

**PROCEEDINGS of the  
CONSULTATIVE TECHNICAL MEETING on  
HIV VOLUNTARY COUNSELING and TESTING (VCT)**

**7<sup>th</sup> and 8<sup>th</sup> September 2000**

**Mayfair Court Holiday Inn Hotel  
Nairobi**

**Family Health International**

**Funded by  
United States Agency for International Development/Kenya  
and  
United States Centers for Disease Control and Prevention**

## ACRONYMS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARV	antiretrovirals
AZT	azidothymidine (Zidovudine)
CBD	community-based distributor
CDC	Centers for Disease Control and Prevention
CHW	community health worker
DASCO	District AIDS/STD Control Officer
DFID	Department for International Development
DHMT	District Health Management Team
DHS	Demographic and Health Survey
ELISA	enzyme-linked immunosorbent assay
FGD	focus group discussion
FHI	Family Health International
FP	family planning
GOK	Government of Kenya
HIV	human immunodeficiency virus
IEC	information, education and communication
JICA	Japan International Cooperation Agency
KAPC	Kenya Association of Professional Counselors
KNH	Kenyatta National Hospital
KSPA	Kenya Service Provision Assessment Survey
LIFE	Leadership in Fighting an Epidemic
MACRO	Malawi AIDS Counseling and Resource Organization
MCH	maternal and child health
MOH	Ministry of Health
MTCT	mother-to-child transmission
NACC	National AIDS Control Council
NACP	National AIDS Control Programme
NARESA	Network of AIDS Researchers in Eastern and Southern Africa
NGO	non-governmental organization
NVP	nevirapine
OI	opportunistic infection
PATH	Program for Appropriate Technology in Health
PLWHA	people living with HIV and AIDS
PMCT	prevention of mother-to-child transmission
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

## Table of Contents

Acronyms .....	2
Introduction.....	4
Expected outcomes of the meeting.....	5
Summary of the opening session.....	5
Summaries of presentations .....	6
Government plan for HIV VCT in Kenya.....	5
Current issues in HIV VCT .....	6
Experiences of HIV VCT in two areas of Kenya.....	9
Experiences in VCT in other African countries .....	11
An overview of the implementing AIDS Prevention and Care (IMPACT) project in Kenya .....	14
HIV VCT interventions—linking prevention, care and support.....	15
The role and application of HIV VCT in TB control in Kenya.....	17
The role and application of HIV VCT in mother-to-child transmission of HIV.....	18
Family planning and HIV VCT: opportunities and challenges .....	18
The role and application of counseling in HIV VCT .....	22
The role of the communications campaign in HIV VCT programs .....	23
Highlights of discussions of presentations.....	25
Group work sessions.....	26
Integrating HIV VCT, MTCT and family planning/STIs .....	27
Communication support for HIV VCT.....	28
The role of counseling in HIV VCT .....	29
TB, care and support and HIV VCT.....	30
Agenda.....	31
Participant list.....	33

## INTRODUCTION

As the HIV/AIDS pandemic continues to spread throughout Africa, much deliberation centers on how best to incorporate HIV voluntary counseling and testing (VCT) services into HIV/AIDS prevention, care, and support programs in the region. A wide variety of views exist about which approaches are the most feasible, acceptable and cost-effective. New public health imperatives, such as the prevention of mother-to-child transmission (MTCT) of HIV, and difficult human rights issues also challenge voluntary counseling and testing service providers.

Building up HIV VCT services in the region is seen as desirable, but how to proceed to do so remains unclear. As Kenya has identified HIV VCT as a priority, Family Health International/Kenya convened a meeting of stakeholders to ascertain the status of current program activities in HIV voluntary counseling and testing in Kenya as a way to learn from recent project experiences in other countries and to plan the way forward.

Historically, HIV testing has been promoted under the assumption that it facilitates HIV/AIDS prevention and care services. Over the years, HIV testing has been linked with counseling and has developed as an important entry point for a variety of program activities, including behavior change initiatives, interventions to prevent MTCT, and early treatment of opportunistic infections and HIV-related disease—all important program goals. However, the implementation of HIV testing programs also raises many challenges, including the need to respect individual choice and rights and to ensure access to care and support services for individuals who test positive.

Through a collaborative study that was conducted by FHI's AIDS Control and Prevention (AIDSCAP) Project, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Kenya, Tanzania and Trinidad, HIV VCT was shown to have an important impact on specific behavioral outcomes.<sup>1</sup> This multisite, randomized, controlled trial measured the impact of HIV voluntary counseling and testing on safer sex behaviors. It showed that HIV voluntary counseling and testing among persons seeking such services was more effective in encouraging risk reduction behaviors than was the provision of health information alone. More specifically, participants who received HIV counseling and testing reported greater decreases in unprotected sexual intercourse with non-primary partners and commercial sex partners over the six-month follow-up period than those who received only health education.

As the prevalence of HIV infection rises in many countries and requests for HIV testing increase in the context of clinical care, employment and social institutions, many are concerned that other problems will arise. The rights and needs of people living with HIV/AIDS (PLWHA) must be protected. Likewise, the regulatory and quality assurance procedures that are needed must be put into place to avoid an abuse of testing, as well as the fear of any negative consequences that might arise from testing positive.

---

<sup>1</sup> The Lancet, vol. 356, July 8, 2000, pp 103-12.

## ***EXPECTED OUTCOMES OF THE MEETING***

- To share experiences implementing and operationalizing HIV VCT services
- To share more information about HIV VCT with potential stakeholders, including addressing the stated need for guidelines and policy formulation in this area
- To establish networks, collaboration and partnerships
- To pave the way forward.

The meeting emphasized participation, and question-and-answer sessions took place periodically following the various presentations. On the second day, participants were divided into smaller groups, and the groups considered several questions. They reported their findings back to the whole group, and the conclusions were discussed. This report of the proceedings was compiled from notes taken by the rapporteur, overheads used by the presenters, and tape recordings of some of the sessions.

## **SUMMARY OF THE OPENING SESSION**

The meeting was opened by Dr. Peter Lamptey, Executive Vice President, HIV/AIDS Prevention and Care Department, Family Health International (FHI), USA, and the Director of the Implementing AIDS Prevention and Care (IMPACT) Project, who welcomed the participants.

Mr. John McWilliam, Kenya Country Director, HIV/AIDS Prevention and Care Department, Family Health International, thanked the cosponsors of the two-day consultative meeting, the United States Agency for International Development (USAID), which is the funding agency for the five-year IMPACT Project, and the U.S. Centers for Disease Control and Prevention (CDC). Mr. McWilliam also welcomed the participants and set the theme for the meeting: to get down to basics, as opposed to academics, in view of the urgency of the HIV/AIDS pandemic.

Mr. McWilliam made reference to the Nairobi Declaration, which was formulated by IMPACT/Kenya's implementing partners in Kenya in August 2000, stating their joint commitment to working on breaking the silence surrounding HIV and AIDS. He acknowledged the expertise of each of the participants, in addition to the presenters, and he asked for comprehensive discussion of the issues. Mr. McWilliam identified the task as looking at the modalities for implementing HIV VCT and integrating other important aspects of care with HIV VCT programs.

Ms. Neen Alrutz, Senior Health Program Manager, Office of Health and Population, USAID/Kenya, welcomed participants to the meeting on behalf of USAID and CDC. She spoke to the participants about "LIFE and Beyond." She explained that LIFE is the acronym for the U.S. Government's program entitled "Leadership in Fighting an Epidemic," which is a mechanism developed in 1999 to expand the government's commitment to assisting selected countries to plan and undertake programs to change the attitudes and behaviors that affect the HIV/AIDS pandemic.

Ms. Alrutz also outlined a strategy to increase program effectiveness:

- Work multisectorally with religious organizations, democracy-focused and governance groups, village banks, and other institutions;
- Develop new partnerships; and,
- Bring many more people into the field as professionals.

## **SUMMARIES OF PRESENTATIONS**

### ***GOVERNMENT PLAN FOR HIV VCT IN KENYA***

Ibrahim Mohamed, Program Manager, National AIDS Council, Ministry of Health (MOH) of Kenya

One of the goals of Sessional Paper No. 4 on HIV/AIDS in Kenya, which was adopted by the Kenyan Parliament for implementation in 1997, identifies voluntary counseling and testing as a major tool for HIV/AIDS control. It is also seen as a viable intervention in the prevention of mother-to-child transmission of HIV. The goal of the Sessional Paper on HIV/AIDS is to provide a policy framework within which HIV/AIDS prevention and control efforts will be undertaken over the next 15 years.

A national survey carried out in 1998 showed high levels of knowledge of AIDS among respondents of reproductive age. The survey showed 14 percent of women and 17 percent of men reporting to have been tested for HIV; however, two-thirds of those who had not been tested so far reported a willingness to do so.

Responding to these statistics, the Ministry of Health (MOH) is establishing HIV VCT centers at district hospitals throughout the country<sup>2</sup> and is encouraging HIV VCT for all men and women of reproductive age. Dr. Mohamed emphasized the special importance of married couples knowing their serostatus, so they can make informed choices about having children, consider alternatives to breast milk for feeding newborns, and plan ahead for the care of orphans.

Dr. Mohamed listed the prerequisites for successful HIV VCT services as:

- Establishing networks with support groups including religious organizations;
- Providing quality counseling; and,
- Establishing patient support services at all levels.

