



LIVERPOOL VCT, CARE AND TREATMENT

**2007 KENYA COUNSELLING AND TESTING WEEK
DOCUMENTATION PROCESS – INTERNAL STRATEGIC
PAPER**

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GLOSSARY OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART/ARV	Anti-retro Viral Therapy/ Anti-retro Viral
CACC	Constituency Aids Control Council
CBHTC	Community Based HIV Testing and Counseling
CBO	Community Based Organization
CDC	Centre for Disease Control and Prevention
CEO	Chief Executive Officer
CORPS	Community Own Resource Persons
CSWs	Commercial Sex Workers
CT	Counseling and Testing
DASCO	District AIDS and STD Control Office
DCT	Diagnostic Counseling and Testing
DfID	Department for International Development
DHO	District Health Office
DSW	The German Foundation for World Population
GoK	Government of Kenya
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDUs	Injecting Drug Users
IEC	Information Education and Communication
JAPR	Joint AIDS Programme Review
KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National AIDS Strategic Plan
LVCT	Liverpool VCT Care and Treatment
MoH	Ministry of Health
MSM	Men who have Sex with Men
MVCT	Mobile VCT
NACC	National AIDS Control Council
NGO	Non Governmental Organization
NHSSP II	National Health Sector Strategic Plan II
OP	Office of the President
PASCO	Provincial AIDS and STD Control Officer
PITC	Provider Initiated Testing and Counseling.
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRC	Post Rape Care
QA	Quality Assurance
QC	Quality Control
RRI	Rapid Results Initiative
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections



TWG	Technical Working Group
UNAIDS	United Nation Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

INTRODUCTION

In 2007, Kenya adopted the idea of a HIV testing and counselling (HTC) week as a means to accelerate uptake of HTC aimed at increasing knowledge of HIV status in the Kenyan population. A target to test 100,000 people in one week was set and a plan developed. LVCT was involved in the development of the plan, implementation and evaluation. LVCT provided technical assistance and implementation support at the national and district levels through our regional offices.

This paper is a reflection of this experience for LVCT. In this paper we document our experiences, results of our participation and lessons learnt. We draw on these to make recommendations for delivering accelerated HIV CT exercises. This document aims to provide a basis upon which LVCT support to national accelerated HIV testing campaigns in the future and provide a planning basis during conceptualisation of such events in the region. This document will be accompanied by a range of policy briefs.



1 BACKGROUND

Kenya has witnessed remarkable developments in the area of HIV counselling and testing over last four years. Voluntary counselling and testing has been successful in scaling access to counselling and testing with over 900 VCT sites established as at December 2007 (JAPR 2007, NASCOP). This strategy has targeted a client initiated, supply of services approach. Increasingly focus has shifted to creating demand for testing through mobilization and mobile VCT. Further the development and launch of guidelines for provider initiated HIV testing has accelerated the rate of testing in Kenya. The two approaches opt-in and opt-out testing has been successfully combined to provide options for accelerated expansion of national HIV counselling and testing programmes.

There has been an increased awareness of the importance of knowledge of HIV status. The Government set a target of 80% knowledge of HIV status in Kenya by 2010. Both the KNASPII and the NHSSP II identify HIV testing as a key strategy (NHSSP 2006: x) for HIV prevention. To accelerate attainment of this goal, Kenya has embraced a range of HIV counselling and testing approaches including provider initiated routine offer of testing (PITC) and a range of client initiated approaches such as mobile VCT, moonlight VCT, camel back VCT, door-to-door VCT, and PCR for early-infant diagnosis.. This diversity of HIV testing and counselling approaches has given new momentum for the acceleration of HIV testing and counselling in line with resolutions adopted at the 2007 HIV Prevention Summit.

In 2007, NACC opted to implement a pilot accelerated HIV testing and counselling exercise through a HTC week targeting testing 100,000 people, a 300% increase in the average number of people tested in Kenya each week through VCT approaches. The idea of a campaign was based on recommendations of the 2007 HIV Prevention Summit and Joint AIDS Programme Review (JAPR) as one of the strategies to be implemented for accelerating HIV prevention in Kenya.

Liverpool VCT, Care & Treatment (LVCT), was involved in this HIV testing week event that preceded the World AIDS Day (WAD) 1st December 2007. This involvement was based on LVCT's track record in service delivery and policy reform for counselling and testing in Kenya. LVCT is committed to contributing to the Governments goal through increasing demand for testing services and rolling out mass testing campaigns.



LVCT's innovative approaches to increasing demand to counselling and testing

The Know Your HIV Status Campaign

In 2006, Dr Albert Henn identified the role of mass testing campaigns in providing the needed boost to counselling and testing in Kenya. Through the use of the poster of the American Senator, Barack Obama, increased awareness was created throughout the country with the key running theme being 'Know Your HIV Status'. Fifteen thousand posters were printed and distributed. The increased profile for counselling and testing culminated in requests for additional public testing by political figures.

Celebrity HIV Testing

Following the demand for testing by political figures, LVCT adopted a celebrity testing event that focussed on the utilization of leaders of various constituencies – sports, education, science, corporate sector to create demand for HTC through public events. During the HTC week, LVCT in collaboration with a range of partners and support from NACC mobilized and facilitated public celebrity testing of 30 CEO's from the corporate sector and the Chief of General Staff and top brass among others.

