Assessment of Voluntary Counseling and Testing Centers in Kenya

Potential demand, acceptability, readiness, and feasibility of integrating family planning services into VCT

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Executive Summary

Kenya continues to experience a high HIV prevalence rate on the order of 15%. A key intervention strategy for reducing the HIV prevalence is the promotion and provision of voluntary counseling and testing (VCT) services to all Kenyans who wish to know their status. Because VCT serves men and women of reproductive age and because HIV is transmitted mainly through heterosexual contact, VCT clients may be in need of contraception to protect from unwanted pregnancies and HIV transmission.

This study gathered information about VCT services in Kenya during June 2002 in an effort to identify and to formulate programmatic options for effective integration of family planning into VCT services. The following questions were addressed to inform the development and implementation of a policy and strategy to facilitate the integration of these two services.

- Is there potential demand for family planning services among VCT clients?
- Is the provision of family planning services during VCT sessions acceptable to the clients, providers, and VCT center in-charges?
- What elements of contraceptive counseling and distribution are VCT services in their current form ready to offer?
- Is it feasible to provide family planning services within the VCT service environment?

Methods: This study was conducted in 20 VCT centers—either integrated or stand-alone—receiving funding and/or technical support from FHI IMPACT and/or CDC. This study employed both qualitative and quantitative methods including interviews, observations, and surveys. In a sub-set of six VCT centers during three to five days (depending on logistical constraints) a 'time-motion' study was conducted. The objective of this component was to ascertain whether providers have time to dedicate to family planning counseling or provision.

Study population: A total of 20 VCT center supervisors in-charge (one per center) and 41 counselors participated in interviews. For the time-motion component, there was a total of 25 observation days. Seventy-two clients agreed to be observed during their consultation with the provider, and 84 clients agreed to exit interviews. VCT clients were equally likely to be male or female, they were relatively young (36% aged 18-23), 56% had no children, and 42% had completed primary school.

Potential demand: Thirty-six percent of clients did not use contraceptive methods or used traditional methods. Twelve percent reported they were not sexually active. Of the 52% of clients who reported using modern methods, 42% were condom users. Eight-four percent of providers counseled clients that condoms prevent HIV transmission, but only 58% mentioned that condoms prevent pregnancy. Referral to family planning services was very low, and providers were dissatisfied with current referral mechanisms. Clients need information on more effective pregnancy prevention methods and counseling to support dual method use (one client reported using condoms with injectables). Providers need to improve dual protection messages as well.

Acceptability: All in-charges and VCT counselors agreed that it was a good idea to provide information and education on contraception to VCT clients. Almost all providers and in-charges

(95%) supported provision of information-education and communication (IEC) materials and referral for family planning services during VCT. Provision of contraceptive methods was supported by almost two-thirds of in-charges and counselors (60% and 61%). Most clients (89%) thought family planning services in VCT was a good idea. Most in-charges and counselors thought that the pre-test session or the post-test session was the most appropriate time to offer these services. Clients preferred that family planning counseling follow the HIV test.

Readiness: Providers were dissatisfied with the current referral system. The main limitations were lack of confidentiality and effectiveness. VCT providers preferred referral by word-of-mouth because it protects the clients' confidentiality; because it is the client's decision whether to disclose his/her HIV status to the family planning provider. However, VCT providers were concerned that clients did not go to their referral points, that they had no way of knowing if clients went, or that clients encountered obstacles in following up on referrals.

Although over 60% of VCT providers came from clinical backgrounds and 37% of VCT counselors had participated in family planning in-service trainings prior to or since becoming counselors, an assessment of VCT providers' contraceptive knowledge found that some were not ready to give methods to all women. Of particular concern was the high proportion of providers who said that a woman should not use a method if she is a teenager, has never been pregnant, has a sexually transmitted infection, has multiple sex partners, or has tested HIV positive.

