

# V is for Voluntary

Uptake of HIV Testing and Counseling in Mombasa District, Kenya

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## ABSTRACT

Voluntary counseling and testing (VCT) is a crucial HIV intervention strategy, promoting safe behavior, providing personalized support, and serving as an entry point for care and treatment. Experts agree that knowledge of HIV status should ideally be universal; however, as VCT is a voluntary service, certain challenges arise in promoting its uptake. Though Kenya has made remarkable headway in expanding its VCT provision, setting a leading example for the world, 80% of adult citizens still have never been tested. This project investigates the factors controlling the uptake of VCT in Mombasa district and seeks ways to reach more people with testing and counseling services. The first section identifies common barriers that keep individuals from seeking VCT services, including psychological, socio-cultural and physical barriers. The second section explores the wide variety of VCT programs existing in Mombasa district, and how they have contributed to recent increases in uptake. The third section is a case study of the 2007 HIV Testing Week, shedding light on the challenges and possibilities of targeting great numbers of people with VCT. Finally, the last section explores the acceptability and future prospects of alternative strategies to VCT, which are being considered to universalize HIV testing. This study finds that the issues of stigma, poverty, and human rights must continuously be considered in any efforts to expand uptake of HIV counseling and testing services. In order to uphold the efficacy of the VCT intervention, the quality and integrity of services must be prioritized above target numbers of clients.

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## **INTRODUCTION**

HIV/AIDS has become one of the most devastating health problems in all of human history, consuming millions of lives annually worldwide. One obstacle is that most people are unaware of their HIV status, which poses a major challenge in preventing HIV transmission and providing effective care to infected persons. In fact, it is estimated that only one in ten people living with HIV worldwide have ever undergone an HIV test (WHO/UNAIDS 2005). Kenya, with one of the highest prevalences of HIV in the world, has taken great strides in tackling this problem by developing an expansive system of voluntary HIV counseling and testing, commonly known as VCT. These services are primarily intended for healthy people, which is significant due to the fact that the HIV infection is mostly spread unwittingly by asymptomatic individuals. The VCT strategy empowers individuals to protect themselves and others against the virus, to access care and counseling, and to plan for the future. Since 2000, Kenya has led a great example to the world through a massive scale-up in VCT, establishing over 700 centers nationwide and servicing a total of 1.2 million Kenyans to date. In spite of this progress, up to 80% of Kenyan adults still do not know their HIV status, and the deadly virus continues to spread at an alarming rate. Evidently, the particular successes and challenges of VCT in Kenya must be further scrutinized before the system can be replicated in other countries.

This project investigates the factors inhibiting Kenyans from participating in VCT, as well as the factors inhibiting VCT services from reaching more clients, through a case study in Mombasa district. Conveniently, the time period during which the field work was conducted coincided with planning and execution of Kenya's first nationwide HIV testing week. This testing week, with the target of testing 100,000 Kenyans, revealed the difficulties of increasing uptake and provision of VCT services, and brought to a head many of the challenges remaining for HIV control in Kenya. This paper will compile the views of VCT counselors, public health officials, peer educators, VCT clients, and non-clients for a comprehensive understanding what controls the uptake of VCT in Mombasa district and Kenya at large. The ultimate question that this paper will address is how more people can be made aware of their HIV status while still respecting human rights and ensuring the quality of counseling and testing services.

## I. Background

HIV/AIDS in Kenya is far more than a health issue, spanning into many other social realms. According to the National AIDS and STD Control Programme, HIV/AIDS “still remains the biggest social, economic, and development challenge” in Kenya. Since 1984, when the first case of HIV was discovered in Kenya, the prevalence rose steadily until peaking at 13.4% in 2000 (NAS COP, 2005), by which time it had already claimed over 1 million lives. As the virus targets adults between the ages of 15 and 49, which makes up the most productive portion of the population, HIV/AIDS has had dire repercussions not only in the health sector but across all economic sectors, and communities have had to struggle to support the sick, the mourning and the orphaned. It was not until 1999, after 15 years of devastation, that the Kenyan government finally recognized HIV/AIDS as a national disaster. However delayed, this move added great impetus to control efforts at the turn of the millenium, and the HIV prevalence rate has declined ever since to the current national rate of 5.1% (NACC).

**VCT Scale-up.** Before the year 2000, there existed only three stand-alone VCT in all of Kenya, covering barely 1000 people per year. At most 14% of the Kenyan population had ever been tested for HIV, and this included people who had been tested without their knowledge and remained uninformed of their status. In 2000, in order to address these shortcomings, the government made a commitment to rapid the extension of VCT, with the goal of opening 350 VCT sites, 5 in each of Kenya’s 70 districts, by 2004. A committee was formed to set out VCT guidelines, to ensure that services would be private, confidential, accessible, affordable and convenient. If VCT sites succeeded in meeting the national guidelines, they would receive a free supply of test kits from the Nation AIDS and STD Control Program. Rapid-testing strategies were adopted, such that the test and delivery of results, combined with pre- and post-test counseling, could be completed within an hour, and thus each client would only have to make one trip to a VCT center. Pilot studies showed that the finger-prick rapid HIV test was an effective and well-accepted procedure, and that VCT effectively brought about positive behavior change, both in those who tested negative, who became more motivated to preserve their status, and in those who tested positive, who then took measures to protect others (Irwin, 67). The VCT model (Appendix A) ensures that clients are well-informed, prepared to undergo testing, and have personalized risk reduction plans.

Remarkably, Kenya has in fact overshoot its VCT target by a huge margin. Between 2000 and 2005, the government and donors contributed USD \$35 million to the scale-up, including mass-media campaigns to educate about testing. Within that time period, the number of VCT sites increased to over 748 (far exceeding the goal of 350) and coverage rose to 545,000 people tested annually (WHO). A major part of the success was the innovative strategies Kenya developed to diversify its programs; according to one UNAIDS report, “Kenya continues to provide global leadership in expanding counseling and testing services beyond traditional VCT.” However, over 1 million Kenyans are estimated to still be living with HIV today, and the large majority of adults, or approximately 80% of those between the ages of 15 and 54 (NACC, 2007), still have never tested for HIV. Considering the vast amount of resources that have gone into making VCT widely available and accessible, the remaining barriers to VCT must be investigated. The following three issues should be considered throughout: stigma, poverty and human rights.

**Stigma.** One issue of particular relevance is stigma, surrounding both the HIV testing process and the disclosure of HIV-positive status. According to an officer from the organization Women Fighting AIDS in Kenya (WOFAK), stigma is the “single greatest hurdle in Kenya’s fight against AIDS”, for it prevents people from going for tests, from seeking treatment, and from disclosing HIV status to sexual partners or spouses. With regard to VCT, many people avoid utilizing VCT services for fear of being sighted by family, friends or neighbors, and consequently raising suspicions about promiscuity or infidelity. According to one counselor, some people avoid the VCTs closest to them and travel far from home to get tested, for the express purpose of avoiding the eyes of their acquaintances. This option, however, is only available to people with the time and means to make the journey. Another study revealed that Nairobi youth avoid VCT because it might suggest to the community that they are sexually active, which is generally socially unacceptable for unmarried youth. This stigma may be exacerbated by high levels of conservative religion in Kenya, such as Catholicism and Islam, both of which emphasize fidelity and pre-marital abstinence as matters of piety. In addition, misconceptions abound about HIV testing being only for those who are ill or already experiencing symptoms of AIDS, which may deter healthy people from utilizing VCT.

A second form of stigma is that which surrounds HIV positive people in Kenya. Some Kenyans have reportedly lost employment, faced violence or rejection from their

partners or spouses, and generally been discriminated and isolated by society after disclosing HIV positive status. Such stigmatization of HIV positive people makes it all the more frightening for healthy people to seek testing, as discovery of positive status might have adverse social consequences. In addition, there are persisting misconceptions about HIV positive status being a death sentence, whereas in reality people can lead very normal and productive lives in spite of HIV infection. Awareness must be spread about the availability of ARV treatment, which is now offered for free in most parts of Kenya and which can greatly prolong the lives of HIV positive people. With the availability of treatment and continued counseling, the benefits of testing usually outweigh the disadvantages of disclosing HIV status.