And, he stated the advantages of HIV VCT as the following:

- Seropositive individuals may prevent further spread of sexually transmitted diseases (STDs) and re-infection of HIV;

---

<sup>2</sup> Currently VCT is offered at the Patient Support Center to in-patients of Kenyatta National Hospital (KNH) in Nairobi. A subagreement between KNH and FHI, with additional support from the government of Japan, to establish a walk-in HIV VCT Center for out-patients on the hospital premises has been concluded recently. On September 27, 2000, the Director of Medical Services, Dr. Richard Muga, announced that free HIV voluntary counseling and testing centers would soon be opened nationwide.

- Mother-to-child transmission of HIV will be reduced; and,
- Quality of life will be improved through enhanced treatment-seeking by individuals with opportunistic infections, and less tendency among individuals testing seronegative to expose themselves to the risk of HIV infection.

Dr. Mohamed described the present situation of HIV VCT in Kenya: few public health centers offer HIV VCT, with Kenyatta National Hospital and Kisumu Provincial General Hospital as among those that do. Other functioning HIV VCT centers are run by nongovernmental organizations (NGOs) and are mainly centered in urban areas, particularly Kenya's capital, Nairobi. However, he stated that counseling services will be strengthened through the MOH Disaster Response Strategy at the district and primary health care levels, and both men and women will be targeted by community health workers, peer groups, and neighborhood health committees.

Pregnant women will also be targeted for HIV VCT at antenatal clinics in health units and communities. In the next four years, 70 percent of the district hospitals will have HIV VCT activities. As a result of training service providers, the stigma against people living with HIV/AIDS will be reduced, and codes of ethics surrounding confidentiality will be enforced. In addition, the MOH is in the process of developing guidelines on home-based HIV/AIDS care.

### ***CURRENT ISSUES IN HIV VCT***

Gloria Sangiwa, VCT Technical Adviser, Population Services International, Zimbabwe

Dr. Sangiwa relied on her experiences setting up HIV VCT centers in Zimbabwe and Tanzania, and she outlined some of the justifications for VCT as well as the constraints. Basically, HIV voluntary counseling and testing can be seen as a human rights issue: people have a right to know their serostatus. For the majority who test negative, HIV VCT relieves them of the anxiety of not knowing their status and allows them to knowledgeably plan for the future. It also reinforces the importance of maintaining their serostatus. For those who test positive, it can lead to early referral for clinical care and support. For couples, VCT can be a pre-marital requirement; and, it may help them plan their families. For those who are already married, a negative result may enhance the feeling of trust between them and strengthen their commitment to their relationship.

However, certain barriers to HIV VCT were also encountered. There are, as always, scarce economic resources and competing priorities; a lack of access to drug therapies and psychological care, especially in the developing world; a lack of access to services for the majority; widespread fear of taking an HIV test; concerns that confidentiality will be breached and of the stigma surrounding HIV/AIDS in the community; and, a fear of being seen at a VCT center. In fact, HIV VCT centers have been more successful in large urban areas such as Harare and Bulawayo in Zimbabwe, where it is easier for clients to maintain anonymity than in the rural areas.

From the perspective of the individual, there can be constraints associated with HIV VCT services that are prohibitive. These include: user fees, the costs of transport to the site, and the "opportunity costs" (the costs associated with utilizing the HIV VCT service instead of, for example, working during the same time period). Many people are afraid to be tested in case they test seropositive, as

the essential drugs used in HIV treatment are unavailable. Women cite their spouse's consent as the biggest constraint to using services, and men cite their own psychological unwillingness to know their serostatus as theirs.

In spite of these constraints, however, studies indicate the following advantages: HIV VCT is effective in promoting behavior change; it is cost effective; and, it is feasible as one of the comprehensive HIV prevention strategies in developing countries.<sup>3</sup>

The criteria for choosing a location to set up an HIV VCT center include: a high-prevalence HIV/AIDS area, the demand for the service, and government and donor interest in initiating the process. Opportunities for setting up HIV VCT services in Africa include the following: VCT can be integrated into existing services; it provides an opportunity for various stakeholders to work with/through the government; despite the lack of access to antiretroviral therapy, options for living healthy lives for those who test HIV-positive do exist; it is feasible to conduct same-day HIV voluntary counseling and testing using a rapid test; and, opportunities are available for trying out innovative strategies, for example, the provision of HIV VCT services using a social-marketing approach.

Dr. Sangiwa presented the major findings of the HIV VCT Efficacy Study conducted in Tanzania as part of a multicenter, randomized, controlled trial (1995-1997). In Tanzania, 1,427 participants were randomized to receive HIV VCT with health information, or just health information (HI) itself. The study findings showed that risk behavior decreased significantly over time in both treatment groups, but was significantly greater in VCT compared to just HI. Self-reported behavioral changes were validated by STD incidence data. Thus, HIV VCT is programmatically feasible and cost-effective, especially when targeted at high HIV-prevalence populations and couples. And, HIV VCT did not significantly increase negative "life events."

The assurance of confidentiality by the HIV VCT counselor facilitates disclosures of risky behavior. Couple counseling is more difficult to do, but more likely to reduce risk. The disclosure of test results is impaired by the client's fear of and experience with stigma and discrimination. Of those surveyed, 87 percent needed one pre-test and one post-test session. Clients reported an average personal expense of US\$7.50 to receive HIV VCT services. They reported a willingness to pay up to US\$5.00; however, when a fee of US\$3.00 was introduced at the study site, the number of clients decreased until the fee was adjusted to US\$1.50.

In addition to the aforementioned study results, the presenter gave detailed information on the development of the Zimbabwe HIV VCT program, including the principles underlying the program, the responsibilities of implementing partners, the site selection criteria, a list of target groups and client characteristics, and a description of HIV VCT service delivery models.

---

<sup>3</sup> Studies referred to included the following: studies among discordant couples in Kinshasa, Zaire (1991) and Rwanda (1992); a study in Thailand on HIV counseling and testing of HIV-infected patients (1995); an evaluation of impact of HIV counseling and testing on behavioral change among AIDS Information Center clients in Uganda (1997), and a multicenter randomized study of HIV VCT efficacy in three developing countries (1994-1997).

Overall, qualities of an effective HIV VCT network include the following:

- Accessibility, including hours of service
- Affordability
- Positive provider-client interaction
- An adequate number of counselors
- Strict quality assurance and supervisory measures
- Knowledge of a referral network
- Support for counselors, and
- An approach focused on sustained health impact.

### ***EXPERIENCES OF HIV VCT IN TWO AREAS OF KENYA***

Gilly Arthur, Gilbert Ngatia, Steven Forsythe, Liverpool School of Tropical Medicine, United Kingdom

Gilly Arthur and her two colleagues presented various aspects of their research: a description of the study, the cost implications, and how to develop a mobilization strategy for primary health care-based HIV VCT services.

The purpose of the study was to assess the feasibility and accessibility of HIV VCT services integrated with health centers in Kenya. The intervention was carried out in health centers in Nairobi and Thika over a period of 19 months: HIV VCT services were integrated with other services at two rural and one urban public health center; counseling services were offered, which included but were not exclusively HIV VCT; prolonged care service was offered; and, free same-day, rapid on-site HIV testing was provided. Methods were evaluated, including client interviews, records and lab-based ELISA testing.

An average of two to seven clients received counseling per day in each health center, and over the 19-month period, 1,281 clients were pre-test counseled. Of these, 91 percent agreed to be tested. Using the rapid test allowed clients to receive their results the same day, and the data show that 80 percent of those tested were informed of their serostatus either the same day as tested or during their second appointment. A dual rapid testing algorithm was used with *Immunocomb*®, and positive tests were confirmed using *Capillus*.® Results showed 98.3 percent sensitivity, 99 percent specificity, and 2.1 percent indeterminates.

The client profile was largely young and single, and nearly half were men. The main reason given for testing was “just to know;” 64 percent were self-referred, and 84 percent came from within the catchment area of the health center.

Their conclusions were that client uptake was reasonable; same-day testing was accurate and facilitated high rates of post-test counseling; clients self-referred just to know their status; and, HIV VCT in health centers attracted a broader range of clients than would normally access health centers.

Mr. Steven Forsythe examined the high cost of HIV VCT and whether it could be offered more affordably if it were integrated into existing health centers. Based on FHI's research findings, the cost of HIV VCT at stand-alone sites is US\$26 per client. Using health center-based HIV VCT, this cost was reduced to between US\$8 and US\$16. Mr. Forsythe compared this cost with Kenya's per capita recurrent health budget of US\$3.40 in 1997, down in real terms from US\$9.50 in 1980. It was determined that HIV VCT adds 9 percent to the annual cost of operating a health center, and the largest component of this cost is labor.

Mr. Forsythe presented figures on the cost to offer HIV VCT nationally in Kenya. The start-up cost would include initial training costs of US\$210,000, plus an awareness campaign cost of US\$60,000. Recurrent costs include those for the health center, supervision, and retraining and would total US\$4.13 million for project-salaried centers and US\$2.76 million for centers using government health workers. Fifty per cent of the clients surveyed were willing to pay US\$5.71 for HIV VCT. However, at US\$0.70 (KES 50) per client, only 7 percent of costs would be recovered—but this would be affordable to 87 percent of the Kenyan population. To raise the percentage of cost recovery to 23 percent, HIV VCT would have to cost US\$2.85, but would be affordable to only 70 percent of Kenyans.