Community Based HIV Counselling and Testing

In order to more effectively reach the community at household level, LVCT is implementing Community Based HIV Counselling and Testing (CBHCT). This was a new innovative approach aimed at enhancing community access by transferring CT services from the facility to the household level. CBHCT testing has been tested in other areas such as Uganda and a CBHCT approach complements the National Health Sector Strategic Plan [NHSSP II-2005-2010] that focuses on service delivery and prevention of disease at communities with support of dispensaries and health centres (level 1, 2 and 3). Over 1200 people accessed services in that week, through this innovative approach. The actors in CBHCT were drawn from HTC service providers, District Health Management Team and Community Own Resource Persons (CORPS), who actively mobilised the community.

Strengthening Routine Testing and Counselling

Shifting towards routine offer of CT was introduced and PITC guidelines developed. However, there has not been very clear guidance on actual methodology for implementing PITC in the context of already high health provider workloads,

Review of CT Standards

LVCT has engaged and continued to collaborate closely with the NASCOP in review of the VCT guidelines in cognisance of changing priorities for CT and has been part of the HTC guidelines development. These are cognizant of the different new strategies and service delivery requirements for CT.



2 PROCESS – HTC WEEK

The NACC announced its intention to have a one week HIV testing week preceding the World AIDS Day (WAD) in 2007. 3 provinces were identified as pilot sites – Nairobi, Mombasa and Kisumu. Province based targets were identified in consultation with the provinces as:

- Nairobi - 50,000; Nyanza - 30,000; Coast - 20,000

LVCT was invited to attend a series of high level planning meetings at NACC headquarters. At these meetings feasibility, targets, logistics and budget implications were closely assessed and an implementation plan drawn up. A concept that outlined the idea, the process and a work plan were developed and approved by a 'high level' meeting of development partners, key stakeholders in the civil society and private sector.

Structure of the Response

Government of Kenya provided the central coordinating role with NACC providing overall leadership through the Executive Director, Professor Alloys Orago. The National AIDS Control Programme (NAS COP) provided technical oversight. A technical committee provided the overarching organizing role including overseeing implementation of the work plan. Five sub-committees on social mobilization, logistics, coordination and supervision, data management and training were formed to provide guidance to the process. The 'high level' committee provided policy guidance and acted as a decision maker on the process. It was expected that district committees would be formed. However, given the short planning time, these were not as clearly articulated as the national level committees.

A nerve centre was opened at NACC and was staffed with 2 technical staff, one administrative assistant and one manager to coordinate the various aspects of the response by the committees and the districts and act as an information collation and dissemination centre.

Partnerships

A range of partners were included in the process: Development Partners, Private Sector Partners and Civil Society.

LVCT's Role

LVCT was identified as a key implementation partner. Its role in carrying out successful public mass campaigns was cited as a key resource. The organization was tasked with:

1. Technical Assistance
2. Training
3. Implementation support
4. Quality Assurance (this was an add-on during the implementation process).



3 HTC WEEK STRATEGIES

NATIONAL STRATEGIES

- High level meetings with key partners to obtain buy in, build consensus and a resource base
- Creation of key technical sub-committees to inform the high level meetings. Counselling and testing committee, logistics and budget and communication subcommittees
- Visit to Malawi to look, listen and learn from their experience with mass HIV testing campaigns.
- Mass communication campaigns through the media
- Ministry of Health leadership in service delivery
- A wide range of stakeholder participation and technical assistance
- Inclusion of province/district levels in the planning

LVCT STRATEGIES

- Experience and expertise in counselling and testing gained over the last 8 years of existence made it essential for LVCT to be a core part of this process.
- Provision of technical assistance in HIV prevention, treatment and care, as stated in LVCT's mission.
- The use of The LVCT Strategic Plan 2007/08-12/13, which focuses on LVCT's role in contributing to knowledge of HIV status in Kenya.

TECHNICAL ASSISTANCE

- LVCT was a part of the Technical team bringing out CT experience into the planning process
- LVCT Executive Director and Director of Services attended the 'high level' meetings, allowing for quick decision making and positioning of LVCT's strategic interests.
- The LVCT MVCT coordinator was attached to the NACC. She went to Malawi as part of a NACC team to pick up key lessons.
- Working through government structures and processes at the national level and at the local levels.

HUMAN RESOURCE AND TRAINING

Rapid Development of Short Protocols and Training Guides: LVCT held a two day workshop that modified the current testing protocol reducing it to under twenty minutes. This was done borrowing from and adapting Botswana's ACTS (Assess, Counsel, Test and Support) protocol developed by our CDC twinning project partners Tebelopele.



Counsellor recruitment was done by the NASCOP with support from LVCT for counsellors aimed at specific mobile VCT sites. LVCT was tasked with coordinating the transport of counsellors, training of counsellors on the utilization of the short protocols, site supervision of counsellors.

IMPLEMENTATION SUPPORT

Working Within and With Government Coordination Structures: LVCT worked with the NACC, NASCOP, Provincial and District teams to identify staff, testing sites, logistics and support for the testing week. This has been a central strategy and underpins all LVCT interventions.

Community Mobilization: The use of community mobilization is a key LVCT strategy aimed at driving demand and creating local ownership. The community mobilization division was tasked with the responsibility of providing key messages, helping with logistics, supporting service delivery and helping control and expand access to counselling and testing services

LVCT Counselling and Testing Service Delivery Points: LVCT identified areas for direct service delivery during the CT week. These approaches had the twin aims of reaching clients within their normal settings and at the same time targeting sites with high populations.