**Poverty.** Another issue that must be explored in relation to VCT is poverty, which may restrict many Kenyans from using VCT. With approximately 50% of Kenya's population living under the \$1/day poverty line, many people must work all day just in order to eat. Surviving on the edge as such, it is very difficult for some Kenyans to even find the time to get tested. Transport is another factor that may restrict the poor from accessing VCT, particularly in rural areas where VCT centers are more spread out. Although VCT services are generally free, the cost of transport may be too much for some families to bear. Following HIV testing, transport becomes an even greater problem for those who need treatment or further counseling on a regular basis. Poverty may therefore prevent certain people from seeking VCT services who may otherwise be very interested in knowing their status or speaking with a counselor. Kenya has employed mobile VCT to address the access problem by bringing services directly into remote and impoverished communities – however, there are questions as to how comprehensive and sustainable such mobile services can be. It should be noted that poverty has many other mechanisms of perpetuating the HIV/AIDS pandemic, but they shall not be listed here for lack of direct relevance to VCT.

**Human Rights.** If we consider health as a human right, it is our duty to fight such a devastating disease as AIDS, which has curbed the freedoms of so many people. Prevention and care strategies, including VCT, must be made available to the maximum number of people to ensure the future generation's right to health. However, human rights must also be considered in our means of providing health services, especially in the case of HIV testing and counseling. HIV testing provides many opportunities for violations of



individual rights, such as coercion, stigmatization and breaches of confidentiality. VCT has developed strict guidelines to ensure that services remain confidential and that clients are truly willing and prepared for the test (NASCO, 2001). A crucial aspect of VCT, as revealed by the name, is that it is voluntary, as emphasized by the UNAIDS HIV and Human Rights Committee (Berer).

However, the voluntary nature of testing poses a challenge when people do not take the initiative to utilize services, and the balance between public health goals and individual rights is not always straightforward. Many debates are currently taking place in Kenya about alternative HIV testing strategies, which recruit testers more aggressively than classic VCT and may not require informed consent. It is debatable whether these alternatives are justifiable in order to get more people tested. One alternative, recently proposed by the WHO, is provider-initiated HIV testing and counseling (PITC), which would make testing a routine offer to all users of health services. This strategy is already protocol in antenatal clinics in Kenya, where pregnant women are routinely tested for HIV unless they explicitly refuse. While this “opt-out” strategy has been successful in many contexts, particularly in Botswana where it was first implemented (Donnelly, 2007), it raises a number of human rights concerns, as people may not be aware of their right to refuse testing or may not have the ability to do so. Forms of mandatory testing have also been proposed, particularly for pre-marital couples and civil servants, and new strategies of testing, such as door-to-door VCT, are currently being explored. Human rights must be a major consideration in evaluating these more aggressive forms of HIV testing and counseling and in guiding the future direction of current programs.

## II. Project Setting and Study Sample

By the most recent estimate, Mombasa District has an HIV prevalence of 12.3% (NACC, 2004), which is the highest of any district outside of Nyanza Province. Situated on Kenya’s coastline bordering the Indian Ocean, the district contains the island of Mombasa Town, which is the second largest city in Kenya, as well as surrounding suburbs and semi-rural areas. As a hotspot for tourism, commerce and commercial sex work, the environment in Mombasa is very conducive to HIV transmission. However, the national scale-up in VCT at the national level has also been very apparent within Mombasa district. VCT centers in the district now amount to at least 42, including both stand-alone sites and

services that are integrated into health facilities. These sites serve the general population in addition to providing specialized services for youth, commercial sex workers, deaf communities, drug-users, and truck drivers. According to the District AIDS and STI Control Coordinator (DASCO), in his three years of experience he has seen a rise in people tested from 8,000 to 44,000 annually, which indicates remarkable progress.

Though I originally intended to conduct this study at the community level, focusing in on only one VCT site and the surrounding neighborhood, several discoveries convinced me to expand the study sample to the district level. First of all, I found that there is a lot of mobility involved in VCT services; clients often avoid the VCT center closest to home and travel far to access services, and VCT centers themselves frequently conduct mobile outreaches to other parts of the district. Also, counselors and peer educators are often rotated through different centers in the district. In order to understand the relationships between clients and services, I could not restrict my study to any single neighborhood. Secondly, VCT services are coordinated at the district level, which was especially apparent during the planning of HIV Testing Week. All VCT sites must report their activities to the DASCOP, or District AIDS and STI Control Program, and the DASCOP reserves the right to control the distribution of resources and personnel as well as coordinate special events such as the testing week. Thus, the workings of each site in Mombasa are tied to the rest of the sites in the district, rendering it pointless to restrict my study to a smaller area. However, I should note that the population included in this study is very diverse, including Christians and Muslims, poor and middle-class, rural and urban dwellers. As a result, this study covers a wide variety of perspectives, and yet I will focus on the common threads that emerged to reveal important factors about VCT irrespective of individual backgrounds.

### III. Objectives

In order to understand the factors controlling the uptake of HIV counseling and testing, I propose five major objectives.

1. Identify barriers to VCT usage, such as the degree to which stigma and poverty are deterrent factors.
2. Investigate current VCT programs and how they attract clients.
3. Explore methods to increase uptake of VCT, with a particular focus on HIV Testing Week.

4. Evaluate the acceptability of more aggressive alternatives to VCT, such as PITC and pre-marital testing.
5. Propose ways in which VCT and other forms of HIV testing may better serve the community.

## **METHODOLOGY**

In order to meet my objectives I conducted interviews, focus groups, and observation both inside and outside the VCT system. I obtained what I will call an “inside perspective” from VCT counselors, peer educators, and public health officials. For a “general perspective,” I spoke to VCT clients as well as local residents and working people, some of whom had never been tested for HIV.

**Interviews.** My most valuable sources of information were interviews, both formal and informal. I conducted 15 interviews with VCT counselors, ten of which were formal and lasted over 40 minutes. These interviews were relatively easy to come by, as I could virtually walk into any VCT center and expect a counselor to be available. The counselors, all of whom help people for a living, were very helpful to me and provided useful contacts for the rest of my project. Through the network of counselors I worked my way up to three key health officials: the Coast Province VCT Coordinator, the Mombasa District AIDS and STI Control Coordinator, and the Mombasa Island Community AIDS Control Council Chairman. Through formal interviews with these three officials I developed an understanding about how VCT activities are coordinated from the top. I also conducted one formal interview with an adult peer educator as well as several informal interviews with youth peer educators.

For an “outside perspective” I spoke to people who were not affiliated with any HIV prevention or VCT program. Some of these interviews were informal as it is often intimidating for people to speak outside their area of expertise. These included four adults living in urban Mombasa and two clients in a VCT waiting room. I also conducted five formal interviews with clients who had just undergone the VCT process and who had been notified of my presence by the counselor. Two of these clients were at a static VCT site, and three at a mobile site. Finally, I conducted another five formal interviews in a semi-rural village within Mombasa District called Kwa Punda. For all ten of the formal

interviews I conducted with people not affiliated with VCT, I offered a drink or small gift in return.

**Focus Groups.** Focus groups were more difficult to organize than I anticipated, and all of them were cut short because of the participants' time constraints. I conducted my first focus group with ten youths from the Likoni Youth Center, and a second focus group with the Youth Post-Test Club at the Magongo Clinic. A third focus group was conducted with three street vendors in Old Town Mombasa.

**Observation and personal experience.** One of the most valuable components of my research was observation, allowing me to develop a more thorough understanding of the scope of VCT programs in the district. Over the course of the study period I visited at least ten different static VCT centers as well as eight mobile VCT sites. Through these visits I was able to observe the set-ups and surroundings of the VCT sites, noting differences in general atmosphere and degree of privacy. I also attended two meetings at the Ministry of Health for the coordination of the HIV Testing Week, among 25 representatives of the major VCT stakeholders in the district. Finally, I went to the Mombasa World AIDS Day function at Likoni Primary School and observed various speeches and skits performed by HIV/AIDS activists. Through these observation activities, not only did I learn about HIV prevention efforts in the district, but just as importantly, I gained a general understanding of life in the region as my research forced me to tour marginal areas that I never would have known about otherwise.

In addition to observation, personal experience also played a role in my research. I underwent counseling and testing myself at a static site as well as couples testing and counseling at a mobile site. The testing experience gave me a much deeper understanding of VCT process, the differences between mobile and static VCT, and the stresses of testing both alone and as a couple. I also experienced the challenge of mobilization first-hand by participating in VCT mobilization at Jomo Kenyatta Beach by approaching people and handing out brochures. These experiences deepened my understanding of the issues addressed in my project.

