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# How to Bridge the Gap: An Analysis of the Coverage and Efficacy of Volunteer Counseling and Testing Centers in Suba District, Kenya

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**How to Bridge the Gap:**  
**An Analysis of the Coverage and Efficacy of Volunteer**  
**Counseling and Testing Centers in Suba District, Kenya**

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## **Abstract**

The Suba District of western Kenya is one of the areas most affected by the HIV/AIDS epidemic. According to Kenyan Ministry of Health publications, at the end of 2005, Suba District had an HIV/AIDS prevalence of 30%. This paper focuses on the numerous volunteer counseling and testing centers (VCTs) in Suba District that test and educate members of the community in effort to curb the spread of HIV/AIDS. Great efforts have been made to attack the problem of HIV/AIDS in Suba district. This paper seeks to illuminate the numerous factors that keep people in the community from seeking VCT center services as well as those that keep the VCT centers from reaching more people in the community. It is meant not to criticize the performance of the centers and their employees but rather to study the area of the community not being reached and how, according to community members and public health officials surveyed and interviewed, to best go about reaching these people. The term “VCT” is defined broadly in this study and includes centers funded by the government, non-governmental organizations (NGOs), and community based organizations (CBOs).

## Introduction

Since the first cases were documented in the early 1980's, the human immunodeficiency virus (HIV) and the resulting acquired immunodeficiency syndrome (AIDS) has led to the demise of millions of people across the world. HIV/AIDS has killed more people living in Sub-Saharan Africa than any other region in the world, and this trend continues today. The United Nations AIDS program (UNAIDS) estimated that at the end of 2005, Sub-Saharan Africa was the home to 25.8 million people living with HIV/AIDS—18.4 million more than South and South-East Asia (the region of the world with the next highest prevalence). Sub-Saharan Africa holds only 10% of the world's population and yet 64% of the people in the world living with HIV/AIDS live in Sub-Saharan Africa.

Not only are there more Sub-Saharan Africans living with HIV/AIDS than in any other region in the world, but the number of new infections in 2005 was also the highest there. In 2005 there were 3.2 million new, documented HIV infections in Sub-Saharan Africa making up 65% of those in the world. 77% of AIDS deaths in the world come from Sub-Saharan Africa, and in 2005 alone 2.4 million deaths were attributed to AIDS.

Like nearly every African nation, Kenya has been severely affected by the HIV/AIDS epidemic. At its highest point in 1997, Kenya had a national HIV/AIDS prevalence of adults aged 15-49 of about 9.5—12% prevalence in urban areas and 7% prevalence in rural areas. Today Kenya has a national prevalence of 6.7% (AIDS in Kenya 11). Prevalence seems to be decreasing, but the problem persists.

Prevalence statistics provide us with important information in general; however calculating a prevalence statistics is a complicated task. Such prevalence statistics in Kenya are calculated from antenatal clinics. Blood is routinely taken from mothers who come into the clinics to give birth. Numerous tests are performed on the blood, one of which is the HIV test. The data calculated from the clinics is then adjusted to estimate the national prevalence using population data from 2003. The studies are done in such clinics because it enables researchers and medical personnel to conduct the HIV test easily in conjunction with the routine blood work done when a mother gives birth. It is,

essentially, the easiest way to gather a statistic on HIV prevalence. The statistic, however, lends itself to confounding, for not all women (especially those in rural areas) give birth in clinics. A great deal of stigma and fear still surround VCT centers throughout Kenya which deter people from being tested and, thus, make calculating an accurate prevalence statistic exceedingly difficult if not impossible. The statistics, however, are calculated the same way throughout Kenya. So even though they may not be exactly accurate, they provide important information on changing trends of HIV/AIDS infections as well as a means to compare regions of the country.

While the national prevalence of HIV/AIDS in Kenya seems to be decreasing, the prevalence in the Nyanza Province of western Kenya greatly exceeds what Kenya's national average was at its worst in 1997. The Nyanza Province of western Kenya, which contains the districts of Bondo, Gucha, Homa Bay, Kisii Central, Kisii North, Kisumu, Kuria, Migori, Nyando, Rachuonyo, Siaya, and Suba, has consistently had a higher prevalence than the rest of the country. Nyanza had an HIV prevalence of 13.1% at the end of 2004, 4.1% higher than Nairobi, the province with the next highest prevalence in Kenya, and 6.4% higher than the national average (AIDS in Kenya 12).

Another variable that complicates the HIV/AIDS situation in many African countries including Kenya, is the traditional practices of the numerous tribes. Many tribes engage in traditional practices that have existed in their culture for generations. Some of these practices perpetuate the spread of HIV/AIDS. One such practice is of the Luo tribe in the Nyanza province. When a husband dies, it is tradition that his wife (or wives, as the Luo are a polygamous people) be "inherited" by the husband's brother. If no brother is available, another male family member "inherits" the wife into his family. The union of inheritance is traditionally consummated by sexual intercourse. In the last decade, an increasing number of deaths are caused by HIV/AIDS and, thus, the practice of wife inheritance spreads HIV to the male family member who inherits the widowed wife.

While HIV can be spread through many means—intravenous drug use, homosexual sex, blood transfusions wherein the donor blood is infected with HIV/AIDS, sharing of sharp

objects that can potential draw blood, and others—heterosexual sex is “...the primary mode of HIV infection worldwide” (Davis and Weller 272). The issue of sex in Kenya is, however, a very complicated one, and numerous economic and cultural issues deeply rooted in Kenya feed the complexity. Tribal practices, poverty, the rural/urban dichotomy, lack of access to medical facilities for many, and a host of other factors contribute to the struggle Kenya has faced in combating the epidemic. The Kenyan Ministry of Health instituted an AIDS Control Committee in 1987. The committee developed a five-year plan for AIDS control from 1987-1991. Another such plan was developed in 1992 and lasted until the end of 1996. Soon after the AIDS Control Committee was created, a National AIDS Control Council was developed which placed AIDS control units (ACUs) throughout all the ministries in Kenya in order gauge the magnitude of the epidemic. The ACUs’ placement and subsequent findings led to increased governmental support, and in 1999 President Moi declared AIDS a national disaster. Moi’s successor, President Kibaki, followed in Moi’s footsteps and declared a “total war on AIDS” as one of his first acts as president of Kenya (AIDS in Kenya 2-3).