The research team came to the following conclusions: the cost of HIV VCT could be substantially reduced by integrating the services into health centers; the national cost of providing HIV VCT in all health centers would be US\$3-4 million per year, or 1.4– 2.0 percent of the MOH's recurrent health budget. Some level of cost recovery is likely to be feasible, although demand is likely to drop off at a price of above US\$1.00 to as high as US\$3.00. The team felt that the pilot study results were promising, that some important issues for scale-up remain unsolved (e.g., counselor selection, motivation, training and supervision), and, that a national HIV VCT strategy should include complementary approaches (e.g., health-center-based, as well as stand-alone HIV VCT).

Mr. Gilbert Ngatia provided further details on how to develop a mobilization strategy for primary health care clinic-based services. The challenge was to convert service access to service uptake. To better understand the barriers to uptake, 18 focus group discussions (FGDs) were conducted with men, women and young people. The results were analyzed and formed the basis for the development of a mobilization strategy.

The community's views on HIV VCT were similar to those presented earlier on the views of individuals. People said they were not tested because of fear, and their impression of counseling was that it suggests inadequacy, foolishness and insanity. They also were unclear as to the benefits of knowing one's serostatus.

Views on confidentiality were conflicting: whereas individuals didn't want others to know their serostatus, HIV VCT was also seen as the community's opportunity to find out who was living with HIV and perhaps quarantine them.

Myths surrounding HIV testing were common, and these included the following: the testing procedure transmits HIV; the results are unreliable; people die of shock after receiving a positive

result; and, HIV-positive clients take revenge by infecting others. These misconceptions were incorporated into the training program for field mobilizers, and communication materials were developed to address the issue of stigma. Thus, developing a community-sensitive mobilization strategy played a crucial role in promoting client uptake.

### ***EXPERIENCES IN VCT IN OTHER AFRICAN COUNTRIES***

Ms. Elizabeth Marum, Technical Adviser, U.S. Centers for Disease Control and Prevention, Malawi

Ms. Marum presented the collaborative experiences of CDC and MACRO (Malawi AIDS Counseling and Resource Organization) in Malawi and Uganda. She added to what earlier presenters had said about the advantages of HIV VCT in that VCT helps build awareness of HIV/AIDS, reduces the stigma of the disease and contributes to surveillance. Early diagnosis of HIV infection assists health workers in providing better care, and HIV VCT serves as an entry point for tuberculosis (TB) preventive therapy and the prevention of mother-to-child HIV transmission.

In Malawi, HIV VCT has been available since 1992, but utilization has remained low. HIV testing has been done off-site at central hospitals, resulting in delays in obtaining test results and a lack of quality control. Inconsistent and inadequate supplies of HIV test kits also have affected the demand for HIV VCT. In 1999, for example, only 69 percent of HIV VCT clients received their results.

The lack of laboratories and laboratory personnel in rural areas in Malawi has made the extension of HIV VCT to new areas difficult. To address these problems, MACRO, the country's National AIDS Control Program (NACP) and CDC developed a protocol for evaluating a new generation of test kits. CDC provided training for counselors and lab technicians, on-site supervision, and the selection of test kits for evaluation. USAID provided funding for additional staff and for increased radio promotion of HIV VCT.

The test kits selected for evaluation included Determine HIV 1 & 2 (Abbott Diagnostics), HemaStrip HIV 1&2 (Saliva Diagnostics), and UniGold (Trinity Biotech). The selection was based on a set of criteria,<sup>4</sup> and the evaluation protocol was presented: kits were first subjected to testing in the central hospital lab. The test results were compared with ELISA tests, and Western Blot was used on 75 samples prior to use at MACRO. An additional 203 samples collected at MACRO were confirmed with Western blot testing. Over a two-month period, venous samples were collected from all clients, in addition to finger-prick samples. All were re-tested using standard ELISA tests in the central hospital laboratories, and two different tests (Determine and HemaStrip) were used simultaneously on all clients.

The test kit performance results were as follows: out of 4,904 HIV tests, Determine had 11 false positives and no false negatives; HemaStrip had no false positives or false negatives; and, UniGold had no false positives or false negatives.

---

<sup>4</sup> The criteria included the following: rapid results and simple procedures (no centrifuging, single buffer, no washing); whole blood from finger-prick samples; no electricity required to run the test; refrigeration not required for storage; documented high rates of sensitivity and specificity; and, well tested elsewhere and on the commercial market.

The counseling procedures for rapid, same-day test results were presented, including: anonymous registration; orientation to HIV VCT with test decision counseling (asking the client if s/he is ready to receive results); finger-prick blood sample taken; counselor provides HIV prevention counseling while the test is run; counselor gives test result counseling and supportive counseling for HIV-positive clients.

They found that counselors much preferred giving same-day results. The portability of test strips meant that counselors could show clients their actual test strips, increasing client trust, and MACRO had more control over the quality of the testing. Most significantly, the provision of same-day results was associated with a fourfold increase in demand for HIV VCT at MACRO, albeit there was no increase in the percentage of women clients. The aforementioned study results led to the following conclusions:

#### *Testing Algorithm*

- The algorithm of Determine and HemaStrip used concurrently gives very accurate results, equal to or exceeding those typically from hospital laboratories.
- The use of two different, concurrent tests means that both positive and negative results are confirmed.
- A third rapid test can be used as a “tie-breaker.”
- The use of whole blood, simple, rapid HIV tests for same-day results is feasible for use in VCT sites, including rural sites with no electricity or laboratories.

#### *The Impact of Same-day Results on Access to HIV VCT*

- Clients and counselors prefer same-day results.
- The percentages of female clients and the rates of HIV infection have not changed significantly since the provision of same-day test results was introduced.
- The number of clients requesting HIV VCT has increased fourfold compared to the same period one year ago.
- The number of clients informed of their serostatus has increased sixfold compared with the number informed in 1999.
- The provision of same-day test results has great potential to increase the access to and the utilization of HIV VCT in Africa.

#### *The Elements Contributing to High Demand for HIV VCT in Malawi and Uganda*

- Anonymous services
- Free-standing HIV VCT sites
- Same-day test results
- Perceived high quality and reliable results
- Consistent radio promotion
- Free testing services now in Malawi; free in Uganda for five years
- Malawi only: fingerprick blood sample

- Uganda only: additional services focused on family planning, STIs, simple medical care, food supplementation for people living with HIV/AIDS in Post Test Clubs.

*The Advantages of Integrating HIV VCT into Existing Health Facilities*

- HIV testing becomes more of a routine event in health care.
- HIV VCT potentially becomes a more sustainable service.
- The existing health-care setting is possibly more anonymous.
- Health workers in the existing facility become involved in HIV prevention.
- The service integration may attract people who would not go to a free-standing HIV VCT site.
- Such service integration allows more direct referrals for services for people living with HIV, such as TB diagnosis, the prevention of MTCT, and the treatment of opportunistic infections.

*The Disadvantages of Integrating HIV VCT into Existing Health Facilities*

- An inadequate number of staff is dedicated to HIV VCT service provision.
- The focus is more on medical diagnosis, rather than HIV VCT for social reasons.
- Clients fear a lack of confidentiality.
- Healthy young men do not use health facilities.
- Urgent medical problems are attended to before “elective” services such as HIV VCT.
- Labs prefer to do batch testing and do not usually provide rapid results.

*Recommendations for Providing HIV VCT Services within Existing Health Facilities*

- Employed staff (including counselors, lab technicians, data entry and reception clerks) should be dedicated to HIV VCT service provision.
- Volunteers can be involved, but not as essential HIV VCT service providers.
- The on-site use of whole blood, simple, rapid HIV tests is recommended.
- Two different tests should be used simultaneously on all samples; a third test should be used as a tie-breaker when needed.
- Same-hour HIV test results are preferred.
- The use of HIV VCT services for medical diagnosis should be discouraged.
- The physical setting should promote the perception that HIV VCT services are of high quality.
- Free services should be considered in the early stages of program implementation, until community acceptance and the demand for HIV VCT services is high.

*Promotion of VCT Services should emphasize*

- Services should be anonymous with no names taken.
- Same-hour test results should be given, with no waiting period.
- HIV VCT services should be provided for people who feel healthy, including young people and men.
- The purpose of HIV VCT is to enable individuals to make more informed and better decisions and change any unsafe behaviors, reducing their risk of HIV infection.
- HIV VCT is not a “medical event”—no doctor’s orders are needed to access the service.

- A finger-prick blood sample is recommended, with a single-use needle.
- HIV test results should be confirmed immediately for each client.
- Clients should be able to see their own HIV test results.
- “Most people” get good news, because most are not infected with HIV.
- Radio advertising is the recommended way to promote HIV VCT services.

### ***AN OVERVIEW OF THE IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT IN KENYA***

Peter Mwarogo, Field Operations Manager, FHI/IMPACT/Kenya

Peter Mwarogo presented the FHI/IMPACT/Kenya project design within which FHI plans to expand HIV VCT interventions. The IMPACT Project is implemented in priority communities in Kenya that were selected with the following criteria in mind: the prevalence of HIV, the presence of high-risk situations and settings, a population density to warrant the investment, and existing programmatic needs and gaps.

The IMPACT Project sites were selected in three provinces: Rift Valley, Western and Coast. The intervention continuum is comprised of HIV prevention activities, AIDS patient care, and survivor support. Various groups are targeted: the uninfected, people exposed to HIV infection, people living with HIV, people living with AIDS, and people coping with the death of a family member. Mr. Mwarogo described the interventions appropriate for each group. The intervention framework includes behavior change communication, service improvements, community-based mitigation, and support.

The objectives of behavior change communication interventions are to increase the perceived distance between exposure and HIV infection and between HIV infection and AIDS; to increase the perceived distance between meeting someone and becoming sexually involved; to improve sexual negotiation skills; to create a better understanding of and confidence in the usage of condoms; to create a greater understanding of the risk of unprotected sex when one has multiple sexual partners; and, to create greater interest and confidence in HIV voluntary counseling and testing.

