

HIV/AIDS
Counselling
Testing
Care and
Support

services
in Nairobi
Kenya

Population Council ♦ Family Health International

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FOREWORD

For over ten years, HIV/AIDS counselling, testing, care and support services have been developed and delivered by dedicated NGO, governmental and private agencies. As cited herein, there have been few attempts to inventory these different services and to make this information available to programme managers and service providers. This report contributes to these previous efforts, and we are confident that it will go a long way in filling current gaps by updating information available to all individuals and organizations responding to this crisis facing the Kenyan society.

The report findings spotlight some of the difficulties and obstacles that can accompany the delivery of new health services. The most troubling and surely the most difficult to overcome are related to stigma. A general social environment where affected individuals continue to be stigmatized and ostracized obstructs access to services for people in need and impedes the ability of organizations to deliver the best services possible. As so often seems to be the case, HIV/AIDS organizations can draw hope and concrete lessons from the history of family planning service delivery. Although hardly an issue today, 20 years ago stigma was a major barrier to women seeking contraception at family planning facilities. Certainly, the psychosocial foundation of stigma related to HIV/AIDS and family planning are not precisely comparable. Nevertheless, the two histories are parallel enough to make lessons learned from family planning valuable for developing HIV/AIDS counselling, testing, care and support services. Important worth emphasizing here is that stigma attached to HIV/AIDS services will be overcome with continued political will and commitment and time.

The family planning experience suggests other possibilities for the field of HIV/AIDS. A request for an inventory of family planning equipment in Kenya in 1989 led to a systematic methodology for conducting family planning situational analyses, which has since been widely used throughout the continent. We are hopeful that this diagnostic study and inventory will lead to a similar methodology for assessing HIV/AIDS counselling and support services. It would in this way represent an important first step in regularizing and improving the overall standards of these critical services in Kenya.

To this effect, we have posted the tools used in this diagnostic study on both the Family Health International and the Population Council websites, and we welcome you to make use of them.

Finally, we wish to extend our sincere thanks and congratulations to the various organizations and individuals involved in the study for undertaking this important initiative and for completing it in a timely manner.

Ms Jessica Price
Kenya Country Director
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Family Health International

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PREFATORY REMARKS TO THE WORKSHOP

By NASCOP

It is very encouraging to note, from the inventory in the report, the number of organizations that have been involved, one way or another, in providing counselling, testing, care or support services to those in need of these services. It is even more encouraging to note that they are offered free of charge in most of the organizations.

Counselling in HIV/AIDS is a very important component to ensure completeness of services in this field, bearing in mind that people who are infected and affected require a lot of psychological, social and even physical support to be able to cope with their situation.

Counselling, testing, care and support centres provide services and an environment that encourages a healing process for all these people.

At this point I would like to thank the Population Council Horizons Project and the Family Health International Kenya AIDS Project for carrying out this study—and also importantly, the United States Agency for International Development (USAID), who funded the study. This inventory will be helpful for both NASCOP and other organizations, especially in planning and networking the services provided. I hope all of you will give your contributions and actively participate in today's deliberations so that we can jointly come up with a final document for all of us to use in future.

Dr Bilha Hagembe

Programme Manager

National AIDS and STD Control Programme

Ministry of Health

By USAID

At the start of this effort, not much was known about the availability of CTCS services in Kenya, and USAID had included assistance to this area in their recently programmed HIV/AIDS five-year plan, so they needed a baseline. They had also been intrigued by the success of Uganda's counselling and testing programme and its possible impact on stemming the AIDS epidemic. In Uganda, counselling, testing, care and support form an accepted part of the national response to the epidemic, as in Thailand, and in both countries the progress of the epidemic has been reversed among some target groups. Third, although the 1998 Kenya Demographic and Health Survey reflects extremely high levels of knowledge about HIV/AIDS, behaviour change has been disappointingly slow. The value of pre- and post-test counselling in supporting behaviour change has been confirmed (Sangiwa and others 1998), and counselling and testing have been shown to be a cost-effective intervention, especially in reducing risk behaviour in HIV-positive men. A fourth reason was that USAID needed help in figuring out how to decrease mother-to-child transmission (MTCT) of HIV. Since a

recent study in Thailand showed that a combination of anti-retroviral therapy without breastfeeding reduced HIV MTCT by 51 per cent, there was an incentive to move ahead with the best mix of services for pregnant women, including counselling and testing.

Focusing on the report itself, we now know there are a number of services available in Nairobi, but there is disappointingly little information about them. There are gaps in services provided and questions surrounding issues of confidentiality, informed consent and the role of Rapid tests. In conclusion, we offer some ideas as to how USAID might proceed to work with NGOs and the government of Kenya to support counselling and testing activities: undertaking rapid assessments of CT services in select geographic areas to identify which facilities are most appropriate to strengthen; working with NASCOP to develop a standard HIV counselling curriculum; undertaking evaluation of different HIV testing protocols for VCT to make recommendations on protocols for Kenya, and providing technical assistance to NASCOP to revise national guidelines on counselling and testing.

Ms Neen Alrutz

Technical Adviser in AIDS and Child Survival
USAID Kenya

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We would especially like to thank the staff of all those institutions who were willing to give their time to provide information for this study, either in person or over the telephone. Their names are listed in the inventory; we appreciate their willingness to respond to our initial requests and to provide further information. We further want to thank the participants of the follow-up workshop, who worked together to verify the accuracy of the entire report. Their names are listed in the appendix.

This research was carried out as a collaborative effort between the Population Council Horizons Project, Cooperative Agreement #HRN-A-00-97-0012-00, and Family Health International Kenya AIDS Project, Cooperative Agreement #623-A-00-97-00954-00, both funded by the United States Agency for International Development. It consists of four parts: the report of the diagnostic study, the inventory of CT and CS sites operating in Nairobi with contact numbers and service information, the case studies of selected counselling and testing and care and support organizations, and the data collection instruments. The first three parts are included in this publication. The inventory is also available as a separate booklet for easy reference to service providers. Both the inventory and the data collection instruments are available on both Population Council and Family Health International websites:

<http://www.popcouncil.org>

<http://www.fhi.org>

<http://beta/pcnairobi>

EXECUTIVE SUMMARY

It is estimated that 1.4 million Kenyans have been infected with HIV, of whom 230,000 are living with AIDS. Prevalence levels range from 5–10 per cent in rural areas to 20–30 per cent in urban areas. Sentinel surveillance of pregnant women attending antenatal clinics estimated that one in every eight Kenyans was living with HIV in 1998. It is reported that of the 30 million people living with HIV worldwide, only 10 per cent know that they are infected. Knowledge of one's HIV status is important to enable one to effectively respond to the epidemic. To find out what is currently being provided in Nairobi, by whom and for whom, in the way of counselling, testing, care and support services, the Family Health International Kenya AIDS Project and the Population Council Horizons Project commissioned a study, which was funded by USAID. It was not known whether current counselling and testing (CT) services were adequately accessible or of good quality; whether clients were being treated ethically, with informed consent and confidentiality; or whether referral networks existed between CT and care and support (CS) sites. It was therefore deemed necessary to conduct a survey with the intention of strengthening CTCS interventions in Kenya.

The study was designed as an exploratory study and began with 48 organizations providing counselling services that comprised the original inventory. From these, a random sample of 18 was selected and in-depth interviews were carried out with the programme managers. To understand the quality of CT services and their system of referrals, a multistage random sampling process was used to select and evaluate four CT sites. These sites were to be the starting point for the study of care and support services. The managers of the four sites were interviewed to identify the CS services to which they referred HIV-positive individuals.

The intention was that four of the CS services listed as referrals by each CT site would be visited to identify the types of service being provided to people living with HIV/AIDS. During the course of the study, however, it was discovered that only two sites referred clients to care and support services. In addition, the researchers agreed that other key organizations should be included in the survey of CS organizations. A purposive sample was identified by the team, including two people-living-with-AIDS (PLHA) support groups, two community organizations known to be providing CS in the slums of Kibera and Korogocho, the Adolescent Counselling Clinic in Kenyatta National Hospital, and two research clinics identified as sources of CS to PLHAs. A further three organizations (a hospital, a clinic, and an NGO providing services to children) were visited, based on information from other CS organizations about significant referral sites for services. In all, 10 CS organizations were visited.¹ During

¹ The sites visited were WOFAK, KAS (PLHA support groups); Kibera Community Self-Help Group, Medical Missionaries of Mary, Korogocho (community organizations); KEMRI, Pumwani MCH clinic (research clinics); the Adolescent Counselling Clinic in Kenyatta National Hospital; Mbagathi Hospital TB programme, MSF–Belgium Mbagathi Clinic, IMANI Rehabilitation Centre for Street Children (referrals from other organizations).

the course of the survey, however, it became apparent that a number of other CS sites existed. Hence, it was decided to expand the inventory to include information on sites providing CS services. The present inventory, therefore, now has 68 entries.

In February 1999, a USAID-funded workshop was held in Nairobi, to which all the stakeholders and participants were invited (see appendix). The objective of the workshop was to elicit feedback from all the CT and CS organizations included in the report: to review the draft report and the inventory and verify the information therein as well as to correct and update information contained in the inventory. All revisions submitted by the 81 participants were subsequently incorporated, and several service organizations were added to the inventory that had not been identified during the study. The workshop also served as a forum to lay the groundwork for referral networks between organizations offering counselling and testing services and between those offering CT and care and support services.

At the time of this report, there is perhaps only one centre in Nairobi where voluntary counselling and testing (VCT) is provided on a walk-in basis—the Kenya Association of Professional Counsellors VCT Centre. Even there, the turnout is low; the results are not obtained that day, and there is no easy link to CS services. Although CT services in Nairobi, as in Uganda, are developed as an *ad hoc* response to the situation by concerned NGOs, no organization has yet been able to gain enough funds and public support to establish itself as a major source of support for people concerned about their HIV status and people living with HIV/AIDS. One can speculate that this is related to the continuing stigma of HIV; however, the result is that people who need such services still do not have a nationally recognized body to turn to for help. Similarly, relatively few CT services are targeted at youth, a population group at high risk for HIV infection.

Out of the 68 sites listed in the inventory of counselling, testing, care and support sites, 8 offer counselling-only services. This means that they offer pre- and post-test counselling but refer the client to another site for testing. If VCT is provided, it is only one service among many. Many clients seek voluntary counselling and testing, having suspected that their partners may be at risk for HIV infection. Some of them are young people who are contemplating marriage while others are individuals who may be worried because of their past or because of having prolonged illnesses. It is not clear whether individuals without physical illness can easily receive CT at hospital facilities. There is a need to address this issue, possibly by establishing referral procedures that require hospital staff to refer healthy individuals who may seek CT services in hospitals to NGOs.

Almost universally, the CT procedure for an individual is a pre-test counselling session, followed by taking blood for HIV testing and a follow-up session after one or two weeks to announce results. Follow-up sessions are encouraged and provided by 10 sites, but most sites report that few clients actually come for the follow-up. One site reports that, although clients are advised where to go for testing during the pre-test counselling sessions, it is entirely up to the client to decide whether to be tested or

not. Hence, unless the client returns for post-test counselling, it is not possible to know whether HIV testing has been done.

Confirmatory tests are supposed to be used when the result is seropositive—before informing the client. However, anecdotal evidence shows that after the first test, if the client is informed of being seropositive—and if the client requests it—the client is asked to go to a second site for a confirmatory test. Unless it is specifically requested, more often than not a confirmatory test is not carried out. There is little use of Rapid tests; the test most frequently used is ELISA. Those that use Rapid tests may send the positive samples for confirmation; however, it is not clear whether the results of the Rapid test are given to the client on that day. This highlights the need to develop a consensus on testing protocols.

Counselling staff fall into two main categories: full-time and part-time salaried professionals employed mainly at medical and dedicated CT facilities; and part-time volunteers, typically working with community-based organizations, who earn per diems or daily allowances.

There is no formal accreditation of HIV counsellors although the expertise of a few organizations—the Kenya Red Cross, the Kenya Association of Professional Counsellors (KATC), the Kenya Medical and Research Institute (KEMRI) and Amani Counselling Centre—is recognized by other CT sites. A number of counsellors and counsellor coordinators have degrees and diplomas in psychology and counselling. This, however, does not imply that HIV/AIDS counselling was included in the degree or diploma requirements.

Most of the sites with support staff with minimal levels of education are involved with large slum populations where a lot of support work for community home-based care is required and where it is difficult to recruit persons with higher levels of education. However, the volunteers from community-based organizations who have been trained on site do provide pre- and post-test counselling. Organizations typically depend on their own resources for training content, although they may occasionally also call in outside expertise.

Anecdotal evidence indicates that many people are still tested without their consent. Many companies and institutions still require pre-employment tests, and HIV tests are almost universally required to take out a life or health insurance policy. However, blood is frequently drawn for these tests without informing the patient or applicant which tests are being performed. In these cases there is no pre-test counselling.

Of major concern also was the fact that many employers in Nairobi, instead of embarking on full-scale HIV/AIDS prevention and care interventions at their workplaces, have resorted to testing employees or potential employees, which may result in discrimination against people living with HIV. Notably, in the inventory two private clinics reportedly perform HIV testing on corporate employees and informal sector workers without their knowledge, on request from their employers. During in-depth discussions at one of these clinics it was found that the individual is usually not

informed of the tests being carried out for the medical check-up, and the clinician is apparently not under any obligation to disclose the results.

In addition, patients in hospital settings may be tested for HIV to aid in diagnosis, without pre-test counselling or informed consent. If the patient is found HIV-positive, it can result in a legal and ethical dilemma for medical personnel. Testing without consent can be grounds for legal action, and the policy in some hospitals is that HIV test results are not to be given out without pre-and post-test counselling, as medical personnel would then be unable to openly discuss the root cause of symptoms with the patient.

In this survey, the availability of HIV/AIDS care and support services appears to conform to a distinct pattern. It is apparent that while we encountered many CS sites within the slums and underprivileged communities of Nairobi, there were very few, if any, that targeted well-to-do individuals. The CS services located in the slum areas could meet the needs of relatively poor PLHAs, the majority of whom had little or no income, with IGAs, orphan care and feeding programmes. However, even if it is assumed that the more well-off PLHAs use private services, the private clinics visited did not offer psychosocial services such as ongoing counselling and group support. There is, therefore, a need to explore the CS needs of the more well-off PLHAs in Nairobi and to design pilot programmes targeting them.

The above findings suggest that different levels of training have to be provided among the CS sites in Nairobi. Hence standardization of course content and duration may be in two categories: a course for staff of the formal health CS services and another for staff of the community CS services. The counselling of PLHAs should include skills and role-plays on how to communicate with partners about HIV. Counsellors should offer to help women discuss HIV with their partners in couple counselling sessions. This is not only a care issue but is vitally important for prevention since there are many discordant couples—15 to 25 per cent according to some studies.

It would be ideal to assess the current capacity of CS service delivery, to gauge whether the CS sites are operating beyond or below capacity. The numbers reported to be currently receiving CS services range from as high as 2000 families for community-based services like the Kibera Community Self-help Programme and 500 for the Kenya Women Fellowship Association to as low as 30 in Women Fighting against AIDS in Kenya (WOFAK) and 25 in The Association of People with AIDS in Kenya (TAPWAK).

Some attempts are being made at cost-sharing. In places like Kenyatta National Hospital, a fee is charged for such tests as the HIV test, TB sputum examination and x-rays, but there is no cost recovery effort for the majority of CS services. In WOFAK, it was envisaged that the clinic would charge a fee to enhance sustainability, but this fee kept many clients away, so it was abolished.

The lack of information on service costs and willingness to pay is a constraint to making strategic decisions about the role of CT and CS services as a public health response to the HIV/AIDS epidemic in Kenya. The dependence on donor funding for

service provision also raises questions about the long-term sustainability of many services.

It is clear that in many of these CBOs, the staff are so busy delivering basic services that sometimes they cannot find time to keep records. However, records are important for the CBOs to plan and to attract and account for resources. They are also essential for planners of national programmes. It is recommended that CBOs be assisted to develop simple management information systems, which they can use for their own management purposes and for reporting. The collection of data would also help to design responsive CS services, and a national database of CTCS services would enhance networking.

It was observed that only a few sites supply condoms to clients. More information on how sites get and pay for condoms would be useful to assess how to improve condom logistics for these sites. All in all, a research agenda needs to be identified to further action in the areas described above.

A major recommendation from this study is that a conscious effort should be undertaken to develop referral networks among CT and CS organizations. The provision of information about who is doing what is vital, and it is hoped that the CTCS inventory developed in this study will be used and updated regularly. During the workshop to review the draft of the report, the group noted that the lack of a referral network was an interruption of delivery of services to the patient. To maintain confidentiality, they suggested brochures listing services be made available at sites for clients. A major recommendation made by the group was to become familiar with a referral site, through a site visit at the very least, before using it in a referral.

Study report

INTRODUCTION

This study was jointly funded by USAID/W through the Horizons Project of the Population Council and USAID/Kenya through the Kenya AIDS Project of Family Health International. Data was collected between March and August 1998 by three consultants: Dr Ruth Nduati, Dr Wairimu Ndirangu and Ms Jacqueline Makokha.

The main purpose of the study was to find out what is currently provided in Nairobi as counselling, testing, care and support (CTCS) services. The objective was to inform programme managers and donors of the gaps in service provision and recommend strategies to overcome these gaps, to make good quality HIV CTCS accessible.

Background

Fifteen years into the AIDS epidemic, it is estimated that 1.4 million Kenyans have been infected with HIV, of whom 230,000 are living with AIDS. The prevalence of HIV ranges from 20 to 30 per cent in urban areas and 5 to 10 per cent in rural areas. Overall, the 1998 estimates were that one in every eight Kenyans was living with HIV. These estimates were based on sentinel surveillance of pregnant women attending antenatal clinics (Okeyo and others 1998).

According to the UNAIDS report of December 1997, of the 30 million people living with HIV only 10 per cent know that they are infected. Knowledge of one's HIV status is becoming more and more important to enable people to effectively respond to the epidemic. The following prevention and care interventions are closely linked to if not dependent on knowing one's HIV status:

- using AZT to prevent mother-to-child transmission
- avoiding breastfeeding to prevent mother-to-child transmission
- using prophylaxis for opportunistic infections, especially TB
- seeking and receiving HIV care and support including social support, income-generating activities (IGAs), ongoing counselling, care for orphans, legal aid, clinical management of opportunistic infections and home care
- preventing HIV transmission among discordant couples

In addition, voluntary counselling and testing (VCT) has been shown to have an enhancing effect on the following interventions:

- sexual behaviour change, for example, use of condoms and reduction in number of sexual partners
- decisions about becoming pregnant
- decisions about abortion
- decisions about marriage
- decisions about whether to donate blood when one has recently been exposed to HIV and may be in the window period

The recently completed study on the efficacy of VCT (supported by UNAIDS, AIDSCAP, USAID and CAPS) demonstrated a 40 per cent reduction in the number of unprotected sexual acts with a non-primary partner among those who received VCT (Sangiwa and others 1998). Previously, Allen and others (1992) had demonstrated a reduction in incidence of HIV and gonorrhoea among discordant couples who received VCT in Rwanda. At Majengo Clinic, Nairobi,² the prevalence of STDs such as gonorrhoea decreased while chlamydia disappeared altogether following the interventions, which included counselling, testing, treatment of STDs and use of condoms. Experience in the Uganda AIDS Information Centre (AIC) and Thailand Red Cross VCT sites has shown that VCT offered at free walk-in sites can be very popular and very effective. It is no coincidence that it is these two among developing countries that have shown consistent declining trends in HIV.

The first counselling services for HIV-infected persons in Kenya were set up in May 1989 by the Kenya Red Cross (KRC) in response to the need to provide support to infected people. The same year, KRC organized its first workshops to train HIV counsellors. Until the mid 1990s, the Red Cross Centre in Hurlingham had an active counselling programme staffed by 10 volunteer counsellors, which provided individual and group counselling for HIV-infected persons, referred people for testing and continued to train counsellors. At that time, testing was usually carried out for blood screening. If the blood tested HIV-positive, the patient was sent for a second ELISA test and Western Blot at Kenya Medical Research Institute (KEMRI). These patients often came on referral from community centres, and confidentiality was maintained by counsellors at both the community centres and KEMRI. The test results were then sent to the Red Cross Centre where the patients met with counsellors. Group therapy was also offered, as many patients wanted to include their relatives. At this stage of the epidemic, most people who came for counselling were those with HIV/AIDS symptoms, and the HIV test was not routinely offered as a service. Many of the services were located in middle or high-income areas and tended to attract a middle-class clientele. HIV-testing was at first primarily carried out as a confirmatory diagnosis for patients presenting with symptoms of advanced HIV infection or AIDS, at hospitals or other medical facilities.

As the epidemic grew, however, those seeking HIV-testing expanded to include the "worried well" (particularly those at high risk) and, influenced by the policy in some churches, those considering marriage. In addition, employers and health insurance companies began to demand HIV-testing as a precondition for employment or insurance coverage. At the same time, from the mid-1990s, services began to be provided to low-income and slum populations by NGOs and community-based organizations in response to the continuing spread of the epidemic and the growing need for services in low-income areas. The Ministry of Health responded by setting up health delivery points as patient support centres and by training a national network of counsellors in the early 1990s. The main objectives of the centres were to train

² Majengo Clinic, managed by the University of Nairobi Microbiology Department, functions as a research site on commercial sex workers.

counsellors and to set up networks of counsellors and referrals. Both government and mission hospitals, using their own methods, were involved, and centres still function successfully in Nakuru, Kitale, Nyeri, Kitui and Kenyatta National Hospital.

Counselling and testing (CT) services in Nairobi have thus been developed independently by different institutions and practitioners in response to different needs and for varied populations. As a result, there has been little standardization of the services provided and no formal agreement on quality control. There is also no central register of available CTCS services in Kenya.

Attempts have been made to address these issues, though analyses and reviews of CT services have so far not led to systemic change. In 1988, the National AIDS Control Programme, Ministry of Health, published guidelines for counselling and testing services. NASCOP, other government departments and NGOs developed a counselling curriculum in 1990 that NASCOP and KRC used until 1993-94. This two-week curriculum included three parts: part 1 covered knowledge, attitudes and behaviour surrounding AIDS prevention, and skills and knowledge for counsellors; part 2 was a teaching methodology for counsellor training; and part 3 covered production of health IEC materials. Some organizations used this curriculum; however, many, like the Christian Health Association of Kenya (CHAK), trained their own counsellors using a variety of guidelines. NASCOP developed a renewed version in 1998: a brief A4-sized pamphlet with definitions of basic CT services. NASCOP also carried out a small survey on the status of counsellor training in Kisumu.

The NGO community had also realized the need to define counselling more precisely. In 1993, a committee of the recently formed Kenya AIDS NGO Consortium (KANCO) produced a five-page guideline describing the different types of counselling. The committee included representatives from the Kenya Red Cross, MAP International, the Amani Counselling Centre, Hope Health Care Services and the University of Nairobi. It is noteworthy that their categorization of seven different types of counselling³ did not include an entry for pre-and post-test HIV counselling, nor was the HIV test mentioned in the text.

Also in 1993, the Ministry of Health published guidelines on community-based health care. Health workers from public and NGO health facilities developed the recommendations. At the time these guidelines were published, it was observed that health services at the periphery needed strengthening and the individual AIDS patient and family needed a minimum package in the form of counselling, palliative therapy, and support. It was noted that a successful community-based care system would require the following:

- a functioning referral system to the community and back to the hospital or other health institution

³ Counselling centre, clinic or hospital-based counselling, community-based counselling, immediate or extended-family counselling, buddy or relationship-based counselling, spiritual counselling, and peer counselling.

- a well-developed system of counselling for the AIDS patient, family and caregiver to enable sincere sharing of information
- a regular supply of drugs to treat the common opportunistic infections experienced by the AIDS patient
- a regular supply of cleaning materials and disinfectants at peripheral health facilities and households that care for HIV-infected individuals
- an organized system of training family or the primary caregiver in simple nursing techniques and infection control
- vehicles, fuel and regular maintenance to allow the health team to visit the ill patient regularly

Rationale for the study

This picture suggests that current CT services may not be adequately accessible or may not be of good quality, however, it is not known what elements of quality are deficient. For example, it is not clear whether it is the quality of HIV testing or the quality of HIV counselling that is lacking. It is not clear how big a problem this might be and whether it is evenly distributed across all CT sites. If CT is being provided, it is not clear whether the clients are being treated ethically, with informed consent and confidentiality. There is also a lack of understanding as to where the fault lies: at the national policy level, within institutional procedures or among attitudes of individual staff. Based on this uncertainty and lack of clarity about the nature and extent of the problem, it was deemed necessary to conduct a survey to describe the existing CT and care and support (CS) services in Nairobi with the aim to strengthen CTCS interventions in Kenya.