In addition to domestic assistance, the fight against AIDS has received a great deal of foreign interest. The United Nations Assembly Special Session on AIDS (UNGASS) has led to financial support from the World Bank Multicountry AIDS Project (MAP), the Global Fund for AIDS, TB, and Malaria (GFATM), the United States President’s Emergency Plan for AIDS Relief (PEPFAR), and the World Health Organization’s three by five initiative to provide three million ARVs to three million Africans by 2005 (AIDS in Kenya 2-3).

Through foreign money and increased interest in the epidemic, the Kenyan government has implemented numerous programs throughout Kenya. The programs include the improvement of HIV-related health services as well as more widespread placement and access to VCTs. The government has also made an effort to make access to Anti-Retroviral medications (ARVs) more widely accessible and at a more reasonable price. Price reductions on ARVs were helped greatly by the Industrial Properties Act of 2002 which removed legal barriers on importing generic ARVs thus lowering the price (AIDS



in Kenya 2-3). Access to ARVs, however, remains sporadic, and for the large number of Kenyans who live below the poverty line, even a greatly reduced price for ARVs is out of their reach.

Lack of universal access to ARVs has caused the annual death rate of Kenyans with AIDS to increase. Those who were infected in the mid and late 1990's are without access to ARVs and, in 2006, are now facing death. On average 150,000 Kenyans die annually from opportunistic infections caused by AIDS, and the average is growing. The national HIV/AIDS prevalence in Kenya is decreasing, but in addition to improved awareness and preventative behavior, a major reason the prevalence is decreasing is simply because more Kenyans are dying of AIDS now than they have ever before. The number of people living with AIDS decreases as the number of people dying from AIDS increases (AIDS in Kenya 2-3).

Volunteer Counseling and Testing centers (VCTs) are a powerful tool in the fight against HIV/AIDS in Kenya. Each year more of them are built in Kenya and more counselors are trained. In 2000, there were only 3 registered VCT centers in Kenya whose counselors saw annually 1000 clients. In 2005, there were 555 VCT centers whose counselors saw over 380,000 clients (AIDS in Kenya 3-4). Clearly the number of VCTs is increasing and more people are becoming wise to the benefits of being tested. However, a new problem is developing surrounding VCTs. More and more people are deterred from being tested due to an ever-growing stigma surrounding the centers. Stigma has always been a problem surrounding HIV+ people, be it felt internally or externally enacted by the community, and the stigma of HIV seems to have projected itself onto the site where one learns his or her status.

The VCT center plays an integral part in the fight against HIV/AIDS, as "...studies in developing countries support the effectiveness of HIV VCT for risk reduction, especially for couples" (Kamenga et. al. 5). The VCT counselor is in an extremely influential position in the community. He/She is the first person a client sees after receiving an HIV+ diagnosis and, so, can have an enormous influence on how the client accepts and

cope with the results. Often times in developing countries, access to ARV treatment is sparse, but Kamenga et. al. has found that “even when HIV treatment is not readily available...HIV VCT provides an opportunity for education and behavior change, and knowledge of serostatus allows individuals to plan, make important life decisions, and seek care and support” (5).

For several years Kenya has had the ABC policy of preventing the spread of HIV/AIDS—“A” for abstinence, “B” for Be faithful to one partner, and “C” for condom use. A recent addition to the policy is “D” for diagnosis: know your status. The movement towards increasing the amount of people who are tested is gaining momentum, but there are several factors that hinder the desire to know one’s status.

This research project was initially intending to study the efficacy of VCT counselors in the Suba district of the Nyanza Province in western Kenya. After a few days in the field, however, it was found that the greater issue was not the performance of the VCT counselors, but rather the gap between the counselors and the high-risk community. That is, the real issue was that a great deal of people in the community knew very little about VCT centers, had misconceptions about VCTs, and simply were afraid of VCTs. It soon became clear that the misconceptions, lack of education, and stigma surrounding VCTs and HIV/AIDS in general were major factors keeping so many members of the community from knowing their status. In a South African study performed by Maclean in 2004, it was found that “...people [who were not tested] were not ignorant to the benefits of being tested but rather were deterred by fear of social stigmatization.” (103) The factors keeping people from the VCTs are extremely difficult ones to combat.

Through formal surveys and informal interviews with members of the “high risk” community (mainly fishermen) I gathered information about ideas surrounding sex, condom use, VCT centers, HIV/AIDS, and behavior change in order to develop a multilateral understanding of why people do not get tested. I also asked this population what they thought VCT counselors and VCT administrators could do to get more people (such as themselves) tested. I also questioned numerous members of the community in

less “high risk” professions such as teachers, community health workers, Non-governmental organization (NGO) representatives, community-based organization (CBO) representatives, and United States Peace Corps volunteers stationed in Suba district about their perceptions as to why people do not get tested and what VCT counselors and VCT administrators can do to get more people tested in the community.

Voluntary counseling and testing centers are extremely important places. The work that is done there is a key factor in the fight against the spread of HIV/AIDS. However, no matter how important an organization is, if it does not effectively reach the clients it is targeting, it is useless. This paper seeks to illuminate some of the factors that keep VCT services from reaching members of the community. Ideally it will be used in conjunction with other researchers and medical personnel to help foster discussion on the issue of VCT coverage in effort to more effectively reach members of the Suba district community.

## The Setting

My research took place in the Suba district which is in the Nyanza province of western Kenya. According to the district public health office statistics, in 2005 Suba district has a population 184,796 and maintains an annual growth rate of 2.9%. 46% of the population is between the ages of 15 and 45, and 20% is between the ages of one and five, with 4.5% being below age 1.

30% of those within the reproductive age in Suba are HIV+. This prevalence, consistently the highest in Kenya, has drastically reduced the life expectancy of those living in Suba district. Women live an average of 42 years with men falling behind them living only 36.5 years.