Mr. Mwarogo described the process of developing the behavior change communication component from the stage of formative assessment to monitoring and feedback: Sex workers have been mobilized into peer-led self-help groups. Workplace-based peer education focusing on male workers, community-based peer education focusing on adult women, popular theatre for development outreach appealing to the youth, school-based peer education with an emphasis on girls and “influential adult” campaigns are all activities that are being implemented with various target populations through the IMPACT Project.

Interventions are also being implemented to improve services; for example, clinic upgrading in STD case management, establishing HIV VCT centers in Mombasa and Western provinces, upgrading of clinics in AIDS patient care to support home-care efforts, and the upgrading of TB centers into diagnostic centers. Community-based mitigation interventions include home care linked to primary

health care clinic- and hospital-based services; psycho-social support activities, such as the formation of support groups; death preparation; establishing revolving funds and micro finance initiatives; and, support to families to meet the needs of AIDS orphans.

Supportive and nationwide interventions are also being implemented and include the following: resource centers have been established through the Kenya AIDS NGOs Consortium (KANCO) in each of the priority areas, and behavioral and biomedical evaluation data in the form of HIV and STD rates have been collected on sex workers, employees at work sites, and a representative sample of youth and adults. At the national level, HIV prevention is being marketed to the private sector; NGO and church networks are being supported; the national blood policy is undergoing improvement; a national HIV VCT center is being established at Kenyatta National Hospital; a national TB reference center is undergoing strengthening; national guidelines for HIV VCT and clinical care are under development with the MOH for national dissemination; and, some small grants are being disbursed across the country.

Mr. Mwarogo presented the project coordination structure between FHI and its coordinating partners at the central level: the Program for Appropriate Technology in Health (PATH) provides technical assistance in and monitors behavior change communications as well as implementation teams in each province. IMPACT Project field offices in Kakamega and Mombasa and the virtual field office in Nakuru are monitored from the IMPACT/Nairobi office. Through this structure, IMPACT is synergistically using implementation teams composed of partners, providing systematic coverage through zone-based planning and monitoring, providing intensive and systematic peer education and an integrated behavior change communication strategy with materials developed to be used by all partners, and facilitating programmatic diversity to operationalize the HIV prevention to care continuum.

### ***HIV VCT INTERVENTIONS—LINKING PREVENTION, CARE AND SUPPORT***

Dr. Eric van Praag, Director, HIV Care and Support, Family Health International, USA

Dr. Eric van Praag presented a diagram laying out HIV voluntary counseling and testing as the entry point to the HIV/AIDS continuum of care. Since people seeking care may go for HIV VCT to determine their serostatus, free-standing HIV VCT sites, health centers and traditional care facilities should include active referral mechanisms. The networks and services these mechanisms should encompass include peer support groups, youth groups, palliative emotional and spiritual support for individuals, medical specialists and specialized care facilities, legal support, and home care providers.

HIV VCT initiates the acceptance of one's serostatus and the need to cope with the results of an HIV test. The VCT service can lead to facilities offering preventive therapy, including for TB and bacteraemia, and to facilities offering contraceptive advice. HIV VCT facilitates behavior change, it can reduce mother-to-child transmission of HIV, and it can help individuals to plan for the future through referral networks to other services, including the provision of legal advice—for example, how to make a will—and for the care of orphans. An HIV VCT client should be able to access

referrals as well for social and peer support, and for the management of opportunistic infections, including STDs.

Dr. van Praag then focused on the care and support needs of a client who may have visited an HIV VCT site and tested positive. He looked at the need for medical care, psychological and spiritual support, and nutritional, socioeconomic and legal information. Medical services should provide full information about the repercussions of one's serostatus, the prevention and treatment of opportunistic infections including tuberculosis, the management of other HIV-related illnesses, interventions to reduce MTCT, new therapies including antiretrovirals, palliation, symptom control, and home care. Fundamentally, the client should be treated with dignity and confidentiality. Psychological and counseling support should include pre- and post-test counseling with informed consent, preventive behavior education and the involvement of the sexual partner, emotional support to cope with the present and plan for the future, guidance on disclosure of one's serostatus to the significant other, reproductive health decision-making planning, drug adherence information, and ways to strengthen self-esteem as well as address denial and stigma. Spiritual support should be available through all stages of the illness to enhance the patient's ability to cope. And, it should continue afterward by supporting the family during the bereavement phase.

Nutritional information should equip the patient to face repeated illnesses and wasting syndrome, to boost his/her immunity with micronutrients, and to provide replacement options for breast-feeding. Socioeconomic support should include care and support for orphans and vulnerable children, helping hands during the late stages of disease at home, and ways to replace lost income and diminish the subsequent family burden. Legal assistance to the patient should be available to ensure that his/her rights are respected, to prevent property grabbing after death, and to reduce stigma, discrimination, abuse and violence.

Dr. van Praag also presented the minimal requirements for establishing an HIV VCT center and the steps toward setting one up. Possible VCT sites could be free standing, at hospitals, through NGOs within a hospital setting that are integrated with general services, attached to a specialized clinic or to an antenatal clinic, in the private sector, or attached to a research or pilot project. There is also the new option of self-testing at home.

Minimal requirements for an HIV VCT center include institutional policy and authorization, an implementation team, community awareness raising, and an appreciation of the importance and role of the center by all health or medical staff. It should build on existing resources and procure long-term funding arrangements, provide high-quality HIV voluntary counseling and testing, and a monitoring and supervision/support scheme should be in place.

To plan the establishment of an HIV VCT site, first a needs assessment should be conducted. The community and health system should be made aware of and be prepared for the establishment of the center to ensure political commitment, institutional ownership and support and sustainability. Existing resources and services should be identified and mobilized; in particular, long-term financing should be secured. Once this is done, objectives need to be defined and a workplan prepared.

To implement the plan a team must be chosen and a site for the work selected. Staff must be identified and trained. Using a team approach, necessary coordination and linkages should be established. The team should choose a testing strategy and organize a distribution and supply system.

### ***THE ROLE AND APPLICATION OF HIV VCT IN TB CONTROL IN KENYA***

Daniel Kibuga, Head, National TB and Leprosy Programme, Nairobi, Kenya

The National TB and Leprosy Programme has been in existence in Kenya since 1980. Between 1980 and 1985 there was a downward trend in annual TB case notification. However, since 1987 there has been a reversal of this trend, and in the last five years there has been a 20 percent increase in TB notification. This means an increase from about 10,000 cases reported in 1997 to nearly 60,000 in 1999 alone. The caseload has increased from about 27 cases per 100,000 population to 50 cases per 100,000. Dr. Kibuga attributed this increase mainly to the HIV/AIDS epidemic, but also to the growing poverty and urbanization in Kenya, resulting in slum areas.

Dr. Kibuga emphasized the importance of HIV VCT in TB control with the following scenario: with Kenya's population of approximately 30 million people, of whom 15 million are adults, and a TB infection rate of 30 percent, there are 5 million people infected with TB. Given an HIV prevalence rate of 10 percent, 500,000 of this group could be infected with both TB and HIV. A TB breakdown rate of 10 percent in dually infected people results in 50,000 new cases of TB due to HIV infection each year. HIV VCT sessions could provide opportunities for early diagnosis of TB and provide an entry point for administering chemoprophylaxis.

If HIV VCT could be provided to even a small percentage of Kenyans, a good number of TB cases could be averted by referral for treatment. HIV VCT sessions could provide a forum for educating counselors on TB symptom recognition so that people could seek treatment and refer relatives and friends early on. This process could also work in reverse, with TB patients being advised to seek counseling and testing for HIV. At present Kenya's National TB and Leprosy Programme is working with the National AIDS Control Council to ensure that HIV/AIDS information incorporates information about TB.

Including HIV VCT in a TB program without linking it to care—treatment and prophylaxis—could be purely an academic exercise. Thus, the MOH is currently discussing the procurement of TB drugs with the donor community and hopes to get some commitments for drug supply for the next five years. Currently, the MOH has a buffer stock for one year.

## ***THE ROLE AND APPLICATION OF HIV VCT IN MOTHER-TO-CHILD TRANSMISSION OF HIV***

Dorothy Ngacha, Senior Lecturer, Department of Paediatrics, University of Nairobi, Kenya

Dr. Ngacha began her presentation by describing “the package” of services required to prevent MTCT of HIV: improved antenatal services, including provision of micronutrients, treatment of STIs and malaria; counseling; HIV testing; and, the provision of retrovirals and infant feeding options. This package is being utilized in two project sites in Kenya—Karatina and Homa Bay—by the Network for AIDS Research in Eastern and Southern Africa (NARESA). The project was contracted by the Population Council, using United States Agency for International Development (USAID) funding, with additional inputs/support provided by the United Nations Childrens Fund (UNICEF) and the World Health Organization (WHO).

Dr. Ngacha walked the participants through the process of project implementation, starting with the improvement of antenatal services. First, a training needs assessment was conducted among health workers. The subject areas covered during the training included facts about HIV and MTCT, counseling, maternal and infant care and infant nutrition—specifically, lactation management, replacement feeds and complementary feeds. To develop information, education and communication (IEC) materials: first, a consultant was sent to visit communities; a development workshop was held to design messages, identify audiences and work out a strategy; and, afterward, materials were developed and field-tested.