Since this was intended to be a quick diagnostic survey, Nairobi was chosen because it was convenient. In Nairobi a number of NGOs have evolved to provide counselling and testing, home-based care, and other care and support services. It is, however, not clear who is providing which HIV-related services nor how well the services have met the demand. There is also very limited information on existing referral networks between the care and support organizations and between CT and CS services. Given the growth of the epidemic in Kenya, the number of organizations working in this area and the inclusion of CTCS in USAID's strategic five-year plan, there was a recognized need to survey what services were available. It is hoped that the lessons learned in conducting this survey will facilitate similar surveys being conducted in other parts of the country as part of a planning process.

Objectives

The broad objective of this study was to identify and describe the counselling and testing and care and support services available in Nairobi. Specific aims of the study included the following:

- to develop an inventory of CT and CS services
-

- to survey a number of CT sites for service delivery variables such as number of staff and volume of work
- to evaluate the quality of counselling carried out in counselling and testing facilities
- to identify the care and support facilities that serve as referral outlets for the VCT facilities
- to determine the types of service offered as care and support services
- to interview people living with AIDS (PLHAs) and identify their care and support needs

Methodology

Study area

The study was limited to sites that provided HIV/AIDS counselling, counselling and testing, and HIV care and support services in the city of Nairobi. The study was designed as an exploratory study, and there was no attempt to provide a comprehensive description of all the CTCS services in Nairobi.

Sample selection

Forty-eight organizations that provided HIV counselling services were identified from consultations with NASCOP and the Kenya AIDS NGO Consortium. A telephone survey was conducted with these organizations to verify whether they provided HIV counselling or CT services, and to ask for basic information about their size, services, hours of operation and charges. This initial inventory was then categorized into five types of organization: local NGOs, government service facilities, private (for profit), church-based facilities and others (for example, a research centre). From these, a random sample of 18 was selected and in-depth interviews were carried out with the managers on a number of service delivery variables (questionnaire A, available at the websites given on page ii).

To understand the quality of CT services and their system of referrals, a multistage random sampling process was used to select and evaluate four CT sites (see questionnaire B at the websites). The four sites selected were the Kenya Red Cross, Kenyatta National Hospital, the Bethesda Clinic and the KAPC Kariobangi Clinic. These sites were to be the starting point for the study of care and support services. The managers of the four sites were interviewed to identify the CS services to which they referred HIV-positive individuals.

The intention was that four of the CS services listed as referrals by each CT site would be visited to identify the types of service being provided to people living with HIV/AIDS. During the course of the study, however, it was discovered that only two sites referred clients to care and support services. In addition, the researchers agreed that other key organizations should be included in the survey of CS organizations. A purposive sample was identified by the team, including two PLHA support groups,

two community organizations known to be providing CS in the slums of Kibera and Korogocho, the Adolescent Counselling Clinic in Kenyatta National Hospital, and two research clinics identified as sources of CS to PLHAs. A further three organizations (a hospital, a clinic, and an NGO providing services to children) were visited, based on information from other CS organizations about significant referral sites for services. In all, 10 CS organizations were visited.⁴ During the course of the survey, however, it became apparent that a number of other CS sites existed. Hence, it was decided to expand the inventory to include information on sites providing CS services. The present inventory, therefore, now has 68 entries.

Study instruments

The CT service delivery variables were reviewed using a structured tool (questionnaire A). At each of the selected CT sites, a face-to-face interview was conducted with the key respondent who was either the chief administrator, the site coordinator or the counsellor in-charge. Where deemed necessary, more than one person was interviewed at the site to ensure that accurate information was collected. Out of the 18 sites selected, 15 were included in the final data analysis,⁵ 3 having proved difficult to gain access to. All the sites visited, however, contributed to the formulation of mini-case reports defining the characteristics of the site.

The managers of the identified care and support facilities were interviewed using a standard open-ended tool (questionnaire B). Information was sought on the types of service they were providing, the beneficiaries of the services, the source of financing for the projects and the type of counselling training the workers had received. They were also interviewed about the arrangements they made to ensure confidentiality of the clients' HIV status. During these interviews, the researcher made observations on how records were kept and the efforts that were made to maintain confidentiality of their clients.

After the meeting the consultant asked the facility manager to assist in setting up a focus group discussion (FGD) with PLHAs (questionnaire D). One manager of the CS organization Women Fighting AIDS in Kenya (WOFAK) agreed to facilitate a meeting between the researcher and clients of her organization, and 10 women attended the meeting. Unfortunately, managers of the other CS services visited were

⁴ The sites visited were WOFAK, KAS (PLHA support groups); Kibera Community Self-help Group, Medical Missionaries of Mary, Korogocho (community organizations); KEMRI, Pumwani MCH clinic (research clinics); the Adolescent Counselling Clinic in Kenyatta National Hospital; Mbagathi Hospital TB programme, MSF-Belgium Mbagathi clinic, IMANI Rehabilitation Centre for Street Children (referrals from other organizations).

⁵ Amani Counselling and Training Institute, Archdiocese of Nairobi: Eastern Deanery, Kariobangi CHBC, Bethesda Clinic, KEMRI CRC, Kenya AIDS Society, Kenya Red Cross, Kibera Community Self-help Programme, Kikuyu Hospital CBHC, KNH Adolescent Counselling Clinic, KNH Patient Support Centre, Mbathi District Hospital, Metropolitan Hospital, NCC Langata Health Centre, St John's Community Centre, University of Nairobi Department of Microbiology.

reluctant to set up FGDs because many of their clients had not publicly acknowledged their HIV status.

To evaluate the quality of counselling, it had been proposed that an independent trained counsellor would sit in on a counselling session. The client and the counsellor would consent to do this before the session. A check list (questionnaire C) was to have been used to evaluate the content, context and process of counselling. This tool was pilot tested using three counselling sessions; two at KEMRI and one at WOFAK, Kayole. The managers of the CT centres were approached to make this arrangement with their counsellors. It was planned that three sessions be observed in each of the four randomly selected CT sites. However, counsellors from three of these sites were very concerned about their clients' privacy and were therefore unwilling to have an observer sit in on their sessions. For the one site where the counsellors agreed to observation, unfortunately, no client came in during the randomly selected times. Hence, what is reported below on the quality of counselling are the findings made during the pilot testing of questionnaire C, the observation checklist.

Workshop to discuss draft report

A meeting of stakeholders and participants in the diagnostic study of CTCS sites in Nairobi was held on 24 February 1999 at the Holiday Inn Mayfair Court Hotel in Parklands, Nairobi, to launch the report and verify the information contained therein. More than 80 participants attended this one-day workshop (see appendix: List of participants) during which the methodology of the study was described, the draft report and the summary of findings were presented, a review of the inventory was made, key issues were discussed, group work took place, and a plenary session was held. Drafts of the executive summary and the inventory were distributed ahead of time and additional copies were included in the workshop packets. These comprised the working documents for the day's meeting and the reference for the group sessions. Three rapporteurs reported on the day's presentations.

The primary objectives of this forum were to receive comments on the draft report and day, the review sheets that had been included in the packets were collected with the necessary revisions clearly written out. These were subsequently incorporated into the inventory from the participants as well as corrections and additions to the same. By the end of the workshop the inventory and main body of the report were ready. A secondary objective was to lay the groundwork for a referral network among the service organizations, particularly between the counselling and the testing sites and between the CT and care and support services.

Data analysis and presentation

Interview data

Counselling and testing information was collected using questionnaire A, which provided both qualitative and quantitative data. The study group reviewed the qualitative data and summarized its responses to the open-ended questions. Emerging themes were used to develop a simplified Epi-Info questionnaire. After this, it was possible to enter and analyse all the data from questionnaire A using Epi-Info. Simple frequencies were generated and are reported below. Due to the limited sample size of 15 sites, no effort was made to perform tests of statistical significance on the data.

All data collected on CS sites was qualitative in nature. The findings from the different interviews were compared and broad trends identified.

Inventory data

The inventory of CTCS sites is presented in alphabetical order in six broad categories comprising the following:

- CT sites (not including hospitals)
- hospitals offering counselling and testing
- HIV-testing sites
- sites providing pre- and post-test counselling without HIV testing
- sites providing counselling services other than for HIV/AIDS
- care and support sites

The CT sites are defined as sites where HIV pre-and post-test counselling is available and where blood is drawn on site for the test. Hospitals are listed separately because, although they provide CT, testing is typically carried out on symptomatic patients, and counselling services in some hospitals are limited. Testing sites do not provide counselling, or only minimal counselling. Some sites offer counselling but refer the client to another site to have blood drawn for testing. "Other counselling" (OC) refers to HIV and other counselling, such as family planning counselling. Care and support sites provide a variety of services that may include HIV counselling but go beyond that alone. Sites are listed only once, in the most appropriate category. A few sites may, therefore, properly belong in more than one category.

Ethical issues

To observe ethical issues, service managers and providers were offered a verbal explanation of the study and what it purported to accomplish. Upon request, a letter seeking institutional consent to participate in the study was provided. Case studies summarized from the interviews conducted were sent back to the respondents for verification and determination of accurate representation of information before incorporating this in the final draft report.

Verbal consent was obtained from the counsellors and clients before setting up the pilot counselling session evaluations. Also, in identifying individuals for the focus group discussion, efforts were made to include only those individuals who were comfortable discussing their problems in a group forum. The PLHA groups had regular group therapy sessions, and these were used as the entry point to a focus group discussion.

Limitations of the study

This study had several limitations: its geographic scope, limited time, and interviews primarily with service managers and supervisors. The study also focused more on service delivery than on demand for services, giving an incomplete assessment of CT and CS services in Nairobi. On several occasions, the study changed from randomized sampling to purposive sampling. This was valuable in exploring leads and making up for a lack of response from the randomized sites but may have reduced the representativeness of the study results. The evaluation of counselling sessions from the pre-test was only minimally successful because the selected method of observation of sitting in on sessions was not acceptable to the counsellors at the sites.

Therefore, the findings in this report should not be interpreted as statistically representative of the CTCS services in Nairobi and certainly not of Kenya in general. Furthermore, while all efforts were made to include all the CT and CS service sites that were mentioned to us in the course of the survey in the inventory, we are aware that the inventory may be neither complete nor up to date. Nonetheless, the researchers are satisfied that the study has achieved its main objective of providing a baseline of the current status of CTCS services in Nairobi. The study has helped to articulate problems and will certainly provide a basis for proposing interventions and designing operations research to test proposed solutions.

CURRENT STATUS OF HIV COUNSELLING AND TESTING SERVICES

Access and availability of services

This section of the report is based on data from the inventories and from in-depth interviews at the 15 selected CT sites using questionnaire A.

Venues for service delivery

In general, CT services in Nairobi are delivered by three broadly different settings: the *medically based services*, the *community-based services* and the organizations that are primarily *counselling centres*. However, the services overlapped, and clients may be referred from one venue to another for follow-up.

Medically based CT services are provided by most of the major public and private hospitals in Nairobi, including Kenyatta National Hospital (KNH), Metropolitan Hospital, Aga Khan Hospital, M.P. Shah, Kikuyu Hospital, Langata Health Centre and Mbagathi District Hospital. Patients at these sites are likely to already have symptoms and to be tested in the course of seeking treatment. They may or may not have sufficient knowledge about the symptoms of HIV/AIDS, and they may or may not be interested in counselling or testing for HIV/AIDS. Medical practitioners set the criteria for HIV/AIDS testing and treatment depending on their own expertise and exposure through training. They will seek patient consent for an HIV test and will offer pre- and post-test counselling for the same. Since they have limited training in HIV/AIDS counselling, they will prepare the client to the extent that the client feels comfortable. The aim of the medical practitioner is to offer curative services. Some medical practitioners have openly declared that they feel uncomfortable telling a client his or her HIV status and will opt to test without consent for fear of the adverse reactions a positive test would have on the client. They feel that disclosing the HIV status to clients is tantamount to telling them they have been sentenced to death. In this case patients are tested for HIV without prior consent and therefore do not receive the full advantage of learning to cope with a devastating illness once its presence is established.

Follow-up is encouraged, although most sites report that it is difficult to maintain client compliance. The medical hospitals and clinics provide continuing medical care, and this tends to encourage participation in ongoing counselling. Those CT sites without medical treatment tend not to have as many clients returning for follow-up. These medical facilities provide HIV-related services to a large number of patients ranging from 700 per week in places like the KNH Patient Support Centre to less than 10 per week in Pumwani Maternity Hospital. It was, however, not possible for this study to ascertain the proportion of clients that receive HIV counselling in addition to clinical management of illnesses. Private clinics, such as those of AAR Health Services and Bethesda Medical Clinic, also provide VCT and follow-up medical treatment. While Bethesda Clinic and Metropolitan Hospital do not have counselling centres with HIV-trained counsellors on site to receive the clients, the rest do and operate mainly as referral sites for counselling and testing.

It is not clear whether individuals without physical illness can easily receive CT at hospital facilities. There is a need to address this issue, possibly by establishing referral procedures that require hospital staff to refer healthy individuals who seek CT services in hospitals to NGOs. This category of clients may include spouses of patients admitted with HIV/AIDS symptoms who, as a result of partner notification and counselling, may desire to know their own HIV status.

In addition to medically based services, Kikuyu Hospital reaches clients in the rural neighbourhoods through its outreach programme. Three full-time HIV-trained counsellors carry out these activities, and the community is encouraged to seek counselling and testing for HIV at the hospital, where over 40 nurses have acquired

basic HIV counselling skills. This programme, however, depends on donor funding and, as funds are now limited, the activities of this programme are threatened.

The *community-based services* typically provide both counselling services and care and support services to meet the needs of people living in low-income areas, including people infected with HIV, many of whom have been identified when symptomatic by volunteer community health workers or members of women's groups. They provide social support, ongoing counselling, day-care facilities, feeding programmes, home care, and often refer clients for medical care.

The majority of these organizations provide ongoing HIV counselling without HIV testing. If VCT is provided, it is only one service among many.

The few professional staff of community-based organizations commonly work with a team of local volunteer counsellors and staff members. Examples of this service include WOFAK, Kariobangi Community Home-Based Care Programme (Korogocho) and Kibera Community Self-help Programme. The number served at these sites ranges from 250 per week in Kariobangi Community Home-Based Care Programme (Korogocho) to 35 per week in WOFAK. Again, because of the wide variety of services offered at these sites, it was difficult to ascertain the proportion of attendees who come specifically for CT.

Similar sites that offer community-based counselling, care and support services are organized under church auspices. The Kariobangi Community Health Programme, based in the Korogocho slums, and St John's Community Centre, based in Eastleigh, have recruited and trained volunteers who run the hospice organized for the very sick in the communities. They also make visits to private homes, where the majority of the patients in the community are assisted to cope with HIV/AIDS. They provide medicine, friendship and moral support. Relatives and friends are taught home nursing skills to enable them to assist the sick. Due to the high incidence of AIDS, testing becomes a luxury and is done only to confirm a diagnosis and only where necessary.

The Kibera Community Self-help Programme focuses more on care and support but also does a lot of preventive work. In this community, women are encouraged to be tested, especially if their partners are HIV-positive. Testing is usually done either at KEMRI or at the Langata Health Centre, both of which are located in the vicinity, and most often, the ELISA test is used. Many of these clients come for assistance when they are in the later stages of infection.

Organizations that are *primarily counselling centres* either focus on or include HIV counselling in their services and may or may not provide testing. Such organizations typically provide services to the general population, primarily to the worried well. They provide follow-up counselling but may refer clients to other institutions for care and support services. The Kenya Red Cross (50–90 per week), Kariobangi Counselling Centre of the Kenya Association of Professional Counsellors (20 per week) and Amani Counselling Centre (under 50 per week) are examples of this approach. Amani reports that, although clients are advised where to go for testing during pre-test counselling sessions, it is entirely up to the client to decide whether or not to be tested. Hence,

unless the client returns for post-test counselling, it is not possible to know whether HIV testing has been done.

Types of service

Counselling and testing is now a widespread, though not widely advertised, service in the Nairobi area. Most CT services are offered in clinical settings, and there are constraints to advertising medical services in Kenya. The inventory of CT services has 36 entries. These offer a full service: pre- and post-test counselling and blood drawn at the same site (even if the lab itself is located elsewhere). Sites designated as "C" in the inventory offer pre- and post-test counselling but refer the client to another site to have blood drawn and tested. There are also primary referral sites for testing alone, referred to by "T" in the inventory.

Sites that offer counselling and testing services

In this study, a site is defined as offering CT services if a client can receive pre- and post-test counselling and have blood drawn for the test at the same location.

The organizations most cited in the 15 in-depth interviews as CT sites were the following:

- KEMRI CRC Clinic
- KNH Patient Support Centre
- Mbagathi District Hospital (MSF–Belgium HIV Project)
- Nairobi City Council (NCC)/Dandora (MSF–Belgium)
- NCC Special Treatment Centre (STC) Casino

Other sites that offer both counselling and testing are the following:

- AAR Health Services (4 sites)
 - Aga Khan Hospital and Executive Clinic (2 sites)
 - AMREF Clinic
 - Canaan Medical Services
 - Chandaria Health Centre and Dagoretti Community Health Services
 - Crescent Medical Aid
 - Department of Defence Medical Clinic
 - Guru Nanak Hospital
 - KAPC VCT Centre
 - Kijabe African Inland Church Hospital
 - Kikuyu Hospital CBHC Programme
 - Marie Stopes Inc.
 - Mater Misericordie Hospital
 - Mediplan Clinic
 - Metropolitan Hospital
 - M.P. Shah Hospital
-

- MSF–Belgium AIDS Project
- Nairobi Hospital
- Nazareth Hospital
- NCC Langata (MSF–Belgium)
- NCC Pumwani Health Centre
- Pumwani Maternity Hospital
- Right Medical Centre
- Seventh Day Adventist (SDA) Medical Centre Milimani
- Soul to Soul International
- University of Nairobi (UON), Department of Microbiology, Majengo Clinic
- UON Health Services Clinic

Apart from KAPC Kariobangi, all of the above are medical settings where people probably go only if they have symptoms.

Sites that offer counselling services only

Out of the 68 sites listed in the inventory, 14 sites offer counselling only services. This means that they offer pre- and post-test counselling but refer the client to another site for testing. Two counselling sites most cited in the interviews are the Kenya AIDS Society (KAS) and the Kenya Red Cross (KRC), which was one of the first sites to provide counselling. KRC formerly provided testing as well but, due to funding limitations, are no longer able to do so.

Primary referral sites for testing without counselling

This applies to laboratory sites and some hospitals where there are no counselling facilities. In the inventory, the Public Health Laboratory of KNH falls into this category.

Services for youth

Services for youth are limited. The KNH Adolescent Counselling Clinic and the Adolescent Outreach Programme of the Kariobangi Counselling Centre, which publishes the magazine for youth *Straight Talk*, provide full CT to the youth. However, of the 68 sites in the CTCS inventory, 24 offer at least one service for youth and thereby qualify as potential venues for CT. Youth services being offered include the following:

- family life education
 - youth seminars and training in health issues
 - peer education and counselling
 - adolescent high-risk clinic
 - family planning services
-

Services for women

In the inventory, five sites out of 68 specifically mentioned women in their target populations. These included the following:

- Kenya Women's Fellowship Association
- Positive Living Promotion
- Pumwani Maternity Hospital
- UON Majengo Clinic for CSWs
- WOFAK

The increased biological and social vulnerability of women to HIV is well known, as is the fact that many times women find it difficult to seek access to services that carry a stigma, such as sexually transmitted disease (STD) clinics. Similarly, women may find it difficult to attend CT sites. It is therefore important that more women-friendly CT services be developed, as women need to know their HIV status to reduce mother-to-child transmission of HIV.

Services for institutions and the workplace

Some companies have begun to provide VCT to members of their work force together with other HIV/AIDS prevention and care interventions. It was noted that of the 68 sites in the inventory, the following six sites fell into this category:

- AMREF Clinic offers CT to AMREF staff
- Crescent Medical Aid offers CT to its staff and the general public
- Department of Defence Health Clinic provides CT to members of the armed forces and their families and to civilian workers within the barracks
- The Mediplan Clinic provides CT to its own staff and the general public
- Tourist Paradise Investment Clinic provides CT to in-house employees
- UON Health Services Clinic provides CT to university staff and students

It was, however, disappointing to note that some major educational institutions, such as the Kenya Polytechnic with over 5000 students, do not provide CT or HIV-specific counselling.

Reasons for seeking CT and numbers served

The client population for VCT in the 15 sites visited is drawn almost equally from those voluntarily seeking HIV counselling and testing and those referred by clinicians. Thirteen of the 15 sites surveyed said clients were referred by clinicians; 12 sites said clients self-referred. The latter figure demonstrates the demand by the public for these services. However, we are not certain whether or not these patients appeared with symptoms.

As people's awareness of HIV increases, increasing numbers of people seek testing services. Local NGOs working with slum populations, primarily in Kibera and Korogocho, have established a

working relationship with the slum dwellers through community outreach educational programmes. Many of them voluntarily seek counselling and testing, suspecting that their partners are at risk for HIV infection. Some are young people contemplating marriage while others may be worried because of their past or because of having prolonged illnesses.

Overall, the client load supports a picture of a combination of larger hospital services and several small organizations catering to a relatively limited number of clients. Of the 15 sites interviewed, 5 saw between 1 and 10 clients a week; 2 saw between 10 and 20 per week, while 8 saw over 20 per week and up to as many as 300 per week. Only 5 of the sites interviewed offered both counselling and testing services, with the other 10 providing referrals to another site for testing. At the community level, this seems to be an efficient model of service, where testing is carried out at centralized facilities, while counselling is provided by small, community-focused organizations.

Hours of service and advertising

Most of the counselling sites are open during regular working hours, five days a week from Monday to Friday. Only the sites operating as in-patient hospitals are open for clients throughout the weekend.

Opening hours are crucial for confidential HIV/STD services, especially for persons like youth, housewives or employees, who need permission from someone else to seek health care. If CT facilities are open only during regular hours, such individuals face the dilemma of either disclosing the reason for asking for time off or having to sneak away. This issue of accessibility is major and needs to be addressed.

Although most of the sites visited make individual efforts to inform potential clients of their services, these approaches to publicizing services are localized and geared to the needs and clientele of a specific site. The sites which said they advertised cited press media articles, posters, signboards, pamphlets and community outreach activities. Some organizations send letters to potential clients informing them of the availability of services while others provide this information during community meetings with leaders or their representatives. Doctors in private practice report that it is against medical ethics to advertise services and so depend on word-of-mouth by clients seen at the centres. Local NGOs and churches primarily use community outreach workers, who reach clients through sensitization and awareness campaigns organized through drama, poetry and educational tours. Hospitals and medical clinics organize health education programmes targeting outpatients and clients seeking medical treatment.

Organized and centralized plans to reach the masses to combat the epidemic, as visualized by NASCOP, are not yet evident in the operational management of CT sites.

Quality of counselling and testing services

The above section reviewed the overall availability and accessibility of CT services in Nairobi. Another factor that affects the effectiveness of CT as an intervention is the quality of the services. This section explores the following variables in quality of care:

- staff available for CT and remuneration
- standard of CT staff training
- counselling content and procedures
- HIV testing procedures
- privacy and confidentiality
- informed consent for testing
- internal quality assurance

This section of the results derives its data from the following sources:

- the review of the 15 CT sites that were randomly selected from the CT inventory (using questionnaire A)
- a qualitative evaluation of the 4 CT sites, randomly selected out of the above 15 (using questionnaire B)
- the observation of 3 conveniently selected counselling sessions (using questionnaire C)

Staff available for CT and remuneration

Counselling staff fall into two main categories: full-time and part-time salaried professionals employed mainly at medical and dedicated CT facilities; and part-time volunteers, typically working with community-based organizations who earn per diems or daily allowances. Of the 15 sites reviewed, one had eight full-time persons while most of the other sites had between one and four full-time staff. The highest number of staff providing CT as a part-time job were reported in in-patient hospital settings. One such hospital had 43 nurses trained as HIV counsellors.

Part-time CT staff were common among community-based organizations, and one CBO had 27 such staff. A number of the above sites provide services over and above CT. The quantity and efficiency of CT services is influenced by the number of staff available and the time they each spend on CT. Persons providing HIV counselling and testing at these sites can be grouped into two categories: some are employed full time and receive a salary and others are part-time workers who receive some kind of daily allowance. As the volume of CT work grows, it is important that staff are given ample time from other duties to enable them to provide CT without rushing.

The number of trained counselling staff, however, may not reflect the need for counselling expertise, particularly in a hospital setting. For example, interns at Kenyatta National Hospital have commented on the need to train doctors in counselling skills, given the growing need to include HIV tests in patient diagnosis, the shortage of trained counselling staff, and the increasing number of HIV-positive patients.