- Our comparative strengths – mobile, static and moonlight VCT services
- Vulnerable populations – targeted moonlight testing and prisons
- Delivering services to clients who may otherwise not get opportunities for testing - Work places and community based CT.

The static sites benefited from referrals for clients not seen during the outreach campaigns and those targeted by mass media aspects of the communication outreach. LVCT aimed to contribute to 10% of the national HTC target.

Logistics for LVCT Service Delivery Sites: LVCT involvement in logistical support and commodities supply was premised on our role for training all service providers and delivering CT services. This included: provision of space (tents, negotiated rooms etc), auxiliary staff (receptionists to manage waiting clients, administrative staff at the local levels), distribution of commodities and supplies to the testing sites, transport and payment terms for providers.

QUALITY ASSURANCE

The provision of a quality service is ingrained in all the levels of LVCT operation. The architecture and design of quality assurance for LVCT represents a continuous challenge. This particularly applies to QA for new and innovative methods of service delivery. The underlying principles remain the same, the *technology* evolves only slowly. While QA/QC was not central to this process, LVCT ensured QA/QC for LVCT supported sites during this week.



4 THE LVCT EXPERIENCE

This section describes key experiences, documents reflections and lessons learnt during this process. It is organized following LVCT areas of engagement described in prior sections.

4.1 TECHNICAL ASSISTANCE

Reflections:

- **Planning:** The planning lead time was short. Planning was hampered by the slow approval process of the implementation plan by ‘high level’ group further decreasing the time between planning and implementation. The initial meetings were held in October, one month before targeted activities. This created huge challenges in planning, coordination, organization, monitoring and control.
- **Coordination:** Coordination between the national levels and the local level was sometimes disconnected. While there were attempts to undertake daily meetings, these were not undertaken, as much of the activity was delivered as crisis management with limited time for any additional engagement or for forward planning.
- **Resource mobilization:** Resources for undertaking the exercise were not readily available when planning commenced as well as through the implementation period. Test kits (the most vital ingredient) were not available, requiring a change in algorithm during the testing week. While the refresher training focused on this, it added a layer of anxiety due to limited familiarity with the algorithm among counsellors and increased supervision and QA requirements.

4.2 HUMAN RESOURCE AND TRAINING

LVCT has established a clear reputation in training VCT counsellors in Kenya. Over 70% of the practicing VCT counsellors in Kenya have been trained by LVCT. During the testing week training played the main anchoring role in the successful launch.

Objectives of Training

- To train counsellors on the new short protocols
- To train counsellors on the new algorithms
- To re-orientate counsellors in mass testing including group counselling techniques
- To provide consolidated training for diverse HIV testing providers including PMTCT, VCT and PITC counsellors to enable them provide CT in the different settings

This one day targeted refresher training was held in Nairobi, Nyanza and Coast. Approximately 655 health care providers were trained; 189 from Nairobi, 100 Nyanza and 80



Nairobi. In reflecting on the comments made by LVCT staff, these training were unique for LVCT in several ways such as:

- The first time to train classes larger than 15 people
- The first training on the new shortened protocols
- The use of a predominantly didactic approach to teach counselling and testing
- No prior preparation
- Combining several different service providers including PMTC, VCT and PITC.

The training was preceded by a one day trainer of trainers' workshop. This drew key trainers and supervisors throughout the country.

Reflections:

- Initial planning for the workshops was hurried and somewhat haphazard due to limited lead-in planning time. Proper prior planning and coordination needed.
- Training budgets were not all inclusive e.g. transport reimbursements for participants was not well budgeted
- The intense one day training session was evaluated to be too short for the level of trainings expected, particularly in the context of changed algorithms that had to be demonstrated. Power-point presentations as the core training methodology may have been subtly less effective than experiential training where role-plays that take longer may have been more effective. However, due to the nature of the workshop, the numerous themes to be covered and the didactic approach (through the use of PowerPoint presentations and plenary sessions), these may have been the most ideal methodologies.

“The introduction of accelerated CT which has emerged as a way forward calls for a reliable, competent and resourceful manpower. This can only be realised through increasing the capacity of the service providers through re-training for holistic service delivery and ensuring innovation in training for campaigns for accelerated HCT”
“... we need to think outside the box...”

(HTC week debrief workshop for LVCT, Gracia Guest House December 14 2007)

Challenges:

- During the HTC week, a number of counsellors were observed as utilizing the longer VCT protocols that they were familiar with, taking too long with one client.
- Drawing from a range of service delivery models such as PMTCT, PITC and VCT presented clashing conceptual frameworks that made training more problematic.
- We were not able to meet the targets of sensitizing at least 850 counsellors in the region.
- Classes of larger than 15 people should be considered during CT training.
- Data training was not undertaken resulting in challenges of data entry and collection.



- Many counsellors were concerned and often unable to tolerate the high intensity and overwhelming numbers of clients.