Suba district is situated directly on Lake Victoria. The district's location makes fishing a major source of income for many men who live there. Great numbers of Tilapia, Nile Perch, and Omena are fished from the lake every day. The fishing industry in Suba district is a fast paced one. The fishermen are constantly moving around the lake to fish. They also make stops at the numerous islands in Suba to sell and trade fish. The fishermen in Suba district are a very dynamic population.

Another important trait of Suba district is its tribal make up. The vast majority of those living in Suba district are of the Luo tribe. The Luo people, as noted in the Introduction, are a polygamous people who practice wife inheritance. Traditionally, many sacred acts, ceremonies, and celebrations are consummated by sex. While this practice may have been a harmless part of Luo culture in the past, today it is a factor that perpetuates the spread of HIV/AIDS.

Yet another important factor about Suba district is the existence (just as in many places in Kenya and around the world) of commercial sex workers. The dynamic of commercial sex workers in Suba district is different than in other parts of Kenya, however. Many of the commercial sex workers in Suba are widows. Women in Suba are more often than not housewives who remain in the home while the husband works and are, thus,

economically dependent on their husbands. When the husbands die, however, the women are thrust into a dire situation. Many women try to find work selling vegetables and crafts while many, unfortunately, are forced turn to commercial sex work to sustain themselves and their families. Commercial sex work is done differently in Suba than in Nairobi for instance. Many commercial sex workers in Suba trade sex for fish with the fishermen, as they do not have enough money to purchase the fish. This practice of trading sex for fish is called *jiboya* in Dholuo, the native language of the Luo tribe that dominate Suba district. The women take the fish and sell it the next day to make money to support themselves and their families.

The dynamic population of the fishermen and their often care-free, promiscuous behavior coupled with Luo traditions surrounding sex and the numerous commercial sex workers make Suba district a prime place for the spread of HIV/AIDS. And, as prevalence statistics have continued to show, Suba district is exactly that.

## Methodology

Data was collected for this study in two ways: through formal surveys and informal interviews both with community members and public health officials. Two surveys were used for this project. The longer survey asked about the efficacy of VCT counselors in promoting behavior change, encouraging positive living, and helping the client to cope with issues related to felt (internal) and enacted (external) stigma. The second survey asked only one question about how to get more members of the community to attend VCT centers in order to get tested for HIV.

The first and more extensive survey was delivered to VCT counselors throughout Suba district. The counselors were instructed to give the survey to their clients after they had given the client an HIV test and the subsequent counseling. The counselors were told to translate the questions in the survey to the language that the client was most comfortable with but to insist that the client fill out the survey him or herself in any of the three dominant languages in the district—English, Kiswahili, or Dholuo. Only if the client was unable to write was the counselor allowed to transcribe the client's answers to the questions. Eight surveys were handed out to eight counselors from eight different VCT centers in Suba district. Of the 64 surveys handed out, a total of 30 were completed and returned from five of the VCTs<sup>1</sup>

The second survey, which asked only one question was distributed to four VCTs as well as numerous members of the community including fishermen, fish-mongers (women buying and selling fish), teachers, hotel employees, manual laborers, HIV+ support group members, and public health officials. Of the 50, one-question surveys distributed, 34 were completed and returned<sup>2</sup>.

Data was also collected through formal and informal interviews with members of the community and public health officials. Groups of fishermen were interviewed informally about their beliefs surrounding condom use, VCT centers, getting tested for HIV,

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<sup>1</sup> See appendices for a copy of the survey

<sup>2</sup> See appendices for a copy of the survey

knowledge of HIV and how it is transmitted, sexual promiscuity, and reasons why many of them had not been tested. One group of about 20 fishermen was interviewed in the evening at a weigh station close to town center in Mbita. One slightly smaller group of fishermen was interviewed on Koguna beach in Nyamanga village of Mbita, Kenya. A third group of fishermen was interviewed at a small beach on Rusinga Island located just after crossing the causeway from Mbita. Other informal interviews were conducted with various members of the community (kiosk owners, repairmen, *boda-boda* drivers, etc.)

Formal interviews were conducted with two public health officers in Mbita, 5 VCT counselors in Mbita, one doctor at a clinic in Mbita, one chairperson from a prominent community based organization (CBO) in Mbita, and two United States Peace Corps volunteers stationed in Suba and Kisumu respectively.

In order to protect the privacy of those who participated in this study the names of the clients who filled out the VCT surveys, community members who filled out the one-question survey, and the officials who were interviewed will not be included in the discussion and analysis portion of the paper. Rather, the information gathered from the surveys and interviews will be synthesized to make a fluid discussion.

## Discussion and Analysis

Providing adequate HIV/AIDS care in an impoverished area such as the Suba district is a very difficult task. Nearly all funding must come from outside sources, as the vast majority of those who live in the Suba district cannot afford to pay for health care themselves—many living below Kenya's poverty line. Central and local governments must financially contribute to health care, but numerous factors keep funding from reaching all the people it is needed for. Outside funds from non-governmental organizations (NGOs) and those community-based organizations (CBOs) funded by foreign donors contribute a great deal to the fight against HIV/AIDS in the Suba district, and yet the prevalence in the Suba district continues to soar above Kenya's national average.

The reasons for this discrepancy between Suba and the rest of Kenya are numerous, complex, interconnected and many remain undiscovered. They exist because of misconceptions about issues directly related, indirectly related and, seemingly, unrelated to HIV/AIDS itself. The vast majority of the misconceptions described below come from fishing villages around Suba. These misconceptions lead to risky behavior and failure to seek out VCT services which, in turn, lead to the spread of HIV/AIDS.

The initial intent of this research project was to assess the efficacy of VCT counselors in the Suba district. The data retrieved from this portion of the project<sup>3</sup> showed that clients who visited counselors were overwhelming happy with the counseling session and 100% reported being motivated to change their behavior<sup>4</sup>. The counselors assessed in Suba district were well trained and their clients spoke highly of them. Having these counselors reach more of the community is how effective change can be made.