It is worth noting that a certain degree of my methodology was spontaneous, and some of the most valuable parts of my research would have been impossible to plan. For example, one of my most powerful interactions was with a man who had just recently tested positive and was waiting outside the VCT room while his wife and child were being tested. As the man was obviously in a state of extreme anxiety, it would have been completely out of place for me to approach him; remarkably, however, he came to me to express his feelings and ask my advice. There is no way I could have sought out such a discussion without violating privacy and human rights, but there is no better way that I could have understood the true terror of testing positive than from speaking with this man. In several other circumstances I was similarly fortunate as people volunteered information that I did not have a right to request, or brought me 'behind the scenes' of events such as HIV Testing Week. Therefore, I will say that part of my methodology was simply to be open to coincidence and seize opportunities as they rise.

## **LITERATURE REVIEW**

During my background research, I used many literature sources to understand the history of the HIV epidemic and of HIV testing and counseling, in both Kenya and the world at large. However, the following four sources were the most crucial for the development of my project.

### **Global AIDS Myths and Facts (Irwin): Ch.4 Prevention vs. Treatment.**

This source first inspired me to pursue VCT uptake by demonstrating the complexity of the topic. The chapter eloquently demonstrates the interdependence of prevention and treatment strategies in addressing HIV/AIDS, and it uses voluntary counseling and testing as its primary example, showing that the effectiveness of VCT as a prevention strategy depends on the availability of AIDS treatment. The chapter identifies the following barriers to broad-based participation in VCT: hopelessness, fear of stigmatization, and the perception that testing positive is a death sentence. The authors argue that making treatment available to those who test positive will make VCT more appealing to all, by giving an incentive for people to know their status and access care. The provision of treatment can also help reduce stigma and normalize HIV, as more people live healthily with the virus. Thus, the authors warn against pooling all resources in HIV

prevention, which may outwardly seem more “cost-effective.” They suggest that linking treatment provisions to VCT will encourage more people to seek their status and reduce fatalistic behavior. Clearly, this book is not context-specific, and thus its recommendations have little practical value on the ground. However, it raises important issues that will be considered and further explored in the study at hand.

**Analysis of Data on HIV Voluntary Counseling and Testing in Kenya, 2001-05.” 2007.**

This study is based on a survey of over 100,000 VCT clients over 5 years, and it identifies major trends during the national scale-up. Data was collected from 17 different sites supported by the NGO IMPACT, 9 of which are in Mombasa District. Questions on the survey included general demographic data as well as how the clients learned about VCT and their reasons for seeking the services. One particularly relevant result was that increases in VCT uptake were shown to parallel the provision of treatment in the different regions. In Mombasa district, a sharp increase in VCT uptake was observed in 2003, just when ARVs became widely available. Increases in uptake were also shown to correlate with mass communication campaigns; for example, in 2002 the number of youth VCT clients doubled over the course of two months, corresponding with a youth-centered HIV campaign involving popular singers and entertainers. Surveys showed that the two top reasons that clients sought VCT were to plan for the future and in anticipation of marriage. Women were more likely to seek services because they doubted their partners’ behavior or because they felt unwell, and overall there were 25% more men tested than women. Regarding education, more than two thirds of clients had secondary education or above, which is significant given that the majority of Kenyans have no secondary education.

This study is very valuable as it presents a vast amount of data about VCT activities over time and raises important considerations about who accesses VCT and why. The large scale of the survey reveals fascinating trends, such as the correlation between VCT uptake and ARV availability. However, the survey method prohibits a deeper understanding of the issues underlying the trends. For example, the study does not explain why women are more likely than men to use VCT when they feel ill, nor does it explore the implications of this trend. More qualitative methods, such as in-depth interviews and focus groups, are necessary to understand the data more profoundly. Another consideration is that all the VCT sites in the study are run by the same NGO (IMPACT), which makes this study valuable as a reflection for IMPACT but perhaps not generalizable to all VCT sites in

Kenya. Nonetheless, the findings this study serve as kick-off points for studies such as my own, which attempts to explain some of the trends.

### **HIV Voluntary Counseling and Testing among Youth: Results from an Exploratory Study in Nairobi, Kenya and Kampala and Masaka, Uganda.**

This study, completed in 1998, examined the uptake and efficacy of VCT for youth in Kenya and Uganda by conducting in-depth interviews, focus groups, and surveys with youth, parents and service providers. The study was designed to explore the problem that while 60% of new HIV infections were between the ages of 10 and 24, only a very small portion of VCT clients were youth. The findings indicated that 77% of youth were interested in getting tested, but that counselors were not equipped to manage youth issues. The study also documented common perceptions among the youth, such as the belief that VCT testing was mainly for the ill, and the fear of being seen at a VCT site. One particular issue was the difficulty of discussing VCT with parents for fear of revealing sexual activity, which is taboo for youth in most of East Africa. The majority of youth in both Uganda and Kenya learned about HIV and VCT from their peers. Universally, counseling was the most significant factor for youth satisfaction with VCT, though a large portion of participants reported an absence or insufficiency of counseling.

This study most closely resembles the intent of my own research in exploring the barriers to VCT for certain groups of people. Not only did it reveal interesting issues relating to VCT for youth, it also culminated in valuable recommendations, such as opening youth-centered VCT sites, targeting youth with social mobilization, and training counselors to cope with youth-specific issues. The only concern with this study is that it may be outdated, as almost ten years have passed and much has changed in Kenya, particularly the VCT scale-up. The cost of VCT, one of the factors covered in the study, should no longer be an issue as virtually all VCT sites offer free services. Also, one should hope that the provision of counseling is more consistent today since the adoption of the 2001 national VCT guidelines. In fact, I can infer from my observations that many of the study's recommendations have already been accomplished in Mombasa, as I have witnessed a number of youth-centered services and youth-friendly outreaches. This study has nonetheless served as a model for my own research.

### **National Guidelines for Voluntary Counseling and Testing**

These guidelines were published in 2001 by the National AIDS and STD Control Program (NAS COP) in conjunction with the National AIDS Control Council (NACC). All VCT sites, both integrated with other facilities and as stand-alone services, must follow these requirements under the supervision of the district VCT coordinator. The first section provides guidelines for operational procedures, such as informed consent, confidentiality, and staffing and management of the sites. Section 2 details the guidelines for counseling, such as the role of the counselor in providing information, assessing the readiness of the client, and making referrals. Section 3 outlines the testing procedure, recommending the use of rapid test kits and confirmation methods. Finally, section 4 details VCT record-keeping, data management, monitoring and evaluation, in order to synchronize data from VCT sites nation-wide.

These guidelines are very constructive and user-friendly. All sites are required to have the guidelines, and over the course of my study I found that many counselors still refer to them for reference. By all accords, these guidelines were instrumental in setting up VCT sites and maintaining the quality of services during the massive scale-up that followed their publication. However, at times the guidelines have also been misused, such as in the case of hospitalized in-patients. Although it is stated in the fine print that the guidelines should not apply for diagnostic testing, there have been cases where unconscious patients have not been administered an HIV test because the doctor or nurse was waiting for informed consent. Such confusion, however, is subsiding as the guidelines become more established. These guidelines have been an invaluable tool for me to understand the policy and procedures underlying current VCT-related issues, and I will cite the guidelines in this paper where applicable.

## **FINDINGS AND ANALYSIS**

### **I. Barriers to VCT Uptake**

One of my major objectives in this project was to understand the reasons why so few people have utilized VCT services, which have been made free and accessible across most of Kenya. I was particularly interested to find out why certain people seek the



services while others do not. In asking this question, a number of factors emerged, spanning the following three categories: psychological barriers, cultural barriers, and physical barriers.

**a. Psychological Barriers**

**Debate of the Street Vendors**

Older man: I have never tested, I do not need to. I have only one mama. If we have HIV, we will die together. Everyone dies anyway. It is better to die without knowing.

Two younger men: This guy is just scared. He fears. His mama lives upcountry; who knows, she may be with others. He may be with others.

Older man: These guys are young. They don't understand. They just play sex.

The decision to get tested for HIV is anything but trivial. In the case of VCT, one has to take the initiative to go to a testing site in order to face potentially life-changing information. Understandably, a decision of such weight requires a long and complex thought process. This section examines common psychological barriers, or beliefs, fears and associations, that prevent people in Mombasa district from coming to this important personal decision.

Over the course of my research, the most common question I asked counselors, clients, and non-clients was why more people did not get tested. Fear of death was by far the most consistent answer. First of all, HIV testing is commonly associated with dying since many people only get tested when they show symptoms; in fact, more than half of people in Kenya get tested for HIV through diagnostic testing, meaning they have already been hospitalized (PEPFAR, 2007). Though VCT is primarily intended for healthy people, the association with morbidity still remains. Secondly, one of the most common responses was that knowing your status can cause you to die from stress. In the words of one man, "It is better to suffer without knowing. The moment you know, you will die." Some people, it is believed, simply cannot handle the information of being HIV positive. They may refuse to eat or socialize, only thinking about death, and this will cause them to die early. By this

reasoning, many people prefer not to know their status, even if it means suffering from HIV without treatment – according to them, they will die either way.