Recommendations:

- Human resource planning and budgeting should be comprehensive in order to cover knowledge and skill requirements, training logistics and inclusive costs.
- Eligibility criteria for trainees needs to be identified
- A comprehensive CT model that merges together all the various CT models is required as a long-term way forward
- All inclusive human resource and training committee (trainers, supervisors, and laboratory personnel) needs to be a stand-alone committee at national level with clearly delegated responsible person/committee at local level planning.
- Human resource coordination during the week requires planning for, with a planning coordination workshop preceding service provider training.
- The drive for oral HIV testing should be in a context where counselors are aware of appropriate messaging and testing protocols.
- LVCT should engage in supporting the development of a comprehensive CT training curricular for Kenya
- During initiation stage or planning all departments could be involved and engaged in a mock activity i.e. CT with the target goal.
- Develop a curriculum for a national refresher course taking into consideration various models of CT service delivery, aimed primarily at supporting accelerated and mass HTC. This would also form the basis for a national refresher CT training curricular as the country moves from VCT to CT service delivery. A balance between time availability and training requirements for experiential and participatory methodologies that enhance conceptualization of the aspects to be implemented must be sought.
- Test the training model through having counsellors pilot CT following the training, prior to the actual intervention and give feedback on their experiences in order to strengthen the utility of the refresher course.
- Classes of 30-40 participants should be adopted.
- Training needs to cover:
 - New thinking for CT (current paradigms)
 - Refresher of skill & knowledge base
 - New short protocols
 - Algorithms and testing SOPs (for current and new)
 - Data collection
 - Quality Assurance
- Ensure to maintain the balance between the public health and human rights concerns regarding informed consent (not coercive), confidentiality and counseling where necessary.



4.3 IMPLEMENTATION SUPPORT

Working within and with National Structures: LVCT worked through our regional offices to strengthen target setting, coordination and service delivery at the local levels. Western Regional office supported Nyanza and Eastern Regional office supported Mombasa.

Reflections:

- It is essential for LVCT to continuously work with and within government structures as this drives forward national processes.

Challenges:

- While working within and with government coordination structures there were challenges of coordination between the Centre and the Provinces/Districts.
- Information to the local levels was done late.
- Instructions for coordination of local partners were unclear.
- Partners that straddle between the local offices and have national offices and were involved in planning at the national level such as LVCT presented additional planning and coordination challenges at the district level as their regional offices were able to receive information ahead of government officers.
- Intense budgetary pressures resulted in little allowance for support services and coordination in all the regions.

Recommendations:

- The Secretariat needs to be given permissions to communicate to the local levels on behalf of NASCOP and NACC. This will facilitate faster and more coherent communication, information dissemination and feedback. This will require that the secretariat be authorized to undertake this function.
- Budgets for local level coordination and support supervision for the District Committees must be part of the national budget.

Community Mobilization

National level social mobilization was well articulated and budgeted in the national budget. Communication played a decisive role in the success of the testing week. NACC's leadership in ensuring communication was essential as it was best placed to articulate the vision represented by the HIV testing week. However community mobilization at service delivery levels, which is very key to generating demand for services and uptake at service delivery points was not planned for in messaging, logistics, personnel and budgets.

Reflections:



- The LVCT community mobilization division was by default then tasked with the responsibility to provide these essential services.
- Based on LVCT data (from LVCT direct supported sites) 52% of those tested in Mobile VCT services during this week were repeat testers. While this is good, it compromises the goal of 80% knowledge of HIV status by 2010 as those who are unaware of their status were not adequately targeted.

Challenges:

- Targeted messaging was not prepared
- There were no advance materials for distribution at service delivery points such as fliers, information on benefits of testing etc
- There was no written information for those that already tested that they could take away with them and be utilized for mobilization

“The continuing success of mass testing will largely hinge on the ability to do targeted highly effective community mobilization during service delivery that targets immediate social, gender and cultural realities within the varied service delivery settings”

LVCT staff member on community mobilization for CT services

Recommendations:

- Develop a plan for community mobilization at service delivery points as an integral part of planning including adequate budgetary provisions
- Engage trained community mobilizers as part of the campaign
- Develop targeted messaging to mobilize first-time testers
- Utilize a range of mobilization and service delivery strategies for targeted groups such as couples, families and vulnerable populations such as men who have sex with men
- Develop tailored messages to help cater for the heterogeneous nature of crowds and ensure targeted messaging
- Develop material for distribution
- Develop cards/written information that can be used by those already tested to mobilize their families and friends by distribution
- Enhance the capacity and visibility of community mobilization at service delivery points as this is primary to uptake.

LVCT Counselling and Testing service delivery points and logistics: LVCT determined to deliver 10% of the national targets as an organization in addition to the other non-direct service delivery done. LVCT tested 11,852 people of the nationals 120,000 during the HTC week thus accounting 10%. Services were delivered in the following areas and results:

**Table 1 Services as delivered during the HTC week by LVCT**

Service type	Target groups	Geographic location	Total	clients seen	
				Male	Female
Static VCT sites	General population	Nairobi Coast Nyanza	840	537	303
Mobile VCT sites	General population	Nairobi Coast Nyanza	6749	3694	3055
Moonlight VCT services	Sex workers	Nairobi	728	444	284
Services in Prisons	Inmates, prison authorities	Nairobi	**249	249	0
Community Based Counselling and Testing	Families	Nairobi Central	1288	654	634
Work place CT		Nairobi	2000		

** prisoners were seen during the week. However, LVCT was able to negotiate for data entry for 249 data forms with KPS.

***A Comprehensive Overview of Client Characteristics is available (n=11,852)**

LVCT's celebrity testing approach: LVCT utilized the Celebrity Testing approach to enhance community mobilization. LVCT has utilized this strategy of testing for leaders in various fields who are influential, to test in public as an avenue to catalyze demand for testing and counselling, and to highlight the importance of knowing ones HIV status. LVCT utilized this approach first with the Senator Barack Obama and developed posters as information material. This approach was utilized in 2007 to test Parliamentarians, and during the HTC week, a group of leaders as outlined in the table below.