To integrate MTCT services into existing maternal and child health services, additional supplies and equipment were procured and buildings were expanded. Staff and space were allocated for these activities. The question was how and where to fit MTCT activities into the patient flow. These activities included imparting health information, carrying out physical exams, and performing any necessary laboratory tests.

Counseling of MCH clients needs to be tailored with specific objectives in mind: to encourage them to go for counseling and HIV testing, to assist them in making decisions on MTCT interventions and providing them with the skills and support to implement their decisions, to seek care regularly for a healthy pregnancy and a healthy baby, and to practice safe sex during their pregnancy and contraceptive methods subsequently. Counseling should be ongoing, from the first antenatal clinic visit through delivery, and all immunizations should continue up to nine months following delivery. Partner involvement should be encouraged, but the decision left up to the mother.

Education can be provided during clinic visits—through videos and other audiovisuals, as part of the usual antenatal clinic health talk, and during group pre-test counseling. However, one-on-one pre-test counseling should also be offered.

The first post-test counseling session includes the presentation of test results. The second session should include safer sex counseling and introduction of MTCT interventions for HIV-positive mothers, with time allowed for the client to consult with the counselor and decide what to do. To

assist a mother in making decisions about MTCT interventions, the counselor should review the situation with her and provide ongoing support of the mother's decision. Support also needs to be provided soon after labor, according to the infant feeding choice, and should include a first replacement feed, lactation management, and preparation for the community reaction to her decision.

The HIV testing algorithm for antenatal clients is as follows:

- Rapid *Immunocomb* is used, and if results are negative, the results are reported to the client.
- If the results are positive, a second test is conducted, rapid *Capillus*, and if positive, the results are reported to the client.
- If the results of the rapid *Capillus* are negative, an ELISA test is performed.

Experience has shown that there is better acceptability of results by the client if she receives them on the same day as she is tested. However, they may be given at any time over the subsequent two weeks. What is not yet known is if this higher acceptability of results with same-day testing also translates into better uptake of the interventions, since this is the ultimate goal of HIV VCT in the antenatal setting.

Infant feeding information was also part of the package. As health workers are used to telling mothers what to do rather than giving them information that they can use to make their own decisions, a different orientation was emphasized. Messages about breastfeeding by an HIV-positive mother had to be modified as health workers had traditionally advocated breastfeeding for everyone. At the same time, questions arose as to the pros and cons surrounding breastfeeding and the dangers of inadequate hygiene.

Health workers also need to support mothers who choose not to breastfeed and thereby expose themselves to the stigma of being suspected as living with HIV. In lieu of breast milk, the mother has to contend with the possibility of an inadequate supply of replacement foods.

The project package included the antiretroviral drugs, AZT and nevirapine. Whereas AZT is initiated during the antenatal period, women who present for antenatal care late or who plan to deliver away from the hospital are given nevirapine, which is to be administered to the mother when she goes into labor and to the infant within 72 hours of birth. However, Dr. Ngacha expressed concern that the packaging of NVP was done in 20 ml. amounts, and only 0.6 ml was required for the infant, thus introducing the danger of overdosing and wastage. Monitoring issues related to long-term safety and the possible emergence of resistance to nevirapine both present difficulties if it becomes available through the informal sector.

Dr. Ngacha then presented the challenges that were identified by the project. The main one was care of the mother. After the onset of labor and administration of nevirapine, which drugs should be administered to her? Where would trained, qualified counselors be found? Who might they be? All antenatal clinic and maternal and child health staff in the pilot sites have received full training in MTCT, but they total very few people. Likewise, counselors in HIV care and support organizations are an integral part of the continuum, but they still number very few.

The project intends to train and employ HIV-positive mothers as peer counselors. Issues of concern regarding counselors include adequate skills, motivation, work load and burn out. Confidentiality surrounding HIV voluntary counseling and testing is a challenge to maintain, as laboratory records and counseling notes are records that need to be treated carefully. Attendants in the labor ward should be informed of these requirements.

The question of using rapid tests was also raised. When should the test be done? Is there time to counsel the mother adequately before receiving results, and is there time for the counselor to debrief and combat burn-out if a number of clients are receiving their results the same day?

It was considered important that a feeling of ownership of the project be maintained. This was achieved through project implementation by the District Health Management Teams (DHMT). The DHMT and the District AIDS/STD Control Officers (DASCO) helped to mobilize the communities. Health workers in all health units in the district are to be trained by DHMTs to give out information and refer patients to support services. Community-based organizations, nongovernmental organizations (NGOs), community leaders, traditional birth attendants and community-based distributors (CBDs) should all be involved in the project.

To monitor and evaluate the project, routinely collected data was used from registers and tally sheets; however, the quality of the data was sometimes questionable. One of the remaining challenges is to evaluate the social impact of these interventions on women's health.

### ***FAMILY PLANNING AND HIV VCT: OPPORTUNITIES AND CHALLENGES***

Michael Welsh, Regional Director for Family Planning and Reproductive Health Programs, Family Health International, Nairobi, Kenya

Dr. Welsh began by reminding the audience of the value of family planning (FP) as a public health intervention. In the context of VCT, providing quality FP services for individuals can lead to important positive public health gains, in terms of MTCT of HIV among the infected and in terms of healthy child spacing among the uninfected.

An overview of the existing family planning infrastructure in Kenya was provided. It was noted that FP is provided in the context of PHC services. There are 206 hospitals, 131 maternity/nursing homes, 574 health centers, 1120 dispensaries, 437 clinics all staffed by 20,000 CBDs and community health workers involved in the provision of FP services in Kenya. Of these providers, 58 percent are public and 33 percent private. This allows for a large number of prospective HIV VCT intervention sites. The directionality of services can go either way: from family planning to HIV VCT or HIV VCT to family planning. The common ground for either service is the client profile: individuals of reproductive age, all of whom require counseling, informed consent, specialized services, follow-up and referral.

The minimum conditions for providing HIV VCT services are that they are acceptable, accessible and affordable; adequate numbers of qualified staff are available to perform them; space is sufficient to allow privacy; counselors have knowledge of referral networks; and, the support for counselors is adequate.

Some relevant characteristics of a family planning clinic in Kenya (based on the Assessment of clinic-based family planning services in Kenya, Ndhlovu *et al*, 1997) were presented:

Average time to facility	45 minutes
Percent walking to facility	75%
Average waiting time before services are provided	1 hour
Average contact time with provider	15 minutes
Cost of travel to facility	KES 5.00

The family planning client flow chart depicts the client registering at the reception, then proceeding to the waiting area. Whether a new client or a revisit, s/he is shown to the family planning counselor/nurse. A method of contraception is discussed and perhaps agreed on. Counseling could include discussions of reproductive goals (spacing and timing of births), personal factors (time, travel costs, pain or discomfort), accessibility and availability of other products necessary to use the method, and the need for protection against sexually transmitted infections (STIs) and HIV/AIDS. Dr. Welsh later used this picture to illustrate the ample opportunities for HIV VCT services in a family planning setting.

A survey of 114 clients receiving HIV/AIDS counseling at FP/MCH clinics, carried out by the National Council on Population and Development of the MOH and presented in the KSPA 2000, reported 19 percent of counselors discussing risk factors, 14 percent mentioning condoms, 11 percent mentioning dual protection, and 6 percent mentioning other means of protection. Dr. Welsh compared some characteristics of HIV VCT and FP clients:

<u>VCT Clients</u> (G Arthur et al., Durban 2000)	<u>FP Clients</u> (Kenya DHS, 1998, FHI 1999)
45% male	Vast majority female
54% not married	>80% in union
64% laborers	26 years, mean age
57% with primary education	95% primary or higher education
11% come as a couple	Rarely come as a couple
13% pregnant	Pregnancy status unknown

From the aforementioned data, Dr. Welsh identified several opportunities, or “exploitable elements or moments” for HIV VCT interventions within FP settings. Family planning clinics have additional capacity with 25 percent down time; a waiting room is available for group counseling on HIV VCT service availability during the one-hour waiting time; HIV VCT services could be scheduled on

specific days; and, job aids for FP providers and HIV VCT counselors could be developed to reinforce both services. Community-based condom distributors (CBDs) could act as referral agents.

Specific issues, however, would have to be addressed: privacy and confidentiality need to be maintained; counselors are constrained by the time they have available for each client; counseling aids for HIV-positive and HIV-negative clients must be provided; a quality control assurance system must be implemented; and, referrals need to be given to clients for care and support services.

In many cases, family planning providers do not even discuss sex, so thorough training would be required before expecting them to be able to counsel clients about HIV. The target groups would be men, women and youth. The stigma associated with seeking HIV voluntary counseling and testing needs to be addressed, and it should start at the highest levels of government.

### ***THE ROLE AND APPLICATION OF COUNSELING IN HIV VCT***

Don Balmer, Executive Director, Kenya Association of Professional Counselors

Dr. Balmer presented a graph that pointed out the direct correlation between the provision of information and counseling and behavior change. Thanks to public awareness campaigns, counselors can assume people already have some information about HIV and AIDS. Counselors and educators do, however, need to keep abreast of the most recent issues and information. Public awareness campaigns should develop appropriate messages for their target audiences. Dr. Balmer noted that the metaphors used when discussing efforts to deal with AIDS, many of which present the efforts as a war, “Fighting against AIDS” and “AIDS kills,” reinforce the stigma surrounding AIDS. The counselor needs to avoid information overload and modify his messages to suit the client.

HIV VCT centers should take advantage of rapid tests and being able to provide clients with test results the same day. Counselors need to increase their recognition of the client’s agenda and guarantee confidentiality. Knowing one’s serostatus is a human right, and the counselor must engender trust from the client that s/he will keep that information confidential.