Standard of CT staff training

Educational level, in-service training and on-site quality assurance were recognized by most of the 15 sites visited as important components in ensuring quality services. Educational requirements for HIV counsellors are, however, not standardized, whether for pre-service or in-service training.

Out of the 15 sites visited, 9 counsellors and project coordinators reported having a master's level education in a related field. These counsellors are distributed in 4 counselling sites. Distributed in 7 counselling sites are 15 counsellors and staff who have completed university or college level education. One of the sites visited, the Community-Based Health Care (CBHC) Programme of Kikuyu Hospital, reports having 46 counsellors with secondary level education. One site reports that they do not employ anyone below secondary level education, and another reports that the community-based counsellors have basic literacy skills that enable them to conduct the work that is required of them.

Most of the sites with support staff with minimal levels of education are involved with large slum populations where a lot of support work for community home-based care is required and where it is difficult to recruit persons with higher levels of education. However, the CBO volunteers who have been trained on-site do provide pre- and post-test counselling.

There is no formal accreditation of HIV counsellors although the expertise of a few organizations—the Kenya Red Cross, the Kenya Association of Professional Counsellors, the Kenya Medical and Research Institute and Amani Counselling Centre—is recognized by other CT sites.

Training in counselling in the above institutions takes from two to six weeks. However, courses that go beyond the initial six weeks have been offered for counselling supervisors and coordinators. Some include a practicum of varying duration and intensity. The Kenya Red Cross was a pioneer in providing counselling services and counselling training. However, currently it has suspended its training activities due to a shortage of funds. A number of counsellors and counsellor coordinators have degrees and diplomas in psychology and counselling. This, however, does not imply that HIV/AIDS counselling was included in the degree or diploma requirements. Many individual organizations have developed their own approaches to training staff and set their own standards for competent performance. Commonly covered topics include current epidemiologic trends in HIV, pre- and post-test counselling, youth counselling, bereavement counselling, reproductive health, community home-based care and group counselling.

Some institutions offer training in other areas, for example, counsellors in some medical centres receive training in syndromic management of STDs. MSF–Belgium provides training in the clinical aspects of AIDS, including epidemiology and use of the national guidelines for treating STDs, to the clinical officers and nurses at its health centres. Other centres have counsellors on staff who have been trained in specific topics outside the facilities, for example, Mbagathi District Hospital has a counsellor trained in home-based care; the KNH Patient Support Centre has

counsellors trained in drug abuse and crisis counselling; and Langata Health Centre and Mbagathi District hospital have counsellors who have received training in group counselling. Church-based CBOs such as St John's Community Centre, CBHC-Kikuyu Hospital and Medical Missionaries of Mary have counsellors trained in spiritual counselling.

Over half (9) of the sites visited had held refresher training courses for counselling staff in the last two years. Organizations typically depend on their own resources for training content, although they may also call in outside expertise.

The most common reference materials used for in-house training came from the WHO Global Programme on AIDS, with some sites developing their own file notes and handouts. However, there is no generally accepted curriculum for training that has been specifically developed for the Kenyan context.

Counselling content and procedures

On arriving, a client fills out an intake form, giving the personal profile. In some sites, the intake interview is referred to as the "initial interview" while others call it the "counselling agreement." Issues of confidentiality are introduced at this initial interview.

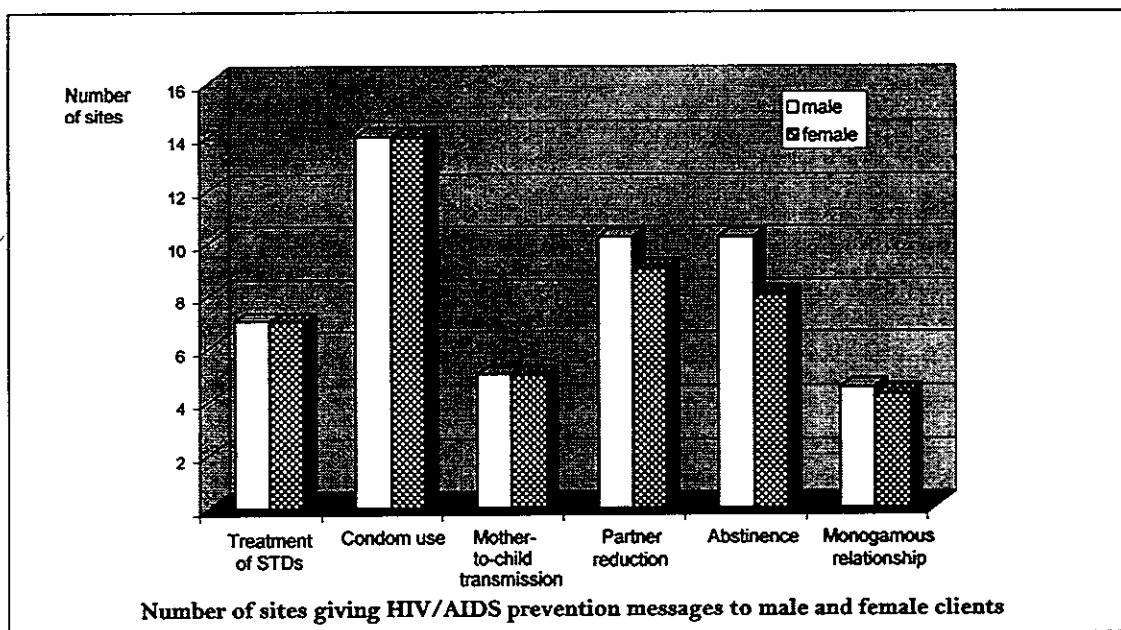
The introductory session is different in community home-based care programmes where the counsellors and workers approach the clients. Here, a relationship is developed as the care is introduced, and gradually, the counsellor and the client get to know one another as part of the continuum of care.

Almost universally, the CT procedure for an individual is a pre-test counselling session, followed by taking blood for HIV testing and a follow-up session after one or two weeks to announce results. Follow-up sessions are encouraged, and 10 sites provided them, but most sites report that it is difficult to maintain client compliance with follow-up.

A typical counselling session lasts about one hour, with pre-test counselling being relatively shorter. According to the information provided from the 15 sites visited, most sites discussed prevention issues during the counselling. The prevention strategy most discussed with both men and women was using condoms, mentioned by 14 sites, and at 10 sites there were condom demonstrations. Sites also said counsellors discussed the need to reduce partners, to stick to one faithful partner and to practice abstinence as prevention options. As many as 12 sites said that they helped clients to assess their personal risk through such means as assessing their lifestyle, discussing their partners' perceived behaviour and strategies for discussing condom use; and 7 sites discussed STD treatment and referrals.

The HIV/AIDS issues discussed and prevention messages delivered by counsellors in each of the 15 sites surveyed are presented in the chart opposite, categorized by gender of client.

The most commonly used IEC materials are brochures and booklets, which are usually supplied to the clients, and posters. The materials are written primarily in Kiswahili and English, and a few are translated into the local dialect. Videos and flip charts are also used to a large extent. These materials are donated by NGOs supporting the centres such as FHI, KANCO and other institutions including NASCOP and the WHO Global Programme on AIDS. Centres without the above materials have come up with innovative methods of communication about HIV/AIDS such as drama and songs presented during outreach programmes to the community. In the community-based centres the clients usually anticipate and request food, medicines and clothing. Condoms are available for clients in only three of the sites visited (Kibera Community Self-help Programme, Mbagathi District Hospital and NCC-Langata). The most commonly used source for condoms is the Central Medical Stores of the MOH. Other sources mentioned were Population Services International, Marie Stopes, MSF-Belgium, GTZ and various government services.



To assess the quality of counselling, three sessions were observed. As mentioned earlier, these three sessions are not considered representative. It had been the intention of the study to observe more sessions; however, many counsellors declined observation for fear of breach of confidentiality. Nonetheless, the three observed sessions served to provide some insight into what takes place in the HIV counselling room in Nairobi. The process of counselling in those sessions was reportedly well conducted. Counsellors encouraged clients to present their problems in an unhurried manner. They discussed the modes of HIV transmission and the need for good nutrition and for seeking health care promptly for opportunistic infections. They clearly explained what an HIV test was and what a positive test meant. In all sessions, good counselling procedures were followed, and it seemed that the clients' psychological needs were met.

But the observer had several concerns about the information shared with the client. First, very little was said about prevention, apart from a discussion of condoms to prevent further spread of HIV infection. Personal sexual history was discussed in only one session, and personal prevention strategies were not explored. There was no discussion of how widespread HIV infection was (and hence the risk of infection following unsafe sex) nor of the role of STDs in HIV transmission. Second, all the requirements for informed choice were not met. For example, it was not made clear that a client could refuse the test and still receive ongoing health care. Third, there was no discussion of the implications of negative test results, either in terms of the window period or of the need for personal behavioural change. Fourth, only one of the sessions discussed sharing results with a partner, and the benefits and disadvantages of sharing information were not explored.

Although these observations are based on only three sessions, they raise serious concerns about both informed consent and whether counselling is being fully used as a mechanism for AIDS prevention with people who, since they have requested the test, are self-defined as being at risk. This raises the question of whether counsellor training includes practicums and regular supervision for quality control.

The CT facilities provide the initial pre-test and post-test counselling but are unable to continue providing long-term psychological support. However, long-term counselling and psychological support services are available at the community NGOs set up by people living with AIDS. Their offices are safe houses where HIV-infected individuals can unburden themselves and share experiences with others facing similar circumstances. Unfortunately, there is still a lot of stigma attached to HIV infection, and infected individuals have had to come to terms with their illness to be able to attend such a facility. There is also a need for the counselling process to facilitate reunification of dying individuals with their family members and repatriation to rural homes.

Although the researchers found that most counselling was done on an individual basis, CBOs offered some group counselling in the form of support groups. KAPC offers group counselling and educational video shows to youth in slum areas. They found that HIV-positive support groups were not popular, however, because of travel inconveniences, particularly distance and cost, and the lack of a facility for treating opportunistic infections. The Kibera Community Self-help Programme offers group counselling and receives patients outside Nairobi as well. Youth over 18 are trained to counsel the younger ones. WOFAK has introduced nutritional counselling.

HIV testing procedures

On-site testing is not an essential component of CT services in Nairobi. Seven out of the 15 sites visited conducted HIV testing on site. The other 8 sites⁶ collaborated with

⁶ Amani Counselling Centre, Kenya AIDS Society, Kenya Red Cross, Kibera Community Self-help Programme, KNH Adolescent Counselling Clinic, KNH Patient Support Centre, NCC-Langata Health Centre, St John's Community Centre

established testing facilities, with 4 sending specimens to the Kenya Medical Research Institute (KEMRI) for testing.

Most of the sites visited reportedly used ELISA testing. Three of the CT sites listed in the inventory use a Rapid test. However, since they send the results for confirmation to a major hospital, it is not likely that they give results the same day they take the blood sample. Some counsellors, who see this waiting period as an important time for reflection, which may bring about sexual behaviour change, are cautious about introducing the Rapid test with same-day results. However, no research has been carried out in Kenya to test this issue.

The laboratories most used for confirmatory testing are KEMRI, STC Casino, Nairobi Hospital and the Microbiology Department of the University of Nairobi. Confirmatory tests are supposed to be used when the result is seropositive—before informing the client. However, anecdotal evidence shows that after the first test, if the client is seropositive and is told—and if the client so requests—the client is then sent to a second site for a confirmatory test. Unless the confirmatory test is requested, more often than not it is not carried out.

There is no national protocol or procedure suggesting which tests to carry out; however, WHO has published a book of recommended assays. Rapid tests have been reported in Nairobi giving both false positive and false negative results. It has been suggested that a Rapid test be confirmed with an ELISA test. There are also advantages of the dry blood spot testing method: the sample is taken from a finger prick and transported dry on blotting paper. There is no risk of contamination to the carrier, and mass screening can be carried out successfully. The sensitivity of the test is reported to equal that of testing with drawn blood, and a confirmatory ELISA test can be carried out by diluting the blood.

Privacy and confidentiality

All the sites except one have instituted a record-keeping system for their clients. Such records are usually kept in patient registers and files. Patient cards are also used, and hard-cover books are used in the remaining sites. The records usually consist of a client profile, frequency of visits, referral sources and a summary of the presenting problem. One site that does not have a record-keeping system maintains that this is the only sure way of maintaining confidentiality.

Client confidentiality and privacy are valued. Most sites visited had at least one private room for counselling. In the few sites where this was not possible, efforts were being made to find a private space. Almost all sites visited reported that issues of privacy and confidentiality are discussed at the initial interview. Most sites visited also have formal procedures to protect the confidentiality of test results. These systems include identifying test results by a client number; minimizing the number of staff with access to results (for example, having only one counsellor or doctor handling and dealing with results); and locking away specimens, results, and client records or keeping them in a restricted area.

However, one observer felt that some staff may not fully understand the distinction between privacy and confidentiality or the ways in which confidentiality can be breached—for example, in a casual conversation, referring to a patient who is easily identifiable by other staff.

Informed consent for testing

Anecdotal evidence indicates that many people are still tested without their consent. Many companies and institutions still require pre-employment tests, and HIV tests are almost universally required to take out a life or health insurance policy. However, blood is frequently drawn for these tests without informing the patient or applicant which tests are being performed. In these cases there is no pre-test counselling.

Of major concern also was the fact that many employers in Nairobi, instead of embarking on full-scale HIV/AIDS prevention and care interventions at their workplaces, have resorted to testing employees or potential employees, which can result in discrimination against people living with HIV. Notably, in the inventory two private clinics reportedly perform HIV testing on corporate employees and informal sector workers without their knowledge, on request from their employers. During in-depth discussions at one of these clinics it was found that the individual is usually not informed of the tests being carried out for the medical check-up, and the clinician is apparently not under any obligation to disclose the results. The actual medical tests are carried out in a neighbouring laboratory that is an independent business. The laboratory does not offer counselling services and assumes that this is already being carried out by the clinician who has sent the patient for testing. The results of the lab tests are filled in on the medical exam form and sent as a confidential document back to the employer or would-be insurer. Occasionally potential new employees are sent back to the doctor with the information that they failed their medical exam. At this point the health provider is expected to disclose the client's HIV status.

In addition, patients in hospital settings may be tested for HIV to aid in diagnosis, without pre-test counselling or informed consent. If the patient is found HIV-positive, it can result in a legal and ethical dilemma for medical personnel. Testing without consent can be grounds for legal action, and the policy in some hospitals is that HIV test results should not be given out without pre- and post-test counselling, as medical personnel would then be unable to openly discuss the root cause of symptoms with the patient.

One of the clinicians noted that this process was always very difficult and expressed the need for more training in counselling skills. Counselling training targeting the health workers who carry out these "mandatory" tests is certainly vital as a step in the right direction and is highly recommended, but it is not enough. In addition, national guidelines on this issue should be strengthened and promoted. (See section on informed consent.) They are needed to help put into operation the principle of informed consent for HIV testing, which was included in the issues agreed on as national policy with the adoption of *Sessional Paper No. 4 of 1997 on AIDS in Kenya*.

Some of those surveyed believed that no policy or guidelines existed surrounding anonymous testing; however, it was pointed out that the onus was on the medical practitioner to inform the patient as to why blood was being tested. It was also pointed out that not only does the MOH have its own policy forbidding termination if an employee is found HIV-positive, but *Sessional Paper No. 4 of 1997 on AIDS in Kenya* specifically protects a person testing positive from losing insurance coverage or employment. The problem lies in the policy not being properly enforced. At the workshop, it was suggested that the Kenya Federation of Employers take up this issue. Research on levels of productivity of HIV-positive persons might also contribute to finding a solution.

In the workshop, the question was raised as to the existence of reporting mechanisms for STD/HIV/AIDS cases. Being outside of government, private clinic statistics are not included. Apparently there is a reporting form available, to both public and private clinics, however it is not currently widely used or distributed. Someone described case reporting as a double-edged sword as some private companies and insurance companies can use this information against prospective employees.

Internal quality assurance

Nine sites reported using a system of quality assurance. Methods cited included weekly monitoring of activities, monthly reports, individual meetings to evaluate counsellor skills and weaknesses, direct supervision and assessing comments from clients. The most common strategy used in supervision was individual meetings. Direct supervision, where the supervisor sits in on the counselling session, was also cited by 4 of the 15 sites. One of the organizations mentioned the need to develop strategies for supervision and is looking for expertise to help put some strategies in place.

In trying to ensure that the clients' needs were being met, comment from the client was utilized in 8 of the sites. In 7 of the sites, this feedback was utilized to improve counselling. Some of the sites felt it important to make clarifications during counselling, to help the clients share their experiences and express their needs, and to constantly review the client's behaviour—what the client asks for, for example—and to reschedule meetings depending on the client's needs. Reviewing and strengthening counselling techniques was reportedly another way of monitoring the service.

Nine of the organizations have set up support systems to deal with counsellor stress. Taking time off, supervision of counsellors and group counselling meetings were cited as some of the more common and favourable ways of doing so. Less frequently cited ways were setting up emotional support groups and joining other related professional services to share experiences.

Perceived programme needs and solutions

Twelve organizations reported conducting evaluations, and 10 have done so in the last year. The evaluations are conducted by collaborating agencies and, in most cases, in-house committees or individuals.

Training and quality of services

One of the most frequent findings was the need for further training. This included both training of clients, particularly youth, and of volunteers, particularly traditional birth attendants, in HIV prevention. The need for further counsellor training was also pointed out. Several sites noted the need to change their services in some way: to enhance visibility of the centre to reach the target population (KRC); to focus more on the needs of HIV-positive clients as a result of poverty (St John's Community Centre); to include group counselling (KNH/PSC); and to survey the status of orphans (CBHC).

Counselling and testing service providers are aware of the need to improve the quality of services and to increase access to them. One of the most commonly cited constraints was insufficient funds (cited by 6 respondents), followed by lack of space and trained counsellors. Other constraints mentioned to a lesser extent were lack of knowledge and skills on the part of counsellors (4 out of 15) and difficulties in establishing a counselling relationship with clients (3 out of 15). The clients were reportedly in a state of denial once positive HIV status had been established and were unable to appreciate interaction with counsellors and the benefits of counselling.

Asked what their plans were for the future, 9 of the 15 sites visited wanted to improve service quality and expand their activities. Specific actions proposed included introducing cost sharing, increasing the number of HIV counsellors, and improving access to HIV information. Plans for service expansion included greater community outreach (through opening centres in the districts, improved advertising and training of peer educators), addressing denial in the community, and introducing new services such as home-based care and youth services.

Funding of services and cost recovery

Information from the 15 sites visited shows that many CT services depend on donor funding. Eight sites do not charge for counselling services, and only 4 of the remaining 7 have established a standard fee for overall services. Donor funding sources include churches, CIDA, the World Bank, MSF-Belgium and USAID through Family Health International.

Of those organizations that charge, the cost of an HIV test to the client ranged between KES 410 and 750 for ELISA and KES 4000 for Western Blot.⁷ Three organizations charge a general fee for counselling and testing services: one site in a low-income area charges KES 20, one site charges KES 500 and another KES 800. Not

⁷ The exchange rate at the time of the survey: 60 KES = USD 1.

all clients can pay the fees, and there is need to grant exemptions or fee reductions in such cases. Granting exemption is determined by the client's ability to pay and the discretion of the counsellor. When asked to estimate the cost of counselling and testing services per client to the organization, 8 organizations cited overall costs ranging between KES 270 and 650, indicating a very narrow profit margin.⁸ The cost and procedure of HIV testing is a major concern. KEMRI is thought by some organizations to provide testing free of charge, but in fact, this was possible only when NASCOP provided the testing kits. Otherwise, they impose a token charge of KES 300 per test even though the cost to KEMRI is estimated at KES 600. In some research projects, the participants are given VCT free of charge. The inventory lists testing charges for many of the CT sites.

This lack of information on service costs and willingness to pay is a constraint to making strategic decisions about the role of CT services as a public health response to the HIV/AIDS epidemic in Kenya. The dependence on donor funding for service provision also raises questions about the long-term sustainability of many CT services.

CURRENT STATUS OF HIV/AIDS CARE AND SUPPORT

Overall coverage and services

This section derives most of its data from interviews of care and support (CS) sites ($n = 15$) and some from the review of the 10 selected CS sites using questionnaire B. The researcher was directed to these CS sites as referral sites by the 4 CT sites discussed above. In addition, to fulfil the requirements of the study at least 2 PLHA organizations were included.

The CS sites can be grouped into four categories according to their primary mission:

- clinical care institutions including research projects, hospitals and health NGOs
- religious missionary organizations
- community-based organizations
- PLHA organizations

The following sites were visited and the managers interviewed, using questionnaire D:

RESEARCH PROJECTS

- KEMRI Clinical Research Centre has a number of ongoing studies looking at HIV/AIDS in adults. It provides medical care free of charge to individuals, sometimes numbering up to 300, who are participating in the studies.
- Pumwani MCH Clinic has a long-standing study on perinatal transmission of HIV. Since its inception in the mid-80s, over 2000 mother-child pairs have been

⁸ The cost to the provider per ELISA test is estimated at KES 120.

enrolled, and currently 600 women and children get medical care regularly through this clinic.

- The KNH Adolescent Counselling Clinic study targets adolescents aged 15 to 24 who come into the hospital for abortions. It also provides ongoing HIV/AIDS counselling and support. At the time of the study, five HIV-positive youth were being followed. They were referred to the main KNH for clinical management. The clinic has expanded to Pumwani Maternity Hospital in Nairobi and to Machakos Hospital in Eastern Province.

REGULAR HEALTH CARE CLINICS/HOSPITALS

- Mbagathi Hospital TB Clinic is a referral centre that collaborates with NCC as well as with other NGOs for screening and treating TB. Within Nairobi there are 36 such centres. TB is a major opportunistic infection of people living with HIV; in 1997 the TB clinics registered 8000 new cases.

HEALTH NGOS

- Mbagathi Clinic, MSF-Belgium. This clinic is housed next to the TB Clinic at Mbagathi. MSF-Belgium, as an NGO, has two additional clinics at NCC-Langata and NCC-Dandora and plans to extend to five NCC clinics. They provide a wide variety of CS services such as clinical management and prophylaxis of opportunistic infections, food supplementation, child and orphan care.

RELIGIOUS-BASED NGOS

- Medical Missionaries of Mary (MMM) Programme in Korogocho provides clinic-based and home-based care (HBC) as well as a hospice for patients with TB, HIV/AIDS, and those who are physically and mentally handicapped. They work through trained community volunteers who are available to talk with patients and counsel them. The volunteers provide treatment for simple ailments and alert the nurse when the patient's condition declines.

COMMUNITY-BASED ORGANIZATIONS

- Kibera Community Self-help Programme was founded by Mrs Ann Owiti in 1990. It provides clinical care, child care, informal school, feeding programme, vocational training, hospital visitation, counselling, placement of orphans and peer group support.
- IMANI Rehabilitation Centre for street children provides CS services for orphaned children and children living in very poor families in Kayole, regardless of their HIV status: literacy skills, vocational training, life skills, feeding programmes and income-generating activities.

PLHA ORGANIZATIONS

- Women Fighting Against AIDS in Kenya (WOFAK), which was started in 1993 by Ms Dorothy Onyango, has offices in Nairobi, Kayole and Homa Bay. It provides the following CS services to women and their partners: clinical care, home-based care, community education to increase tolerance of PLHAs and IGAs.
-

- The Kenya AIDS Society (KAS) was founded in 1989 by Mr Joseph Muriuki. It provides the following CS services: counselling, health education talks delivered by PLHAs to institutions, home-based care, orphan care and feeding programmes.

The above CS sites and those listed in the inventory are struggling with an ever-growing burden: the number of people living with HIV/AIDS and their families who are seeking these care and social support services will continue to grow. Unlike CT services, those seeking CS services need them on an ongoing basis. The numbers reported to be currently receiving CS services range from as high as 2000 families for community-based services like the Kibera Community Self-help Programme and 500 for the Kenya Women Fellowship Association to as low as 30 in WOFAK and 25 in The Association of People with AIDS in Kenya (TAPWAK).

It would be ideal to assess the current capacity of CS service delivery, to gauge whether the CS sites are operating beyond or below capacity. For formal health CS sites, this appears possible. The MSF–Belgium home care project has 100 patients in Dandora and 60 in Langata. It has a target of one home-care nurse providing care for 100 patients with the help of the community.

However, for community-based CS sites it is difficult to ascertain the number of service recipients because many different services are provided. Furthermore, the services are not exclusively given to those living with or affected by HIV. For example, the Kibera Community Self-help Programme cares for 600 orphans, of whom 350 attend an informal school run by the programme. Currently 23 children live on the premises because they have no home to go to. Also, the feeding programme of MMM has about 50 families at any given time. It is not clear how many of these are affected by AIDS. MMM also cares for many orphans in Korogocho, the majority of whom are thought to be orphaned by AIDS. Similarly, MMM volunteers reach 1500 undifferentiated ill people in the community.

