will do it.”* (Internal)

KNASP III identifies this as a challenge on a larger scale: ***“Denial and Social Intolerance of many MARPs: This leads to reluctance to prioritise interventions and services aimed at them, even among professional planners and policy-makers”*** (KNASP III document)

Documents that Support Equity

There are many documents that support equity in The NGO, but there are some challenges in follow through. There are multiple priorities for staff on any given day, and lots of work to be completed, sometimes affecting how top-of-mind equity is on the agenda.

There is a lack of awareness of the codes of conduct that The NGO has signed on to that identify equity. The codes and manuals that are available are not always active documents: *“It's a document that we read through, some of it is integrated in our strategies and the way we are working, but some of it is not, and we have not sufficiently translated it”* (Internal). While there is senior management support for equity, there are opportunities to strengthen this: *“There is an interest... among all the senior management team that it's important, but... I wouldn't say that they are very strong ambassadors”* (Internal). Some documents, such as the Gender Mainstreaming document from Headquarters, are available but there is limited follow through in terms of evaluating whether or not this has been implemented. There is no point person to contact for follow-up: *“How do we continue to make this a living document?”* (Internal)

Conclusions

There are a number of issues that challenge the implementation of equity principles in HIV/AIDS work in The NGO, which likely also affect other NGOs, governments, and donors.

- *“But that does not mean people just dream and think and sleep equity, no... It is still an abstract term, from my colleagues, even senior ones. It's something desirable, it's something aspirational but, you have so many things to think in between, and resources to take care of there, cost effectiveness aspects to look at”* (External)

Potential Opportunities

Based on this research, there are a number of potential opportunities for NGOs working in equity in HIV/AIDS.

1) The NGO is in a position to lead on the issue of equity - with donors and governments - based on evidence-base from projects as well as knowledge of communities where The NGO works (these are two areas where The NGO is viewed as having a major influence). The fact that The NGO is Kenyan-based also gives a “comparative advantage”.

- *“In terms of issues of equity/gender— [NGO] has been given an open door to influence—so they have a big opportunity. They have to base it on some evidence.” (External)*

2) There are many opportunities to continue to work to operationalize equity in The NGO, including identifying how to do this in everyday work. The following were identified in the research:

- Developing guidelines or a checklist for equity to assist in mainstreaming this in everyday work
- Ongoing capacity building for all staff at all levels to engage them in equity
- Ongoing support to make codes and guidelines “living documents”, including a contact person for any follow-up
- Providing codes and documents (e.g. gender mainstreaming document, codes that The NGO has signed on to) for new staff
- Working on how best to capture how The NGO is doing in meeting its values/principles of equity (metrics/evaluation)
- Continue to build on work underway e.g. Kenya-specific gender mainstreaming guidelines based on Headquarters’ work

Ultimately, I hope that....

This research will help to increase understanding of the multiple influences affecting INGOs in implementing equity in their HIV/AIDS work. Findings may help INGOs to better reach their equity objectives in their HIV/AIDS work.

Items for Discussion

The following are items I would like to discuss when we have the feedback session.

- New constitution and equity
- U.S. – move from Obama to Bush and from PEPFAR to GHI
- Vertical/horizontal programming and equity
- KNASP III
- The NGO and advocacy for equity
- Influence of other Southern NGOs or other INGOs
- Community Strategy and equity
- Metrics on equity
- Sustainability
- Multiple accountabilities
- Other opportunities
- Other contacts/documents

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