The fishermen in these villages (with whom the many of the interviews were conducted) lack a great deal of basic education about HIV/AIDS, condom use, and VCT services. While a great deal of data assessing the HIV/AIDS prevalence of this population is

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<sup>3</sup> See Graphs A-J

<sup>4</sup> Survey given upon exiting the VCT and no follow up analysis on actual behavior change was done



unavailable (as the majority have never been tested) most Suba district public health officers, local NGO representatives, and locals believe the fishing community is a major spreader of HIV in the Suba district. One fisherman in a rural village, speaking for himself and his fellow fishermen nearby, admitted that “fishermen don’t have good, moral behavior.” He went on to explain how sex to him was a bit of a solution to boredom, “after fishing there’s nothing to do—no TV, no clubs—the only thing to do to relax your brain is to have sex...The widows in the area (majority of whom lost their husbands to HIV/AIDS and are most assuredly HIV+ themselves) are the ones available.” A study conducted in November and December of 2005 by Emma Llewellyn of Merlin, a prominent NGO based in Suba, supports this claim:

“The key economic activity in [Suba] is fishing, a seasonal activity which leads to population movement within and from the beaches...The beach culture is characterized by widespread commercial, casual and transactional sex because the high turnover of cash transactions from the fishing industry attracts many people in search of work. Often these are widows and widowers whose spouses have died from AIDS related illnesses” (7).

The following sections will first outline myths believed by this community. They will then detail several factors found to keep VCT services from effectively reaching a broader proportion of the Suba district population.

#### *Myths/Misconceptions about Condom Use*

Condoms are potentially life saving tool in area like Suba so devastated by HIV/AIDS. They are 91.2% effective in preventing HIV transmission (Davis and Weller 274). Despite the fact that they serve as a powerful way to prevent the spread of HIV/AIDS, a great deal of controversy surrounds them—keeping many from using them. In a study conducted in the Nyanza province in June 2005, 26% of adult women sampled, 51% of adult men, and 52% of youths admitted to having ever used a condom (HIV/AIDS Data Book).

The most common myth expressed from the community interviewed that keep them from using condoms dealt with the condom's effectiveness. Nearly every fisherman expressed his belief in the existence of miniature, invisible holes in the condoms that render them useless. When asked about where the holes came from, they explained how no one maliciously poked holes in the condoms. They felt that condoms were an inherently flawed product that did not protect them from HIV/AIDS and were, of course, useless during sexual intercourse.

The other major criticism surrounding condoms was about the "oil" (lubricant) on the condom. Many fishermen believed that the oil would enter the woman's body during intercourse and make her violently ill. Others believed that the oil would lead to lacerations and rashes on the penis after using the condom. A third group felt that the oil *itself* was responsible for the spread of HIV/AIDS. While the latter notion was expressed by the fewest number of interviewees, it did represent a sizeable proportion of the whole sample of interviewees.

The men also expressed confusion over the number of condom brands available as well as the price being too high (they were unaware that VCT centers provide them free of charge). Several men brought up the issue of stigma. They explained how they will not buy condoms (or use them) because if a man is seen purchasing a condom in a store he is automatically assumed to be having sex with an HIV+ woman and will thus be stigmatized for his relationship.

Simply the lack of knowledge about how to use a condom was a factor for several men. Several of the fishermen were uneducated and could not read English or Kiswahili (the languages that the instructions for the condoms are in). Even if he had a condom, one fisherman explained in Dholuo through a translator, he would not know how to use it nor could he read the instructions.

The final reason that kept people from using condoms was religiously influenced. Many men simply felt that condoms were bad because the church had told them that condoms are bad. However, when asked about what else the church teachers about matters pertaining to sexual relations, the majority was unable to answer. The fishermen interviewed are only aware of half of the message the church. They hear and internalize the “do not use condoms” part of the teaching, but they forget the teaching about abstaining from sex until marriage—a very dangerous message to forget if one chooses not to use condoms.

#### *Myths/Misconceptions about HIV/AIDS*

A very important concept in Luo culture is that of *chira*. *Chira* is an illness that befalls someone for numerous reasons. Many of the reasons that one falls sick with *chira* have to do with issues of marriage. For example, if a younger brother gets married before the eldest brother, the younger brother will get *chira*, or if a wife refuses to be inherited, she will get *chira*. Other ways to get *chira* simply have to do with behaving in a manner that is against society’s norms. The symptoms of *chira* are very general symptoms such as headache, thinning of the body, aching joints, and swelling. When the HIV/AIDS epidemic began to hit Kenya, many Luo believed that HIV/AIDS was, actually, *chira*. Many people did not acknowledge the existence of HIV/AIDS, and if they did they would always think an illness was *chira* before they thought it was HIV/AIDS. While today the notion is falling out of favor, many people in Suba district still believe that *chira* and HIV/AIDS are the same illness. In an interview with officials from the Suba district public health office in Mbita town, they explained that they officially recognize the existence of *chira* in the community, but work to educate the population about the difference between *chira* and HIV/AIDS.

The notion that having sex with a virgin or a small girl can cure one of HIV/AIDS is certainly not a mainstream belief, however, it exists in pockets throughout the community. In a study conducted in 2005, 4.5% of the men and 1.3% of the women believed this to be true while 6.7% of men and 19.6% of the women in the sample admitted to not knowing if having sex with a virgin or a young girl cured one of

HIV/AIDS (Llewellyn 23). While the percentage of those who believe this practice to be true is small, it is clear that a sizeable portion of the population is confused as to the benefits of the act. The same study also found 27.8% of the men and 47.3% of the women to believe a mosquito bite can transmit HIV/AIDS.

### *Reasons Why People Do Not Get Tested for HIV*

Understanding why members of the community do not seek out VCT services is very important in the assessment of VCT centers. It is important to fully understand the ideas and misconceptions people have about VCTs so that counselors and VCT staff have a better understanding of what they can do to reach more people. While some of the beliefs expressed are simply misconceptions about VCT centers, many delve into deeper, social and economical issues that plague communities in Suba district and make expanding the coverage of VCTs very difficult.