**Table 2 Celebrity testing as delivered during the HTC week**

Date	Public Celebrities Sector tested	celebrities tested	CT site	Partners involved in CT
26 th /11/2007	Range of Celebrities	8 celebrities were tested	All Saints Cathedral	LVCT, NACC, NASCOP
27 th /11/2007	Private Sector	CEO's of 26 of Kenya's premier companies (list attached as annex 3)	Kenyatta Conference Centre	LVCT, GBC, FKE, KHBC, NCC, AKDN, NACC
28 th /11/2007	Women leaders	4 leaders for maendeleo ya Wanawake	Nairobi 'Bomb Blast' site	LVCT, NASCOP
29 th /11/2007	Youth leaders	Youth Celebrities performed	University of Nairobi	Hope World Wide, NASCOP, LVCT
30 th /11/2007	Uniformed Services	The Chief of General Staff and top brass in the Uniformed Services	Nairobi 'Bomb Blast' site	LVCT, NACC, NASCOP
31 st /11/2007	Education Sector	20 Teachers and leading educationists	Nairobi 'Bomb Blast' site	LVCT, NACC, NASCOP

Reflections:

- The celebrity testing approach as proposed and driven forward by NACC with primary support of LVCT was an essential community mobilization tool and in strengthening among the public the demand for counselling and testing.
- LVCT was able to determine to make this contribution due to our engagement with the process, an opportunity that many organizations did not harness.
- Delivering services to people within the context of their daily lives was considered important as there were many people who appreciated this much.
- LVCT's counsellor support was considered essential especially in targeting groups that may not be able to access services elsewhere. Clients also appreciated counselling support and information.
- Although the level of awareness has tremendously increased within the last decade, many people still don't know their HIV status or about HIV. Those who are infected or are at risk of being infected live in fear of stigma and prejudice.
- The preventive function of testing and counselling was discussed. Counsellors told stories of the effects of knowledge of HIV status and clearing the misconceptions that people still have of HIV.



- There still exist many assumptions that one's status can be diagnosed through one's regular sexual partner. Information on discordance requires further dissemination. Emphasis on individual HIV tests for status has not been strong enough.
- Actual service delivery at some of the sites such as the site next to the previous American Embassy, famously known as "Bomb blast", the Jogoo Road roundabout and other city council sites were out of bounds for two days, as the City Council asked for commercial user payments reflecting challenges in planning and arrangements for logistics.

4.4 STORIES THAT SPEAK TO THE REFLECTIONS OF THE HTC WEEK

These stories were narrated by counsellors during the LVCT reflection following the HTC week. These stories are part of a larger pool of stories. These were selected as they speak to specific issues and challenges that were raised during the reflection as outlined above.

Story 1

The story of Peter, a young prison inmate speaks to limited knowledge and information about HIV despite awareness levels of over 90% in Kenya.

"Two years ago, one evening I was with my buddies This meeting was not just another meeting to gossip over a can of beer, but rather to discuss in details how we were going to get rich.....you see living in Kibera is not a cup of coffee. It requires one to have means of survival..."

I could imagine the long rows of mud houses, narrow lanes filled with filth, my own siblings going hungry for days...I figured out if we stole some cash from the neighbouring shop keeper, it will be a chance to for me to get rich and help my family out... HIV never occurred in my mind...though there were rumours that some people have died of it. I Had more serious things to think off like my stomach you see.... But our plan never went through...two of my friends were shot dead, I was brought here and I don't know what will happen to..."

For the first time, in my life.....I have somebody who can listen to me...tell all about this disease.....I am touched,,,,,,deeply touched because I know how I can get infected, how to protect myself and also how one can live with the virus...I am only lucky that I don't have it...If what you told me is true (Anal Sex without protection), I am only lucky...if you guys never came here I don't know whether I could have heard about HIV"

Peter*, youth male from Kibera: Peter has been in remand for two years now and being charged for robbery with violence and attempted murder. This offence accounts to a conviction of life imprisonment. This is his story as narrated by the counsellor who provided him with services during the CT week.

* Peter's name has been changed for confidentiality reasons



Story 2

The story of James emphasizes the effects of the limited information on discordance and belief of partner status.

*“*James, 43 years old, a widower and says he has lost all his three children and wife to HIV. Six years ago, James was working in Nakuru and had five hectares of land with potatoes, which he had inherited from his family to meet the needs of his wife and their three children.*

In 2003 however, the health of his wife began to deteriorate. It started with headaches. When they lost their thirteen months last born child, his relatives and friends attributed the whole issue to a curse. This led James and his wife to a traditional healer. His wife eventually died and three years later he also lost his two other children, all from failing health. He lost all property in trying to get them medication. His children were HIV infected confirmed through testing. He never got tested.