It is clear that in many of these CBOs, the staff are so busy delivering basic services that sometimes they cannot find time to keep records. However, records are important for the CBOs to plan and to attract and account for resources. They are also essential for planners of national programmes. It is recommended that CBOs be assisted to develop simple management information systems that they can use for their own management purposes and for reporting.

Staff availability

The research projects and health-care NGO CS sites tend to have full-time staff: doctors, clinical officers, nurses, pharmacists and counsellors. For example, the KNH Adolescent Counselling Clinic, a research project, has 1 doctor, 1 manager, 1 coordinator, 3 nurse counsellors, a psychologist and a secretary. The same applies to health care NGOs such as the MSF–Belgium project, which employs 2 doctors, 2 expatriate nurse-managers, 10 counsellors, 2 social workers and 1 community organizer.

Community-based programmes and religious NGOs tend to have fewer trained staff and more volunteers. For instance, MMM Korogocho has a nurse midwife and a counsellor, 5 community enrolled nurses, a social worker, a counsellor and 60 active volunteers. Community-based organizations also tend to have part-time professionals who work as volunteers; in WOFAK, a doctor volunteers once a week at the clinic to see the very ill patients.

As expected, PLHA organizations tend to have PLHA volunteer staff. For example KAS has a health education programme that uses PLHAs to educate the public about HIV by giving personal testimonies; KAS provides home care using PLHAs, who earn a living from their work.

Target populations

Many groups and individuals are providing care and support to people infected with and affected by AIDS. The target populations for these CS services were identified through discussions with managers of the CS sites. In the discussions, it became obvious that the CS organizations were providing services throughout the span of HIV disease. The target populations can be categorized in the following way:

People living with HIV who are largely asymptomatic. These are persons who from time to time experience an infection requiring medical treatment. Many of these persons were diagnosed during active recruitment into research studies or after they were refused a loan or insurance policy. For example, the Pumwani MCH study has over 2000 families registered, of whom 600 mother-child pairs get regular care each year. Other examples are men recruited into risk-reduction studies after presenting with STDs. These persons have a need for ongoing counselling and clinical care, as well as other support services such as income-generating activities.

Symptomatic HIV-infected individuals. These are persons who are immunosuppressed and have begun to present to health care services with a severe illness that has led to their being tested. Such persons have a heightened need for health care and counselling services. The majority of them get care through private and public health services as the need arises. A number have been able to enrol in KEMRI research studies of clinical care and in this way receive regular treatment.

Late-stage AIDS patients. Dying with HIV is often a long, drawn-out process. Persons at this stage of disease are often unemployed, without money and too weak even to visit the nearest health service. This category of the HIV-infected relies on the family care provider or outside volunteers. Managers of NGOs working in the slums observed that there were increasing numbers of terminally ill AIDS patients living on their own or of women living with young children and depending on them to take care of their needs.

Youth living in families affected by AIDS. Managers of the CS sites reported that there were increasing numbers of children living in families with AIDS in need of shelter, food, protection and education. Many youth were unemployed and in need of

education, vocational training and capital to begin income-generating projects. Youth who were heads of households or who were caring for ill parents were on the increase. Some of the youth were already infected with HIV and needed to deal with their disease as well as the adolescent challenges of growing up.

The general public in slum communities. The general public in the communities were also beneficiaries of CS services. For example, the community-based organizations did not differentiate between the HIV-infected and uninfected but rather provided services to all in need. Managers of the CS organizations noted that the communities required extensive information and skills to be able to provide care to those living with AIDS in a compassionate and dignified manner.

While the above is an analysis of individuals who seek and receive HIV-specific services at the CS sites, most CS sites were not only providing care and support for the HIV-infected; their target populations went beyond those with HIV-related problems. In the inventory, some CS sites have indicated target populations as those people vulnerable to HIV and its impact within a community such as barmaids, youth out of school, orphans, destitute children and street children, commercial sex workers and matatu touts. However, other CS organizations work in neighbourhoods where social ills are so rampant that it has become difficult to select a particular target population. For example, the Chandaria Health Centre and Dagoretti Community Health Services consider the whole population of Dagoretti as its target population, and the Kibera Self-help Programme targets all women and orphans living in the Kibera slums.

This is an important consideration; vertical national programmes and funding programmes must realize that community needs are integrated and interrelated. For communities where there is a high level of HIV prevalence and vulnerability, it might be better to plan for integrated, comprehensive health care and social support programmes for disease specific problems.

Geographical coverage

In this survey the availability of HIV/AIDS CS services appears to conform to a distinct pattern. It is apparent that while we encountered many CS sites within the slums and underprivileged communities of Nairobi, there were very few, if any, that targeted well-to-do individuals.

The CS services located in the slum areas could meet the needs of relatively poor PLHAs, the majority of whom had little or no income, with IGAs, orphan care and feeding programmes. However, even if it is assumed that the more well-off PLHAs have access to private services, the private clinics visited did not offer psychosocial services such as ongoing counselling and group support. There is, therefore, a need to explore the CS needs of the better-off PLHAs in Nairobi and to design pilot programmes targeting them.

Quality of care

Standard of training of caregivers

The quality of care at CS services is very much influenced by the knowledge, attitudes and skills of the staff. Some of this is acquired during basic training, but for many CS services it is vital to provide in-service HIV training to enhance the caring skills and attitudes of staff. Furthermore, community volunteers, who also need training, deliver many CS services.

Among the CS sites reviewed, the formal health CS sites tended to have full-time staff who are basically professionally qualified health workers such as doctors, nurses, midwives, or psychosocial workers such as psychologists, sociologists and professional counsellors. They have degrees and diplomas. In addition, many have received in-service HIV counselling training to varying degrees. In the KNH Adolescent Counselling Clinic, all the staff have taken a one-week counselling course. In the MSF-Belgium project, the counsellors were trained for two weeks by the Red Cross, KAS and KAPC. The programme included three-day in-house training for all clinical staff of the Mbagathi District Hospital as a way of enhancing the caring capacity and attitudes toward HIV patients admitted to the hospital.

In community-based CS sites, however, there were fewer professionals and more volunteers. In WOFAK, only two counsellors were trained; one had had two weeks of training while the other had taken a slightly longer course. One of the home-based caregivers had not completed nursing training.

The MMM has trained over 60 volunteers. Because the volunteers have other work to do, the course is given for only four hours a week and lasts for six to eight months. It includes recognition and home management of common illnesses.

The above findings suggest that different levels of training have to be provided among the CS sites in Nairobi. Hence standardization of course content and duration may be in two categories: a course for staff of the formal health CS services and another for staff of the community CS services.

Types of care and support services provided

Different types of care and support services that were available in the communities included the following:

- clinical care
 - home-based care
 - psychological support
 - support groups
 - feeding programmes
 - child-care and youth programmes
 - legal services
 - community education
-

- income-generating activities

Clinical care services

Clinical care is one of the services observed in this study to be the most developed. It includes diagnosis and treatment of common infections, sexually transmitted disease treatment services, and TB screening and treatment services. Diagnosis and treatment of tuberculosis, the most common serious opportunistic infection in HIV-infected persons, is a major activity within the public health institutions. It is managed as a special programme of the Ministry of Health.

The quality of clinical care of AIDS patients is also beginning to be addressed. The MSF–Belgium project has developed treatment algorithms and has introduced the service of prophylaxis for opportunistic infections in AIDS patients. Although prophylaxis is a well-established practice in developed countries, it is a new practice in Kenya. During the workshop, participants expressed the need for an in-depth assessment of clinical care services, for example, how people are managing AIDS-related illnesses.

In the community, clinical care NGOs and community organizations provide primary clinical care to supplement what is provided in the formal health sector. These organizations are now operating small two-to-three bed hospices within the slums where they rehydrate AIDS patients by using oral rehydration therapy or IVs and provide nutritional support. Workshop participants noted the lack of sites offering holistic care.

MSF–Belgium has initiated at Mbagathi District Hospital the first HIV referral clinic in a public health institution.

Home-based care

A Kenya pilot study demonstrated that through counselling it was possible to identify and train a primary caregiver for terminally ill AIDS patients. Through this counselling process, 60 per cent of the AIDS patients in this study were able to receive home-based care in familiar circumstances and be cared for by loving family members or friends. The study also demonstrated that home-based care could be implemented successfully in rural and urban areas, albeit constrained by poverty, where the sick person's resources could not sustain visits to the local health centre (Ngugi and Njenga 1995).

This study determined that the bulk of home-based care was provided by NGO volunteers, who visited the sick, helped with household chores and did the essential errands. These volunteers were the "feet" of the CS organizations in the community and formed the link between the patients and the NGO services. Volunteers in the religious NGOs worked for free while those working with the secular NGOs were provided with small incentives such as clinical care for their families.

During the visits, the researcher observed that soiled linen was washed with bare hands without initial soaking in a disinfectant such as bleach. Open wounds were also cleaned and ointments were applied with bare hands. One PLHA said, "We do not worry because we also have the same infection." This suggests that the volunteers had limited knowledge, skills or resources for infection control. This area needs further exploration by PLHA networks to identify the constraints to practising proper hygiene and to address them.

Funding issues

Home-based care (HBC) has been conceived as a strategy for reducing health costs. In reality it is a process of shifting health costs from hospitals to family members. Family members are usually under tremendous social and psychological pressure to take on caring activities, and willingness to do so is not necessarily an indication of the ability to cope with the situation. A study carried out in Zambia (Chela and others 1994), compares the lifetime cost of HBC to hospital care. The average cost for a home-care visit by a health professional was USD 14 to 26 compared with USD 7.25 per hospital day. Although HBC clients stayed on average two days less in hospital at a cost saving of USD 14.50 per case, this saving did not offset the higher cost of HBC services. However, 45 per cent of HBC costs were for transport. To demonstrate a break-even value, a low-cost HBC visit would need to avert four hospital days or one admission. The social benefits of HBC, if measured, however, might well outweigh their cost.

Most people receiving CS in Nairobi are not wage-earners, hence they are not able to contribute to the cost of their own care. In a Kenyan pilot study (Ngugi and Njenga 1995) it was noted that some AIDS patients who were referred to peripheral clinics for continuing care were too poor or too sick to be able to use those services.

At present, all the CS sites reviewed are operating almost 100 per cent on donations. Resources come from a variety of sources. The NCC and government of Kenya provide the clinic space in many cases. For example, the IMANI Centre was allowed to extend its home on NCC land. The MSF-Belgium project is funded by the European Union, Sida, DANIDA, JICA and the Australian government. The Kibera Community Self-help Programme receives funding and goods from local well-wishers, the government of Kenya, and from external donors such as Action Aid, UNICEF, Ford Foundation, FHI and the Rotary Club.

The directors of these institutions spend a lot of time trying to find resources to support their activities. Kenya AIDS Society, an AIDS support organization, tried to address the problem of orphans. They abandoned the project when they became completely overwhelmed by the financial needs and rigours of trying to organize shelter and placement for the orphaned children.

There is a need to assist these organizations to examine the costs of the different components of CS and to make choices regarding the components that give them the best value for their money. Such a cost analysis may help them to attract funding and other resources.

Some attempts are being made at cost-sharing. In places like KNH, a fee is charged for some tests such as the HIV test, TB sputum examination, and x-rays, but in the majority of CS services there is no cost recovery effort. In WOFAK, it was envisaged that the clinic would charge a fee in order to enhance sustainability, but this fee kept many clients away, so it was abolished.

Psychological support

The CT facilities provide initial pre-test and post-test counselling but are unable to continue providing long-term psychological support. Persons who were enrolled in research studies received ongoing counselling as long as the study was going on. Most HIV-infected people received long-term counselling and psychological support services from the community NGOs set up by PLHAs. Their offices were safe houses, where the HIV-infected could unburden themselves and share with others faced with the same circumstances. Unfortunately, persons needed to have come to terms with their illness to be able to attend such a facility because there is still a lot of stigma. (Women from WOFAK described how neighbours would cross the road to avoid walking past the front of the WOFAK office in Kayole.) Another source of long-term counselling was the support groups that met at various community organizations.

Feeding programmes

A limited feeding programme is available for newly diagnosed HIV-infected TB patients in both Kibera and Korogocho and for persons who are found to be malnourished. In Korogocho, a programme provides uncooked and cooked food for those who are dying and have no resources available. The local community NGOs are sporadically providing food to needy families as resources become available.

Child-care and youth programmes

The two community organizations that provide care for youth visited in this study were the Kibera Community Self-help Programme and the IMANI Children's Rehabilitation Centre. These organizations provide services to 350 and 250 children respectively in overcrowded informal schools. The services include formal and informal education, vocational training, shelter and clothing.

Legal services

One community-based organization, the Kibera Community Self-help Programme, provides legal advice on how to write a will and arrange for long-term care of children. The same NGO strives to ensure that children placed in foster homes, whether with family members or volunteers, are safe. Through the Children's Department, this NGO reclaims any children it has helped place who are being mistreated by the guardians.

Community education

Ongoing community education aims to increase the acceptance of those living with HIV/AIDS as well as to prevent further spread of the epidemic. The community initiative includes efforts to improve psychological and physical support to individuals living with HIV/AIDS and their families. There is some measure of success in this initiative, for example, there is a PLHA women's group in Kibera slum with a thriving fast-food business.

Income-generating activities

Income-generating activities for PLHAs are limited. At the Kenya AIDS Society, the home-based caregivers are paid a fee as a way of addressing their need for an income. MSF-Belgium employs PLHAs as counsellors. WOFAK has just completed a needs assessment for income-generating activities for its members.

A business advisory group carried out the survey and found that the women were not interested in a group activity and that they required start-up capital and business skills. There was no clear vision of how to manage successful businesses for HIV-infected individuals.

As idleness is particularly demoralizing, the PLHAs felt there was a need for occupational counselling and income-generating activities. Group counselling and legal support were also needed services.

Needs of people living with HIV/AIDS

Focus groups with PLHAs were included in the survey to determine whether their needs were being met, and the best ones to articulate those needs are PLHAs themselves. Unfortunately, because of issues of confidentiality, only one organization, which had sufficient exposure to and experience with the public and the media, participated.

The most important needs the women had were the need for a regular source of income to meet their everyday needs, clinical care, and an assurance that their children would be well taken care of in the future. The education of their children was a major concern even though they were finding it difficult and sometimes impossible to keep their children in school.

This group of women, most of whom had been diagnosed with HIV at least two years earlier, had a great need for ongoing psychosocial support. They expressed a loneliness brought on by the inability to share and rely on support from their families over the problems they were facing because of being HIV-infected. They feared that their children would be mistreated because they were HIV-positive. They found the friendship of other women living with HIV who visited the WOFAK office helped them meet their psychological needs.

Representatives of several PLHA groups attended the workshop and voiced their concerns. Some PLHA groups felt an in-depth assessment was needed regarding

clinical care services, for example, how people are managing AIDS-related illnesses. They wondered if clinics could share experiences using treatment protocols.

The groups also brought up the lack of sites offering holistic care. They felt that care of individuals at the workplace was particularly important and that human resource managers should address the needs of families and communities as well. They wished to know where PLHAs could receive treatment for opportunistic infections as this was not specifically listed in the inventory.

The needs of the PLHAs interviewed can be grouped into the following categories:

- problems relating to the spouse
- problems relating to the family and social network
- work-related problems
- socio-economic problems
- physical health issues
- issues relating to feelings and emotions

It should be observed that this was a superficial attempt to assess the needs of PLHAs by conducting focus group discussions. It is also important to note that these findings are based on one focus group discussion held with a specific group of PLHAs: women attending a PLHA support group, many of whom could cope with being identified as members of a PLHA organization. The women in this group attending WOFAK are poor and barely able to meet their basic needs. Nonetheless, the focus group discussion allowed the researchers to identify the following needs.

Problems relating to the spouse or partner

Women living with HIV need support and skills to communicate with their partners about their HIV status:

“My husband is not sensitive about my illness because he considers me the source of the illness.”

“My husband has refused to be tested.”

“My husband does not want to use condoms; if I insist it leads to a fight.”

“My husband takes a lot of alcohol.”

The counselling of PLHAs should include skills and role-plays on how to communicate with partners about HIV. Counsellors should offer to help women discuss HIV with their partners in couple counselling sessions. This is not only a care issue but is vitally important for prevention since there are many discordant couples—15 to 25 per cent in some studies.

“I parted with my husband when he learnt of my status.” [husband was HIV-positive]

“I had a lot of fights with my husband.”

Problems relating to the family and social network

The women identified a number of problems in communicating with their relatives and friends about their HIV-status:

“Once I knew I was infected, I tried to talk to my mother, but she never agreed, and she was too wild about it, hence could not care about me and more so, I felt I was neglected. I did inform her because my husband, who could have been next [close] to me, had died in 1993.”

The social network is an important source of support for a PLHA, and with good counselling this important resource can be harnessed. Counsellors should help the clients explore their social support resources and select those relatives and friends who will accept them and support them emotionally.

How to share confidentiality with a support person or group is a skill that should be emphasized in counselling training programmes.

“Her mother wanted to know why she keeps on going to Kenyatta Hospital. She fears telling the rest of the family, feels that it will lead to misunderstanding. Later after counselling at WOFAK, they reconciled.”

The women had minimal support from their families because they feared disclosing their status and their problems. Ongoing counselling of the PLHA and his or her family may assist in disclosure and advocacy for care and support.

Work-related problems

Some of the women were reluctant to look for formal employment because they feared the pre-employment medical tests. Most formal employment openings had come through relatives and they feared this would lead to a disclosure of their HIV status.

“I am not even free to look for work because I feel the employer can ever ask for my blood to be tested.”

Pre-employment HIV-testing is an effective barrier against employment for HIV-infected individuals. Community education efforts about HIV should include messages that discourage discrimination against PLHAs at the workplace and should emphasize that many PLHAs are physically fit to work and that casual contact at the workplace does not transmit HIV.

“The best way society can deal with the socioeconomic needs of us people living with AIDS is to give us employment.”

Care and support programmes should include job creation. Indeed, a few of the women in the focus group discussion were working as peer counsellors. They were happy with their work and felt confident because they had employment even when their employer knew of their HIV status.

“I do not have any problem as my work mates are positive too and my bosses know me and accept me the way I am.”

Socioeconomic problems

Poverty predisposes individuals and communities to HIV/AIDS. The impact of living with HIV is most felt among those in the lower socioeconomic levels.

“My husband and I are not employed. I wash clothes for people to get money for 100 or 150 shillings a day or payment in kind. My husband is not bothered to look for work. We have three children. There is a lack of school fees so they are not in school full time.”

“The family has separated because I cannot afford to pay rent, and currently I am living with my mother.”

The economic problems experienced by this group of HIV-infected women are aggravated by marital strife. HIV counselling needs to address couple relationships beyond disclosure of HIV status. Social support programmes are overwhelmed with these problems. More efforts should be made to enhance the efficacy and efficiency of income-generating activities as these are still the only hope of a sustainable effort to relieve the socioeconomic ills of PLHAs.

Physical health issues

At the time of the focus group discussion, the women were well and did not have any major health issues. Apparently they were well cared for in terms of physical health. The women identified their AIDS support group, WOFAK, the research clinic and sympathizers as their main support system. But repeatedly, financial and psychosocial needs could not be separated from physical well being.

I have been supported by sympathizers who have been caring for my health and some financial status. The WOFAK has been helping us with counselling. Also medicine from paediatrician sympathizers.”

“I do not worry so much, try to eat a well-balanced diet and see a doctor whenever I am sick.”

“I depend on public health institutions like Kenyatta National Hospital.”

“I receive medical attention from KEMRI and WOFAK. I also receive counselling from WOFAK and they keep me busy. When I’m lonely I’ll visit their drop-in centre, read the latest news about HIV, watch videos and we chat together.”

This is a true testimony to the need for comprehensive care. The women had access to clinical care at the WOFAK clinic, while they took their children to the research clinic at KNH or a paediatric filter clinic because they were assured of good quality treatment there. The women were unhappy with the health services in the Kayole area, which are “expensive and give poor quality medicine.” Clearly there is a need for improved quality of clinical care. However, the needs of PLHAs cannot be addressed only medically. Care and support services must also address their financial and social needs.

Issues relating to feelings and emotions

Women were asked about their feelings since being diagnosed with HIV. The women expressed a variety of feelings such as guilt, fear and worries about how they could improve their financial stability.

"I think too much, which results in constant headache."

"The feeling that I have been undergoing is the guilt and the fear of being with the family and my entire community."

While some appeared to have accepted the diagnosis, they were very much concerned about the future of their children and who would care for them when they were too ill to help themselves. Children of women living with AIDS, particularly single mothers who have been widowed, are experiencing difficulty in accessing education.

"I accepted my status and am not really disturbed. I only think a lot about my innocent daughter who is only four years and negative."

Some fears about death and about the last day often came up:

"My feelings towards this problem, I keep on thinking so deeply about what will happen the last minute. The only thing I do is just pretend to myself and assume that I'm okay."

These quotes clearly illustrate the need for continued psychological support through ongoing counselling, support groups and the availability of someone to talk to. HIV-infected individuals need ongoing counselling even many years after they find out their status. Even those who appear to be coping well have feelings of guilt coming back; the fear of death cannot be ignored, and the worry for their children's future continues to haunt them. These people need someone to talk to, someone who is warm and understanding, who can be trusted and is always available. Such persons exist within the social network of many individuals, if only they have the opportunity to talk about the reality of AIDS with the infected person.

Clearly, each counselling programme should work toward ensuring that all clients have a confidante within their social network who provides them with ongoing emotional support.

REFERRAL NETWORK

Nairobi does not have a full CTCS service comparable to The AIDS Support Organization (TASO) and the AIDS Information Centre (AIC) in Uganda. Although CT services in Nairobi, as in Uganda, are developed as an *ad hoc* response to the situation by concerned NGOs, no organization has yet been able to gain enough funds and public support to establish itself as a major source of support for people concerned about their HIV status and people living with HIV/AIDS. One can speculate that this is related to the continuing stigma of HIV. The result is that people who need such services still do not have a nationally recognized body to turn to for help.

Given this, one would assume that a strong referral network exists among the various CT and CS organizations. This was observed only in a few situations. For example, the community-based TB screening programme of MMM in Korogocho refers the diagnosed TB patients to the Mbagathi Hospital TB clinic for registration and treatment. In turn, the TB patients are referred to the nearest NCC clinic for continued treatment and supervision. The Nairobi City Council has 36 designated TB treatment points within the city of Nairobi.

Home-based caregivers network with the formal health care system. The MSF–Belgium project in collaboration with Mbagathi Hospital has forged links with community-based organizations in Kibera and is the referral point for those found to be too sick and in need of in-patient care. Within the Kibera community, the MSF–Spain community clinic is the referral point for clinical care for HIV-infected individuals from the various care organizations in this community. The community organizations within Kibera that provide services to HIV-infected individuals have regular meetings to help strengthen collaboration and quality of services they provide within the community.

In the above examples, the pathway for referrals appears to be well defined and understood by the community organization and volunteers. However, the criteria for referral were not well defined, and as a result some very ill patients were cared for at the community level by individuals with limited skills. The researcher got the impression that once patients obviously had AIDS, there was some reluctance to refer them to the big hospitals even for fairly severe infections. It was not possible to establish clearly the reason for the volunteers' reluctance to refer a dying AIDS patient to the bigger hospitals; however, it is possible that the volunteers felt the patients' palliative needs at this stage of illness were more important to treat than their medical needs.

It was also observed that CT sites do not routinely refer their HIV-positive clients for CS. The Bethesda Clinic does not refer patients anywhere. The Kenya Red Cross sometimes refers to KAS and TAPWAK but usually does not refer patients anywhere. KNH makes a few referrals to MSF–Belgium Dandora, St Teresa Dandora, CPK Church Kibera and Trinity Church Kibera.

For such a network to function effectively, there are a number of prerequisites. Referral has to be a part of the policies and procedures of the participating organizations. This unfortunately was not observed to be the case. For example, the KNH Patient Support Unit provides CT and clinical management, but the staff and management do not feel that it is their role to provide ongoing care and support to PLHAs. This is considered the function of a primary, rather than a tertiary, health care facility. Initially the management envisioned a system of referral of patients to the Nairobi City Council clinics within the communities for ongoing care. Indeed, there are a number of NCC clinics that provide care and support, such as Dandora, Langata and Kibera. It is reported that discussions are going on to establish a referral system. In the meantime, however, one of the nurse counsellors at KNH stated that it was her

feeling that NCC was not ready for this type of service because they perceive care and support to be a concern of KNH.