A major issue described by members of the community that has kept them away from VCTs was fear—fear of the notion of the VCT in general as well as fear of what goes on within the facilities. A fisherman in a rural village on the outskirts of Mbita town speaking for a group explained how he felt the counselors at VCTs would tell people in the community the status of the client as soon as he/she leaves the VCT center. “There is no secret between only two people,” he declared. Several of the men standing behind him nodded their heads in agreement. His fear of disclosure to the community kept him from seeking a test.

The fear of death is another fear brought up by many. “I fear knowing my days are numbered,” admitted another man in the group being interviewed. The majority of community members interviewed felt that receiving an HIV+ diagnosis at a VCT meant one would die shortly after. Whereas not knowing one’s status allowed life to continue just as it was before and was seen by most to be a better option. Another fear is that VCTs actually *cause* HIV/AIDS. The sight of people going into a VCT and then leave

knowing they are HIV+ has perpetuated the spread of this belief throughout the uneducated community.

The issue of fear among women is an entirely different concept. HIV+ women at a self-help meeting at the Akado Women's Group in Suba district were asked why people do not get tested for HIV/AIDS in the community. They, too, brought up the issue of fear, but they described fear of being abandoned by their families and husbands that would ultimately lead to their worst fear—losing their children. Women are afraid to get tested because they do not have the ability to speak out. One woman explained that if a woman in her village was found to be HIV+ and knew it was from her husband, she would not speak up. The woman's husband would undoubtedly blame her for being unfaithful—even if he knew that he was the one who was unfaithful. The reality for the women—where speaking up about one's sero-status can have extremely harmful repercussions—serves as a huge deterrent for seeking VCT services.

Another major fear expressed by both men and women was the fear of being stigmatized by the community. HIV/AIDS has an enormous stigma attached to it in the Suba district, and people fear what such a stigma will bring them and, so, are discouraged from being tested.

A United States Peace Corps volunteer and certified VCT counselor stationed in Suba whose project focuses on reducing the stigma surrounding VCTs has encountered all of the aforementioned reasons for people not getting tested. He also explained in the interview that another major concern of people he has interviewed over the course of a year and a half is a fear that their names will be taken when they go to a VCT and then given to the government. Many think the government will then “mark” the names of those who test HIV+ and watch them in the future.

Still other fishermen expressed concern of knowledge of the status in general. One man described a mental struggle he went through without even being tested. “My mind went

back and forth between thinking I was negative and positive...I couldn't take it." He was never tested despite working less than one kilometer from the district VCT.

Another category of reasons for not being tested for HIV/AIDS at a VCT is lack of knowledge about the VCT itself. At a fish *banda* (location where fishermen weigh their fish to then be shipped off or sold locally) less than one half of a kilometer from two separate VCT centers in Mbita town, many fishermen claimed not knowing where VCTs are. In a study conducted in 2005 in the Nyanza Province, 57% of the 293 adult women sampled and 55% of the 294 adult men sampled did not know the location of a VCT center. 59% of the 304 youths sampled (age 15-24) did not know the location of a VCT (HIV/AIDS Data Book). Others admitted knowing where the VCTs were located but not know how to go about getting a test performed. Many men said they did not go to VCTs because they did not want to spend the money (they were unaware that all of the services and condoms at VCTs are provided free of charge). And finally, those who knew where a VCT was and how to get tested still refused to go, for if they were tested positive they felt that the drugs they would need to take would be too expensive. Essentially, they felt there was no reason to know one's status if there was nothing he could do about it. The notion that knowing one's status can help prevent the spread of HIV/AIDS and (if no drugs are available) one can learn about ways to lead a healthier life to prolong death as long as possible does not seem to exist in these communities. These men were unaware that it is possible to receive free ARV medication in Suba district.

A relatively small group of interviewees from several villages expressed a very angry sentiment about the notion of being tested. "If I get tested and am positive," one man admitted, "I am going to want to infect as many people as I can so that I will not die alone." While knowledge of one's status is an important first step in curbing the spread of HIV, men who possess such anger and resentment pose a large threat to the effort to stop the spread of HIV/AIDS.

Unemployment and the resulting poverty are major issues in Kenya, and the Suba district is no exception. Being a fisherman in Suba is a very good job—steady money and a relatively stable market. The fishermen interviewed realized they had a good job and

needed to do all they could to keep it. Many said they would not go to a VCT because they could not take the time out of their schedule to go and get tested (nearly everyone was unaware that a test can be completed in only one half hour). Many admitted to being more concerned with making money than with finding out their status. Money was hard to come by, they explained, and it was not something they were willing to part with. As a result, they were not interested in going to a VCT.

Fishermen make a great deal more per day than the average person in Suba. In an interview, the organizer of a major CBO in Mbita town said that poverty was the major barrier between the community and the VCT. “People are too busy searching for money to buy a bit of food and to pay for their child’s school fees...there is no time to make it to a VCT,” she explained. A teacher at an orphanage on Rusinga Island also commented on poverty being a major issue—specifically hunger. She said, “many people are too weak and hungry to walk the distance to a VCT, so they are never tested.”

#### *How to Get More People in the Community Tested*

It is imperative to understand the factors (aforementioned) that keep members of the community from seeking an HIV test at a VCT. The factors are related to tribal, economic, psychological, and educational issues that penetrate deeply into the community.

In addition to assessing the factors which keep individuals from going to a VCT, a major portion of this research project was spent gathering ideas from members of the community (both professional and non-professional) about what VCT counselors can do to get more people in the community tested for HIV/AIDS.

The surveys given both to clients after visiting a counseling session at a VCT as well as members of the community completely unrelated to the VCT revealed that the most important things a VCT counselor could do to reach more members of the community were bring the services to the community so that they do not need to go to a VCT and educate the rural community about VCTs and HIV/AIDS. The two answers made up

47% of all the responses collected (23.5% each). At a village interview on Rusinga Island in Suba, several villagers said that VCT counselors “holding seminars” in more rural villages wherein they talk about HIV/AIDS and VCT services would be extremely helpful. In an interview with three VCT counselors and a doctor stationed at a VCT in Suba, they agreed that mobilization of VCTs is an extremely effective way to reach the community.