The quality of counselor training must be improved. Dr. Balmer noted that at his institution it takes 120 hours for a trainee to receive the core skills of counseling, yet many organizations ask their staff to counsel clients after a three-day training session. Counseling needs to be recognized as a profession, and ad hoc, short-term training efforts do not suffice. The length, quality and quantity of training are equally important. After training has been completed, independent and professional supervision of counselors needs to be provided to ensure quality control. This should be done regularly by someone from outside the clinic in a non-threatening way.

Finally, Dr. Balmer pleaded that project planners and funding agencies reduce their obsession with the cost-effectiveness of HIV VCT services. Counseling takes time and has costs that must be absorbed by the system. The sustainability of HIV VCT projects depends on political will, institutional support and the demand for services.

## ***THE ROLE OF THE COMMUNICATIONS CAMPAIGN IN HIV VCT PROGRAMS***

Amy Power, Regional Technical Officer HIV/AIDS, Population Services International/Rwanda

Amy Power described the strategy of social marketing in general and more specifically with respect to marketing HIV VCT programs, using Zimbabwe as the example. Advertising, she said, is equivalent to demand creation, and an advertising campaign utilizes several methods to disseminate messages: interpersonal communication, mass media and outdoor media.

In this case, the specific goal is to get clients to visit an HIV VCT site. This process involves behavior change; raising *awareness* of an unaware and unmotivated population, developing a positive *attitude* toward HIV VCT, making a *decision* to visit an HIV VCT site, visiting and *using* the HIV VCT site, and *sustaining* this behavior.

Various techniques can be used to maximize the impact of a campaign: segmentation, targeting, and positioning. Population groups sharing common attitudes and behaviors are identified or “segmented.” Specific segments within the population are designated as the priority recipients of the intervention, known as “targeting.” A simple selling argument is then identified, based on what is known about the target group’s needs and desires, called “positioning.”

When promoting HIV VCT, some challenges need to be taken into consideration: Prospective clients will need to overcome the fear of knowing their HIV status. The demand for HIV VCT services is usually low, and the perception of the services is negative, consistent with the perception of HIV/AIDS. There are few HIV VCT experienced “customers” who have trust in the service and can act as promotion agents. And, the supply of available services is still limited. Moreover, there is very little access to treatment for people living with HIV. Lastly, sustaining behavior change over the long term is difficult.

Marketing HIV VCT is different from marketing products. HIV VCT provides a channel of communication leading to behavior change, and a campaign must focus on motivating sustained behavior change both during the visit and after the visit to an HIV VCT site. Visiting the site is only the first step. As every client is a new “user/adopter,” the campaign must offer messages that are constantly changing, to target clients at different stages of the behavior change continuum. There are early adopters, the late majority and laggards. A campaign must also harness the potential of the private medical sector as “influencers” or advocates for HIV VCT services.

Various aspects of HIV VCT services can be marketed: what are the benefits of knowing one’s status, of high quality counseling, and of a testing service? The benefits of knowing one’s status can be presented as getting relief from the anxiety associated with the uncertainty about one’s serostatus, helping to plan one’s future, and taking advantage of the opportunity for early detection of HIV to lead to clinical care. What’s more, high quality counseling can motivate a client to change their behavior. Finally, an HIV VCT service will confirm one’s HIV status and can help an individual to gain a partner’s trust.

Before a communications strategy is designed, research should be carried out on the target populations. Targeting the right groups is important, and research needs to be interpreted accurately. It should focus on what people really care about, and simple but targeted messages should be developed based on what the research elicits. To begin with, the following issues should be identified:

- Do people know where to find HIV VCT services?
- Do parents and peers support HIV VCT?
- Are people aware of the benefits of HIV VCT?
- Are people confident they will receive high quality, confidential and caring services?
- Can people afford HIV VCT?

Research results should be used to help prioritize the issues with the highest impact, and the communications strategy should be designed based on what these are. This entails developing effective messages by identifying a unique selling point, deciding on whether to use generic behavior change communication messages versus brand-focused messages, and selecting the appropriate channels of communication to use.

In Zimbabwe, research indicated that there was low awareness as to what constitutes HIV VCT. The population did not know where to access HIV VCT, and many voiced negative feelings about HIV VCT. From this starting point, the communications campaign entered phase 1, “awareness creation.” The target population was familiarized with what constitutes HIV VCT, where the services are offered, and what the benefits of visiting an HIV VCT site are. The communication channels that were used included brochures, radio programs, radio, TV and press advertisements, signs, posters, T-shirts, pens and a newsletter.

The campaign entered phase 2 for the clients who had attended an HIV VCT clinic. The research had indicated a lack of social support. Thus, the campaign addressed this phase with “aspirational communications,” showing people who had gone for HIV VCT being admired by their peers.

The impact of the communication campaign in Zimbabwe was as follows:

- 52 percent of clients who have visited a “New Start Center” reported hearing about HIV VCT from the mass media.
- 87 percent of the target audience could recall the main message in the campaign, including being able to name the closest New Start Center.
- The Zimbabwe experience showed that offering high quality HIV VCT is important, and effective marketing and communications can help get the people in the door.

## **HIGHLIGHTS OF DISCUSSIONS OF PRESENTATIONS**

Between presentations, question-and-answer sessions were conducted. The highlights of these discussions are summarized below.

- The Ministry of Health (MOH) intends to provide HIV VCT services at 70 percent of Kenya's district hospitals over the next four years. All district hospitals should have HIV-testing equipment; however, one study showed that only one-third of them had kits currently.
- The participants were anxious to know when the government would have guidelines available for HIV VCT.
- A research study (Arthur et al.) set the cost of setting up an HIV VCT center at \$3-4 million per year including test kits, equipment, materials and project-paid counselors. The major cost is for personnel.
- Trying to assess the cost/benefit ratio of HIV VCT is difficult, especially when care and support services are included. Some felt care and support should be included with HIV VCT regardless of cost. It was pointed out that it may not be appropriate to link care and support only to HIV VCT, because clients who require care and support do so because of their serostatus, not because they have sought the HIV VCT services.
- The MOH has developed guidelines for HIV/AIDS care and support, and they have been dispatched to the districts. Dr. Mohamed is managing this effort.
- Some Kenyans do not wish to know their serostatus because they do not have access to antiretroviral treatment for HIV/AIDS.
- The element that contributed the most to demand for HIV VCT services at free-standing VCT centers in Uganda and Malawi was consistent radio promotion. It also prepared clients to receive their test results the same day. No data currently shows that a longer wait for results is preferable or beneficial.
- When post-test clubs are offered, some clients will return, but most HIV VCT clients do not return for additional counseling after they receive their post-test counseling unless medical care is provided to people living with HIV.
- The counseling of persons who are self-testing for HIV needs to be addressed.
- More services for adolescent girls should be made available and accessible.
- Some "mobile" HIV VCT interventions have been tried out in Uganda; however, taking blood elsewhere for testing was a problem. Rapid HIV tests should provide a better option, but adequate support is required to provide post-test counseling.
- Patients currently being treated for TB do not have the opportunity for HIV VCT because of other demands on health workers; however, 40-50 percent of TB patients are HIV-positive.
- The integration of TB treatment services with HIV VCT is desirable, though it poses some challenges. A major component of TB control is chemoprophylaxis, and drugs are in limited supply. A mobile drug facility is currently being established by the World Health Organization, but a buffer stock of one year must also be kept available.
- Guidelines for the treatment of MTCT of HIV have been developed by the MOH Kenya ObGyn Society.

- Community-based distributors (CBDs) are key players in promoting family planning services and making referrals, even though they have a thin layer of credibility among health workers.
- The obsession with project sustainability as justification for project support should be reduced, particularly with regard to HIV VCT, and implementation begun: HIV VCT has been shown to bring about behavior change.
- One of the biggest constraints to counseling and testing is that people equate HIV with AIDS.
- People think of counseling too much as a one-way dynamic, as giving advice. It must be recognized as a two-way exchange.
- The standards of The World Bank are probably not applicable in the counseling context; for example, looking at the relative merits of different interventions is not useful, mainly because the resources are too limited to allow this exercise to be productive. People may use the number of people reached as an indicator of successful counseling programs when counseling depends on establishing a client-provider relationship to bring about behavior change. The time it takes to accomplish this may not allow a high number of people to receive counseling, yet the overall objectives still could be reached.
- Social marketing of HIV VCT focuses on marketing a service rather than a product. A private service that is paid for is often more valued than a public service, but there aren't yet any data on this with regard to HIV VCT.
- In Kenya there is not enough pressure to date to get antiretroviral drugs for HIV/AIDS and make them available.

## **GROUP WORK SESSIONS**

At the beginning of the meeting, each participant had been asked to sign up for participation in a thematic group that would address issues presented on the first day. The subject areas covered the following:

- Integrating HIV MTCT and VCT
- Integrating HIV VCT, family planning and STI treatment
- Communication support for HIV VCT
- "Counseling" in HIV VCT
- HIV/AIDS care and support in the community
- TB and HIV VCT

Given the limited number of participants in some of the groups and the closely related themes, HIV MTCT and family planning/STIs were combined, and care and support was combined with TB. Guidelines were given, and at the end of the morning sessions, a representative from each group presented their findings. The questions to be addressed included the following:

- What are the critical issues in HIV VCT as they relate to your subject area?
- What are the next steps that need to be taken to operationalize these issues?
- What resources are needed/available to operationalize these issues?