Another psychological barrier is the fear of stigmatization, both for being HIV positive and for utilizing VCT. People fear that revealing their positive status will cause them to lose friends, business, and respect in their communities. One counselor claimed that family members were the worse perpetrators of discrimination; HIV positive members may be isolated so that the family's reputation is not tarnished. Even if the result is negative, people fear that the very act of visiting a VCT center would raise suspicions. For this reason many people choose to get tested as far from home as possible to avoid seeing familiar faces (see next section). In the words of one man, some people have the mentality that "if only I could get into the VCT room, then I would get tested." However, several counselors and health-workers attested that stigmatization of HIV positive people is in fact minimal, and it is really "self-stigma" that keeps people from accessing VCT and treatment. When concerned about HIV, people change their own attitudes, and ultimately are more affected by stigma from themselves than from others.

Another psychological barrier to HIV testing is the association of HIV status with good and evil. A common perception is that HIV testing is only for people who have done immoral things and consequently "doubt themselves." One woman, who actually knew very little about the mechanisms of HIV transmission, simply stated that HIV testing was not for her because she was a moral person and did not "doubt herself." Another person said that if you test positive, it is because God hates you, and so the best way to encourage testing is to know that God forgives. Along the same vein, one client who had just emerged from the testing room said that people avoid VCT because they "fear for their souls." "Don't worry," he added, "I don't have it. My soul is good." Such association of HIV status with good and evil, God's favor, or the sanctity of the soul renders HIV testing like Judgement Day. It is no wonder that many people do not feel ready to undergo the test.

How can these psychological barriers be addressed and individuals encouraged to seek VCT? Most of the participants were aware that treatment and support are available for those who test HIV positive, but this information is not sufficient to ease such deeply engrained fears and associations. Saadu Rashid, a peer counselor for the National Museums of Kenya, said that the most effective mobilization strategy is to demonstrate

that people can live happily and healthily with HIV, or as the slogan goes, “live positively with HIV.” The experience that had the most impact on her was seeing a healthy and beautiful woman speak about HIV, and only find out afterwards that she was HIV positive, to the shock of the entire audience. According to Saadu, the speaker said “I know, I’m beautiful!” and then revealed that she had been positive for five years without treatment. Such real-life demonstrations can convince people that HIV positive status is not a death sentence at all, nor does it entirely change one’s life, which thus makes it easier for people to decide to undergo testing.

### **b. Socio-cultural Barriers**

Certain characteristics of Kenyan society, such as the existence of polygamy and female disempowerment, are known to promote the spread of HIV. However, my concern in this paper is how such socio-cultural factors may affect the uptake of VCT. In Mombasa District, strong Muslim influences combine with African as well as Christianity tradition for a unique and vibrant culture. The tight “small world” communities allow rumors to spread very fast, and this causes some people to doubt the confidentiality of HIV testing and fear that their secrets might be known. Another factor is the great attention placed on marriage, particularly among the Swahili community. Swahili marriages are massive affairs, involving entire communities and great investments of effort and money, which creates a lot of pressure for couples who wish to undergo pre-marital testing. In one example, a couple went for pre-marital testing and was found to be discordant: the groom was HIV positive while the bride was HIV negative. The couple decided to break up, as many discordant couples do, but not without involving the entire community and causing a family feud. Additionally, Swahili culture places great emphasis on the virginity of the bride, which is confirmed on wedding night. Parents who trust their daughters see no need for HIV testing before marriage, though in fact many youth engage in anal sex; while preserving vaginal virginity, this puts young women at even greater risk of contracting HIV. These youth are therefore misguided and may neglect to use needed VCT services.

Another socio-cultural barrier is that of gender imbalance and female disempowerment. It has been a general trend that more men seek VCT services than women do, in spite of the fact that HIV prevalence is almost twice as high among women. In some Kenyan families, women are not allowed to leave the house and thus are unable to

reach VCT services. Even if women do access VCT, they may have difficulty to communicate the results to their partners or husbands. One counselor told the story of an HIV positive man who brought his three wives to the VCT center without ever discussing the subject or notifying them of where they were going. When the husband tried to force them to get tested, the three women were shocked and entirely unprepared. Such gender imbalances pose additional challenges to VCT uptake and efficacy.

### **c. Physical Barriers**

Though most VCT services in Kenya today are offered free of charge, time and distance continue to be barriers to much of the population, particularly in rural and even sub-urban areas. In some parts of Mombasa District, it may take up to 45 minutes to walk to the nearest health center, and sick people are brought in wheel-barrows. Many people, particularly those living in poverty, do not have the time in the schedules to make the journey for VCT services. Certain strategies, such as mobile VCT (see next section), have been developed to reduce these time and distance barriers; however, it is impossible to eliminate them entirely and so they should continue to be a consideration.

## **II. Overcoming Barriers**

As mentioned earlier, in recent years Mombasa District has made enormous progress in provision of VCT, and now up to 50,000 people get tested per year. This progress would not have been possible without the wide variety of VCT activities, including static VCT, mobile VCT, moonlight VCT, and associated mobilization efforts, as well as other forms of HIV testing which lie outside the bounds of VCT. These innovative programs help overcome many of the obstacles mentioned in the prior section, and cater to individual preferences of clients. In the following section, each of these types of VCT will be examined for both advantages and disadvantages, particularly emphasizing how and why clients choose the particular services.

### **a. Diversity of Services**

**Static VCT.** Traditional VCT services still have a major presence in Kenya. Run by government agencies, community based organizations (CBOs), or NGOs, these services can be found at stand-alone sites or may be integrated into other health facilities. There are a total of 42 of these sites in Mombasa District, and so most residents live within walking distance of more than one site. Over the course of my interviews, I tried to discern how clients choose which site to attend.

Counselors and clients almost unanimously reported that people rarely choose the site that is closest to home. Sites located in Mombasa Town serve mostly people from outside the island, some from even as far as Lamu. The main reason is the fear of being seen or losing confidentiality; in the words of one youth, “I go as far from home as possible!” At the Kaderbhoy VCT, located right next to a mosque in the very Muslim area of Old Town Mombasa, I was surprised to discover that the majority of clients are non-Muslim. One fear is that the counselor may be related to the client, or may divulge the client’s secrets to people who know the client. This is especially the case in “small world” communities and in rural areas. One VCT site in a rural area reportedly went for months without receiving one client, until the site employed a counselor from a different tribe. In order to address this common problem, the Mombasa District DASCOS has adopted the policy of rotating counselors between sites every few months. Another fear related to static sites is that of being seen by friends or relatives while entering a VCT site, or the mentality that “I’d get tested if only I could get inside the VCT room!” At Bomu clinic, the staff expressly chose not to label the counseling room as VCT, suspecting that the sign would be “too strong” and clients would not want to be seen entering. These fears revert to the issue of stigma surrounding the HIV test.

However, other factors do play into clients’ choices of testing location. Many people I spoke to were unaware that VCT services were provided outside the hospital; in fact, some reported paying 400 Kenyan shillings for testing at a private hospital, unaware of the free stand-alone VCT located one block away. Mobilization outreaches can help spread awareness about VCT services and location; for instance, the Mombasa Youth Counseling Center receives many VCT clients from secondary schools, near and far, after conducting outreaches. Another factor is the reputation of the center, or recommendations from peers. For example, Bomu Medical Center, rated the highest of all VCT providers in

Coast Province, attracts many clients from afar because of its reputation of having friendly staff and quality services. From these factors we can infer that VCT sites can attract clients by ensuring confidentiality, maintaining a good reputation, and spreading awareness about the site's location.

**Mobile.** Mobile VCT has become very popular, as it reduces the barriers of time, distance, and stigma. . It is intended to reach populations with low uptake of VCT services, both in rural and urban areas. Typical mobile initiatives last between one and five days, and testing is conducted in tents or trucks. Counselors are often accompanied by mobilization teams that attract clients with public announcements, music, or performances of skits. Successful mobile initiatives require early planning and communication with community leader; it is beneficial for mobile teams to understand in advance the particular issues of the community, such as drugs, prostitution, or ignorance, and plan their programs accordingly.