The stigma attached to HIV/AIDS in his home area was overwhelming. The villagers ‘knew’ his status, and he avoided them, but, went into a depression and was sacked from his job. ‘Without family, land and job I decided to come to Nairobi where people don’t know me and look for kibarawa (casual labour). I have to take alcohol day in day out to be able to cope, as I wait for my worst days to come. I am becoming weaker and weaker day by day as you can see, and I know one day I will be bed ridden’.

James assured the counsellor he was HIV positive even though he had never been tested. He accepted to test as an avenue for entering into care and ART. The test result was HIV negative. With an expression of shock and dissatisfaction he denied that he was HIV negative. Four days later James came back looking for the counsellor who tested him first and shared with him that ‘it is true’. He had repeated the HIV test with two different counsellors and the result were still negative. He was beginning to believe it, and was also going to a government hospital to be tested again”.

LVCT counsellor during the feedback meeting on her experience during the CT week given at the
Gracia Guest House



Story 3

There were opportunities emerging for counsellors to test couples. Often, these opportunities are passed. It is essential that counsellors are able to handle couples in order to facilitate counselling. The experience of this counsellor in Thika emphasizes this:

*“My community work takes me to many places, I meet different people. This day I met a group of men and women. As usual I introduced myself and my work. After a short conversation about the importance of getting HIV and AIDS information and testing, some of them were excited that we were willing to test them. One man said ‘If I am going to know my status today my wife will have to know her status also’ A 27 years old male from Githurai said **“maya ngai, angikorwo ndi HIV negative gutiri mukingo** (I swear by God, if I turn out to be HIV negative, then there is no HIV). This gave me an opportunity to discuss HIV and correct these misconceptions. I tested this man with his wife and they promised each other to live responsible lives”*

LVCT counsellor from the Community Based HIV Counseling and Testing Team during the week, during the feedback meeting at Gracia Guest House

Recommendations:

- LVCT needs to continue focusing on vulnerable groups.
- The organizing committee of future HTC campaigns will need to develop strategies to identify partners and mobilize them to make their contributions towards this national strategy in order to meet the national objectives.
- Services to vulnerable and high-risk groups need to be considered during planning as a strategic group for counselling and testing given the primary aim of accessing treatment and care for all those infected with HIV. LVCT already provides leadership in responding to vulnerable groups and requires to be pro-active with this strategy.
- Targeted messaging is essential to be able to address critical issues relating to:
 - Couples counselling and testing
 - Discordance
 - Specific vulnerable and special needs groups such as Prisons
- Site identification for outreach and mobile services needs to be done in advance and appropriate negotiations made between NACC/NASCOP and other relevant government authorities.



4.5 LOGISTICS

Challenges:

- There was no financial support for administrative support at service delivery including receptionists resulting in many missed opportunities, impatient clients and general disorganization e.g. Nairobi Deaf had challenges working with an assistant who was not very knowledgeable, so the site supervisor had to do almost everything, doubling her duties without concentrating on service delivery.
- Waste disposal was challenging as the logistics for this had not been organized in advance
- There was some tension between MOH & partner supported counsellors that affected service delivery. LVCT and other partners such as DSW paid their counsellors on time during the week, while MoH counsellors' pay was delayed.
- There were discrepancies in payment of staff that was de-motivating. Deaf counsellors got Ksh. 500/= while hearing counsellors got Ksh. 750/=
- Tents that provided the space for service provision were not enough or standardized. Their set up and security were included much later as an add on.

Recommendations:

- There should be an assigned responsibility to review service delivery needs, taking up a mobile VCT site as a unit of operation in planning for sites. This will ensure that logistical concerns such as administrative support, generators and fuel and security for night functionality are taken into consideration. These should form part of the core budget at planning.
- Standardize provider allowances at the on-set and ensure buy-in of all partners.
- Standardize payment procedures and scheduling.

4.6 QUALITY ASSURANCE & SUPERVISION

Reflections:

- QA should start from selection of counsellors for training to on-going monitoring during service delivery. It encourages the organization to uphold the integrity of HIV testing especially with regards to consent, confidentiality and counselling.
- There was no QC done during the exercise or planned for. QA/QC and client satisfactions interviews were only undertaken in specific LVCT supported sites and provided the basis upon which QA for the exercise was evaluated.
- Counsellor self assessment in the context of high workloads, high volumes and long working hours have an impact on the quality of service delivery and this should be evaluated.



Challenges:

- Quality assurance was taken into consideration at advanced stages of the planning process. Thus QA was not carried out in all sites and it was not systematic when it was undertaken.
- The staffing for the event represented a unique challenge. With mass testing and shorter algorithms, the optimal numbers for counsellor service delivery with quality was not clear.
- Conflict in numbering of the forms in relation to client codes. Issuing of client codes should be centralised at each site to avoid repeat codes.

Recommendations:

- Standards for service delivery in the context of mass testing require to be developed.
- QA/QC must be central to the planning process and be input into the budgeting.
- Systems to pick out professional breaches in practice require to be developed. Ideas suggested included daily debriefs, ongoing shortened client exit interviews, empowering LVCT staff to play an overseer and enabler role during such campaigns and constantly advocating for the inclusion of a quality component in each and every campaign.
- Have a central mechanism to issue counsellors with codes to avoid code conflicts that complicate quality assurance, collection and reporting.
- The *tools* though have to constantly adapt to reflect the shifts in practice. Operating in this highly unstable environment of mass testing will require loose organizational structures, inter and intradepartmental collaboration to maintain quality. LVCT should use its present ad hoc project teams to facilitate thinking for QA in the next HTC week and ensure their implementation.