Feasibility: The greatest concern about adding family planning to VCT services was that it would increase the session time for clients or workload for VCT providers. Providers spent 22% to 51% of their day with clients. Average VCT contact length in the time-motion study varied by facility from 26 to 61 minutes with an average of 44 minutes. Time to provide family planning services could be gained if providers came to work on time and did not leave early and if providers used the time spent on non-work-related activities to serve clients. Time spent on service support activities varied widely by facility. In some cases time spent on these tasks could be reduced and reallocated to provide family planning.

Conclusion: Some core elements of VCT—condom use counseling, condom distribution, and referral to services—overlap with those of family planning. However, in this study, VCT providers addressed these areas inadequately. While reported modern method use among VCT clients was relatively high, a high percentage did not use a modern method or used a traditional method. Condoms were the most frequently used method, but dual method use was low. Counseling is needed to raise the level of use of contraceptive methods including dual method use. The finding of very low levels of referral to family planning services is of particular concern for those clients who test HIV positive, since they will need effective pregnancy prevention methods to prevent vertical transmission of the virus.

Given the wide variation in VCT provider backgrounds and in VCT service delivery, the decision about what level of family planning service to integrate is best left to those organizations implementing VCT services. The level of family planning integration in VCT will have to be decided on a facility-by- facility basis to address provider training needs, referral mechanisms, supervision needs, and contraceptive supply channels. VCT provider training curricula in family planning will have to be flexible enough to accommodate a variety of

professional backgrounds. All VCT providers will need training on how to counsel using an integrated approach so that providers address the client as a "whole person" and assess her/his risk for pregnancy, STIs, *and* HIV.

It is recommended that possible program inputs for family planning into VCT be conceptualized as a continuum of services, since it is unrealistic to expect VCT services to provide all contraceptive methods. A basic first step would be to assess the client's risk for pregnancy, STIs, HIV, then provide IEC on methods, counsel on method choice, provide condoms and pills, and refer for other methods.

VCT is conceptualized as an entry point to care and support, but VCT clients are receiving little in the way of family planning services. Although provision of IEC on contraception was not initially part of the VCT counselor training, a chapter on contraception is being added to the VCT training manual in Kenya. Failure to offer contraceptives to women and men who want to space or limit births results in thousands of unintended pregnancies and HIV positive births that could be averted. Contraception is a primary HIV prevention strategy and VCT is an obvious opportunity to reach individuals who need to prevent unintended pregnancies.

Background

Like most countries in sub-Saharan Africa, Kenya has a high HIV prevalence rate (15%) (UNAIDS, 2002), a high proportion of women of reproductive age with an unmet need for contraception (32%) (Carr & Way, 1994; Ropey et al., 1996), and a rapidly deteriorating economic situation (-0.2% annual growth rate of GNP, 1999-2000, World Bank).

To respond to the HIV/AIDS epidemic, the National AIDS and STD Control Programme (NASCOP) coordinates HIV service delivery from within the Ministry of Health (MOH). The Government of Kenya has also established a National AIDS Control Council (NACC), which has the responsibility of developing, facilitating, and overseeing the implementation of a multi-sectoral HIV and AIDS policy and strategic planning.

VCT services in Kenya

A key intervention strategy to reduce HIV prevalence is the promotion and provision of voluntary counseling and testing (VCT) services to all Kenyans who wish to know their status. This strategy is based on evidence that HIV counseling and testing results in behavior change including decreased unprotected intercourse (VCT Efficacy Study Group, 2000). In addition, VCT connects people testing positive with early and appropriate services (Baggaley, 2001). Knowing one's HIV status helps those not infected to decide on prevention strategies and the infected to make decisions on how to live positively with the infection and to protect their partners.

In addition to services for those testing HIV positive, VCT is an opportunity to extend other reproductive health services because VCT clients, particularly men and adolescents, may not normally attend conventional health services. There is a natural intersection between VCT and contraception because HIV is mainly transmitted through heterosexual contact. Individuals at risk for acquiring or transmitting HIV may also be vulnerable to an unintended pregnancy.