Most people I interviewed said they would be more likely to utilize mobile services than static ones, mainly because they are more convenient. One man explained that going to the hospital for testing is like “deciding to meet your death,” especially as you will have to wait in line surrounded by sick people. As for mobile VCT, which is right outside your home and much less of an ordeal, all you have to decide is “yes or ignore.” Understandably, the convenience of mobile VCT makes it easier for people to have the initiative to get tested. Mobile VCT has also been said to reduce stigma, as the counselors come from outside the community. However, the stigma argument has a flipside, as people seeking services near their home are more likely to be seen by their neighbors. For this reason, one woman said that she preferred the hospital – where “no one knows you” – over nearby mobile VCT services.

In spite of the many benefits to mobile VCT, there are also new challenges that arise. Many counselors testified that sometimes clients are not sufficiently prepared during mobile initiatives, and only use the services because they see their friends doing it or feel coerced. Counselor have a great responsibility to assess the readiness of their clients, otherwise testing could result in shock, violence, or denial. Also, the quality of mobile VCT services does not always match that of static services. Mobile initiatives often target large numbers of people because ultimately it is the numbers that attract donors; this forces counselors to rush through sessions with clients. Also, the settings of mobile VCT usually

do not offer the same amount of privacy as static sites, as many counseling and testing sessions may be occurring simultaneously under one tent.

The following anecdote describes a mobile initiative in the town of Mariakani and highlights the challenges of mobile VCT.

### **Mobile in Mariakiani**

Mariakani is a small town in a rural area of Coast Province, about one hour's drive from Mombasa, and has only developed as a rest stop for truckers along the Mombasa-Kampala transnational highway. While the town has maintained some of its rural character, alcoholism and prostitution are rampant, and HIV prevalence is estimated to be high. A group of local peer educators called Solwodi requested mobile VCT services from Bomu Medical Center, and I had the privilege to accompany the Bomu counselors on this initiative. Over the course of the day, however, many factors prevented the VCT from working as effectively as hoped.

The first issue was venue, as the VCT had initially been set up inside a Muslim school beside the town's mosque. The peer educators lingered outside, but the proximity to the mosque prohibited them from using the public announcement system and playing music to attract clients. By afternoon the site was moved to a more central location, but still not ideal as the testing was conducted inside the storage room of someone's home. The peer educators used music and a soccer game to raise interest, and before long a large crowd had gathered. Coincidentally, a blood drive had been organized on the same day and was taking place just a few meters outside the testing room. As there was no sign indicating the VCT room, many people were confused and came to believe that the blood drive was the same thing as the VCT. One man even became angry as he agreed to give a liter of his own blood but was never told his HIV status. By the end of the day, a large crowd was dancing outside the VCT and alcohol was being consumed abundantly, yet less than ten clients had gone for testing and counseling.

The major lesson that can be learned from this experience is the importance of communication in mobile VCT. There was insufficient communication between the counselors, the mobilizers, the community leaders, and the community itself. The venue should have been thought out in advance, and the distinction between VCT and blood donation should have been clarified. Even more importantly, the community should have been informed and educated about VCT before the testing day. According to one

counselor, the people of Mariakani are “too ignorant” – unaware of the most basic information about HIV. Indeed, several local residents reported to me that they did not need to test because they did not feel sick. This highlights the importance for mobile VCT teams to know the context of the site and form an appropriate plan well before arriving with testing kits. In spite of its advantages over static VCT, mobile VCT clearly takes a lot of time, effort and resources, and may be difficult to conduct consistently.

**Moonlight.** A recent innovation in the world of counseling and testing has been moonlight VCT, meaning that services operate at night. Moonlight VCT may involve both extending the hours of a static VCT site and conducting a mobile initiative overnight. This strategy too reduces the barriers of access and stigma, for people often have more free time at night, and are less afraid to be seen due to the feeling of secrecy afforded by darkness. In particular, night-time services have been used to target commercial sex workers and truck drivers. Moonlight VCT was first attempted in Kenya little more than a year ago, but has quickly risen in popularity due to great initial successes.

As part of my research, I witnessed the first moonlight VCT ever to occur in Mtwapa, a nightlife hub on the northern border of Mombasa District. Situated near beach resorts, the town is also home to many poor, with parts even considered a slum. The proximity of poverty to tourism explains the abundance of commercial sex workers who prowl the bars at night. During this moonlight VCT event, the local VCT center remained open until midnight, and a mobile testing truck and tent were set up right outside the main stretch of bars. Solwodi, a group of peer educators who are mostly former sex workers, mobilized the community by approaching people at bars and informing them about the VCT. The event was very successful, surpassing the target of 50 clients.

Two concerns emerge, however. First, there are higher security risks during moonlight VCT services, and security forces may need to be hired to survey the site. Secondly, there is the same question of client readiness as in mobile VCT. During moonlight services, there is an even greater risk of coercion to undergo testing, as many of the targeted individuals are at bars and clubs and may be intoxicated. If such is the case, counseling sessions may be ineffective or even dangerous.



## **b. Mobilization strategies**

The above programs would not succeed if it were not for the creative mobilization and promotion strategies that have been employed in Mombasa. How is the population alerted of the presence of particular VCT services, and how are individuals encouraged to voluntarily seek services? For one, there are the striking purple and yellow VCT signs which indicate services all over the district as well as the entire nation. There are periodic announcements through radio, television, and billboards. Most notably though, there are the continued creative efforts of peer educators, particularly youth.

The most prominent of the mobilization teams in Mombasa district are called Post-Test Clubs (PTCs). The name is somewhat of a misnomer; originally intended as support groups for people following the HIV test, the Post-Test Clubs have emerged more as youth groups of artists and peer-educators, creating dramas, poems and songs to fight stigma and encourage testing among their audiences. According to Victoria, an experienced counselor and organizer of the Bomu PTC, people learn from arts and entertainment more effectively than from speeches by doctors or professionals. PTC performances catch people's attention, and present HIV-related issues in a language that they can understand, from a perspective that they can relate to. In particular, youth Post-Test Clubs serve as role models for other youth in Kenyan society.

From the perspective of clients, many recall getting information about VCT from peers and family-members. Clients at mobile VCTs, on the other hand, mostly find out about testing activities only after hearing the music or noticing the testing tents, and inquiring about the purpose of the festivities. One man admitted that the only reason he got tested was because the counselors were offering free T-shirts; in his opinion, the best way to attract people is to offer prizes. This highlights a current challenge with HIV-related activities: the popular perception that any HIV program has money to spare. Indeed, relative to the greater Kenyan economy, massive amounts of funds have arrived from international donors to support HIV-related programs. This has created many jobs for counselors, peer-educators, and other health workers, and the general population often wants a share. One peer educator complained that whenever she speaks to people about HIV prevention, they ask her for money because they assume she is getting paid to speak to them. "They don't understand that we are doing them a service!" she added. As money

is now being partitioned between testing, treatment and care, there is little to spare, but mobilization teams continue working with the little resources they have to spread awareness.

The diversity of VCT services and mobilization strategies has undoubtedly enabled much of the progress in Mombasa district regarding knowledge of HIV status. Individuals who may not feel inclined to seek static VCT services have now been covered by mobile services, and others by moonlight services. The deaf, the youth, and drug-users now have access to VCT services catering specifically to their kind. Mobilization has involved great amounts of effort and creativity, spanning from the media to live performance. By any judge, Mombasa district has made very impressive strides to fill in the gaps in VCT coverage. However, as most of the adult population still has not been tested, there is still room for improvement. How much further can these current strategies be pushed to increase HIV uptake? The next section focuses on HIV Testing Week as an illustrative case of the possibilities and challenges of increasing VCT uptake.

### **III. HIV Testing Week**

This year, the week of November 25 has marked Kenya's first ever national HIV Testing Week, a special event leading up to the December 1<sup>st</sup> World AIDS Day. It was announced by the National AIDS Control Council with only a few weeks notice, and aimed to universalize testing through mobile VCT, moonlight VCT, and VCT in health facilities, the workplace, and places of worship. The target number of clients to be counseled and tested was 100,000 nationwide; broken down, this meant 20,000 in Coast Province and 12,000 in Mombasa district. Within Mombasa district, where the average number of people tested per week is 2200, the target was over five times the normal uptake.

Over the course of my study period, I had the privilege of witnessing how this ambitious task would play out. Instead of only speculating how VCT uptake might be increased, I was fortunate enough to observe experts actually making it happen. First, I was able to observe the planning committee at work, and through the committee's discussions came to understand the challenges of scaling up VCT. Throughout the testing

week, I observed the special activities and spoke to participating counselors and clients along the way. Finally, I interviewed several of the committee members at the end of the week as a follow-up on the successes and shortcomings of the event. In this section I will detail my observations with particular relevance to the factors controlling VCT uptake, and then summarize the lessons learned that will help guide VCT activities in the future.