A referral network also requires that the staff of the organizations are aware of the referral sites and the services provided there. KANCO maintains a roster of NGO services but it does not seem to include enough information about CT and CS in the government system. Even among NGOs, the provision of information about CT and CS services appears to be ineffective. For example, although the Kenya Red Cross CT site is situated one building away from the WOFAK office, some of the Red Cross CT staff were not aware of the existence of WOFAK.

A referral system can also be constrained if the receiving site does not facilitate easy access for the referred cases. For example, it is reported that the waiting time and bureaucracy at KNH are daunting; the WOFAK nurse has often spent a whole day in the casualty department to get one patient admitted.

In general, there is no systematic organization of referrals and links between CT and CS services, with the exception of some hospital services, such as those at Aga Khan Hospital where there is internal referral. Informal clusters of services and referrals from and to NGOs have, however, developed in response to needs, with certain sites being recognized as providers of counselling, testing or support services. All 15 CT sites visited, however, recognized the importance of networking to help clients and to minimize the stress on resources and expertise of any one organization.

A major recommendation from this study is that a conscious effort should be undertaken to develop referral networks among CT and CS organizations. The provision of information about who is doing what is vital, and it is hoped that the inventory developed in this study will be utilized and updated regularly.

Furthermore, CT and CS organizations need to develop or strengthen referral policies, procedures and guidelines indicating the criteria for referral and the reasons for referral to various referral sites. All staff should be trained in how to confidentially make referrals.

The referral system of CT patients to CS services has been recognized as weak. Neither the patients nor the organizations know what services are available. Some patients look on referrals as a breach of confidence; however, counsellors could now refer patients to the inventory for names of organizations rather than making a formal referral. Nonetheless, advertisement of counselling services would be valuable. It was pointed out that a referral list specific to counselling needs of PLHAs as well as psychological counselling for children of PLHAs would be useful. People also need to seek counselling earlier on in disease progression than they do.

DISCUSSION AND CONCLUSIONS

Overall, it is apparent that, driven by need, a great number of institutions in the Nairobi area began or expanded CT services in the mid to late 1990s. This *ad hoc*, individual response to need has resulted in a widely divergent pattern of service

provision, dealing with different target audiences. The target audiences, size and range of services offered by the CT sites in Nairobi vary widely, and sites have specific concerns related to their own mission and location. Nevertheless, some common issues were evident from the in-depth interviews. These include the need to develop guidelines to ensure quality, to improve networking, to explore options for reducing costs and to identify key research questions for further study.

Despite the intentions of HIV CT sites to set high performance standards, the lack of universally accepted standards for HIV counselling raises serious issues that may affect the attitudes of the most well-meaning medical staff. For example, untrained health personnel may see their task as "helping to die" rather than "helping to live." As the demand for HIV CT services increases, the need for training in HIV counselling has also increased. This study suggests that we should assess the need for agreed Kenya-specific standards for a training curriculum and counselling service protocols for different levels of staff, both professionals and volunteers.⁹

In countries where VCT services have become popular, for example, Uganda, Zambia, Thailand, the VCT site is usually a stand-alone, non-medical site. At the time of this report, in Nairobi there was only one such site—the KAPC Kariobangi VCT centre. However, at KAPC the HIV test results are not provided on the same day, and the turn-out at KAPC still remains low.

Hence, overall conclusions arrived at in the study include the following:

- Human rights issues related to HIV tests are still a matter of concern. Although CT sites are concerned about client privacy and confidentiality, HIV tests are still being carried out without informed consent in some locations, particularly for insurance and employment purposes. National guidelines are needed on how to operationalize this human rights concern.
- While CT sites recognize the importance of education and in-service training in maintaining quality services; there is no standardized training curriculum or protocols for service delivery and quality assurance. National criteria should be established for certifying qualified HIV counsellors.
- Initial observations suggest that the prevention content of CT sessions could be strengthened; further research would be valuable. Counsellors also lack skills in helping clients to share their HIV status.
- Only a few sites supply condoms to clients; more information on how sites get access to condoms and pay for them would be useful to assess how to improve condom logistics for these sites.
- The Rapid HIV test is little used. Research is needed to assess whether and how use of the Rapid test would affect behaviour change.
- There is need to clarify the HIV testing protocols, including the Rapid test, ELISA tests and confirmatory tests.

⁹ Existing manuals on this subject are listed in the bibliography at the back of this publication.

- Relatively few CT services are targeted at youth, a population group at high risk for HIV infection. There is also a lack of CS services for middle- and upper-class clients.
- There is a lack of knowledge among PLHAs and their families about the importance of hygiene to protect themselves from opportunistic infections.
- The continuing stigma surrounding HIV still presents obstacles to collecting the data needed to design responsive CS services.
- Several CT sites have developed linkages between CT and CS services, but other CT services do not refer HIV-positive clients for further care. Improved networks to link complementary services should be explored. A national database of CTCS services should be developed to enhance this networking.
- Many sites are dependent on donor funding to support services, and many provide free services. Little information exists on the overall cost of CT. Further research is needed to cost services and to assess the issue of sustainability of services.
- A research agenda needs to be identified for further action.

Case Studies

AMANI COUNSELLING AND TRAINING INSTITUTE
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Contact: Ms Elecah M. Mbithi
Counsellor

This is a non-profit-making organization that provides counselling and training services. The counselling services are provided to individuals, couples and families seeking help in solving their psychological and psycho-spiritual problems. All counsellors are qualified and are supported professionally with in-service training and supervision to maintain a high standard of service. For the last eight years, Amani has offered both pre- and post-test HIV counselling. Clients are usually advised to seek testing if need be at KEMRI, Kenyatta National Hospital or wherever they prefer. Amani does not have testing facilities. Although there is a standard paying charge for the client, a sliding scale has been instituted for the low-income client or charges waived for the client who has no income. At least one of the counsellors felt that she needed to know what other counselling and testing centres charged, especially for testing, to inform her clients of the same.

**ARCHDIOCESE OF NAIROBI: EASTERN DEANERY
KARIOBANGI COMMUNITY HEALTH PROGRAMME**

**Korogocho
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**Contact: Sr Gill Horsfield
Programme Coordinator**

This is a pilot project of the Eastern Deanery of the Catholic Church in Nairobi. It started in 1986 as outreach into this poor community. The programme began as a training programme for women volunteers in simple hygiene and home management of common ailments such as diarrhoea and skin diseases. Gradually the programme has grown to deal with home care of major illnesses like TB, physical and mental handicaps, and AIDS.

Home-based care

The current project mission is to provide home-based care for impoverished people who are dying. The small Christian communities (Jumuiya) in Korogocho have identified volunteers who are then trained by Sister Gill as community health workers. Because the volunteers are busy with other activities, the training is only four hours a week for six to eight months. The volunteers are taught recognition and home management of common ailments such as diarrhoea, acute respiratory infections, asthma, convulsions and malnutrition. During the training, the volunteers are encouraged to visit their neighbours and to help them with their health problems. The community volunteers assist the sick by being there to talk to them, counselling them and assisting with daily activities of life. They strive to ensure that the sick die at peace with themselves and with other family members.

Each community health worker has a number of clients that he or she visits regularly. The community health worker alerts the nurse when a client is ill. The nurse will come and visit the sick person and then give the community health worker medicine to take back to the client. The community health worker and the health team refer patients to Kariobangi Health Centre, Mbagathi Hospital, KNH and STC Casino clinic, depending on the client's needs.

Clinic and hospice

In the Korogocho slum there is a small clinic that provides primary clinical care for the community. They have basic drugs that are used for common ailments experienced by AIDS patients. There is also a list of alternative therapies that they promote and that seem to be effective. For example, the milk from the frangipani tree is useful in treating shingles. There is a four-bed hospice to be used by the dying. There are plans

to expand this by two more beds to enable the centre to cater for both men and women.

The mkokoteni

This is a hand-drawn goods cart with a bicycle bell that has a mattress to carry very sick patients to the health facility. When it was first introduced, it was difficult to push the cart through the village because everyone was curious to see who was being carried. It then became stigmatized as the bed for carrying AIDS patients. Over the years, the *mkokoteni* has been used to carry people with all manner of problems. It is now accepted, and the community willingly assist in pushing it when a patient needs to be moved from one point to the other, such as to the small clinic within Korogocho or to the dispensary. It has also been used to ferry individuals back and forth from the dispensary to get their daily TB injections.

Planning for death

The project tries to unite the dying with their families. The programme staff obtain the addresses of family members and write to them to come and see their relatives. Many parents have been shocked by the state of their children whom they had not seen for a very long time. The relatives are often willing to assist and to take the patient home. The Korogocho programme tries to arrange for people to travel home when they are still well enough to travel on public transport.

Community TB screening programme

The Eastern Deanery has developed a community TB screening programme. Persons with cough are encouraged to have their sputum checked. The community volunteer takes them bottles for samples that are already labelled. The relatives are requested to drop off the sputum samples at Kariobangi church on their way to work. The receiving centre is open from 6 a.m. The sputum samples are sent to a special laboratory at Eastleigh Parish, where a laboratory technologist has been trained. Persons with sputum positive for TB bacteria are linked to the Mbagathi Hospital TB clinic to start their treatment.

The community volunteers also ensure that their clients use the TB drugs. They provide needles and syringes to the patients to make sure they receive their injections. Fortunately, the TB treatment programme in Kenya is moving towards oral therapy and therefore reducing the need for injections. Family members of people who require home-based care are offered one-day training.

Korogocho is a community with people of many different ethnic backgrounds. The community volunteers have to find ways to break through barriers brought about by these differences to provide care.

Child care

This is a new arm of the project. There are many orphans in Korogocho, 80 per cent of whom are AIDS orphans. Many mothers are commercial sex workers who indulge in alcohol and *Cannabis*. As a result, the children have been exposed to sex, physical and sexual abuse by their mother's "friends" and a general lack of structure in their lives. The older children are expected to care for their siblings, sometimes by children as young as six. More recently, there has been an influx of video viewing in the community that has exposed the children to violence.

The Korogocho programme has two interventions for the children. The first is a shelter where children can stay with a foster mother when their only living parent dies or is admitted to hospital. The child lives there until an appropriate long-term care programme is worked out. Relatives often take the children. However, every once in a while children return to Korogocho with reports of being abused and neglected by the relatives who took them back to their rural homes. Other children are left without any family. Their own mothers may have been embarrassed about their lifestyle and were unwilling to let their relatives know where they were. The second intervention for the children is life-skills training. In many ways, this training is a simplified version of what is taught to the community volunteers who are trained to be clinical care workers. The programme seeks to empower children to be able to care for their younger brothers and sisters, do household chores, exercise safety, use oral rehydration salts and recognize diseases. Most of the participating children are aged 8–14 years.

In collaboration with other NGOs such as Action Aid, the programme is trying to organize a counselling programme for the children. A one-day workshop was held with 100 orphaned children in Korogocho during the month of August. Through skits, songs and poems, the children enacted their own experiences. The children long for adequate food, clothing, shelter and blankets. They would like to go to school. They would like to have something they call their own. They wish for a moment to be children.

Feeding programme

There is a meal programme for people recently diagnosed with tuberculosis. The patients are provided with cooked food if they are unable to cook for themselves and dry ingredients and fuel if there is someone to help with the cooking. The food includes beans, rice, maize and cooking fat. The family is given food according to the number of children in the home. The cooked food usually includes rice, beans, *sukuma wiki* and other vegetables. Unimix is also distributed once a week to people with TB. At any one time, there are 50 families in the feeding programme.

Income-generating activities

At the beginning of the programme there were major efforts to help women start income-generating activities. The activities included selling paraffin and vegetables, making sweaters that the programme buys from them, making jewellery, tie-dying and batik work. However, these activities have generally been unsuccessful. Initially women were provided with start-up capital for free, then it was turned into a loan to instil value in taking initiative, but it did not work out. The money was consumed by daily needs, clinical care, travelling up-country for funerals, and so on. There has also been tremendous peer pressure for women to continue drinking and practising commercial sex rather than engaging in income-generating activities.

Staff

The staff at the project include two nuns (a nurse midwife and a counsellor), five community enrolled nurses, a social worker and a second counsellor. There are 60 active volunteers reaching 1500 ill people in the community. All the patients have cards that are sorted according to their status: those who are up-country and may come back, those who are in remission and have not required health care for three months, those who have not been at the clinic for three months or more, and those requiring visits from the doctor.

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Contact: Dr N.P. Kahenya

Bethesda Clinic, a private (for-profit) practice, has been offering HIV testing with some counselling by the current medical practitioner for the last four years. This is a general clinic that attracts all paying clients and company clients. It has medical facilities, and the doctors who practice are very interested in HIV counselling but have received limited training for the same.

Most of the clients are sent from companies for medical examinations and pre-employment HIV testing for insurance purposes. Other clients seek HIV testing in preparation for marriage and when involved in high-risk behaviour. Others are identified routinely by the doctor and asked to be tested for HIV based on their presenting symptoms. One of the concerns raised in regard to HIV testing is that most individuals, especially males, decline to notify their partners once they have tested positive. They also decline to use protection (condoms) if they did not do so before, because they do not want to raise suspicion. This becomes especially challenging for the medical practitioner, who feels responsible for saving lives but also for maintaining confidentiality with the clients.

The clinic is interested in policy issues surrounding AIDS. They identify the need to offer more information to clients regarding HIV testing when referred by institutions and companies, such as whether HIV testing means that an employee can lose his or her job or is not eligible for employment. Many of these employees are sent to be tested but have no idea what the implications of the testing are. This poses a dilemma for the medical practitioner, who is seen as an accomplice in deciding the fate of these clients. A supportive policy on AIDS at the workplace could address these fears, making it easier for the client to seek counselling for HIV and the practitioner to offer the counselling.

IMANI REHABILITATION CENTRE FOR STREET CHILDREN
Capt. Mungai Street off Juja Road (behind St Teresa's Church)
P.O. Box 50504
Nairobi
Tel: 761699/765134

Contact: Ms Mary Wanjau
Senior Social Worker

IMANI (Incentives from the Marianists to Assist the Needy) Rehabilitation Centre is sponsored by the Marianist community under the Catholic Archdiocese of Nairobi. The centre was started initially as a reserve centre for street children; however, over the years it has expanded to provide care for orphaned children and for children living in very poor families in Kayole. The centre is currently operating two facilities within Kayole. It does not differentiate between children who are HIV-infected and those who are not.

Literacy skills

The centre has an informal school that provides free education. The children who are found to be performing well are referred for enrolment to Nairobi City Council schools. The NCC schools are not free: they charge KES 8000 for enrolment. This payment is a significant barrier to these children's education. The informal school is able to give only limited services as they have many children and few teachers with limited facilities. The French Embassy has provided some support by offering books.

Vocational training

Older children are taught tailoring or baking, which become income-generating activities for the home. IMANI Centre sells cakes through Nakumatt, one of the large supermarket chains in Nairobi. A variety of infant wear and kitchen accessories that are made at IMANI are on sale at Nakumatt as well as at the centre workshop in Kayole.

Life skills

The centre considers the training of children in life skills a priority. The children are expected to keep their own bodies clean and to be able to clean their clothes and living area. Every morning children are inspected for cleanliness before going to school. On Saturday the children wash their clothes and clean up the building they are living in. On Sunday the children attend church with the director of the home, who lives with them at the centre.

Feeding programme

The centre provides meals for both the boarders and day students. A number of businesses in town regularly provide the centre with food and vegetables.

Rehabilitation of children

The primary goal of the centre is rehabilitation of children. Many of the children who have been on the streets are malnourished and have been abusing drugs. The centre gives the children a structured environment and food and caters to both physical and psychological problems. The children are referred to various health personnel in the city of Nairobi for treatment.

Beneficiaries

Currently there are 350 children benefiting from the services provided by the centre, 95 of whom are boarders. The youngest is a baby of nine months. The day attendees come to the centre every morning and return to their homes in the evening to sleep. In a sense, the home takes on the caring and nurturing of children. Currently there are 48 children in the formal primary school while the other children attend the informal school within the centre. The services are targeted at all poor children.

Youth income-generating activities

The youth living at the centre are the backbone of the home's income-generating activities (cake making and craft production). The centre has started a programme of using the money from the sale of their products to put back as capital for youth to start a business. Five youth have successfully begun businesses in this way and have relocated upcountry.

Records

The centre keeps records of all the children out of reach and off-site.

Funding

The home receives support from various sources in the form of food and other consumables. The Nairobi City Council has allowed the home to extend to City Council land. The Rotary Club assisted in the construction of dormitories for the children. The home also sustains itself through its IGA activities. A few children receive sponsorship from outside Kenya. The director of the home also encourages parents of children who are living at home to make an effort to meet the costs of enrolment in the formal school system.

KEMRI-CLINICAL RESEARCH CENTRE

P.O. Box 54840

Nairobi

Tel: 725106

Contact: Mr Ribondo

Many NGOs mention KEMRI (Kenya Medical Research Institute) as a source of HIV testing. The research centre looks at various aspects of HIV disease in adults. It provides health-care admission free of charge to individuals participating in the studies, each of which have had up to 300 patients. There are referral services between research projects within KEMRI and with the University of Nairobi.

During the recruitment phase of the studies, HIV-testing has been provided to members of the public who are referred from NGOs. The unit has a counsellor who has worked with AIDS-support organizations for many years and is accepted by PLHAs, who frequently consult her to validate information that is provided in the various research clinics.

The KEMRI-CRC clinic is situated at the far end of the large complex of KNH Public Health Laboratories. Patients visit this facility only if they are participating in one of the outpatient studies. The patients wait on the lawn or on a bench under the eaves of the research building. There is a small private counselling room where the counsellors conduct interviews. HIV testing is carried out at these facilities, and the records are kept safely.

The KEMRI-CRC clinic provides diagnostic services that include physical examinations and laboratory testing, drug therapy for their infections and admission to the KEMRI hospital as required.

The research staff include a medical doctor, clinical officers, nurses, pharmacists and counsellors. The clinical services are funded through research grants; for example, one of the ongoing studies with 300 persons enrolled is funded by the Rockefeller Foundation.

KENYA AIDS SOCIETY

Pangani

P.O. Box 76618

Tel: 760370

**Contact: Mr Joseph Muriuki
Director**

Formerly known as the Know AIDS Society, KAS was developed in 1989 through the initiative of a person living with AIDS who recognized the need to bring other PLHAs together to foster ways of promoting positive living. Their main activities are counselling, health education and home-based care. With a staff of 15 members, three of whom are full-time counsellors, KAS is able to provide general, spiritual and HIV/AIDS counselling on a regular basis and focuses on the general population with a special interest in the youth. In the past five years, KAS counsellors have been working alongside health professionals in various institutions: the Patient Support Centre at KNH, and Nairobi City Council clinics at Casino, Dandora and Langata. In the new programme, this activity was transferred to MSF-Belgium, which employs the PLHA counsellors in their testing and counselling centres. Counselling services continue to be available at the centre.

Most of their work is done through community outreach activities, and many community volunteers are encouraged to participate. By using drama groups in *barazas* and market places, the society is able to reach large numbers of people in an effort to create awareness about HIV/AIDS. KAS staff are frequently called to institutions to talk about HIV/AIDS; the presence of a PLHA helps young people to internalize the realities of the disease.

KAS is currently facing constraints through lack of funding and lack of enough counselling space. They also experience problems with clients who are unwilling to be counselled and tested for HIV. They plan to work toward overcoming these barriers through soliciting funds, advertising their services to enable them to receive more support, and through developing specialized counselling services.

Home-based care

For the last eight years, KAS solicited both financial and social support from local and international donors and has collaborated with other professional organizations to develop community-based care for PLHAs. The objectives of the home-based care programme have been to provide care to the bedridden and to generate some income for the caregivers. Many of the caregivers in this programme had been in sex work in the past, and this has been a way of rehabilitating them and offering them a different type of income-generating activity. The home-based caregivers receive a small stipend

for their work. The activities in the home-based care programme include the following:

- visiting the bedridden
- assisting with household chores
- referring cases to the health services when an individual's health deteriorates

Family members of terminally ill AIDS patients are usually frightened to provide these services. They are also frightened that neighbours may find out about the existence of an AIDS patient in the family.

Mr Muriuki noted that there was inadequate training and resources for carrying out effective home-based care. The caregivers used soap and water to clean the linen or bathe the individual, and an antiseptic was generally used for cleaning wounds. One person who was providing care did not have any protection and felt that because they were already HIV infected, there could not possibly be any other problem.

There was some knowledge of management of diet and supplements, but little was known about prophylactics for opportunistic infections. The general strategy for staying well was described as follows:

- Eating a well balanced diet
- Practising personal hygiene and sanitation
- Developing a sense of self worth
- Seeking health care promptly

Orphan care

KAS had initiated some activities to support AIDS orphans but became overwhelmed after a very short time. The problems were too big because there are so many orphaned children, and there was a need to provide for all their needs including shelter, education and health care.

Feeding programme

A number of agencies donate food regularly to KAS. This food is then distributed to PLHAs.

Staff

Currently KAS has 12 members of staff. They have all received a basic two-week course in counselling that has been strengthened by in-house training and counselling experience. Each of them has the advanced diploma in counselling offered by Amani Counselling Centre.

Record keeping

KAS keeps records of the individuals who have been counselled, and records are kept on the desks or tables of nearly all the workers at KAS. Newly diagnosed PLHAs are encouraged to feel that this is a safe house where they can let down their guard and discuss their HIV status freely.

**KENYA ASSOCIATION OF PROFESSIONAL COUNSELLORS
VCT CENTRE
Kariobangi Counselling Centre
P.O. Box 55472
Nairobi
Tel: 786310/796283**

**Contact: Mr Geoffrey Wathome
Counsellor**

The Kariobangi Counselling Centre is the brainchild of the Kenya Association of Professional Counsellors. A local NGO, it operates in Kariobangi and targets clients from Korogocho, Huruma, Kariobangi and Mathare slums. Many of them voluntarily seek counselling and testing while others are referred by clinicians in the neighbourhood. The clients' reasons for seeking testing are high-risk behaviour, suspicion of partner's infidelity, preparation for marriage, prolonged chronic illnesses and referrals made by clinicians. Of those referred by clinicians, the majority are prenatal mothers. Although follow-up service is available, most clients are not consistent in using it, making effective counselling difficult.

The centre works closely with the Dandora City Council clinic, the Lions City Council clinic, the Kariobangi Community Health Programme, Mbagathi Hospital, STC Casino, and the Microbiology Department (UON) for counselling, testing and continuity of care. A one-time payment of KES 20 for all services provided is required. If for any reason a client is not able to pay this amount, it is waived upon receipt of a letter from the local chief confirming that they are unable to pay. All infants are exempted from this charge.

Although the centre operates with two full-time counsellors, all the seven staff members are familiar with HIV pre- and post-test counselling procedures. The centre identifies the need to offer STD services, FP services and antenatal services to its clientele. It is, however, limited by lack of resources and funding. It has services in place for adolescents such as educational shows, condom-use demonstrations and distribution and education about HIV transmission. It has started a magazine, *Straight Talk*, which targets adolescents. The centre's main source of funding is USAID through FHI.

KENYA RED CROSS SOCIETY
P.O. Box 40712
Nairobi
Tel: 248640
Fax: 248641

Contact: Ms Wambui Kairo
Project Coordinator

The Kenya Red Cross Society is registered as a "relief development organization." For the last six years, the Society has actively been involved in HIV counselling and has worked closely with the Kenya Medical Research Institute (KEMRI) for HIV-testing referrals. The main clients are the poor and underprivileged, but clients also come from institutions and companies. The services offered are free of charge, and the society has relocated from the suburbs to city centre to facilitate accessibility by the target group. At the beginning, the society trained HIV counsellors, but it has since stopped due to unavailability of funds. Most of the funding was from the Norwegian Red Cross. However, they collaborate with other organizations that provide services in counselling and testing such as KEMRI, Kenya AIDS Society, TAPWAK, NCKK and Population and Health Services. With additional funding, the society plans to expand services to include on-site testing, a post-test club and an information centre.

**KENYATTA NATIONAL HOSPITAL
ADOLESCENT COUNSELLING CLINIC (HRC)
P.O. Box 19676
Nairobi
Tel: 722810 or 726300 ext. 43034**

**Contact: Ms Margaret Gechaga
Project Coordinator**

This clinic was started in 1992 in response to the growing burden of adolescents presenting with abortions at KNH, many of them repeatedly. The clinic sees about 2000 youth per year. The clinic has expanded and has branches at Pumwani Maternity Hospital and Machakos Hospital. The services of the Adolescent Clinic are regularly advertised in the newspapers. The clinic targets adolescents aged 15–24 years who have come into the hospital with an abortion. Married and unmarried adolescents aged 15–19 years who present with pregnancy are also referred here. The clinic also serves as a drop-in facility for both male and female adolescents who are seeking information on treatment for sexually transmitted diseases. A variety of services are provided at the clinic and include the following.