The doctor also discussed “continuous mobilization.” Empowering the people who visit the VCTs (especially those who are HIV+, as they are in a very influential role in the community if they choose to use it) to speak to their communities about the benefits of being tested. This “continuous mobilization,” he explained will reach greater expanses of Suba and, if effective, will penetrate more deeply than any mobile VCT clinic could. Members of the HIV+ self help group at the Akado women’s group in Suba agree with the concept of continuous mobilization and make an effort to make change in their communities—especially amongst the high risk female population.

VCT participants [can] influence how individuals respond to the program. They may, for example, make people more receptive to the behavior change messages they hear in counseling. People may be more willing to test or change behavior even without testing if they see that others around them are doing so. As VCT attains broader coverage, such interactions or spillover effects will become more prevalent. (Glick 341)

The women also brought up an interesting concept pertaining to the effect ARVs have on a person. “People see the body of a sick person changing and getting better...” one woman explained. “When people see someone getting better because of ARVs, it is important to use that momentum and to then talk to people about getting tested.” Upon completing counseling session, counselors ought to put great emphasis on the importance of continuous mobilization—empowering the client to enter the community as a confident HIV+ individual and educate and destigmatize. There is only so much a person can do from the outside penetrating in, but a person who is already an integrated part of the community can bring about a great deal of effective change so long as he/she has the confidence and proper education.



According to several counselors and a secondary school teacher, the health curriculum in schools is severely lacking in issues pertaining to HIV/AIDS and sexual health. Sexual health programs implemented in schools in Uganda geared towards HIV/AIDS awareness, sexuality, and health issues showed a drastic reduction in sexual activity amongst teens. Before the program was implemented, the sample group of students (average age 14) had 42.9% sexual activity. After the program that percentage fell to 11.1% (*Innovative Approaches to HIV Prevention*). In Kenya, there used to be a course taught on such matters, explained the teacher, but it was removed. The ministry of education opted to remove the course from the curriculum because he felt the information should be incorporated into all of the subjects. “This doesn’t happen...” the teacher revealed, “...so many teachers don’t like talking about the subject with the students so they just ignore it. The kids have nowhere to get the information.” “When kids leave school,” a VCT counselor admitted, “they have no idea about HIV/AIDS and other STIs (sexually transmitted infections).” Issues relating to sex and relationships are traditional not discussed in Kenyan households. So when the official curriculum was removed on the matter, and teachers were expected to bring it up in other courses, many simply did not discuss it.

An officer at the Mbita constituency AIDS control office brought up an idea similar to the notion of empowering HIV+ individuals to speak out about getting tested for HIV/AIDS. He described what he called “family” empowerment. “When a mother is tested at an ANC (antenatal clinic) for HIV, she needs to return home and encourage her whole family to be tested.” He also stressed the importance, as did many VCT counselors, Peace Corps volunteers, and members of the community, in training and educating prominent members of the community influence (be it local celebrities, radio personalities, or politicians) and elders to speak about HIV/AIDS. People with a large span of influence can have a profound effect on the way people think about HIV/AIDS in a community with such a problem.

The next most common answer on the survey, making up 20.6% of the responses, was the suggestion that the counselor should maintain confidentiality. This answer is very revealing, as it shows how little the community understands about the services provided at a VCT. Confidentiality is one of the first topics discussed in a counseling session. The client is given an identification card so that his/her name will never be used. All of these precautions are taken and yet over 20% of the sampled community felt that the maintaining of confidentiality was something counselors could do to increase the likelihood of people seeking out VCT services. In an interview in Kisumu, a Peace Corps volunteer described how the organization he works for in Suba district wants to rotate all the counselors in shifts. This will, he feels, help reduce fear about revealing personal information to the same person again and again. If the community feels the counselor is only a temporary part of the community, the fear of revealing information to the community will, he hopes, dissipate.

The issue of confidentiality and misconceptions ties into what Peter Glick in his 2005 paper discusses as “cost” as it relates to the expansion of VCT centers. He writes:

The expansion of coverage under consideration may involve greater incentives or reduced costs, broadly defined. These can include not just lower financial costs...but also publicity campaigns to familiarize the population with VCT, to reduce fears or misconceptions about testing, and to address issues of stigma surrounding testing and a positive test result. When VCT is still rare, the psychological or social barriers to its use may be quite significant, and the measure just described may reduce these costs, raising the acceptability of the program (338).

Another suggestion (14.7% of the total) was that VCTs should offer incentives for being tested. Most people, interestingly, did not suggest money as an incentive, but rather food or drink (chai). The last major group of responses (11.7%) suggested that VCTs employ a more aggressive advertising strategy. Several people suggested using the radio as a means to educate greater numbers of people in the Suba district (radio is a hugely popular means of communication in the Suba district). Others suggested sign posts and posters in

the more rural areas to familiarize the community with the VCT and information on HIV/AIDS. VCT counselors in an interviewed agreed about strengthening advertising campaigns as a means to “reach the large pockets of the community not being reached as of now.” They stressed the power of the radio in this area as nearly everyone listens to a radio and the high-risk fishermen often bring radios with them on the boat while fishing.

*Analysis of Factors Found that Hinder Widespread HIV Testing*

It is extremely difficult to assess all of the factors that keep VCT services from reaching the more than 180,000 people in the Suba district. The topography of the region itself is an enormous limiting factor, as much of the population is found on numerous islands in Lake Victoria. However, the community and several NGO, CBO, and public health officials expressed numerous limiting factors keeping more people from being reached in the district.

The HIV/AIDS prevalence statistics coming out of the Suba district are very striking. Because the area is hit so hard and because the prevalence statistics are staying very high, there has been a huge amount of NGO and CBO aid poured into the area. The aid is a very good thing of course; however, without proper communication between the organizations, their services can only go so far.

In a document published by family health international in 2002, it says:

The success of VCT services depends on partnerships among the various organizations working in a community to ensure community support, public awareness, and high quality, comprehensive services...[not doing this] undermines the potential impact of VCT services for both HIV prevention and HIV care and mitigation (5).