#### **a. Planning of the event**

The first meeting I attended was on November 19, 6 days before the initiation of testing week. The committee was chaired by the District AIDS and STI Coordinator (DASCO), and approximately 25 other stakeholders were present, including representatives from various organizations, community AIDS control coordinators (CACCs), and religious leaders. Specifically, the organizations included, but were not limited to, Red Cross, Liverpool VCT, APHIA II, Jama Foundation, DSW, and the Council of Imams. Plans for testing week were still in the ground stages. The members agreed that the major targets would be youth, commercial sex workers, densely populated areas, churches and mosques, and the workplace. Particular mobile VCT sites would include the Likoni ferry, where countless working people pass every day; public beaches on Sunday; clubs and bars at night; marketplaces; prisons; educational institutions; and residential estates. In addition, they would “beef up” static VCT sites, including those integrated into ante-natal clinic and TB clinics, by providing extra counselors and extending hours. However, the planning process soon stalled as too much was contingent on funding, which still had not been confirmed by the national council. It was universally acknowledged that mobilization needed to begin as soon as possible, but this would be difficult as no one knew what funds were available for promotion materials, public announcements systems, or transport and food for mobilizers. A general sentiment of distrust became apparent, as the members questioned whether the national government would follow through with its promised support. Earlier that week, the DASCO had planned and executed a training program for counselors, but the government ultimately provided only 35,000 of the promised 800,000 Kenyan shillings, which meant that trainers were not paid and volunteers were forced to spend their own money. Members at this meeting were thus reluctant to begin plans for fear that the funds might fall through. Ultimately, this first meeting ended inconclusively, and another meeting was scheduled for later in the week when funds and the availability of test kits might be known.

The following meeting for the planning of HIV Testing Week occurred on Thursday, November 22<sup>nd</sup>, three days before the start of the activities. Progress had already been made: the majority of the 130 needed counselors had been recruited and trained; the 12,000 test kits would arrive the following day; and a representative from the National AIDS Control Council (NACC) was present to discuss funding. The NACC representative brought the news that everyone had been apprehending: only 3 million of the promised 5 million Kenyan shillings were being allocated to the testing activities in Coast Province. Consequently, some cuts would have to be made and stakeholders would have to chip in. The confirmation about funding nonetheless added impetus to the planning process, and the members of the committee broke up into three groups to address specific events: fixed sites, mobile sites, and social mobilization. Plans for fixed sites included strengthening certain sites with extra counselors, alerting hospital staff, and extending the hours of VCT services. The mobile VCT group made a list of the many sites and discussed writing letters to hotel managers, church leaders, and other parties to get the rights to set up certain sites. Finally, the social mobilization group planned to produce flyers, banners and posters and to alert the media and community leaders. By the end of the meeting, a creative and comprehensive plan emerged thanks to the enthusiasm of the members; however, the plan was also astoundingly ambitious considering that only three days remained before the launching of HIV Testing Week.

Over the course of the planning for HIV Testing Week, several general issues about VCT emerged that apply year-round. First, many static sites have extra capacity, or as one stakeholder at the meeting said, “VCTs are usually underutilized.” The national guidelines state that counselors should see no more than 10 clients/day, 40 hours per week (12), but in actuality I have gathered that most counselors see only 5 to 6 clients on an average day. Also, static sites usually start turning clients away around 4 pm so that counselors can leave by 5 pm without cutting a session short; thus VCTs generally close just before people start coming home from work. During HIV testing week, it was proposed that VCT counselors should use shorter protocols and stay open for longer hours in order to see more clients. “Floating counselors” or those who have been trained but are idle for lack of VCT job openings, could supply relief and work in shifts. Though this plan was only intended for HIV Testing Week, a similar long-term plan could perhaps be formed to extend the hours of static VCT sites.

The planning for testing week sheds light on another ongoing problem: the restrictions imposed by target numbers of clients and limited funds. Among the committee members there was resentment that the national government had set unmovable targets while providing insufficient funds; in the words of one member, “how do you translate money into numbers without compromising the quality and integrity of the services?” In general, donors and NGOs put ongoing pressure on VCT sites to serve large numbers of clients in order to receive funds. With such restrictions, VCTs are often forced to make compromises, but the results are always unfortunate. If you cut down on mobilization, clients are less informed. If you cut down the time of the testing protocol, then clients may not receive adequate counseling. If you extend the working hours of counselors with insufficient compensation, they become overworked. If you pack clients under one tent, there is inadequate privacy. If you don’t make any compromises, less clients will be served and donors will be unhappy. Particularly for VCT, large numbers of clients does not necessarily indicate success, because ultimately the primary aim of VCT is to promote safe behavior. If clients do not come prepared and willing to undergo counseling and testing, and if the counselors do not take the time to serve each client thoroughly, then it is quite possible that clients will emerge from VCT without any gains. If they test negative, they may continue risky behavior as before, and if they test positive, they may remain in denial and contribute to the spreading of the disease. The success of VCT must be measured client by client, not by the total number of clients. That said, target numbers are good motivators to universalize testing, as long as quality is maintained, and the next section will address how this statement applies to HIV Testing Week.

#### **b. HIV Testing Week Outcome**

“There is no stigma here.” –VCT counselor, Likoni Ferry

Throughout testing week, most of the activities were very successful. VCTs in common gathering areas, such as the beaches, the ferry, and the market, were particularly popular – the Likoni ferry VCT tested up to 1200 people in one day. In addition, counselors reported that moonlight VCTs were particularly successful, attracting more

numbers than expected. All over the district, people lined up for VCT services out in the open, some even fighting over spaces in line. According to counselor a CACC chairman William Bota, this is an indication that there is little stigma, and that people are more aware than ever of the importance of knowing their status. One of my main questions was how these activities drew so many clients. From what I gathered, the most effective mobilization techniques were simply the public announcement (PA) systems and music – most of the clients said they had heard the music and saw the tents and were simply curious about what was going on. However, even where PA systems were lacking, such as at Jomo Kenyatta Beach, peer educators compensated by distributing brochures and spreading the word about VCT. As expected, some complications did arise. Letters were not received, trucks went missing, and flyers never materialized; yet the activity leaders adapted to the circumstances and so there were no major roadblocks. Each day of testing week, every VCT site in the district sent the daily data to the district coordinator (DASCO) by SMS over cellular phones. By the end of the week the DASCO had compiled the grand total for the numbers of people counseled, tested, and positive, disaggregated by the following groups: men, pregnant women, non-pregnant women, and couples.

The results were remarkable. Mombasa district actually surpassed its target of 12,000 by a large margin, counseling and testing 15,209 people over the 7 days. This is nearly seven times the normal VCT uptake in Mombasa District. Furthermore, among the 15,209 tested people, there were only 809 who tested positive, indicating a prevalence rate of 5.3% which is significantly lower than past estimates for Mombasa District. This is a sharp contrast to the VCT statistics for July to September of this year, for which the rate of HIV positive clients was 11.3% (PASCO). While nothing can be concluded from this data without further inspection, the low rate during testing week is nonetheless a cause for optimism. Most of the counselors were astounded by the low numbers of HIV positive people they encountered, according to one counselor, it means that “people are learning.” On the other hand, it is possible that the rate was low because the VCT techniques used during the week appealed particularly to people at low risk. Even so, this is an important step towards normalizing VCT, as it is meant for use by the general population and not only by promiscuous or careless individuals.

Another significant result was that 65% of the clients during HIV Testing Week were male, almost double the amount of females. However, the number of clients who

tested positive were split evenly between male and female. This means that the prevalence rate for males was 4.0% whereas for females it was 7.4%. These gender imbalances must be explored more deeply, not only to understand why there was a higher prevalence rate among females, which is a widely acknowledged trend, but also why VCT uptake by males was so much higher than by females. Perhaps it was the simple fact that more men were passing near mobile sites, while many women were working at home. Whatever the case, the results of HIV Testing Week suggest that new techniques must be explored to reach more women.

### **c. Lessons Learned**

HIV Testing Week was a very informative assessment of the limits and potential of VCT programs in Kenya. First, it revealed that services do indeed have the capacity to serve more people, and that there are indeed large numbers of people willing to be tested. Though the huge efforts of HIV Testing Week are not sustainable, the event confirmed the hope that VCT can be made more universal in the future. However, the testing week activities gave rise to some major concerns, including poor quality of counseling, overworking of counselors, and insufficient privacy of services. The problems must be further scrutinized in order to avoid them in future efforts to expand uptake of voluntary counseling and testing.