Counselling

Counselling of young people is the primary activity in this clinic, and especially all women presenting with abortions at KNH. The clinic also specifically targets married and unmarried youth aged 15–19 years who come to KNH for counselling. Youth who drop in at the clinic are counselled on how to maintain healthy sexuality. The clinic also addresses other informational needs the youth require.

Treatment of sexually transmitted diseases

Youth, particularly males, attend the Adolescent Clinic for treatment of sexually transmitted diseases. They receive clinical consultation, counselling and drugs free of charge. This is a special arrangement because of the limited resources of most youth.

Family planning services

The youth are given family planning counselling, supplied with contraceptives and encouraged to use condoms for every sexual exposure. Many of the adolescent girls prefer injectable, long-acting contraceptives, Depo-provera being the most commonly available brand.

HIV counselling and testing

Many youth drop in at the clinic requesting HIV testing. The nurse counsellor observed that many are worried-well while others have already been tested once but want confirmation. The youth are provided with pre- and post-test counselling free of charge. The hospital charges KES 450 for an HIV test, and youth are expected to pay.

Information, education and communication

The clinic provides information, education and communication on healthy sexuality. There is a TV and a VCR in the waiting room and many videos on HIV in particular. During the holidays, many young adolescents visit the centre to see the audio-visual materials.

Care for HIV-infected youth

From time to time HIV-positive youth have attended the clinic, where they are given counselling. At the time of the interview, there were five youth who were using the Adolescent Clinic to meet their needs for counselling and support.

Clinical care

Senior doctors at KNH evaluate sick adolescents attending this clinic. A consultant obstetrician gynaecologist and a psychiatrist are regularly available for consultation.

The Adolescent Clinic arranges for referral for other services as required within the hospital and facilitates the waiving of fees. Other units within the hospital constantly refer the youth to this clinic for ongoing counselling and clinical care.

The Adolescent Clinic is run as a project from the Department of Obstetrics and Gynaecology. The staff includes a director (Dr Koigi Kamau), a manager (Ms Jennifer Liku), and the coordinator (Ms Margaret Gechaga). The KNH site has three nurse counsellors, a psychologist and a secretary. The staff have a variety of counselling and training skills, usually acquired from Daystar University and Amani Counselling Centre. All the staff have taken a one-week counselling course. The staff are young and very friendly. One nurse is paid by KNH while the others are employed by the project.

Records

The clinic keeps a register and records of the clients. Three small counselling rooms provide privacy. The clinic is in a completely different area from the clinic for adults, thus providing adolescents with adequate privacy. The staff are well trained in maintaining records. HIV test results are confidential, and they are sent in a sealed envelope back to the clinic.

**KENYATTA NATIONAL HOSPITAL
PATIENT SUPPORT CENTRE
P.O. Box 20723
Nairobi
Tel: 726300**

**Contact: Dr Mulindi
Dr Mak'anyengo**

The Patient Support Centre of KNH was established in 1991 and officially opened in 1992. The centre, situated inside the old wing of the Kenyatta National Hospital, has recently been refurbished and partitioned to hold counselling offices with the assistance of WHO and NASCOP. WHO, through the AIDS programme secretariat (NASCOP), has assisted with furnishing, partitioning and training counsellors. The centre also supervises and arranges for home-based care. With three full-time nurses trained as counsellors, a social worker, an occupational therapist, a clinical psychologist and a psychiatrist cum director, the centre is well equipped with professionals who provide HIV counselling for voluntary clients and hospital patients and carry out community home-based care.

Thirty clients are counselled and sent for testing daily in the laboratory located in the same hospital. Mandatory HIV tests are carried out for invasive investigations such as cardiac catheterization, haemodialysis and tubal plasty. Where patients are unable to pay the testing charge of KES 450, social work department can waive it. Maintaining confidentiality is usually difficult as the hospital is based on the old system where specimens and results are handled by more than one person. Clients are advised that there is no known cure for AIDS but are not discouraged from seeking various treatments. They are, however, cautioned about the controversy surrounding some of the treatment centres. HIV treatment referrals are made upon clients' requests and preferences to the following:

- Dr Stone (ozone therapy)
- Dr Obel (Pearl Omega)
- Dr Chege (Cheetan)
- KEMRI (Kemron)
- Nairobi Hospital (AZT, triple therapy)

The centre is involved in training counsellors, including community-based counsellors and workers, and therefore spends much time preparing training materials and conducting training. Although it does not have a supervisory procedure for the counsellors, plans are under way to develop this. Supported and maintained by KNH, the centre works in collaboration with KAPC, Department of Community Health in the College of Health Sciences at UON, and KANCO. Condoms are received from the Family Health Education Unit of GTZ. The centre experiences a shortage of resources such as personnel, supplies and space due to the high number of clients. They have plans to develop outreach services, advertise their services and develop training in community home-based care.

KIBERA COMMUNITY SELF-HELP PROGRAMME

Mashimoni Village, Kibera Drive

P.O. Box 49531

Nairobi

Tel: 571081, 571600

Fax: 571600

**Contact: Ms Anne Owiti
Coordinator**

This programme, located in Mashimoni Village in Kibera, is a local NGO that provides HIV counselling and testing and has been in operation for the last eight years. The programme deals directly with slum dwellers from nine slum villages in Kibera, and most of the clients are women and children. The services provided include non-formal schooling for needy children, vocational training for the youth, medical care comprising preventive care such as immunizations for children and a resource centre for the community. Family planning services are provided, and contraceptives are available including pills, injectables and condoms. Midwives are trained to handle delivery care at home with antenatal and postnatal services made available for the women. HIV-testing is facilitated through KEMRI and Langata Health Centre, which sends specimens to STC Casino. For very sick patients, the specimen is drawn and sent to the testing sites.

Most of the work is done through community outreach programmes in schools, churches and the communities. Community health workers, many of whom are volunteers trained through the programme, do the work and follow-up. Training is conducted on a regular basis to meet the needs of the community. Most of the clients have multilevel needs beyond the programme resources, such as food, drugs and other social needs. The programme is also struggling with funding to sustain itself and, with the increased numbers of HIV-positive persons and orphans left behind, they face the challenge of the increased demand for care and support of these persons. The programme plans to strengthen the ongoing training, the AIDS orphan care, youth programmes and home-based care and to open their own medical facility with beds and a laboratory. Income-generating activities (IGAs) have been introduced for the low-income seropositive clients. The youth in particular operate and utilize the IGAs and entertainment centres.

Ms Owiti is deeply aware of the need to provide information on HIV/AIDS to women. During the course of her work she has met women who were prostitutes for many years and yet had never seen a condom. She had also noted the overwhelming poverty within Kibera slum. She gave up her job as a nurse in KNH to start this project. The challenge was to create awareness about HIV among women and to empower them to be able to negotiate safe sex relationships. She noted that it was the feeling among the women that the men had no control over their sexual activities and were seen as the source of HIV infection to their female partners.

The women who first became involved in the project were the "bad women" who often were in sex work and reputed to hijack men. Many of the women were in sex work as a way of being able to feed and educate their children. The women expressed their need for skills to negotiate for better financial support from their partners.

The Kibera Self-Help Group evolved from these early concerns and became a broad-based organization with a mandate to provide home-based care and support to women and their children. The services that are provided include the following:

- clinical care
- child care and placement of orphans
- informal schooling
- vocational care
- hospital visitation
- training of community members
- counselling
- peer groups

Clinic

The centre, which is in the Kibera slum bordered by the railway on one side and the golf course on the other, has a small clinic and pharmacy. The clinic provides health education, immunizations and family planning services. Very ill persons are referred to Mbagathi Hospital for admission. The facility has applied to NASCOP for drugs to manage opportunistic infections. The clinic also provides other services. For example, during the interview, the nurse was called out to assist in a home delivery.

Home-based care programme

The clinic is the closest link to home-based care activities. The unit relies on the community members to alert them when there is a need. The nurse had the responsibility of visiting the very ill patients and administering IV fluids and injections. The centre at Kibera has five beds that are used as a hospice for very ill patients living alone and requiring close management. The centre works closely with Mbagathi Hospital and refers patients for care. Two women spend the night at the centre and can be called to assist a family as the need arises.

Child care, child placement, informal school

The centre provides care for 600 orphans, 350 of whom attend the informal school. Some of the other children are in secondary school or vocational training. Twenty-three children were living at the centre at the time of the interview. Other orphans go to the homes of mothers' friends or members of the church. The children who attend formal school require school fees, uniforms, books, pocket money and someone to visit them in school. The classes reach standard 5. In the morning, the children receive formal teaching while the afternoons are devoted to vocational training.

Library

The school has inadequate supplies of books and other teaching resources. To address this, the centre has developed a small library to support the teachers. There is a limited collection of storybooks that the children can read during classes.

Feeding programme for the children

The centre recognizes the need to give children nutritional support. They noted that if the children went home over lunchtime, they would return without having received any lunch after expending their energy going home. Hence, they have tried to give the children some kind of lunchtime meal. This activity is not funded, thus the type of meals provided is varied, and it is not always possible to provide a nourishing meal at all.

Child placement

The Kibera Self-Help Group is very concerned about child placement. Every effort is made to enable a child to grow within a family. Orphaned children are placed with relatives, friends and volunteers. The centre follows up to ensure that these children are not mistreated, and they will withdraw a child from a home if that is the case. There is a volunteer lawyer who assists persons being cared for to make a will and effect property protection for orphans and widows. The director noted that a number of relatives are interested in the children only if there is economic gain.

The centre also regularly conducts community education programmes to promote acceptance and care for orphaned children. Community meetings have discussed problems such as the need for psychosocial care for bereaved children or children living in families where adults are ill.

Youth programme

There are many youth in this Kibera community whose problems are compounded by extreme poverty and unemployment, and a number of the youth are living with HIV. The youth associated with the centre meet every Saturday. They are involved as volunteers within the self-help group, carrying out health education, and are currently trying to develop income-generating activities. Once a week they go out into the community and distribute condoms in the public places and markets. During this exercise, they discuss prevention of HIV. A small number of youth are receiving vocational training at the SOS and Don Bosco youth-serving organizations.

Health education

There is an active AIDS education programme in the Kibera community. The programme targets individuals conducting small businesses. These include bar owners, hairdressers, butchers, market women and sex workers. The individuals are

invited to the NGO offices where they are informed and trained in prevention of HIV/AIDS. Personal risk reduction and workplace safety is also discussed. The health educators then follow up the training by visiting participants at their workplaces and supporting them in bringing about changes there.

Women's self-help group

A group of women using the services of the NGO have formed a self-help group. The centre provides them a facility to meet in but also encourages them to be independent. Although a number of women are HIV positive, they have not necessarily self-identified as such. The women are carrying out a fast-food business outside the offices of the centre, where they sell chips and *mandazi* (donuts).

Record keeping

This centre keeps records of all persons using their services locked away safely. The Kibera Self-help Group carries out pre- and post-test counselling but refers the clients to Langata Nairobi City Council clinic where MSF-Belgium is carrying out testing. Results of tests are collected by the counsellors, who then carry out post-test counselling. Only the identification number appears on the laboratory form as a further measure of confidentiality.

Funding

Ms Owiti started the project with a revolving fund. Most of the support has been in-kind such as volunteer services, good will, advocacy, goods and money. Organizations have also given support, for example, Action Aid, UNICEF, Ford Foundation, USAID through FHI and the Rotary Club. They have a management board to look over their activities.

**KIKUYU HOSPITAL COMMUNITY-BASED HEALTH CARE
PROGRAMME**

P.O. Box 45

Kikuyu

Tel: 0154 - 32057, 32412

Fax: 0154 - 32413

**Contact: Ms Tabitha Mbugua
Project Coordinator**

A church-based organization, Kikuyu Hospital started its community-based health care (CBHC) programme seven years ago. It has a full-time coordinator who facilitates HIV counselling and community-based health care activities. There are three full-time counsellors, but most of the nurses have been offered HIV counselling training and 43 of these offer HIV counselling on a part-time basis in their respective wards. The clients seeking HIV counselling and testing are usually blood donors, hospital patients and voluntary clients. Through community outreach programmes, potential clients are influenced to seek counselling and testing services. Training in HIV counselling is usually done in-house and is continuous. During these training sessions, areas of weakness are addressed, and information on HIV/AIDS is updated. The programme plans to organize surveys on the status of orphans and to contact MEDS for low-cost AIDS test kits. The cost of testing is KES 700, which is prohibitive for most clients. The client load is very high, and the counsellors are suffering from burn-out. The current funding source, Christian Health Association of Kenya (CHAK), is no longer able to sustain this programme, and the hospital is uncertain if it will be in a position to take on the responsibility itself.

LANGATA HEALTH CENTRE, NCC
Chweya Road, Otiende Estate
P.O. Box 30108
Nairobi
Tel: 506991

Contact: Ms Ann Mburu, MSF Counsellor
Sr E. Githu

The Langata Health Centre is an ultra modern building located in Otiende Estate in Langata. Much of the building was not in use at the time of the interview. Preparations are under way to complete this centre with the assistance of MSF-Belgium. The health centre was first opened to the public in 1974 for antenatal services, and two years later it expanded to include family planning services. The nurses administer family planning services with doctors intervening for new cases requiring intrauterine devices. In 1987, a private consultant specializing in sexually transmitted diseases introduced STD services at the centre, and these services continue to be available to the community. Currently, this centre serves the whole of Langata and has clients coming from the nearby Kibera slums and from Ongata Rongai.

It offers both curative and preventive primary health care to the general population. The preventive services include antenatal care, family planning, sexually transmitted infections and Rapid Plasma Reagin (RPR) services for pregnant women in early pregnancy. Where women are found to have RPR-positive results, they are offered free treatment for syphilis. Health education is available at the centre for all visiting clients. Community-based care and counselling is conducted in the nearby Kibera slums. Where testing is required, it is facilitated by the centre through the STC Casino clinic. The centre serves up to 400 clients each day for general treatment and about 10 to 15 clients with HIV/STIs. They have a flat rate of KES 40 per drug item for the general patient and a sliding scale for poor clients, exempting some from charges as appropriate. The antenatal care is free of charge, and so is tuberculosis treatment. With the completion of the facility, there will be laboratory services, dental services and treatment and counselling of commercial sex workers. The centre receives support in the form of drugs for STI from CIDA, the World Bank and STC Casino.

The HIV counsellor is trained and supported by MSF-Belgium. Currently she reports having clients who are better informed and more knowledgeable about HIV/AIDS than she is, making her feel inadequate as a counsellor. She also is challenged by the multifaceted problems that clients present, some of which cannot be met by the centre, such as unemployment. The counselling services are organized through MSF-Belgium and are therefore dependent on MSF's plans in the coming years.

MAJENGO CLINIC, UNIVERSITY OF NAIROBI
DEPARTMENT OF MICROBIOLOGY
P.O. Box 19676
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Tel: 719851/2 ext. 43214
Fax: 712007

Contact: Dr E. Njagi
Coordinator

About ten years ago, a research team from the University of Nairobi Microbiology and Community Health Departments and the University of Manitoba, Canada, mobilized commercial sex workers in the Majengo area of Nairobi in an effort to give them information about practising safer sex. Plans to offer them incentives to take out small loans for small enterprises and offer an alternative to the commercial sex trade were also introduced; however, so far the latter has not been successful. Commercial sex workers agreed to participate in an STD/HIV research project where they would be closely followed and at the same time receive HIV counselling, testing and other STD services and treatment.

The team at the clinic consists of three nurses, three doctors and two support staff members. All are trained in HIV and STD counselling. The participants, all commercial sex workers, are engaged in high-risk sexual activities but also have plans to have children, get married and abandon prostitution. Over 95 per cent of them have tested positive for HIV and are therefore discouraged from getting pregnant and are encouraged to use prevention methods such as condoms. They are also encouraged to seek STD treatment. Since the majority do not have regular partners, partner notification becomes meaningless, but as much as possible they are encouraged to use condoms.

Monitoring of participants' HIV serostatus is carried out by the staff at the clinic. In cases of sickness, the clients are referred to KNH. The research findings indicate that in almost all the participants, chlamydia, a common STI, has disappeared; the prevalence of gonorrhoea has decreased from 40 to 10 per cent in the last 10 years; and more than 80 per cent of the participants currently use a condom. Since 1997, there have been no HIV seroconversions. These results are considered very promising by the research team, and they have started similar research activities in other areas. Like all other organizations, lack of resources and funding is a major challenge. The clinic has received funding support from the Rockefeller Foundation, the National Institutes of Health (Bethesda, Maryland, USA), Oxford University, the University of Manitoba, Canada through CIDA and IDRC, and the University of Nairobi Microbiology Department.

MBAGATHI DISTRICT HOSPITAL
off Mbagathi Way
P.O. Box 20725
Nairobi
Tel: 726300 ext. 43728/43712/43643

Contacts: Ms Nancy Kaharu, MSF Counsellor
Ms Roselyn Okumu, Social Worker
Ms Catherine Mwaura, Counsellor

A government hospital that has long been known for treating infectious diseases (formerly known as the Infectious Diseases Hospital or IDH), Mbagathi Hospital has recently been transformed into a district hospital. Although it offers curative services for inpatients and outpatients, it is still primarily recognized for its infectious disease services, and 90 per cent of the inpatients have an infectious disease, primarily tuberculosis (TB).

MSF–Belgium Clinic

The MSF–Belgium Clinic at Mbagathi Hospital is housed next door to the TB clinic. They have two additional clinics within the Langata and Dandora NCC clinics and plan to extend to a total of five health centres around the city of Nairobi. The clinics offer services to the general population and especially to people who have access to their health care through the NCC clinics. Many types of clinical services are provided through the MSF–Belgium project. The project provides services by strengthening the existing health facilities instead of setting up a parallel health system.

HIV testing and counselling

This is a new service that has been started as a result of the collaboration between MSF–Belgium and the government health facility. Counselling and testing services are also available in the Langata and Dandora clinics. The Mbagathi clinic offers HIV testing and counselling free of charge. The blood is taken to the STC Casino clinic laboratory for testing. Currently about five clients per week go for testing. MSF–Belgium recruited the counsellors from the Kenya AIDS Society to provide pre- and post-test counselling services.

Treatment services

There is global support for the clinic in providing drugs to the health centres and training of health workers. MSF–Belgium has developed a treatment algorithm to strengthen the health workers' diagnostic and prescriptive practices. The algorithms promote prophylaxis for pneumonia, PCP, toxoplasmosis and isospora. MSF–Belgium has collaborated with NCC to ensure that drugs are available and subject to cost-

sharing but with an easy process of waiving fees for those who cannot afford them. There is also a three-day training course for health staff on counselling.

Health education

MSF-Belgium has strengthened health education activities in the participating health facilities. The project has provided TV, VCR and educational videos to be shown in the reception area as clients wait to be attended to. Locally filmed videos on AIDS prevention are shown at these facilities.

Food supplementation programme

HIV-infected individuals who are diagnosed with tuberculosis are provided with additional food during the first months of treatment. They are given maize, soya and beans blended into a flour that can be used to make porridge. Sometimes they are given beans and maize flour. Severely malnourished patients, wasted patients and those with extremely adverse social circumstances also benefit from the food supplementation programme.

Child and orphan care

MSF-Belgium does not have a child-care programme but networks with other agencies providing this type of care.

Home-based care

The home-based care programme is an effort to extend clinical services to AIDS patients right into the household and is still in the early stages. Currently they are providing care for 100 patients in Dandora and 60 patients in Langata. The expansion of the home-based care programme depends on the number of volunteers available. It is anticipated that one nurse will be able to provide home-based care for 100 patients with the support of community volunteers.

The currently available volunteers of home-based caregivers are not related to the patients but do this work out of their own dedication. MSF-Belgium provides some support to the volunteers in terms of free medical care for them and their families.

HIV referral clinic

Every Wednesday morning there is a referral clinic for HIV-infected people at Mbagathi Clinic. This is the referral point for a number of NGOs in Kibera that provide care for HIV-infected individuals. The clients are provided with free clinical consultation, counselling and treatment within this clinic. Mbagathi AIDS clinic has a session on Wednesday parallel to the TB clinic. On the other hand, Langata and

Dandora clinics are primary care clinics that provide care to the general population in normal working hours.

Staff

The MSF–Belgium project employs two doctors, two expatriate nurse-managers, ten counsellors, two social workers and one community organizer. The counsellors have received a variety of training from the Red Cross, KAS and KAPC. The programme also conducts a three-day in-house training course for the clinical staff within Mbagathi as a way of enhancing the caring capacity for HIV-infected individuals admitted to the hospital. The doctors on the MSF project visit the patients registered in the programme when they are admitted to hospital.

Future vision for MSF–Belgium programme

MSF–Belgium has plans for a more comprehensive programme of care in the city of Nairobi that would include the following:

- TB surveillance with systematic testing for TB of all HIV-positive patients
- counselling and testing available at all primary health care clinics
- antenatal voluntary counselling and testing

Confidentiality for clients

MSF–Belgium ensures confidentiality of HIV testing by sending samples with only an ID number and no name. The counsellor retains the results.

Funding

The programme gets funding from different sources: the European Union, Sida, DANIDA through the Home-Care Project, laboratory services by JICA and Australia.

MSF–Belgium Counselling Programme

The hospital has three full-time HIV counsellors who offer counselling to both inpatients and outpatients. One of the counsellors is supported by MSF–Belgium and works under the supervision of the project while the other two are employed by the Ministry of Health. They, however, work as a team and are able to counsel 50 clients per week. They also collaborate closely with existing NGOs in the Kibera community for follow-up and community-based care, as most of the clients seeking HIV counselling and testing are from this community. Most of the clients seeking counselling are referred by laboratory technicians and clinicians. The counsellor assesses the clients' level of knowledge of HIV. Important information is imparted, and requests for notification in case of positive results are made. With consent, the client is scheduled for a post-test counselling session. Over 90 per cent of the clients who seek HIV testing test positive. If inpatients, they are followed closely by the counsellors,

HIV testing test positive. If inpatients, they are followed closely by the counsellors, but if outpatients, they are given the opportunity of follow-up by health centres in the community such as Kibera self-help programme or Dandora clinic, which has counsellors supported by MSF-Belgium. The hospital counsellors identify the need for sensitizing more hospital workers to the importance of HIV counselling to facilitate referrals. They are also struggling with lack of space for counselling, and this interferes with confidentiality. They feel they are understaffed. MSF-Belgium plans to develop a patient support centre for group counselling at the hospital. They also plan to train more counsellors to help meet this need.

TB programme

Tuberculosis is the most serious, frequently occurring opportunistic infection in HIV-infected individuals. The TB control programme has been collaborating with clinical researchers to establish the most appropriate method of treating HIV-infected individuals suffering from tuberculosis. Major policy changes have been made in the treatment protocols as a result of the research findings and the high prevalence of HIV among TB patients. The Ministry of Health provides free TB screening and treatment services countrywide.

Screening for tuberculosis

Two tests are used routinely to screen for tuberculosis: sputum examination and chest radiograms. Sputum examinations are free of charge at Mbagathi TB clinic. In the city of Nairobi, other centres that examine sputum are Rhodes Avenue Clinic, Karuri Health Centre, Chandaria Dagoretti Clinic, St Teresa's, Pumwani, as well as the major hospitals. In hospitals like KNH, a small cost-sharing fee is charged for the sputum examination. Chest x-ray facilities are available at the Mbagathi TB clinic and at the Rhodes Avenue City Council clinic. Patients have to pay a small fee for the x-rays.

Treatment of tuberculosis

The Ministry of Health considers TB treatment a major public health priority: TB drugs are provided free of charge and are always available. There has been an enormous increase in the number of TB cases in the city of Nairobi: in 1997 the TB clinic registered 8000 new cases, and the estimate for 1998 was 10,000. The majority of patients are from the eastern part of the city (Kariobangi, Mathare North and Dandora).

Mbagathi Hospital TB Clinic is a referral centre that works in collaboration with the Nairobi City Council as well as NGOs providing care for TB patients. Within Nairobi there are 36 centres that have staff trained in provision and supervision of TB treatment.

The TB control programme has been a vertical Ministry of Health programme. In the wake of the AIDS epidemic, collaborative arrangements with NGOs have emerged.

For example, the Eastern Deanery of the Catholic Church in Nairobi has a community-based TB screening programme. All patients with TB-positive sputum are sent to Mbagathi District Hospital for registration and commencement of treatment. The programme supports the patients by providing syringes, needles, and sometimes transport to go and collect the drugs.

Screening of close contacts

Tuberculosis is an airborne infectious disease that is transmitted through close contact with persons with open tuberculosis. The government does not have resources to carry out contact tracing. However, the TB clinic encourages family members who have been in close contact, and especially those sharing the same bedroom and children aged less than five years, to present themselves for screening.