4.7 MONITORING AND EVALUATION AND REPORTING

Target setting

The targets served as both a symbolic and performance guiding function. The bottle neck identified was the availability, skill and motivation of HIV counsellors in the field.

Data Collection, Management and Analysis

Reflections:

- What gets measured gets done (Peter Drucker). Crucially LVCT's ability to generate best practice evidence hinges upon the ability to define and redefine the important measures of performance.
- There were data collection tools that were developed. However the utility of these tools, reporting and analysis of this data at the national level remained a challenge throughout the week. Reporting mechanisms were not structured in advance.



Challenges:

- Data collection, management and services delivery at service delivery point were not planned for effectively. It was assumed that counsellors would know when to collect data during the short protocol.
- The forms that were used did not capture enough information that could be adequately used to define several variables as related to mass testing. More accurate variables are needed to ensure accurate facts and detailed reporting.
- There were discrepancies in LVCT & NACC reported data
- There may have been data lost although people were provided with services

Recommendations

- A daily reporting mechanism should be developed in advance of the exercise. It should potentially include a site in-charge reporting to a designated officer, who then reports to a central place and that the channel for communication is clear.
- An M & E system is essential. It must be based on clear requirements for the outcomes of the week and must measure process as well.
- Indicators for delivery of services need to be identified and discussed in advance. The following indicators were developed during the workshop at Gracia. They have been presented as is and will require refinement. Their importance cannot be overestimated.

4.8 SUGGESTED PROCESS AND OUTCOME INDICATORS

Process Indicators:

1. Counselling

- No of Counselling sessions
- Types of counselling undertaken
- # of individual counselling sessions undertaken
- # of group counselling sessions undertaken
- # of people provided counselling services
- # of counsellors supervised
- Supervision- how it should be done, how many counsellors to supervisor
- Duration of counsellor supervision
- Frequency of supervision
- Adherence to shorter protocol

2. Testing;

- # of tests done
- Type of tests done
- # of testing accessories utilized



- Types of testing done – oral, anti-body, PCR etc
- Type of QC done
- # of QC conducted
- # and places where QC validation is undertaken
- % of discordance in results
- Adherence to SOPS(Standard operating procedures)
- Adherence to protocols
- Testing targets: Celebrities
- # & types of testing strategies: Moonlight VCT's, Mobile VCTS, Workplace
- Client testimonies collected

3. Logistics

- Types & levels of meetings
- Content of meetings (ensure to capture all issues outlined in the logistics section of this document)
- Number of meetings
- Time spent at meetings
- # of counsellors
- Counsellor stations and service delivery assigned
- # of Community Mobilization staff
- Types of messages developed
- # and types of IEC developed
- Recognition by media (media monitoring)
- No. of burners

4. Data

- Type of data collected
- # of data collation sites
- Methods of data verification and audit
- # of client exit interviews done
- Time taken for client exit interview analysis
- Log book availability
- Lot card number availability
- Clashing counsellor codes

Outcome Indicators

- # of people tested
- Characteristics of people testing - gender, age, sex, region, type of service
- # of people knowing their HIV status for the first time



- # of couples tested
- # of children tested
- Characteristics of couples tested
- # and types of vulnerable groups served
- Characteristics of vulnerable groups served
- # of people accessing referrals
- # of people accessing care and treatment
- # of pregnant women accessing PMTCT services



4.9 STRENGTHENING THE CONTINUUM OF CARE

During the year 2007 HTC the continuum of care was not taken into consideration. It still remains unclear to what extent the week had an impact on uptake of care and treatment, as well as uptake of PMTCT services. As shown in the indicators developed, planning must include:

- mapping of referral services
- undertaking a needs assessment of referral care and other services
- Undertaking parallel planning for counselling and testing and care and treatment services to plan for all those who will need to be absorbed into care and treatment
- Planning for the expected increased numbers for care and treatment

5 FINANCES

LVCT was significantly exposed to unbudgeted expenditure during the testing week. The budget arrangement called for expenditure to be charged once activities had been undertaken. This unfortunately meant spending core funds in the hope that such expenditure would be reimbursed. Often unforeseen expenditure around logistics raised expenditure significantly. Of note was the purchase of test kits and accessories that were central to the event.

The need to develop proper financial systems and bulwarks to control and manage expenditure is an important lesson learnt. Further, the creation of a cost-effective model, hinges upon the proper identification of hidden driver of costs like the back office support that includes time allocated by LVCT staff and administrative/logistics support.

6 METAPHORS

The power of the captured experience is best expressed in the stories of individual who were part of the testing week. These stories provide us with a snapshot of the experiences of the clients. They are not substitutes for well structured client exit interviews, but they provide a strong sense of the testing week experience. They have shown that with the large number of programmes and projects, senior programme advisors tend to remember the anecdotes and in turn relate these anecdotes to the individual programmes. This creates a great perception template and provides important mileage for any organization.

LVCT has developed this tradition as part of its monitoring and evaluation programmes. Beyond M&E, the stories or metaphors serve the distinct function of helping the service provider relate the story to reconnect with a memorable experience and locate him r



herselves within this experience. This creates the kind of transformational model that improves the skills and attitudes of service providers.