Most counselors, though pleased with the successes of HIV Testing Week, admitted that the quality of VCT services were partially compromised in order to reach the targets. First, clients were given significantly less counseling time during testing week than they would have gotten otherwise. In order to serve more clients, counselors had been trained to use a short protocol lasting only 20 minutes, rather than the standard time of 45 minutes to one hour. This shorter protocol cut down the time for risk assessment and especially for post-test counseling, which was modified to last only 3 minutes for HIV negative clients and 5 minutes for positive clients. In the words of one counselor, it is clear that these modifications “put clients to harm” as clients who turn out HIV positive generally need thorough counseling immediately. In the crowded settings of HIV Testing Week, adequate post-test counseling was difficult to provide, and one counselor feared that shocked clients may even jump off a nearby bridge. Fortunately, no one ever did jump off a bridge, but the limited counseling time is still a major concern.

At the same time, counselors were indisputably overworked during testing week. With so many VCT sites running at once, several of which stayed open throughout the nights, many counselors were forced to work all day and all night, taking only a few hours off to rest in the early morning. As stated before, according to the national VCT guidelines counselors are supposed to see no more than 10 clients per day; during testing week, this limit was extended to 15, but most counselors actually saw between 20 and 30 clients per day. To top it off, most counselors were not even compensated for working overtime due to the lack of funding. In the end, the counselors deserve to be commended for their admirable devotion and massive contribution to the event's success. However, with better planning and foresight, more counselors could have been trained to avoid the overworking of these individuals. The long hours and many clients presumably made it difficult for counselors to keep up the quality of their counseling.

Another concern about the execution of testing week is privacy, for many of the testing activities took place in crowded, open spaces, where conversations could easily be overheard. At the ferry site, for example, there were up to twenty counseling sessions happening at once under one tent, with large crowds surrounding the area. During rush hour, one counselor reported, waiting clients became impatient and crowded around counselors even as they were drawing blood. Though it is encouraging that so many people were willing to use the services in spite of the open setting, the lack of privacy is nonetheless unacceptable according to human rights. It is vital that VCT services remain private and confidential both for the sake of the clients themselves and onlookers who may be considering VCT in the future.

Overall, most members of the planning committee were very pleased with the outcome of HIV Testing Week, and hope to repeat it next year, though with earlier planning and more counselors. However, client satisfaction and the efficacy of the week's activities are still to be determined. Granted, the 2007 HIV Testing Week succeeded in terms of reaching its target, but what was its real impact? With the short length of counseling sessions, and the potentially distracting settings, were clients truly encouraged to adopt safer behavior? Several representatives from the national government were assigned the task of evaluating efficacy, but they have yet to release a report. Until then, it is unclear to what degree the testing week actually was a success, and whether its strategies should be replicated.



#### **IV. Remaining problems and Future Possibilities**

In spite of the many successes of VCT programs in Kenya, such as this most recent HIV Testing Week, the strategies are not working for everyone, as evidenced by the 80% of Kenyan adults who do not know their HIV status. Perhaps not all parts of the country have as active VCT programs as Mombasa District; yet, even within the district, there remain pockets of society that are not receptive to VCT initiatives. One such pocket is the village of Kwa Punda, which I visited during HIV Testing Week, though it was not included in any of the week's activities.

##### **The case of Kwa Punda**

Kwa Punda is a coastal village only a few kilometers north Mombasa Town. Perched on a hill sloping down to the mangroves, it consists of several groups of mud houses and a population ranging from 5,000 to 10,000 in number, depending on the season. Many of the inhabitants sell home-made alcoholic brews, and there is considerable interaction with the nearby prostitution hub of Bangladesh.

I spent two full days in Kwa Punda in order to investigate the semi-rural perspective on VCT in Mombasa District. My findings were very striking. First, stigma against HIV positive people in Kwa Punda is very pronounced; according to one resident, "people in this village have no love." Most inhabitants reportedly fear to associate with HIV positive people; almost all of the individuals I spoke to said they would not provide business to an HIV positive vendor. One woman explained her fear, saying "maybe that HIV positive person has poisoned the food on purpose to get revenge on me." In turn, this stigma has caused HIV positive people in Kwa Punda to hide their status. One HIV positive woman told me that the only person she has revealed her status to is her own daughter.

In addition to the stigma, knowledge about HIV transmission and prevention was relatively limited among the people I spoke to. Most of the information was learned from hearsay or from the radio, though according to one resident, "knowledge from the radio is just theory, not practical." In addition, few people have ever gotten counseled or tested for HIV, and most pregnant women do not seek ante-natal services partially in fear of the HIV test. While I was interviewing people, however, they seemed very interested to know more

on the topics of HIV and VCT, and many asked me to clarify HIV prevention strategies for them.

At the end of my visit, I was determined that Kwa Punda simply needed a sensitization outreach and mobile VCT, similar to the activities I had witnessed elsewhere in Mombasa district. The stigma was alarming, VCT uptake low, and information insufficient, and at the same time interest appeared to be high. I decided to ask some of the organizations and Post-Test Clubs (PTCs) I had encountered whether a group might be willing to conduct an outreach to Kwa Punda. I was shocked to discover that most groups had already sent mobilization and VCT teams to Kwa Punda several times in recent years, yet with little avail. Of the four Bomu mobile VCT initiatives in Kwa Punda, only one of them reached up to ten clients. One counselor reported that the people there are always intoxicated and never listen, and a youth peer educator reported feeling ignored and even disdained by the residents during the sensitization program. Mobilization groups felt unwelcome in Kwa Punda and ended their programs early to move on to different sites. It appears to me that Mombasa HIV activism groups have all but given up on Kwa Punda

After hearing these views on Kwa Punda, it occurred to me that this was not just a simple matter of bringing a mobilization group to the village to sensitize the population. The obstacles that have prevented past efforts from succeeding need to be understood, and new intervention strategies need to be designed accordingly. With more time, I would have liked to see this process through; however, I am forced to settle on the promise that the Bomu team will approach the cause in January.

New counseling and testing strategies, as well as general sensitization strategies, must be explored to reach people such as the residents of Kwa Punda, for whom current strategies are not succeeding. According to Zaituni Ahmed, the provincial VCT coordinator, she sees HIV counseling and testing moving away from classic VCT to more aggressive forms, such as door-to-door and provider-initiated counseling and testing. Throughout my research, I asked people about their opinions on alternative forms of HIV testing in order to investigate their acceptability and future prospects.

The first possibility, described by Zaituni as the up-and-coming strategy to universalize counseling and testing, is door-to-door VCT. By this system, community health workers would visit households to discuss about HIV and encourage the residents to know their status. These health workers might even carry test kits with them to conduct

testing on the spot. Though this strategy has not yet been attempted in Mombasa district, most people I encountered spoke favorably of the idea, particularly in Kwa Punda. The fact that people in Kwa Punda were so willing to discuss VCT as I was sitting in their homes is a hopeful sign that door-to-door counseling and testing might succeed. In fact, the HIV positive woman I spoke to – let her be called Sandra – had only gotten tested after experiencing a very similar process to door-to-door counseling: a Catholic health-worker came into her home and spoke to her kindly about HIV, then brought her to the hospital for testing. Sandra said she “could not live without” the Catholic health-workers, highlighting the importance of home-based counseling and care. Perhaps if more people were given the opportunity to discuss HIV and testing in the privacy of their own homes, they would be more willing and prepared to know their status.

One concern with door-to-door testing is that it may put counselors in an unmanageable or dangerous situation. One counselor told me she would never be willing to conduct door-to-door testing, for in a stranger’s household she would lack all the security and support that she normally gets from clinical settings. She suggested that door-to-door counseling without the testing might be more appropriate, and clients should be referred to a clinic for testing. Whatever the case, it appears that the door-to-door strategy is worth exploring in order to sensitize people who have so far escaped the reach of existing HIV-related programs.

The next possibility I investigated for expanding VCT was the extreme case: making it mandatory by law to get counseled and tested. HIV testing is already required in certain cases, such as for entering the police force or for getting a visa. Some people I spoke to suggested that it should be required for all civil servants, as they should be role models for society. A few people believed HIV testing should be required for everyone, though their incentives were questionable: one man said it would allow him to have unprotected sex without fearing, while another said that HIV positive people should be made to wear badges. The majority of the people I spoke to, including all of the counselors and peer educators, said that HIV testing should never be forced. The main explanation, generally, was that HIV testing should be a personal decision, otherwise clients may not be ready to receive the results. Unprepared individuals may face long-lasting denial, or purportedly may even die from stress. One counselor told the story of a recent client who had come in for testing, already very sick. This client had tested three years ago as a

requirement for his job, but after testing positive he lost his job and went into denial. This man died just a few days after coming in for his second round of testing. Clearly, his first testing and counseling experience, which had been forced, did not benefit him or anyone else. The individual risks of forced testing may outweigh the benefits of universal status awareness.