HIV testing

Within Mbagathi Hospital, HIV-testing and counselling services are available, however, the staff are not enthusiastic about counselling and frequently refer the patients to the MSF-Belgium clinic, which provides services on the same premises as the TB clinic. Within the Mbagathi Hospital system there are no special arrangements to protect the confidentiality of laboratory results, and the clinical care manager who was interviewed was concerned that there was some degree of testing without counselling.

METROPOLITAN HOSPITAL
Buruburu Estate, Phase 3
Rabai Road
P.O. Box 33080
Nairobi
Tel: 792221/790317/790286
Fax: 790275

Contact: Ms Catherine Mwangi
Matron

Since it opened its doors in 1995, the Metropolitan Hospital has had a bed capacity of 38 patients and casualty outpatient flow of an average of 80 patients per day with an ever-increasing demand for both services. A private investment with shares open to the public, the hospital is the brainchild of very young and upcoming medical practitioners who identified the need for a modern, functional hospital accessible to the community.

The hospital offers HIV and STD testing, and doctors and nurses prepare patients for the tests although they have received limited training in HIV/AIDS counselling. In-patients are counselled before and after screening. A seropositive patient receives counselling with his or her spouse and health education. A positive approach to life with HIV is promoted, nutrition is emphasized, and for those who cannot afford long hospital stays, home-nursing care is recommended. Since the majority of the clients are poor, HIV counselling is provided free of charge. Follow-up is done at the clinic level for a small fee. Once facilities are available and a trained counsellor is put in place, an affordable fee will be instituted.

Many of the clients who seek HIV testing are advised to receive pre-test counselling. Many are young people preparing for marriage or seeking overseas travel. The hospital identifies the need for establishing counselling facilities for HIV-positive persons but is still in its initial stages of developing the main hospital structures and has therefore not budgeted for specialized services such as these. The management, however, predicts that HIV counselling and testing structures will take priority as more and more patients present with this need. They currently have four to ten HIV/AIDS patients for in-patient treatment per day but have high numbers of out-patients seeking HIV testing. They have identified a number of patients who move from one medical facility to another trying to ascertain their HIV status. Eventually, the patient identifies one medical facility or medical doctor and seeks treatment and support. With proper counselling for HIV, they feel that this activity can be curbed and patients given the proper information and care that they are seeking.

SPECIAL TREATMENT CENTRE CASINO, NCC
Cross Lane and River Road
P.O. Box 30108
Nairobi
Tel: 228845/250192
Fax: 251511

Contact: Dr Peter Otiato

The Special Treatment Centre, better known as STC Casino for its location near the Casino theatre, is well known for its treatment of STD/HIV/AIDS and related skin infections. This centre has been in existence since colonial times. The treatment centre has been offering STD testing, condom distribution and health education for clients with STDs and related infections. It also serves as a major referral centre for other health clinics (both public and private) and especially those managed by the Nairobi City Council.

In the last four years, STC Casino has developed its services to include HIV counselling and testing, and training for counsellors. As an NCC clinic, STC has received support for various services from the European Union and the Canadian International Development Agency (CIDA). The services include the procurement of STD drugs, training in STD prevention and counselling, research activities and renovation of the treatment site.

All clients who attend the centre are first interviewed to establish their status. Those who wish to be tested for HIV are then sent for pre-test counselling. Services are tailored to suit the needs of the clients. Those clients who seek specific HIV testing services are required to pay KES 300 for the service. All other clients pay a standing charge of KES 100, which covers all the treatment and services provided.

Eleven counsellors have been trained for one month in HIV pre- and post-test counselling at KAPC. Only two counsellors are on duty at a time, and the rotation changes about every three months. The centre is open for services and treatment from 8 to 5, Monday to Friday. Most of the clients seek voluntary treatment while others are referred from other health centres by clinicians for specialized treatment and HIV testing.

Between 30 and 70 clients are counselled each month, not all of whom test positive for HIV. The clinic has a staff of 45: 4 are medical doctors, 2 are clinical officers while 11 are trained nurses and counsellors. The rest consist of laboratory technicians and other support staff. Counsellors are offered support and supervision from the KAPC counsellors once a month. The supervision takes the form of two-hour briefings where each counsellor participates in the group discussions, narrating difficult cases and experiences and receiving feedback from the group with suggestions for improving or approaching the case. This has proven to be very effective, and the centre has good-quality service. Stress is also alleviated through group meetings.

To provide various services, such as IEC, treatment and training, the centre collaborates with the following organizations:

- Central Medical Stores (for condoms)
- KANCO
- KAPC
- KAS
- KEMRI
- Kenya Red Cross
- Ministry of Health
- NASCOP
- TAPWAK
- University of Nairobi Microbiology Department

They hope to incorporate family planning and reproductive health services to complete the care provided to clients and to include the many commercial sex workers living near the area who need STD treatment, HIV counselling and testing. The centre is committed to continued service provision and will be looking into ways and means of sustaining these activities.

ST JOHN'S COMMUNITY CENTRE
(near Pumwani Maternity Hospital)
P.O. Box 16254
Nairobi
Tel: 767656/761624
Fax: 765798

Contact: Ms Sarah Karanja
AIDS Programme Officer

This organization was started in 1957 by the missionaries of the Anglican Church of Kenya as a response to the needs of the community. Initially, they concentrated on social welfare and spiritual counselling. As needs continued to expand, training included community-based workers to work with the poor.

In the last five years, the centre has responded to the need for counselling, especially for HIV. The community is encouraged by community-based workers to seek medical care and testing for HIV at nearby centres such as STC Casino, Pumwani Health Centre (MSF), KEMRI and Crescent Medical Aid through the Undugu Society. Where patients are not able to afford medical services, the centre works with the Eastern Deanery Catholic Church home-based care programme and the social workers of the main government hospitals.

The centre concentrates on vocational training and non-formal education for the youth. Volunteers are trained in basic counselling, environmental health and leadership skills. The volunteers, who are also members of the community, are involved in outreach work as well. Both men and women have basic literacy skills. For remuneration, they receive assistance in kind such as medical services and skills training to enable them to generate their own income. Counsellors also receive support during fortnightly group counselling sessions.

The HIV/AIDS programme has one full-time AIDS programme officer who provides counselling and coordinates the programme activities. She is also responsible for supervision of the 22 part-time volunteers trained as counsellors. Since the work is community based, the centre has many clients known to them through community outreach services. The community leaders are an integral part of the work of the centre, and they hold monthly meetings to discuss community issues.

WOFAK (Women Fighting AIDS in Kenya)
Aladdin House, off Haile Selassie Avenue
P.O. Box 58428
Nairobi
Tel: 217039/332082

Contact: Ms Dorothy Onyango

WOFAK is a local NGO registered in 1994. In addition to the headquarters in downtown Nairobi, it has offices in Kayole and Homa Bay. For the last five years, the organization has been reaching women living with HIV/AIDS and has been offering counselling and testing services, social support, home-based care, condom distribution, and educational campaigns for HIV/AIDS care and prevention. These activities are carried out in the main office and at the Kayole walk-in clinic where the targeted community, women and their partners, live. Hospital visits are regularly made, and school outreach programmes, especially to girls' schools, are organized.

The organization is highly dependent on volunteers who are also members of the community. The volunteers are offered in-house training to enable them to work effectively with the clients. They work closely with the four trained counsellors and two home-based care field workers. They identify persons who need care, encourage them to be tested for HIV when necessary, and promote the use of precautionary measures such as the condom. Biweekly medical consultations are organized at the walk-in clinic where a general practitioner and a nurse attend to clients with opportunistic infections. The nurse screens and treats patients regularly, while the doctor visits twice a week to assist in the more complicated cases. Referrals for testing are made to KEMRI and KNH and, if needed, admissions to KNH are facilitated. Weekly meetings are held to enable the staff to relieve stress through sharing of experiences.

This organization is highly dependent on donor support, and once a year staff review their needs and send out proposals for support to various organizations such as Ford Foundation and Norwegian Church AID. WOFAK plans to improve services by including orphans as a target group and developing a hospital fund for its members. The membership fee is KES 50 per year on an affordable basis and is open to all women living with HIV. HIV seronegative women willing to contribute professionally or as volunteers are also welcomed. All other services are free for members.

In 1995, WOFAK opened a coordination office for western Kenya in Homa Bay. Staff conduct follow-ups to ensure that communities who have been trained to conduct HIV/AIDS education, counselling and home-based care are doing their work effectively. They also ensure that IEC materials (posters, booklets and so on) are distributed, together with condoms. WOFAK has so far trained 35 women's group leaders as community trainers of trainers (TOTs) in awareness, counselling and home-based care for HIV/AIDS infected persons. The Homa Bay office is staffed by a coordinator and a counsellor.

Clinical care

Clinical care is offered at the Kayole centre and includes clinical consultation and drugs. Very ill patients are visited by the nurse at home and, if the need arises, they are referred for admission to Kenyatta National Hospital. There are two home-based caregivers based at the Kayole site. They visit the ill clients and ensure that they are taking their medications as directed.

Home-based care

WOFAK also provides personal care as required such as bathing and housecleaning for their clients and even provides them with meals. The centres also offer individual and group counselling. Clients are then referred to KEMRI for testing. WOFAK organizes social support for newly diagnosed individuals. Staff also regularly visit their old clients. Their offices at Kayole function as a walk-in centre and resource facility.

Community health education

WOFAK has a community outreach programme to create awareness about HIV and to increase community tolerance and support for those living with the illness. Some of the women volunteers are reaching out to sex workers in the Kayole area with AIDS awareness and condom promotion.

Income-generating activities

In Nairobi, WOFAK has identified lack of income as a major constraint among the women using their services. A study was carried out in collaboration with an NGO called "Improve Your Business" to identify what the women would like to do as income-generating activities. Overwhelmingly, the women wanted to undertake individual and not group activities; they felt that their children would not necessarily benefit from the group activity if they died. WOFAK is presently trying to source funds to support these IGAs.

The Homa Bay facility, in addition to counselling and home-based care, has income-generating activities. The site is training women to sew and make home crafts. Currently staff are trying to develop income-generating activities with their clients.

Constraints

At the initiation of the project, it was assumed that the clinic would offer the services at a fee to their clients and in this way they could sustain their services. Unfortunately the organization has found that many of the clients who require health services are unable to afford the drugs. If the services are to be paid for, such individuals stay away and many die prematurely from opportunistic infections. Therefore, WOFAK is looking for other ways of generating income to sustain their services.

Hospital referral is the other major difficulty: the waiting time and bureaucracy for admission to Kenyatta National Hospital is daunting. The WOFAK nurse has often spent a whole day in Casualty trying to get a patient admitted.

Staff

The programme advisers are volunteers. The Nairobi branch of WOFAK employs one nurse, two counsellors, two home-based caregivers, two outreach educators and an administrator. Only two counsellors are trained; one had a two-week training course while the other had a slightly longer course. Of the home-based caregivers, one had incomplete nursing training while the other was a social worker. A doctor volunteers once a week at the clinic to see the very ill persons. In Homa Bay there is one trained counsellor who doubles as an administrator and one outreach worker.

Records

The organization keeps records of the clients they see. These records are locked up and are accessible only to the nurse, doctor or counsellor. The programme adviser is a trainer in record keeping and has been providing in-house training for the staff.

Inventory

BACKGROUND TO THE INVENTORY

The inventory was developed using two different methods: on-site visits and telephone interviews. An asterisk (*) indicates that the data was collected on site. Where cells have been left blank, the information was not available. However, the inventory is a dynamic instrument, subject to the updating and verification of information by all the organizations listed herein. The inventory and data collection instruments are available on the websites of both Family Health International and the Population Council:

<http://www.fhi.org> • <http://www.popcouncil.org> • <http://beta/pcnairobi>

Inventory data

The following key is used throughout the inventory:

- C** Sites where only pre- and post-test counselling is available, but the client is sent elsewhere to have blood drawn for HIV testing.
- CS** Care and support sites provide a variety of support services for HIV-positive persons, including counselling.
- CT** Sites where HIV pre-and post-test counselling is available and where blood is drawn on site for the test.
- CT-H** Hospitals are listed separately as, although they provide CT, testing is typically carried out on symptomatic patients, and counselling services in some hospitals are limited.
- OC** Refers to counselling in addition to or other than CT.
- OS** Sites where support other than counselling is available to HIV-positive clients.
- T** Testing sites do not provide counselling, or only minimal counselling.

Sites are listed only once, in the most appropriate categories.

Terminology used in other columns includes the following:

- CHBC** Community home-based care is care for HIV/AIDS-affected members of the community.
- Follow-up** Refers to patients who have gone through initial HIV counselling and have been requested to return for ongoing counselling.
- Outreach** Community health workers provide HIV education and counselling and other support services to the clients within their own communities.
- Referral** The site refers clients and patients to other centres for HIV counselling or testing or both and for other medical treatment.
- Walk-in** The facility has an "open-door" policy.

Inventory of counselling, testing, care and support sites in Nairobi – page 86

No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
1a	AAR Health Services*	Box 41766 tel: 715319	Ngong Road	24 hrs	Private HMO	East Africa	Testing, counselling, medical care, referral	Individual membership, corporate clients	CT	100+ every 2-3 days	1000/- for HIV test	None	Walk-in, referral	Screen for insurance purposes and referrals from doctors
1b	AAR Health Services*	Margaret Kianduma Medical Centre Mgr tel: 531830 fax: 533649	Odessa Plaza, South B, Mukoma Road	8 to 8	Private HMO	Nairobi	Testing, counselling, medical care, referral	Individual membership, corporate clients	CT	see no. 1a	see no. 1a	None	Walk-in, referral	Testing for AAR services is centralized to economize; non-members charged 2000/- for HIV tests
1c	AAR Health Services*	Dr Chal 712276/9 fax: 717267	Yaya Gold Card Centre, Yaya Cntr, Hurlingham	9 to 5	Private HMO	Nairobi	Testing, counselling, medical care, referral	Individual membership	CT	see no. 1a	see no. 1a	None	Walk-in, referral	Most of those tested at AAR have been referred by insurance companies
1d	AAR Health Services*	Grace Munuhe 783252/3	Kariobangi Outreach Clinic	8 to 5	Private HMO	Nairobi	Testing, counselling, medical care, referral	Individual membership	CT	see no. 1a	see no. 1a	None	Walk-in, referral	
2a	Aga Khan Executive Clinic	Box 30270 tel: 740000	Parklands	8 to 5	Private clinic	Nairobi	Counselling, testing	General population	CT	< 10 per day	At least 1000/- for HIV tests	None	Walk-in	
2b	Aga Khan Hospital	Box 30270 tel: 742531	Parklands	24 hrs	Private hospital	Nairobi	Counselling, testing	General population	CT	< 20 per day	1200/- for ELISA and Rapid tests	None	Walk-in	Lab technician trained in HIV counselling
3	AIDS Community-Based Outreach Services (ACOBOS)	F. Mhonie Box 20971 tel: 716730	Ngumo Estate	8 to 5	NGO	Nairobi	Supportive counselling, home-based care, IGA information, health education, nutrition for PLHAs	PLHAs	CS	10 per day	No charge	None	Walk-in, referral	
4	AIDS Orphans Support Organization of Kenya	Jane Muriithi Muriuki Box 67913 tel: 788473 fax: 332176	Buru Buru Phs 1, Eastlands, Nairobi Calvary Temple Church	8 to 5	NGO	Nairobi	Counselling, referral, home visits	Orphans	CS	Not given	Free	Peer group counselling, study of RH for adolescents	Walk-in	
5	Amani Counselling and Training Institute*	Elecah M. Mbithi Box 41738 tel: 602672	Mbagathi Way next to Kenyatta Market	8 to 5	NGO, training institution	Nairobi	Counselling	General population	OC	< 5 per mo for pre-test counselling	200 to 800/- depending on ability to pay	None	Walk-in, referral	Centre gives post-HIV counselling at a fee if client is willing to return
6	AMREF Clinic	S. Nzyuko, Project Manager Box 30125 tel: 501301/2/3 or 602191	Wilson Airport	8 to 5	NGO, medical research	East Africa	Supportive counselling, testing, HBC	Staff; referrals from KANCO and private clinics	CT, OC	< 10 per mo for CT	Lab 954/- for ELISA and Rapid tests; free counselling	Youth seminars and peer training	Walk-in, referral	Christine Adhiambo, medical lab technologist, is a KAPC-trained counsellor; clients seen by appointment at the Wilson Airport counselling room
7a	Archdiocese of Nairobi: Eastern Deanery, Administrative Centre	Lucy tel: 794785	Umoja 1 Assumption of Mary	8 to 4 Mon to Fri	Religious CBO	See 7b-7g	Administrative support for 7b-7g	General population						
7b	Archdiocese of Nairobi: Eastern Deanery, Baba Dogo	Lucia Muntuve Caroline no telephone	Baba Dogo	8 to 4 Mon to Fri	Religious CBO	Baba Dogo and its environs	Counselling	General population	CS, OC	< 10 per day	None	None	Walk-in	Community health workers, 2 nurses

No.	Organization	Contact Information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
7c	Archdiocese of Nairobi: Eastern Deanery, Dandora	Alice Njoroge, Progr. Coordinator Box 811421 tel: 811421, 794785	Dandora Catholic Church	8 to 4 Mon to Fri	Religious CBO	Dandora	Counselling, medical care	General population	CS, OC	< 10 per day	None	Family Life Education Outreach programme	Walk-in	Community-based workers provide counselling, 1 nurse
7d	Archdiocese of Nairobi: Eastern Deanery, Kariobangi Community Home-Based Care (Korogocho)	Alice Njoroge, Progr. Coordinator Box 53376 Sr Gill Horsfield tel: 793288	Kariobangi Catholic Church	8 to 4 Mon to Fri	Religious CBO	Kariobangi, Korogocho, surrounding slums	Counselling, medical care, care and support, training of health workers	General population	OC, CS	< 10 per day	None	None	Walk-in	60 community-based workers, 7 nurses, 1 counsellor, 1 social worker
7e	Archdiocese of Nairobi: Eastern Deanery, Kayole	Ann Njeri, Health Worker tel: 785623	Kayole Catholic Church	8 to 4 Mon to Fri	Religious CBO	Kayole residents and those living within its environs	Counselling on social and economic needs	General population	CS, OC	< 20 per day	None	None	Walk-in	Community health worker, 1 nurse
7f	Archdiocese of Nairobi: Eastern Deanery, Shauri Moyo	Margaret tel: 530360	Shauri Moyo Catholic Church	8 to 4 Mon to Fri	Religious CBO	Shauri Moyo	Counselling	General population	CS, OC		None	None		1 nurse
7g	Archdiocese of Nairobi: Eastern Deanery, St Teresa's	Ruth tel: 760005	Eastleigh near St Teresa's High School	8 to 4 Mon to Fri	Religious CBO	Eastleigh and Mathare slums	General counselling as well as pre-HIV counselling	General population	CS, OC	< 10 per day	None	None	Walk-in	Community-based workers, 2 nurses
8	Bethesda Clinic*	Dr Kahenya Box 52951 tel: 221650 or 331010	National Bank Building, South Wing	8 to 5 Mon to Fri 8 to 1 Sat	Private clinic	Nairobi	Medical services, limited pre- and post-test counselling	Corporate clients from companies, general population	C	> 10 per week	650/- for ELISA and Rapid tests; testing is referred to a lab in bldg and results returned to the clinic	None	Walk-in, referral	1 industrial health worker, 1 pediatrician, 1 nurse trained in HIV counselling; clients referred here for insurance, pre-employment and medical; use Nairobi Hospital for test confirmation
9	Canaan Medical Services	Mrs Musuva Box 48981 tel: 335456 or 335467	Comer House, 1st floor	8:30 to 12:30, 2 to 5 Mon to Fri 8:30 to 12:30 Sat	Private clinic	Nairobi city centre	Counselling, testing, medical care, referrals made if requested	General population, companies	CT	3 to 4 for HIV CT	500/- standard fee for all med. services incl. pre-test counselling	None	Walk-in, referral	Pre-employment medicals and pre-marital counselling and testing; insist on client consent before HIV testing
10	Chandaria Health Centre and Dagoretti Community Health Services	Peter Njenga Pamela Ochieng Box 43678 tel: 566122 or c/o AMREF tel: 501301	Dagoretti Market	8 to 5	Local NGO	Dagoretti, Walthaka, Ruthimiti, Mutuini	Training for community-based caregivers; technical support for home-care workers; MCH, laboratory, dental services family planning, testing and counselling, community and peer education	General population	CT	1 to 2 per day for HIV counselling	Testing 150/-		Walk-in, referral	Under AMREF management: Peter Njenga, public technician; Pamela Ochieng, community nurse/counsellor; have 8 CHAK-trained counsellors; most clients are referrals from Dagoretti and Kayole; offer FP, antenatal and child welfare services

* Information was collected on site (at other sites, it was collected by telephone).

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No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
11	Crescent Medical Aid	Said Aboud Executive Director Box 33041 tel: 220811/222575	Jamia Mosque; other clinics in Pangani, Mukuru in Industrial Area, Pumwani, Eastleigh, Kibera	8 to 5	Local NGO, private clinic	Nairobi (Mombasa and Nakuru)	Counselling, testing, condom promotion	General population; health workers and slum schools	CT	2 to 5 per day per clinic	550/- for HIV test (Jamia Clinic)	None	Walk-in, referral	General out-patient MCH care and immunization
12	Dept of Defence Medical Clinic*	Col. Mutungi Box 40668 tel: 721100	Off Lenana Road	24 hrs	Government hospital	National Army barracks	Counselling and testing, medical care	Armed forces personnel, families and civilian workers	CT	< 20 per mo for CT	None; perform ELISA, Rapid and Western Blot	None	National Army	
13	Family Life Counselling Association	Margaret Ogola Box 18077 tel: 558926/555977 Christine Ng'ang'a Progr. Manager tel: 762085	Nairobi South B	8 to 5	Local NGO	Nairobi, Mukuru	Family life counselling, youth seminars, referral training	Family, primarily the youth	OC		100/- for services, 200/- for couples	Youth seminars in tertiary institutions	Training, walk-in	Director, Margaret Ogola; Nairobi office is admin. HQ; training sessions held in Kilimambogo Centre of parish-based counsellors, upper primary school teachers in counselling; have community-based counsellors, 1 qualified counsellor, nurse, MD
14	Family Life Promotion Services	Isabella Njagi Box 19608 tel: 339087	Mumbi House Ronald Ngala St	8 to 5 Mon to Fri	Local NGO	Nairobi, Kisumu	Counselling, medical care (STDs, FP), referral	Informal sector workers; general population	OC	< 7 per day counselling, testing referred	80/- per visit for counselling	Youth training in peer counselling	Walk-in, referral	Clients referred to hospital as need arises
15	Guru Nanak Hospital	tel: 763481	Park Road, Ngara	24 hrs	Private hospital	Nairobi	Counselling, testing, medical care, referral	General population	CT-H	< 10 per day	760/- for ELISA or Rapid tests	None	Walk-in, referral	Regular counsellor for HIV; counselling done by nurses; very limited CT
16	KEMRI-CRC*	Mr Ribondo Box 54840 tel: 725016	Kenyatta National Hospital	8 to 5	Parastatal	Nairobi	Counselling, testing, research	General population	CT		300/- for testing w/o referral; tests include ELISA, Rapid and Western Blot	None	Walk-in, referral	
17	Kenya AIDS Society*	Joe Muriuki, Director Box 76618 tel: 760370	Pangani	8 to 5	Local NGO	Nairobi (Kiambu and Embu)	Counselling, support, HBC, education	PLHAs	OC, CS	20 per week for pre-test counselling	None	Reproductive health education	Walk-in, referral	Michael Onyango, trained counsellor; patients referred to KEMRI for free HIV testing and return for free post-test counselling
18	Kenya Association of Professional Counsellors VCT Centre, Kariobangi Counselling Centre*	G. Wathome Box 55472 tel: 786310/766283	Sanoda House, 3rd floor Kamunde Road--off Outer Ring Road	8 to 5	Local NGO	Nairobi--Kariobangi	Counselling, testing, training, research	General population	CT	20 per week	20/- for CT	Adolescent activities, Straight Talk magazine, discussions	Walk-in	Counsellors are trained in HIV and other areas of counselling; condom promotion in Eastleigh and Dandora