The comprehensiveness of the services in Suba is negatively affected by the lack of communication between the CBOs and NGOs. According to documents from the district public health office, as of December 2005 the Mbita constituency alone had 80 registered CBOs dealing with HIV/AIDS issues and Suba had 12 major NGOs. A VCT counselor recalled a day when three CBOs and NGOs arrived at the same location at the same time

to perform the same services. Clearly all three organizations were not needed at the same site, and had the groups spoken to one another, two groups could have been testing two separate communities that same day.

Every CBO, according to the Mbita constituency AIDS control officer, is supposed to report to the main office in Mbita twice a year. At this meeting it is expected that the CBO representative will deliver plans for the next six months as well as a report on what had been done for the 6 months prior. The CBO representatives, however, rarely report to the office and their work and plans go unregistered.

It is difficult to keep track of over 82 organizations in a place like Suba where internet and phone access is sketchy at best. However, it is exceedingly important that a meeting be held wherein the vast majority of NGOs and CBOs are represented. In this meeting the entire district should be divided up between the organizations. Not just the land, however, but also the types of people within each area. For example, one CBO should be in charge of X-number of villages on Rusinga Island and in those villages they are responsible for educating and testing the adult men. Another organization will be in charge of the women in that region and still another the youth. This way the methods used to educate can be specifically tailored to the demographic of interest. All of Suba district should be divided in this way, and the organizations should meet biannually to discuss the progress in the region. At these meetings the representatives can share ideas on what is and is not working in order to return to the defined district and more efficiently educate and test. Without elaborate networking and frequent communication, the CBOs and NGOs in Suba district are only accomplishing half of what they could be.

Another issue surrounding NGOs and CBOs is that of funding. The vast majority of the organizations in Suba district are funded by companies, countries, and investors that are located abroad. The life of the NGO/CBO and the livelihood of its employees depend on the donations from investors abroad. This situation can lead to a fixation on numbers and statistics. That is, in order to satisfy the investors, sometimes NGOs and CBOs will perform services to gather statistics that are helpful to the community, but not as helpful

as they could be. An example of this situation given by two long-term NGO volunteers in Suba district had to do with counseling. They had witnessed a mobile VCT wherein the counselor was counseling about 10 people in the same room at the same time. Given, each person was effectively tested for HIV/AIDS, but the counseling services provided were most certainly below average. A room full of 9 strangers is not an environment conducive to sharing intimate fears, anxieties, and questions. The reason for this type of counseling session was so when the mobile VCT returned the location it could report to its donors that a very high number of people were tested for HIV/AIDS. Had the group sessions not happened, certainly fewer people would have been tested, but counseling would have been done properly and, perhaps, more effectively influenced clients to change their behavior.

Combating this issue can only be done from the top levels of the organizations. It is reality that statistics catch people's attention. In publications they are easy to read and look very organized and impressive. However, the issue of HIV/AIDS is very complex one and sometimes the quantity of those being tested does not matter nearly as much as the quality of the services. NGO donors must realize that the delivery of statistics is not the most important part of their investment. Not only can statistics be extremely misleading if the reader does not possess adequate knowledge of how to read them, but fixation on statistics can drastically shift the focus away from where it should be—on the quality and efficacy of the services.

Representatives from NGOs abroad visit the site where their organizations money is being spent. However, many counselors and health officials expressed concern over the fact that the representatives do not remain at the site for a long enough time, stay far away from the site (in Suba people say that representatives often remain in Kisumu during site visits—at least a two hour drive away), and do not get a true idea of what is happening on the ground. It is important that representatives be prepared to spend an extended amount of time on the ground so as to leave with an accurate impression of how the NGO is functioning. It takes at least several days to begin to understand the inner workings of an organization on the ground. Extending the stay of representatives can

both help them deliver accurate details to the donors abroad and, perhaps, help them realize the importance of quality over quantity in the delivery of HIV/AIDS health services.

Money is an issue that seeps into every issue surrounding the fight against HIV/AIDS. Simply, without money, reaching large numbers of people is extremely difficult. Donor money from abroad comes into Suba district, but, according to the director of a prominent CBO in Suba, the money is often mismanaged. “People just aren’t educated in business and accounting,” she admitted. “Lack of education leads to mismanagement of the money...so some are forced to hire an accountant to handle the money which costs a great deal.” Other groups, she added, simply do not hire an accountant in order to save money and end up mismanaging it. Money quickly runs out because it is spent when it should not be and forced to be thinly spread across many areas. This mismanagement of funds coupled with pressure to produce statistics about what the money has been spent on leads to an organization reaching less people less effectively than had it managed money properly.

The donors should be more active, advises the CBO organizer, in managing the funds donated. Rather than just collecting reports on where the money is spent, a representative with knowledge on such matters should be stationed in Suba at the onset of the organization. Money can be managed and planned at first by NGO representatives, and local organizers can be taught basic management skills. Taking this step will help save some money from being mismanaged as well as save money from being spent on an accountant.

The top suggestion from the community about what VCT counselors can do to have more people tested for HIV was mobilization of services. Mobile clinics to the neighboring islands and to distant rural sites are extremely important but also extremely expensive. While great sums of money should be spent on such services, as these are the communities in highest need, mobile clinics do not always need to be far away from VCTs. In a group interview with over 20 fishermen at a banda just meters from two

major VCT centers in Mbita town, it was discovered that none of the men had been tested. Not only that, but once they were informed about the VCT centers locations, they still admitted a lack of desire to be tested. After being asked if they would be tested if the services were brought to them, they all agreed that if they could remain at the banda near their fish and boats, they would all get tested for HIV. The next morning, a local VCT counselor from the nearby youth friendly VCT center brought supplies to the lakeshore and began testing. Over 20 fishermen arrived to be tested, but unfortunately due to time constraints only 6 were tested.