- What relationships/partnerships should be formed to accomplish this?
- How can we foster better coordination of HIV VCT issues and activities?

### ***INTEGRATING HIV VCT, MTCT AND FAMILY PLANNING/STIs***

The critical issues that were identified included deciding on the model to be used to incorporate HIV VCT with existing family planning programs or other health service programs, the number of counselors that would be needed, and their required level of experience and training. In the case of the government, which is in the process of retrenching staff, how to plan for more staff for HIV VCT service provision was also identified as an issue. The group felt it was important to make linkages with other service delivery points to facilitate program sustainability. And, monitoring and evaluating services was seen as an important contribution to increasing the number of users.

Next steps to operationalizing the HIV VCT model should begin with a meeting to establish policy guidelines and direction. Providers need to receive training, both pre-service and in-service, and be sensitized to the new needs of clients. For those clients who test HIV-negative, counseling and support must be given to help them maintain their status.

Resources will be needed in the forms of human, material and financial. Health care providers will need to be reoriented to perform expanded service provision. This might include more highly skilled, “master” counselors as overseers, as well as those who have only attended short courses. The MOH Medical Training Center, NGOs and private sources should provide additional training in HIV/AIDS counseling and information. Supplies will need to be procured, such as HIV test kits, drugs for opportunistic infections, replacement feeds and antiretrovirals, and, of course, funds secured with which to buy them.

In setting up HIV VCT sites, a mapping exercise will first be carried out to establish partnerships, to determine the availability of health resources, and the existence of religious groups, community-based organizations (CBOs), nongovernmental organizations (NGOs), community-based distributors (CBDs), and community health workers (CHWs). Linkages will be made to provide support to people living with HIV/AIDS.

To coordinate activities, a mechanism should be set up by the MOH assisted by the National AIDS Control Council (NACC). Stakeholders’ fora, including donors, should be established at the district level, as well as a secretariat to work with both the MOH and stakeholders to oversee services offered in MTCT and FP.

#### *Discussion*

- The concern was expressed that the mother was not being targeted enough in providing HIV MTCT services. Once a mother has given birth, would she have access to prophylaxis? More innovative ideas than just giving referrals are needed to help the mother. And, mothers could be used as peer promoters of HIV MTCT services.

- As a model, that of MCH services linked to the MOH Health Unit could be used. However, the question arose as to how to add an HIV VCT component to already over-utilized MCH clinics.
- Counselors with short-term training are also already overworked, and some incentives are needed.
- About 20 percent of ANC patients who receive 15-minutes of pre-HIV test counseling are new. This amount of counseling may not be sufficient to make an informed decision.

### ***COMMUNICATION SUPPORT FOR HIV VCT***

This group first identified the audiences to target: the government of Kenya in the form of Parliamentarians and policymakers at all levels; the end-users or beneficiaries; health care providers; the media and the community, including CBOs, NGOs, and networks. The issues of concern include creating a demand for HIV VCT, and that at present there is a lack of understanding of the role of VCT in preventing the transmission of HIV. Knowing where to go for quality services, generating support from opinion leaders, educating providers about their role in outreach and referrals, recognizing the lack of an integrated HIV/AIDS communication strategy, and barriers to client uptake are all issues that need to be addressed.

The following resources exist that can be utilized: in terms of financial capacity, there is the United States Agency for International Development, the U.S. Centers for Disease Control and Prevention, the United Kingdom's Department for International Development, the Kenyan Government, The World Bank, The Japan International Cooperating Agency, and NGOs. Institutional resources include mass media, advertising agencies, NGOs and communication specialists.

A joint committee could be set up by NACC to develop a communication strategy, based on HIV VCT guidelines. Such a communication strategy should take into consideration any available misinformation about HIV/AIDS and how to counter it.

#### *Discussion*

- To address misinformation being disseminated by some religious organizations, specific ones should be targeted and educated.
- A research component might be necessary to determine what motivates people to go for HIV voluntary counseling and testing.
- The media often spread negative rumors, and a communication strategy should include a rapid response mechanism to refute them. The National Network of People Living with HIV/AIDS should be involved in crafting a strategy that would utilize their experience in message design.
- Community views are important. PLWHA should be involved, as they speak from experience. Those who have utilized the services of HIV VCT facilities, both people living with HIV and people who are HIV-negative could share their experiences.

## ***THE ROLE OF COUNSELING IN HIV VCT***

Critical issues identified included a recognition of the different types of counseling and the clients—groups, individuals, adolescents, couples, sex workers—and the importance of all of them. Roles of counselors need to be defined and their skills improved. A cadre of counselors with career progression and selection criteria should be clearly defined. Health workers should be educated about the difference between counseling and educating.

Adequate space is needed in a facility for counseling, quality assurance, supervision and support. Issues of counseling should be broadened to include more than just HIV/AIDS. A client's right to knowing his/her HIV serostatus and the need for confidentiality must always be taken into consideration.

The next step to be taken is to train and sensitize all staff. Who should be trained? Counselors, supervisors, trainers and trainees need to be identified. What should be the course content and the duration? Where should counseling be offered and when? Pre-service or in-service training could be offered at the district, regional and national levels. Policy and VCT guidelines need to be developed; and, existing ethical guidelines should be reviewed and adapted, taking into consideration client issues and rights. Top management should be sensitized to facilitate having a cadre of counselors and all staff sensitized on issues related to counseling.

Human resources should include a dedicated staff. Funding, space and time are also required. Partnerships should be formed with the government, the private sector, NGOs, donors and international organizations, communities, support groups and PLWHA networks. In order to foster better a coordination of efforts, a national HIV VCT inventory could be drafted, and a newsletter could be utilized for information exchange. The group suggested establishing a central coordinating body for HIV counseling and related issues, as well as a technical working group and local, community-based HIV VCT advisory groups.

### *Discussion*

- There was some fear that too many parallel groups were being proposed, rather than working within the existing structure.
- A hospital could provide a Department of Counseling so that counselor trainees do not end up working as nurses under the control of the chief matron, able to transfer nurses at will. At present, the number of people trained as counselors compared to the number performing counseling is minimal.
- Standards for training counselors, a certifiable national curriculum, and an accreditation system for counselors need to be established.

## ***TB, CARE AND SUPPORT AND HIV VCT***

The issues include how to integrate HIV VCT into existing TB clinical services and facilities, and how to link HIV VCT with care and support groups in the community. Pro-active referrals are needed that go “beyond medicine,” i.e., taking into consideration a client’s other needs in addition to the medical.

Among health workers stigma is still attached to HIV infection. Stigma must be addressed through education and attitude change by health workers themselves. The policy surrounding treating people with HIV described in the Sessional Paper No. 4 on AIDS has not yet been put into practice. However, there has been some change in the government and donor perspectives, and HIV/AIDS care is being featured in proposals and projects.

Addressing the aforementioned issues could be done in phases, starting with meeting the minimum criteria for operationalization. HIV VCT demonstration centers could be launched, and HIV VCT could be promoted among health workers, policy makers and the community. Chemoprophylaxis, palliation, social support, etc., could be provided later. Guidelines and operational procedures could be set. Medical school curricula could be upgraded, and paramedics trained in pre-service or in-service courses. Finally, an attempt at standardization could be made.

To accomplish the aforementioned objectives, resources are needed, including: human, financial and material. Partnerships with government must be formed for the provision of HIV VCT, and NGOs, CBOs and the private sector should participate in drafting and implementing national policies on HIV VCT. Functional committees should be formed at the national, provincial, district and community levels.

To foster better coordination of efforts, an HIV VCT inventory could be compiled to facilitate networking. National guidelines for HIV VCT are needed and standards of service developed. Indicators for evaluating services need to be drafted. Exchange visits could be made between centers in Kenya and other countries where HIV VCT and TB services have been combined. A newsletter would facilitate information exchange. The National AIDS Control Council should take the role of leader. And, a national consensus meeting on VCT should be held after one year.

### *Discussion*

- What tangible items can be offered to people coming for HIV VCT or home-based HIV/AIDS care or TB treatment?
- Emergency counseling and treatment with ARV therapy, such as for rape victims, may be needed.
- Most media show people with HIV/AIDS dying in their beds, not knowing what to do. HIV VCT needs to be linked with these messages in a productive way.
- People living with HIV should be presumed to have been exposed to TB and thus should be given chemoprophylaxis.