No	Organization	Contact Information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
19	Kenya Evangelical Lutheran Church	Mr Elf Box 54128 tel: 792564/78, 780454 fax: 792564	Jerusalem, Nile Road	8:30 to 5:00 Mon to Fri	Church organization	Jerusalem, Buru Buru, Dagoretti, Kangemi, Mathare	AIDS education programme, peer counselling, resource centre	Youth: street girls in Mathare targeted by Pangani Lutheran Children's Centre	OC, OS	Outreach (11,000)	None	Drama, videos; training in youth counselling, vocational training for jobless youth	Church organization	Can also contact through Dagoretti Lutheran Church, tel: 882180, or Women's Desk, Alliance for the Advancement of Children, tel: 443868
20	Kenya Red Cross Society*	Wambul Kairo Box 40712 tel: 248640 fax: 248641	Red Cross Bldg off Parliament Road opp. St John's Gate	8 to 5	Local NGO	Nairobi Uasin-Gishu, Kisumu, Machakos	Counselling, support, follow-ups, referral	General population	C	50 to 90 per week for counselling	None	None	Walk-in	Counsellors are trained in HIV counselling; operate a hotline where people can call for counselling; clients referred to KEMRI for testing
21a	Kenyatta National Hospital, Adolescent Counselling Clinic (HRC)*	Dr R.K Koigi, Director Jennifer Liku, Project Manager Margaret Gichaga, Project Coordinator Box 19676 tel: 726300 ext. 43034, or 722810	Off Ngong Road in KNH Tower Block, ground floor opposite Physiotherapy Dept	8:30 to 4:30 Mon to Fri 9 to 3 Sat-Sun	Government hospital	Nairobi	Counselling individuals and groups, FP/STD/RH, primary and secondary intervention	Young, single adults (25 and below), hospital patients in ObGyn and post-abortion wards, rape victims, suicide victims, drug abusers	C	About 5 per mo for pre-test counselling; are referred to Patient Support Centre at KNH	None	Individual and peer group counselling, preventive services, STI treatment, psycho-social counselling, psychiatric care, video shows, hotline, referral	Walk-in, hospital and referral clinic	Clinic contributes to an outside newsletter column on FP issues and has a hotline for counselling; outlet of youth variety shows; similar clinics in Eldoret Hospital, Coast Province General Hospital, Machakos District Hospital
21b	Kenyatta National Hospital, Patient Support Centre*	Dr Mulindi and Dr MaKanyengo Box 20723 tel: 726300	Ngong Road opp. Nairobi Hospital	8 to 4:30	Government hospital	Countrywide	Counselling, testing, medical care, community health care, training	General population attending KNH referral hospital	CT	< 20 per day for CT	450/- for ELISA test	Referred to HRC	Walk-in, referral	CHBC training for family care providers
21c	Kenyatta National Hospital, Public Health Labs	Jane Kabue Box 57763 tel: 725390/98	Off Ngong Road	8 to 5	Government hospital	Nairobi	Testing, research, referral	General population and those referred by the KEMRI Project	T	30+ per week tested for HIV	None	None	Lab	Project supported by Rockefeller Foundation in close collaboration with KEMRI and Wellcome Trust Research Laboratories
22	Kenya Women's Fellowship Association	Box 74197, Nairobi tel: 570602 fax: 230230	Kibera Drive, Ayany 42	9 to 5	Local NGO	Kibera	Counselling, home-based care; home visits: clothing, school fees, food; referral	Infected and affected women, destitute children, street children, HIV/AIDS orphans	C, CS, OS	500 per week		Skills training for unemployed, income-generating projects	Walk-in	Referrals to KEMRI for testing; rescue home for AIDS orphans and destitute children while awaiting foster parents; awareness seminars
23	Kibera Community Self-Help Programme*	Ann Owiti Box 49531 tel: 571081 fax: 571600	Kibera Drive Mashimoni village	8 to 5 Mon to Fri 8 to 12 Sat	Local NGO	Kibera	Counselling, group therapy, HIV/STD/TB, HBC, training, community outreach, HIV/AIDS education	General population	CS	100 per day for outreach < 30 per day for medical; 15 per day for pre- and post-test counselling	None	Planned (depending on funding)	Walk-in	Centre has a school for HIV+ children and orphans; awareness education of community on HIV/STD/TB; medical clinic open Mon to Sat; provide counselling in HIV; 5 staff trained in HIV counselling
24	Kijabe African Inland Church Hospital	tel: 0154 64439	Kijabe	24 hrs	Mission hospital	Kijabe, Nairobi	Counselling, testing	General population	CT-H				Walk-in, referral	Serve anyone who comes, from all economic levels

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No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
25	Kikuyu Hospital, Community-Based Health Care Programme*	Tabitha Mbugua Box 45, Kikuyu tel: 0154 32057 or 32412; fax: 32413	Off Naivasha Rd, 25 km from city centre	8 to 6	Mission hospital	Kikuyu and environs	Counselling, testing, medical care, referral	General population	CT-H		100/- consultation, 700/- HIV, ELISA tests	None	Walk-in	Many low-income earners from Nairobi come here for services
26	Marie Stopes, Inc.	Martha Warathu Box 59328 tel: 564682/567227/ 567172/567144	Kilimani, Kindaruma Road	8 to 5	NGO	Nairobi- Pangani, Eastleigh, Mathare and Kenyatta Market	Counselling, testing, FP, ObGyn, curative services, immunization	General population	CT		1000/- or less for HIV tests	Family planning lectures	Walk-in, referral	Contact person: Repher Anyonyi
27	Mater Misericordie Hospital	Mary Joy Onalo (contact person) Box 30325 tel: 531199 fax: 534289	Nairobi South B	24 hrs	Mission hospital	Nairobi, countrywide	Testing, counselling, medical care, referral	General population	CT-H	< 10 in 2 weeks for CT	1000/- or less for HIV tests; free counselling	None	Walk-in, referral	Have 3 counsellors who are trained professionals and employed full time as counsellors; young adults counselled
28	Mbagathi District Hospital (MSF-Belgium)*	Esther Mwanyika, Patient Support Centre Roselyne M. Okumu, Social Worker Box 20725 tel: 724712/728530/ 726300 ext. 43728/43712/43643	Mbagathi Way, next to Kenyatta Market	24 hrs, lab 6 hrs	Government hospital	Nairobi	Testing, counselling, referral, STD, provision of care and social support, condom distribution, HBC for HIV/AIDS, PLHA follow-ups	General population	CT-H		410/-; hospital provides counselling and HBC	None	Walk-in, referral	Two-way referrals from community to institution
29	Medical Missionaries of Mary	Sister Pauline Dean Box 14754 tel: 440995	Makina, Kianda, Katwikeru	8 to 5	Mission centre	Nairobi-Kibera	Counselling, HBC training, referral for testing; public workshops educating on HIV/AIDS	PLHAs, health workers	CS	12 to 25 per week get CT services; testing referred to Mbagathi	No charge for counselling services	None		
30	Mediplan Clinic	Ann Delorie Box 20707 tel: 711024, 710924 fax: 710924 email: mediplan@ iconnect.co.ke	Josem Trust Place, Bunyala Road-Upper Hill Road	8 to 5 Mon to Fri 8:30 to 12 Sat	Private clinic	Nairobi	Pre-employment HIV testing and testing for insurance companies, food handler certification, curative services		CT	200 to 500 per mo for HIV testing	600/- per test (ELISA or Rapid)	None	Walk-in, referral	Contact person: Ann Delorie, Director, Counselling Services (under development); nurse on staff being trained
31	Metropolitan Hospital	Catherine Mwangi, Matron Box 33080 tel: 790282/790286/ 790317/792221	Rabai Road Buru Buru Phase 3	24 hrs	Private hospital	Nairobi- Eastlands	Hospital services, limited counselling, testing	General population	CT-H	4 to 10 in- patients 1 to 2 per day for CT	900/- bed; counselling services free; testing 750/- for ELISA and Rapid tests	None	Walk-in	Executive Director: Dr K. K. Gakombe
32	MP Shah Hospital	Box 14497 tel: 742763	Parklands	24 hrs	Private hospital	Nairobi, countrywide	Testing, counselling, medical care, referral	General population	CT-H	80 per mo for CT	850/- for ELISA and Rapid tests	None	Walk-in	

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No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
33	MSF–Belgium AIDS Project	Ms Veerle Moreau-Eygenraam Box 38897 tel: 564419, 565969, 570021/5 or 572094/5 fax: 572157	Kileleshwa off Manderu Road, near Kenya High School	8.30 to 5.30	NGO	Langata, Dandora, Pumwani, Kibera community, Mbagathi Hospital	Drug supply, technical assistance for first line at health centres and second line at hospital, clinical care for HIV-related conditions, CT, health talks and video sessions, home care, condoms available, referral system, social assistance, networking	General population	CT, CS, OC, OS	approx. 30 per day in all sites for clinical care, home care, incl. 15 to 20 per week for testing	Free for Langata and Dandora Health Centres, 50/- for Pumwani Health Centre and Mbagathi Hospital	Counselling	Walk-in, referral, follow-up	Blood samples for Dandora and Langata Health Centres are screened at STC Casino; blood samples for Pumwani Health Centre and Mbagathi Hospital are screened on site; technical support provided to Mbagathi District Hospital
34	MSF–Spain	Box 52837	Kibera, area 42	9 to 8	NGO	Kibera, Kianda village	Therapeutic: drugs, medicine, diagnoses; home-based care, counselling, referrals for HIV testing	Residents of Kibera, Kianda village	CS, C	250 per mo	> 5 yr 100/-, < 5 yr 80/- all inclusive	Youth community counselling, education through audiovisuals, individual counselling in the home	Walk-in	This facility offers free home-based care to the residents of Kianda village and networks with other organizations working within Kibera
35	Nairobi Hospital*	Box 30026 tel: 722160	Argwings Kodhek Road	24 hrs	Private hospital	East Africa	Testing, counselling medical care, referrals, training	Middle to upper-level income earners	CT-H	< 10 per day for CT	1170/- for ELISA test	None	Consultant and hospital referral	Carry out confirmation tests for referrals
36	Nazareth Hospital	Box 49682 tel: 0154 40644	Banana Hill	24 hrs	Mission hospital	Nairobi (Tigoni)	Testing, counselling, medical care, referral	General population	CT-H	< 30 per week for CT	< 700/- for ELISA test	None	Walk-in	Several clients from Nairobi prefer to be attended to at Nazareth Hospital
37a	NCC–Dandora Health Centre (MSF–Belgium)	Sr Lydlah (sister in charge) tel: 570021	Dandora	9 to 4 Mon to Fri	Municipal clinic	Dandora	Counselling, testing, primary clinical care, referral, condom distribution, health talks, video sessions, home care, social assistance	Dandora	CT, CS, OC, OS	5 to 10 per day in health centre, 5 to 10 per day for home care	None	None	Clinic, follow-up, CHBC, walk-in	MSF–Belgium provides counsellors for HIV and pays their salaries
37b	NCC–Langata Health Centre (MSF–Belgium)*	Sr E. Githu Box 30108 tel: 506991	Chweya Road Otiende Estate near Otiende Shopping Centre	24 hrs for health care; 8 to 5 for CT	Municipal clinic	Langata, Kibera slums, Ongata Rongai	Counselling, testing, primary clinical care, referral, health talks, video sessions, condom distribution, HBC in Kibera, social assistance	General population	CT, CS, OC, OS	approx 5 per day at health centre, 5 to 10 per day for HBC	Free counselling and testing	None	Walk-in, referral, clinic, CHBC	CT services provided by MSF–Belgium; research done by STC/EU project; health centre opened in 1974; FP started in 1976 (doctors only); in 1983, nurses trained as family planners; in 1992 NCC took over; drugs for STI are offered by CIDA World Bank and STC
37c	NCC–Pumwani Health Centre (MSF–Belgium)	Sr Priscilla (sister in charge) see no. 33 for MSF–Belgium contact	Pumwani, inside Gikomba Market	8 to 5	Municipal clinic	Pumwani	Clinical care (first line), referral, counselling and testing, condom distribution, health talks, video sessions	General population	CT, OC, CS	4 to 5 per day	Free counselling, 50/- per HIV test	Not specified	Clinic, follow-up, walk-in	

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No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
37d	NCC-Special Treatment Centre, Casino*	Dr Peter Otiato tel: 228845 or 250192 fax: 251511	Cross Lane River Road	8 to 5	Municipal clinic	Nairobi, countrywide	Testing, counselling, STD treatment, dermatology	General population	CT	30 to 70 per mo	300/- for HIV test plus 100/- for card processing	None	Walk-in, referral	Counsellors: Sr Mureithi and Sr Gichuru; undertake referrals from practitioners and KNH Patient Support Centre; project funded by EU; local adviser, Dr Caroline Fonck
38	NCKK AIDS Programmes	Rev. Kiarie Box 45009 tel: 215560 or 219554	Church House Moi Avenue		Religious CBO	Nairobi (Huruma, Mathare)	Counselling, support services, referral	Slum population, street children	OC		None		Walk-in	Counselling provided for HIV, pastoral counselling; also conduct training seminars
39	Nyumbani Children of God Relief Institute	Father D'Agostino Box 21399 tel: 884303 882684/ 882371/716829	Karen, off Dagoretti Road	24 hrs	Private voluntary organization	Countrywide	Care for HIV+ children, care for orphans of AIDS, home for abandoned HIV+ children, placement of children in foster homes, education for HIV+ children	HIV+ children	CS	60 resident children; 62 in foster homes	None	Monthly educational workshops organized for adolescents in the 62 families	Walk-in, referral	Caroline Matsalia, social worker
40	Oasis Counselling and Training Institute	Esther Gathurima, Dr Mutiso, Psychiatrist Edith Box 76117, Nbi tel: 715023	Ufungamano House	8 to 5	NGO	Nairobi Kigali, Rwanda	Counselling, referral to KEMRI, training	Youth, couples	OC	30 per year	500/- per session of counselling	Majority of clients are youth	By appointment, walk-in	Provide marital, individual, group and HIV counselling
41	Positive Living Promotions	Jane Kabue Box 55493 tel: 722570 fax: 722570	Rose Avenue off Ngong Road	8 to 5	Private organization	Nairobi and upcountry	Training in general and HIV/AIDS counselling, home-based care, home visits, educational seminars, peer education	General population: youth, women, families, refugees	CS	4 per week for HIV counselling, 20 per week general psychological counselling	Sliding scale	Educational workshop for students	Walk-in, referral	Training provided in general and HIV counselling to teachers, NGOs and others; uses guidelines from KANCO; programmes to strengthen family: premarital and marital counselling
42	Pumwani Maternity Hospital	Dr Kiragu, Med. Superintendent-Supervisor Sr Wanjala Jane Mureithi Box 30108 tel: 763291 ext 148	Pumwani	24 hrs	Government hospital	Nairobi-Eastlands	Testing, counselling, medical care, MCH and FP, HIV research	Women PLHAs	CT-H	1 to 10 per week for HIV services	Counselling free	High-risk clinic	Walk-in	2 lab personnel; lab samples sent to STC for blood donors only
43	Right Medical Centre	Dr Surendra Patel Beatrice Oloo Box 42435 tel: 48530, 48591/93	James Gichuru Rd, Lavington	8 to 8 Mon to Fri 8 to 12:30 Sat, Sun, holidays	Private medical centre	Westlands, Parklands, Lavington, elsewhere	Counselling, medical care, nutrition for PLHAs, home visits, follow-up, group therapy	General population, PLHAs	CS, CT, OS	4 per day	300/- for consultation, 600/- for HIV testing	Education, awareness and counselling	Walk-in, ambulatory care beds	Targeting 18 schools in area for HIV and substance abuse in particular; full-time pharmacy; immunizations

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No.	Organization	Contact Information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
44	Salvation Army (Kibera Corps Community Centre)	Major Rebecca Nzuka Box 21608 tel: 567064 office near Jevanje Gardens tel: 227541 Contact: April Foster	Kibera, Kianda village, end of route no. 42 Bombotulu Bldg	24 hrs	CBO Kibera and AIDS Self-Help Project	Kianda and Gatwikira villages within Kibera	Home visits (MSF–Spain nurse and Rebecca), promotion of behaviour change, IGA for young women, community counselling weekly, education in home-based care, door-to-door education, hospital visits, care of orphans	People living within Kianda and Gatwikira villages of Kibera	CS	approx. 15; about 3 new cases of AIDS per week	None	Provide seminars and train adolescents in music and drama for HIV/AIDS IEC	Walk-in, outreach	Give support to malnourished children; funds for the programme are raised by the community, which also monitors the growth of the child; they give extra training to single mothers, enabling them to generate their own income
45	SDA Medical Center, Milimani*	Sister Muchiri Box 46829 tel: 721200	Milimani Road	8 to 5	Religious CBO	Nairobi	Testing, counselling, medical care and referral	General population	CT	10 per week for lab test	1000/- for HIV test, counselling free; perform ELISA and Rapid tests	None	Walk-in	Trained counsellors: Mrs Huma and Mrs Mukaya; use Nairobi Hospital for test confirmation; lab technicians trained by CHAK in HIV counselling; branch in Likoni Road, Industrial Area
46	Soul to Soul International	Dr Surendra Patel, Michael Onyango Box 39779 tel: 48530/48591/48593	Office at Right Medical Centre, Lavington	Same as Right Medical Centre	NGO	Nairobi	Counselling, testing; patient-support group for PLHAs, HBC	PLHAs and outreach to private sector	CS, CT	4 per day	None	As for Right Medical Centre	Walk-in	Recently sent 5 PLHAs to Nairobi Hospice for 1-week training in HBC; currently have 60 participants in patient support; conduct research on locally applicable HIV treatment methods; developing their own website
47	St John's Community Centre*	Sarah Karanja, AIDS Programme Officer Box 16254 tel: 767656/761624 fax: 765798	Gen. Waruinge St, next to Christian Industries Technical College, by Pumwani Hospital	8 to 5	Religious CBO	Nairobi–Pumwani, Eastleigh	Counselling, prevention education in addition to counselling the centre; assistance to orphans; peer education to youth, training in HBC	Slum pop of Majengo, Pumwani and Eastleigh	C, CS	< 5 per week get pre- and post-test counselling; testing is referred to STC Casino and KEMRI, where it is done free	None	Centre runs a school and vocational training for out-of-school youth; also involved in income-generating activities for groups		1 trained HIV counsellor
48	The Association of People with AIDS in Kenya (TAPWAK)	Rowlands Lenya Box 30583 tel: 603421	Nairobi West	8 to 5	Local NGO	Nairobi Kisumu	Counselling, education, outreach, home and hospital visits	PLHAs	C, CS	< 10 per week		None	Walk-in	Referrals to KEMRI
49	Tourist Paradise Investment Clinic	Dr Odero, Clinical Officer Box 12846 tel: 742600	Museum Hill	8 to 5	Private clinic	Nairobi	Counselling, medical care	In-house employees	C					Clinical officer: Dr Odero
50a	UON Health Services Clinic	Box 30195 tel: 728308		8 to 5	Parastatal	Nairobi	Testing, counselling	Staff and students	CT					

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No.	Organization	Contact information	Physical location	Hours of operation	Classification	Geographic area served	Services offered	Target population	Service code	Numbers served	Fees charged	Adolescent services	Type of facility	Comments
50b	UON Microbiology Dept, Majengo Clinic*	Dr E. Njagi Coordinator Box 19676 tel: 719851 ext 43214 Dr Bwayo, Mr Omari Microbiology Dept tel: 726300	KNH Annex	8 to 5	Parastatal	Nairobi– Pumwani, Majengo, Casino, Langata	Testing, counselling, STD research, referral	CSWs in the study	CT		None	None	Walk-in	Study has been going on for the last 15 years; on average 5 to 10 new CSWs per year join the study to replace those who die of AIDS; the new CSWs receive CT for free
51	Women Fighting AIDS in Kenya (WOFAK)*	Dorothy Onyango Box 58428 tel: 217039	Aladdin House, Haile Selassie Ave, and Kayole Walk-in Centre	8 to 5	NGO	Nairobi, Kayole, Kisumu, Homa Bay	Counselling, HBC, networking, training, income-generating activities; limited RH services in Kayole Centre	HIV+ women or women living with AIDS	C, CS	3 to 5 people come in for this service per day	Counselling free to AIDS patients in Kayole office	Counselling for adolescents, especially young women; education outreach to schools and in barazas	Walk-in	Trained HIV counsellors at Kayole walk-in centre; also conduct training for counsellors; HIV testing referred to other hospitals
52	Youth for Christ Kibera	Emmy Gichinga Box 19899 tel: 721009/445997	Kibera	8 to 5	Religious CBO	Nairobi	Counselling, support services; monthly HBC counselling in reproductive health; pregnancy crisis counselling	Youth, families	OC	3 people counselled per day on family matters	Counselling 150 to 300/-, depending on subject covered in marital issues	Teaches Bible principles to in- and out-of- school youth	Referral	

APPENDIX

Participants in workshop to review draft CTCS report 24 February 1999 Holiday Inn Mayfair Court Hotel

Name	Organization	P.O. Box	Telephone
Alrutz, Ms Neen	USAID/Kenya	30261	751613
Asiedu, Mr Kwame	Population Council Horizons Project	17643	713480/1/2
Auma, Ms Consolata	TAPWAK	30583	603421
Balmer, Dr Don	KAPC	55472	786310/796283
Baumi, Ms Mercy	TAPWAK	30583	603421
Costigan, Dr Aine	Strengthening STD/HIV Control Project, UON	19676	718895/714852
Delorie, Ms Ann	Mediplan Clinic	20707	711024/710924
Denison, Ms Julie	Population Council Horizons Project		
Dickerson, Mr Don	DFID	75367	718135
Eygenraam, Ms Veerle	MSF-Belgium	38897	577157/570021
Folsom, Ms Michelle	USAID REDSO	30261	751413
Gar, Ms Caroline	Population Services International	22591	440125/8
Gatei, Ms Margaret	KANCO	69866	717664
Gatei, Ms Sally Margaret	St John's Community Centre	16254	767656
Gikuri, Ms Anne	Univ. of Nairobi, Dept of Community Health	19676	718895
Gitau, Mr Tom	Nation Newspapers	49010	221222
Githuthu, Ms Florence	Amani Counselling and Training Institute	41738	602672/3
Hawken, Mr Mark	KEMRI	43640	576472
Hayman, Ms Janet	USAID REDSO	30261	751613 ext.2321
Jebet, Ms Dorothy	Kenya Times	30958	241763
Kabue, Ms Jane	Positive Living Promotion	55493	722570/713145
Kaharu, Ms Nancy	Mbagathi District Hospital	20725	726300 ext. 43728/43712/4 3643
Kahenya, Dr N.P.	Bethesda Clinic	52951	221650
Kairo, Ms Wambui	Kenya Red Cross Society	40712	219895

Name	Organization	P.O. Box	Telephone
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ABBREVIATIONS AND ACRONYMS

AIC	AIDS Information Centre
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention
AMREF	African Medical Research Foundation
AZT	azidothymidine (Zidovudine)
CAPS	Centre for AIDS Prevention Studies
CBHC	community-based health care
CBO	community-based organization
CHAK	Christian Health Association of Kenya
CHBC	community home-based care
CIDA	Canadian International Development Agency
CS	care and support
CSW	commercial sex worker
CT	counselling and testing
CTCS	counselling and testing, care and support
DANIDA	Danish International Development Assistance
ELISA	enzyme-linked immunosorbent assay
FGD	focus group discussion
FHI	Family Health International
FP	family planning
GTZ	German Agency for Technical Cooperation
HBC	home-based care
HIV	human immunodeficiency virus
IGA	income-generating activity
IMANI	Incentives from the Marianists to Assist the Needy
IV	intravenous
JICA	Japan International Cooperation Agency
KANCO	Kenya AIDS NGO Consortium
KAPC	Kenya Association of Professional Counsellors
KAS	Kenya AIDS Society
KEMRI	Kenya Medical Research Institute
KEMRI-CRC	KEMRI-Clinical Research Centre
KES	Kenya shilling; value about KES 60 = USD 1 at time of study
KNH	Kenyatta National Hospital
KRH	Kenya Red Cross
MAP	Medical Assistance Programme
MIS	management information system
MMM	Medical Missionaries of Mary
MOH	Ministry of Health
MSF	Médecins sans Frontières
NASCOP	National AIDS and STD Control Programme
NCC	Nairobi City Council
NGO	non-governmental organization
OC	HIV and other counselling
ORT	oral rehydration therapy
PCP	pneumocystis pneumonia
PHN	population, health and nutrition
PLHA	person living with HIV/AIDS
PSC	Patient Support Centre

RH	reproductive health
RPR	Rapid Plasma Reagin
SDA	Seventh Day Adventist
Sida	Swedish International Development Authority
STC	Special Treatment Centre
STD	sexually transmitted disease
TAPWAK	The Association of People with AIDS in Kenya
TASO	The AIDS Support Organization
TB	tuberculosis
UNAIDS	United Nations Joint Programme on AIDS
UON	University of Nairobi
USAID	United States Agency for International Development
USAID/W	USAID/Washington, DC
VCT	voluntary counselling and testing
WHO	World Health Organization
WOFAK	Women Fighting against AIDS in Kenya