A full mobile clinic with several counselors and HIV testing kits just meters from a VCT will be free. Such local, mobile clinics can lead to the testing of countless people who would never have been tested otherwise. From the experience that day on the shore, it is clear that such local mobilization needs to occur more frequently. Just as CBOs and NGOs need to have more frequent, organized communication, it seems in Suba the same holds true for the more than 14 VCTs. VCTs should speak with each other and organize weekly local mobile clinics—sharing supplies and counselors. Suba has a great deal of trained VCT counselors that are without work—many of whom would probably be willing once a week to volunteer for free (as many employed VCT counselors work on a volunteer basis). Local mobilization would be an easy, cheap undertaking and would make a huge difference. Many people would be tested who never would otherwise, but in addition to testing people, frequent mobilization in the community will make VCT centers and counselors more visible to the public. This hopefully would help familiarize people with the services and help to reduce stigma surrounding the VCT centers.

## Conclusion

The HIV/AIDS problem in the Suba district of western Kenya is a very complicated issue. Cultural and tribal practices that have existed for generations before HIV/AIDS was known to exist in Kenya now perpetuate the spread of this fatal disease. Myths and misconceptions surrounding topics related to sex and HIV/AIDS penetrate deeply into the urban and rural areas in the district increasing risky behavior. AIDS caused widows are forced to find ways to support themselves and in desperation many turn to practices of *jiboya*, which spreads the disease further. Suba's large fishing industry further complicates the spread of HIV/AIDS, as fishermen travel to the numerous neighboring islands and often engage local women in sex for the exchange of fish.

Myths and misconceptions remain a strong presence in the district because the rural community is not exposed to proper education on condoms, HIV/AIDS, and VCT centers. Without education these dangerous myths and misconceptions are left in the community to become truth. The longer they remain the more difficult it becomes from VCT counselors to intervene with the truth about these issues.

It is imperative that a more extensive education plan be implemented in the Suba district. This plan, which must be coupled with VCT services, will help to discredit the myths and misconceptions that lead to the spread of HIV/AIDS to so many members of the community.

A great deal of support from foreign donors exists in the Suba district; however, without proper communication and teamwork, their services can only extend so far. Health officials in the district must work very closely with NGO and CBO representatives to restructure their plan of attack. With proper allocation of land across the district, a great deal more people can be reached and tested for HIV/AIDS. More extensive VCT coverage will also enable more widespread education and the gradual debunking of the myths and misconceptions that plague the district.



This project illuminated the many factors that contribute to the delivery of health care and services to a large community such as Suba. Much of what is being done today is working and is effectively getting people in isolated communities tested for HIV/AIDS. However, despite the donor support and work of health officials and volunteers, there remains a great deal of work left to do. The aforementioned factors that were found to hinder the effective delivery of VCT services to the community must be assessed in order to streamline the delivery and reach more people more efficiently. The Suba district does not need to have the highest HIV/AIDS prevalence in all of Kenya. Efforts must be taken to further assess why more people are not being reached and to implement effective policy to fix the problem.

## Recommendations

My project has just begun to scratch the surface of the issues in the Suba district. If I had a great deal more time I would have liked to talk with NGO officials about their thoughts on the delivery of VCT services in Suba. I would have also liked to attempt to organize a meeting with as many NGO and CBO representatives as possible to start conversations between the organizations about the issues.

The members of the high-risk community that I spent most time with were the fishermen. However, *matatu* drivers in the district have been shown to be a high-risk population similar to the fishermen. Also, *jiboya* is another factor that needs to be addressed in greater depth within the community, as it too leads to the spread of HIV/AIDS.

There is a great deal of important work to be done in the Suba district. Creating a greater body of research will help influence policy makers and donors to address the problems at hand.

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### **Websites**

<http://www.unaids.org>

## Appendices

### Glossary

*Banda* – A fish weighing station

*Boda-boda* – A bike taxi

*Chai* – Local tea

*Chira* – An illness believed by the Luo tribe to be caused by acting against society's norms. It is treated only with herbal medicine.

*Dholuo* – The mother tongue of the Luo tribe. Dholuo is widely spoken the Suba district.

*Jiboya* – The word given to act of a woman having sex with a fisherman in exchange for a predetermined amount of fish

*Matatu* – Name for the local bus service.

*Survey given to VCT Clients after Counseling*

This survey is part of an ongoing research project being conducted by Joseph Lippi, a student at the School for International Training based in Nairobi, Kenya. Joseph is an American student on an exchange program in Kenya for 4 months. This research project has been approved by the district public health office of Mbita, Kenya and will last for 4 weeks. When the project is finished, the results will be available to you at the district public health offices in Mbita, Kenya.

The project will evaluate how effective VCT centre counsellors are in helping their patients deal with concerns surrounding HIV/AIDS.

If you choose to participate, your name will *never* be included. Neither the counsellor, the researcher, nor any VCT centre staff will ever know who is responsible for filling out the survey. Your name will never be written down, and your anonymity is guaranteed.

If you choose to participate, please check the box below marked "I have read the instructions and agree to participate" and continue to the next page.

Please take your time filling out the questions. If you choose not to participate kindly return the survey to the counsellor.

Thank you very much for your time.

**Tick the box below if you have read the instructions and agree to complete the survey:**

**1) Are you prepared to disclose your HIV status to your partner?**

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**If not, what may keep you from disclosing?**

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**How has your counsellor influenced how you feel about disclosing your status?**

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**2) When did you first consider seeking an HIV test?**

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**When you decided to seek out VCT services, was stigma something you worried about?**

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**If so, how has your counsellor helped support you with these worries?**

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**3) Before you were tested, what did you think life with HIV was like?**

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**How has your counsellor influenced how you feel about living a life with HIV?**

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**4) Will you change your behaviour now that you have been tested?**

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**If so, how?**

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**How has your counsellor affected this decision?**

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**5) Will you come back for counselling sessions in the future?**

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**Would you be willing to fill out another survey like this one in one week?**

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**You have completed the survey.**

**Please return this survey to the counsellor.**

**Thank you very much for your time.**



*Survey Given to Various Members of the Community*

**What can VCT counselors do to make more people from the community come in  
and get tested for HIV/AIDS?**

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