1) Counsellor: In Kisumu District, the clients really appreciated the services being taken to them at their work places. We had the opportunity of going to different places like the Jua kali area, the Jubilee market (the biggest in Kisumu), offices and other places at night.

As I was walking in the market place with my bag doing door to door CT, a lady called me and I went to talk to her. She was selling second hand clothes and had customers, among them was a Nurse at the Kisumu District Hospital, who after hearing me out was quick to remind me that “these people need their privacy” yet the person who wanted to be tested was not overly concerned about privacy.

The lady was aged 25 years and married. She had been tested a year ago. She asked me to test her just there, and I suggested we move to the back of the stall but she declined and I did the test. She was able to interpret her results as negative and was very happy.

This actually showed me that we counsellors are the ones with issues around stigma and confidentiality and not the clients, and that we have denied many clients the chance to know their HIV status.

Recommendation:

In future added training on keeping a journal for the chronicling of stories from the field would be necessary. This journal will be a rich source of material for the development of structures to capture stories that can be vivid portrayals of experiences. The stories should as far as possible capture all settings including clients who declined to test.



31st February 2008

7 LVCT Capability statement

Liverpool VCT, Care and Treatment (LVCT) is a Kenyan non-governmental non-for profit organization established in 1998 and registered in 2001. LVCT provides technical assistance to the government of Kenya (GoK) and partners in strengthening responses to HIV prevention and care. LVCT partners with the National AIDS Control Council (NACC) and the Ministry of Health's National AIDS and Sexually Transmitted Infections Control Programme (NAS COP) to strengthen the **scaling up of quality-assured HIV counseling and testing services**, treatment and care programmes, and services to vulnerable groups or groups with special needs: survivors of sexual violence, the deaf, men who have sex with men (MSM), youth and sex workers.

LVCT continues to play a central role in developing standards and guidelines for HIV counseling and testing (HCT) providing technical assistance to the National Quality Assurance Team (NQAT) to enhance quality assurance for service delivery. Of the roughly 1,000 VCT sites in Kenya, LVCT has helped to establish over 400. Through **capacity-building of local partners**, over 200 VCT have been 'graduated' to be managed by GoK, community organizations (CBOs) and faith-based organizations (FBOs). LVCT has enabled over 900,000 Kenyans know their HIV status through delivery of counselling and testing. LVCT is proud to have heard it said that, *'When it comes to VCT, Liverpool has set the "gold standard".'*

LVCT currently provides care and treatment to 19,000 patients with 6,500 on anti-retroviral therapy. Clinical mentorship, decentralization of services and capacity building are key to these achievements. To strengthen capacities for the HIV response LVCT trains over 700 health providers annually and has trained over 70% of all the 3,600 VCT counselors in Kenya and 90% of HIV counsellor supervisors. Over 95% of counsellors providing trauma counselling following sexual violence in public health settings in LVCT are LVCT trained. LVCT is offering a **Diploma Course in HIV Counselling and Testing for Clinical Settings**.

LVCT sub-grants and provides technical support to and community ownership through a robust, replicable model that includes training health providers, supervisors and managers; observed practice, support supervision and quality assurance; training in financial and programme planning; monitoring and evaluation involving end-users and community stakeholders; data management and dissemination of lessons learned; and best practices.

LVCT's response continues to be guided and framed within the principles, goals and targets of the Kenya National HIV/AIDS Strategic Plan II (KNASPII) and the Kenya National Health Sector Strategic Plan. We participate actively in a range of committees at national and regional levels, are involved in developing annual health sector plans and national guidelines for regulating service delivery. All of LVCT's work receives oversight from the Provincial and District Health Management Teams, and these are also among the targets of LVCT's capacity building efforts.



Policy and Standards Impact

National HIV Testing and Counselling guidelines
 National VCT Guidelines
 National Guidelines on the medical management of rape/sexual violence
 National ART Guidelines
 National Quality Assurance Strategy
 Licensure & Accreditation Systems
 Operations Research Guidance
 Comprehensive Care Center Standards
 Diagnostic CT Guidelines (ongoing)

Curricula Developed

VCT Counselor Training
 Trauma Counseling

 ART Management
 Quality Assurance
 Counseling Supervision

 Adherence Counseling

The **operational and health systems research** is imperative to our contribution to evidence-based policy and programming. LVCT research and data has been instrumental in the development of VCT, Quality Assurance, Post Rape Care and Provider Initiated Counselling and Testing Programmes.

Innovative approaches continue to contribute to Kenya's goals of prevention and treatment. The 'Know your HIV status campaign' that LVCT has actively promoted through Celebrity Testing, Work place programmes and Community Based HIV Counselling and Testing aim to promote Kenya's goal of 80% of knowledge of HIV status by 2010. Regional offices located in Kisumu and Embu support service delivery. LVCT's operations beyond Kenya include technical support in HIV counselling and testing, Quality Assurance and Care and Treatment in Botswana, Cote d'Ivoire and Ethiopia.

LVCT's work has been continuously supported by our partners and sponsors including CDC/PEPFAR, CIDA-GESP, DfID, DSW – the German Population Fund, Elton John AIDS Foundation, Ford Foundation, Hewlett Foundation, HIVOS, the Population Council, UNFPA, USAID, Trocaire and the American International Health Alliance through the Twinning Centre.