These arguments also apply to pre-marital testing, which is already required in many Kenyan churches. The advantage of pre-marital testing is that it might prevent transmission both between the couple and from mother to child, and allow the couple to plan for the future before having already committed to marriage. In addition, religious leaders hope that such measures might deter both men and women from engaging in pre-marital sex or other high-risk activities. A law passed in 2000 prohibits clergy from refusing marriage based on HIV status, but pressures still exist. Most of the people I spoke to said that pre-marital testing is good, but should not be required, for it is not the role of a religious leader or government official to determine who can or cannot get married. If a man and woman truly love each other, I was often told, they will agree to get tested on their own accord. On the other hand, one man was against the idea of pre-marital testing altogether. In his opinion, discovering discordant HIV status before marriage would be too devastating for anyone to handle. People who love each other, he said, should wait until after marriage to get tested, once their “blood has mixed” – then, if both are HIV positive, they will support each other. Whatever the case, mandatory nation-wide pre-marital testing does not appear to be a desired solution.

A final testing strategy that has been considered to reach more people is routine testing in health facilities, or provider-initiated testing and counseling (PITC). This strategy is already being implemented for tuberculosis patients, who are more likely to have the HIV virus, and especially for pregnant women, in order to prevent mother-to-child transmission (PMTCT). Because of routine ante-natal testing, a large portion of Kenyan women in recent years have discovered their HIV status. However, the acceptability of the current ante-natal testing system is still in question. In many cases, women are not informed of the HIV test, and according to one source, some are even given treatment without being notified of their HIV status. Several women I spoke to found this unfair and would have liked to be notified of the procedure. However, there is concern that the HIV test is scaring some pregnant women away from ante-natal services. In Kwa

Punda, the majority of women do not go to the hospital for ante-natal care or delivery, reportedly because they fear being told their HIV status, among other reasons.

As for generalized routine testing in health facilities, as recommended by the World Health Organization, it is possible that, like ante-natal testing, it would scare people away from seeking other forms of health care. Kenyans have also expressed several other concerns about routine testing relating to the capacity of government hospitals to conduct such tests. In a recent survey in the Daily Nation about provider-initiated testing and counseling (30 September 2007), 30.4% of respondents said they were against implementing PITC while 69.6% said they agreed with it. The main arguments cited by those for PITC were that doctors are better informed about HIV treatments; that doctors can be better trusted than VCT counselors; and testing will reach more people. On the other hand, the main arguments against PITC were that hospitals are too congested; that doctors are not trained to be counselors; that VCTs are generally better equipped for testing; and that PITC would leave out the majority of Kenyans who do not visit doctors on any regular basis. We have yet to see whether routine PITC will really be pursued in Kenyan hospitals, but for now this is the most widely discussed prospect for universalizing HIV testing.

## CONCLUSION

Though my project has covered many diverse issues, the question that flows throughout is how to reach more people with testing and counseling services. The first section identified the psychological, socio-cultural and physical barriers that keep individuals from seeking VCT services, most notably fear of death and stigmatization. The second section explored the wide variety of existing VCT programs, revealing how different strategies have worked in synergy to reduce barriers and enable the recent progress in Mombasa district. The third section examined the case study of the 2007 HIV Testing Week, showing that existing strategies do have the capacity for even greater uptake of VCT, but that the challenges of maintaining quality and privacy must be considered. Finally, the last section examined the alternative strategies to reach trouble spots, finding that coercive means would be unacceptable but door-to-door methods might be promising.

Returning to the issues discussed in the introduction, my findings shed light on how the issues of stigma, poverty, and human rights relate to VCT uptake in Mombasa district. First, I found that HIV-related stigma is still significant in Mombasa, but more in certain pockets such as Kwa Punda. Self-stigma is a major barrier for uptake of VCT, which becomes evident as people from all over the district seek VCT services far from home. In order to counter this stigma, HIV testing and the virus itself must be normalized, and people made to understand that you can “live positively with HIV.” HIV Testing Week was a great step towards universalizing testing and thus reducing associated stigma.

As for the issue of poverty, I found that Mombasa has taken great strides to reduce this barrier by making VCT services free, and using mobile initiatives to make VCT accessible and less time-consuming. However, poverty is still an important issue in determining people’s interest in services like VCT. It is impossible to make people pay attention to health messages if they are, for instance, currently thinking about how to feed their children. Surely the dire poverty in Kwa Punda has contributed to the disinterest in outreach programs there. Victoria of Bomu Clinic provides the following advice: “make your initiative the last initiative,” or in other words address the community’s more urgent needs before trying to impose VCT services. Wilberforce of MYCC similarly noted that, while certain areas need more VCT outreach, they also need to be supplemented by income generating activities, for “us alone, we can’t do it.” Economic deprivation thus continues to be a hurdle for uptake of VCT and HIV prevention messages.

Thirdly, I found that the issue of human rights is a constant consideration when it comes to VCT. First, most people value the voluntary aspect of VCT and reject the idea of mandatory testing. Personal choice is necessary for people to be ready to receive their results and willing to change their behavior. Another human rights issue is confidentiality, which becomes a concern in large mobile sites, such as those of HIV Testing Week. With the continued presence of stigma, it is unfair to expose clients to the risk of having their results revealed to the public. The ultimate question is, how can more people be made aware of their status without imposing on the freedom and rights of individuals? This conundrum highlights the delicate balance that exists between public health goals and individual rights. In an ideal world, all people would come to know their HIV status and modify their behavior or seek care accordingly; AIDS deaths would drop sharply as would new HIV infections, and the HIV pandemic might truly approach a halt. However, if this

result required the widespread violation of human rights, it is questionable whether the end would justify the means. The way forward must optimize both public health goals and individual rights as best as possible, which is not an easy feat.

Finally, I would like to add my own realization that HIV testing and counseling is not all about the numbers. I came into this project with the simplified notion that the main issue at hand was getting people to the counseling and testing room – once inside, all would benefit. This is the assumption of many donors and NGOs, and the source of pressure on VCT providers to reach large numbers of people. However, it has become apparent through this project that it is not only a matter of getting people to VCT, it is getting them there in a prepared state, open and receptive to advice. Therefore, mobilization efforts should strive not only to attract large numbers of people, but also to sensitize them adequately so that they are truly ready to utilize VCT and resolute about their decision. Ultimately, VCT must stay true to its name, and whatever service providers and peer educators may do to encourage uptake, it will always revert to the individual to volunteer for the test.

## RECOMMENDATIONS

Here I will state my humble opinion about the future direction of HIV counseling and testing, and follow with recommendations for further research. Based on my project's findings, counseling and testing should continue in Kenya by non-coercive means. The capacity to "live positively with HIV" must be further advertised to quell people's fears of testing. Existing static and mobile VCT activities should continue to expand, but with continuous self-evaluation to maintain the quality of services. There should be a sustained effort to work VCT into people's schedules for convenience, extending static VCT hours and conducting frequent moonlight initiatives. Door-to-door sensitization should be attempted to educate people in their own homes and universalize testing, but most importantly, numbers should always remain a secondary priority to quality control. A final recommendation is not to Kenya but to the rest of the world, to commend Kenya for its contribution of innovative HIV testing and counseling strategies, and adopt these strategies accordingly. With a disease as complex and menacing as AIDS, there will always be problems, but Kenya has truly taken great steps in fighting the pandemic.

There are several topics that my project touched upon that I would have liked to pursue in more depth. If someone is interested in expanding upon this project, I recommend focusing on one of the following subjects:

- Door-to-door testing. Investigate the results of the pilot study known as Family Test Pack, conducted by Family Health International.
- Hospital-based testing, both routine and diagnostic. Are hospital staff overloaded? Do clients get adequate counseling?
- The role of religion in HIV prevention.
- Client satisfaction with mobile versus static VCT services.
- A follow-up on HIV Testing Week, and whether it had any long-term effects on VCT uptake.
- The provision by chemists of take-home HIV test kits.

Lastly, I feel very strongly about bringing HIV sensitization to the village of Kwa Punda. If I don't come back myself, I only pray that someone investigates the obstacles and attempts new strategies to reach that population. No community should be considered a lost cause.



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Appendix A  
The VCT Model (Horizons, 10)

VCT is the process by which a person undergoes counseling enabling him or her to cope with stress and make informed choices about HIV testing. Confidentiality of counseling sessions, test results, and the voluntary choice to test are emphasized.