## **AGENDA**

Consultative & Technical  
Meeting on VTC  
**September 7<sup>th</sup> & 8<sup>th</sup>, 2000**  
**at the Holiday Inn, Nairobi**

Thursday, September 7

- 8:30 **Welcome, introductions, and identification of what we want out of meeting:**  
*Mr. John McWilliam and Dr. Peter Lamptey, FHI*
- 9:00 **Official opening:** *Dr. Richard Muga, DMS*
- 9:15 **The USAID Plan for HIV and AIDS in Kenya:** *Ms. Neen Alrutzy, USAID/Kenya*
- 9:30 **The Kenyan Government Plan for HIV VCT:**
- 10:00 **Current issues in HIV VCT:** *Ms. Gloria Sangiwa, PSI*
- 10:15 **Experiences in HIV VCT in two areas in Kenya:** *Dr. Gilly Arthur, Liverpool*
- 10:30 **Experiences in HIV VCT in other African countries:** *Dr. Elizabeth Marum, CDC*
- 10:45 **Discussion on VCT**
- 11:30 **Tea**
- 11:45 **A synthesis of participants' expectations for the meeting**
- 12:00 **An overview of the IMPACT Project in Kenya:** *Mr. Peter Mwarogo, FHI*
- 12:30 **Lunch**
- 1:30 **HIV VCT interventions – Links with prevention, care and support:**  
*Dr. Eric van Praag, FHI*

## **The way forward**

- 2:00 **The role and application of HIV VCT in TB control in Kenya:**  
*Dr. Daniel Kibuga, Ministry of Health, Kenya*
- 2:30 **The role and application of HIV VCT in mother to child transmission of HIV:** *Dr. Dorothy Ngacha, University of Nairobi*
- 3:00 **The role and application of HIV VCT in family planning:** *Dr. Michael Welsh, FHI*
- 3:30 **Tea**
- 4:00 **The role and application of counseling in HIV VCT:** *Dr. Don Balmer, KAPC*
- 4:30 **The role and application of social marketing/advertising in HIV VCT:**  
*Amy Power, PSI*

Friday, September 8

- 8:30 **A review of yesterday:** *Ms. Debbie Gachuhi*
- 8:45 **Group work sessions**
- **Counseling Group:** *Moderator - Dr. Gloria Sangiwa*
  - **Care and Support in Community Group:** *Moderator - Dr. Eric van Praag*
  - **TB Group:** *Moderator - Dr. Daniel Kibuga*
  - **MTCT Group:** *Moderator – Dr. Maina Kahindo*
  - **FP/STI Group:** *Moderator – Dr. Mike Welsh*
  - **Communication Support for HIV VCT Group:** *Moderator – Ms. Michelle Folsom*
- 10:30 **Tea**
- 10:45 **Report back of the groups and discussions**
- 1:00 **Closing and lunch**

## PARTICIPANT LIST

NAME	TITLE	ORGANIZATION	CONTACT ADDRESS	TELEPHONE	FAX
Alrutz, Ms. Neen	Senior Health Program Manager	USAID/Kenya	PO Box 30261, Nairobi	862400	860870
Arthur, Dr. Gilly	VCT Project Consultant	LSTM	Pembroke Place Liverpool L35QA	+44-151-708-9393	
Ayisi, Dr. Kangwana Robert	Medical Superintendent	Ministry of Health	15 Kakamega	0331-30009	0331-200
Baggaleh, Dr. Rachel	Consultant/VCT	WHO	WHO, Geneva	+44-207-976-5695 or +41-22-791-4834	
Baghazal, Dr. Anisa	Project Director	Mkomani Clinic	95683 Mombasa	011-433152	
Balmer, Dr. Don	Executive Director	Kenya Association of Professional Counsellors	55472 Nairobi	786310	784254
Corijn, Dr. Wim	Exploring Mission MICT Project	MSF-B/ICRH	38897 Nairobi	577157/ 570021/5	572157
Costigan, Ms. Aine	Project Manager	UON	19676 Nairobi	718895	712007
Debuyscher, Ms. Rose	Resident Adviser	FHI/Namibia			
Dickerson, Mr. Donald	Project Coordinator	Futures Group	73367 Nairobi	718135/ 719540	
Essah, Mr. Kwame	Resident Adviser	FHI/Ghana	CT4033 Accra Ghana	233-21-250456	233-21-7010281
Esuchi, Mr. Rufus	Program Associate	FHI/Kenya	38835 Nairobi	713911-9	726130
Folsom, Ms. Michelle	Country Director	PATH/Kenya	76634 Nairobi	577177	577172
Forsythe, Mr. Steven	Lecturer	LSTM	Wellcome Trust	714590	
Gachuhi, Ms. Debbie	Consultant	AED	21529 Nairobi	574806	574806
Getambu, Dr. Esther	Coast Provincial HIV/TB Coordinator	Ministry of Health	90237 Mombasa	011-224599	011-22666
Grubel, Ms. Alix	Regional Quality of Care Coordinator	USAID/REDSO	30261 Nairobi	862400	
Hawken, Dr. Mark	Project Manager	ICRH	1696 Mombasa	011-316900	011-3144
Jure, Mr. Stephen	Consultant	FHI/HAPAC	9082 Kisumu	40286	
Kahindo, Dr. Maina	Technical Officer	FHI/Kenya	38835 Nairobi	713912	726130
Kairo, Ms. Wambui	HIV/AIDS Coordinator	Kenya Red Cross Society	40712 Nairobi	503916	
Kalibala, Dr. Samuel	Medical Associate	Population Council/Horizons	17643 Nairobi	713480	713479

NAME	TITLE	ORGANIZATION	CONTACT ADDRESS	TELEPHONE	FA
Kayaywa, Dr. Walter	DMOH	MOH	87 Busia	0336-22136	
Kimuu, Dr. Peter	Medical doctor	Ministry of Health	90502 Mombasa	011-435061	011-4355
Kinuthia, Mr. James	Program Assistant	FHI/Kenya	38835 Nairobi	713911/2/3	726130
Kisoo, Mr. Michah K.	Program Officer	NASCOB	19361 Nairobi	729549/02	
Kurashina, Mr. Yoshiro	Deputy Resident Representative	JICA	50572 Nairobi	724121	718202
Lamprey, Dr. Peter	Executive Vice President, HIV/AIDS Prevention & Control Dept.	FHI/Arlington	2101 Wilson Blvd; Suite 700 Arlington, Virginia 22201 U.S.A.	703-516-9779	703-516
Lenya, Mr. Rowlands	Executive Director	TAPWAK	30583 Nairobi	603421	603421
Lusiola, Ms. Grace	Project Manager	Pathfinder	48147 Nairobi	224154	
Marum, Dr. Elizabeth	Technical Adviser	CDC	CDC	713008	
McWilliam, Mr. John	Country Director, HIV/AIDS Prevention & Control Dept.	FHI/Kenya	38835 Nairobi	713911	726130
Mohamed, Dr. Ibrahim	Program Manager	National AIDS Council, MOH	19361 Nairobi	729549/02	
Muita, Dr. Jane	HIV/AIDS Project Officer	UNICEF	44145 Nairobi	622174	215584
Mulindi, Dr. Sobbie	Senior Lecturer	UON	20723 Nairobi	712907	712907
Mutungu, Dr. Alice	Chair. RH Committee	KMA	48055 Nairobi	714991/ 717170	717170
Mwai, Mr. Charles	Research Officer	Population Council/Horizons	17643 Nairobi	713480-3	713479
Mwarogo, Mr. Peter	Field Operations Manager	FHI/Kenya	38835 Nairobi	713913	
Naamara, Dr. Warren	Country Program Adviser	UNAIDS		624389/91	624390
Nathoo, Ms. Shairoz	Program Coordinator	Strengthening of STDs/HIV Control Project, UON	19676 Nairobi	725960/ 718895	726626
Ndiang'ui, Ms. Esther	Program Officer	USAID	30261 Nairobi	862400	
Ngacha, Dr. Dorothy	Senior Lecturer	UON	19676 Nairobi	720947	
Ngatia, Mr. Gibert	Project Manager	HAPAC	43640 Nairobi	714590	711673
Ngugi, Dr. Elizabeth	Coordinator		19676 Nairobi	718895	
Njuguna, Ms. Emma	Program	USAID	30261 Nairobi	862400/2	

NAME	TITLE	ORGANIZATION	CONTACT ADDRESS	TELEPHONE	FA
	Management Specialist				
Nyanjom, Mr. Gordon	Field Manager	FHI/IMPACT	135 Kakamega	0331-20635	0331-20635
Ochieng, Mr. Simon	Program Assistant	FHI/Kenya	38835 Nairobi	713911	726130
Odhiambo, Ms. Dorothy	Program Adviser	WOFAK	35168 Nairobi	217039/ 332082	243164
Odindo, Ms. Ruth	Field Manager	FHI/Mombasa	16961 Mombasa	314065	011-3144
Ouma, Dr. Christopher	Program Director	MSF-Belgium	38897 Nairobi	577157/57002 /5	572157
Plummer, Prof. Frank	Co-Director	UON	19676 Nairobi	521368	521570
Power, Ms. Amy	Regional Technical Officer HIV/AIDS	PSI/Rwanda	1120 19 <sup>th</sup> St. NW#600 Washington DC 10034	250-77813/ 72896	250-778
Rachier, Ms. Cecilia	Associate Executive Director	KAPC	55472 Nairobi	786310	786310
Sangiwa, Dr. Gloria	VCT Technical Adviser	PSI/Zimbabwe	4 Kensington Rd. Highlands	263-4-497620/ 263-11-608-415	263-4-57
Schmidt, Ms. Karen	Population Fellow	PATH	76634 Nairobi	577177	577172
Sonnichsen, Ms. Cheryl	Consultant, Reproductive Health	FHI	38835 Nairobi	713911/2/3	726130
Taegmeyer, Dr. Miriam	Project Leader, HAPAC	LSTM	Wellcome Trust	714590	
Tennah, Ms. Angeline	Country Director	POLICY Project	38835 Nairobi	713913	726130
van Praag, Dr. Eric	Director, HIV Care & Support	FHI/Arlington			
Voetberg, Dr. Bert	Senior Health Specialist	World Bank	1818 H Street. Washington	+1 (202)458- 1149	+1 (202)458- 8299
Walumbwe, Mr. Wangila	Assistant Technical Officer Care & Support, VCT	FHI/Kakamega	135 Kakamega	0331-20635	0331-20635
Wambua, Ms. Caroline	Secretary	FHI/Kenya	38835 Nairobi	713911	726130
Welsh, Dr. Michael	Regional Director, Family Planning & Reproductive Health Programs	FHI/Nairobi	38835 Nairobi	713911	726130