People who test HIV negative may need condoms to prevent future infection and they may need information and methods to prevent unintended pregnancy. People testing HIV positive may elect to use more effective pregnancy prevention methods in addition to condoms to avoid unintended pregnancies. Pregnant women who test positive can protect their unborn child by accessing antiretroviral therapies like Nevirapine to protect the newborn. These women will also need contraception following their pregnancy to help avoid any future unintended pregnancies.

As a result of the policy and strategic direction in response to HIV, the government of Kenya, non-governmental organizations (NGOs), and donors in the region have invested significantly in the establishment of VCT centers. Over 250 VCT centers have been established in Kenya and more are planned to open in the next three years.

Three models are being used to provide VCT services in Kenya. The most common model is referred to as "integrated" in this document, and this is the main VCT service delivery model being pursued in Kenya and is preferred by MOH and NASCOP. The advantage of the

integrated model is that health facilities serve a high volume of potential VCT clients, and it has a strong potential to be scaled up. On the other hand, people desiring VCT services may not visit health facilities out of a concern over lack of privacy. In this model:

- VCT services are located in the same physical structure housing other health services;
- Personnel are typically recruited from within the same facility, they are paid by the same employer, they are sometimes called upon to perform other duties in the facility, and the supervisors and in-charges manage the supervision of other services; and
- Clients access different services through a series of referrals, although a client must wait in line to receive each service.

Some may prefer the term "co-located" because "integrated" has typically implied that a client can receive all the health services s/he needs with one visit to one provider. Whereas, the term "co-located" implies that VCT operates in the same facility but relies on separate resources.

The second model is "stand-alone" VCT. In this model:

- Centers are usually not located in health facilities; and
- Centers often have no direct linkages to the health care system.

In the stand-alone model, the potential advantages are that the service attracts people who would not go to health care facilities because of concerns about confidentiality and that providers are specialized in VCT service provision. The drawbacks of this approach are that it may be more costly as resources are needed to hire staff dedicated to the provision of VCT services (Forsythe et al., 2002) and that creating linkages with existing health facilities for continuation of care is often difficult.

The third model may either be a "stand-alone" or the "co-located" model but connected to an ongoing community or church-based program. This model may provide better post-test support for individuals testing positive and negative through links with community-based services (e.g., post-test clubs), but linkages to health services may be weak.

A major concern of the Kenya government, program implementers, and donors is that the VCT program is evolving as a vertical program parallel to other efforts, despite MOH efforts to integrate services. One effort has been the development of MOH guidelines for the provision of VCT services. These clearly indicate that, "information on family planning, its role for both HIV-positive and HIV-negative clients, and how to have access to services should be included in VCT counseling sessions. If possible, family planning should be provided at VCT sites" (Kenya MOH NASCOP, 2001, p.15). Although this is the desired position of the Kenya MOH, there is very little information on preparedness of staff and facilities to add family planning to VCT services.[1]

[1] It should be noted that some experts in the field prefer the term "contraception" or "contraceptive services" to "family planning" or "family planning services". The rationale is that some people, for example adolescents, are not planning families; thus use of this term may be confusing. However, the use of the term "family planning" implies a more comprehensive service than contraceptive distribution. For the purposes of this report, we use the term "family planning" to imply a broad content of services, but recognize that for the purposes for service delivery, particularly in the VCT context, some evolution in our vocabulary may be warranted.

Experiences with reproductive health service integration

It is widely accepted that there are problems with defining 'integration' in developing countries (Lush, 2002). In an ideal situation, although unrealistic in most settings, the client receives all the health services s/he needs with one visit to a provider. Integration is better conceptualized as a continuum where the level of integration may vary by the type of facility, the training background of providers, and the feasibility given the organization of financing and logistics. The focus on integrating contraception into VCT does not preclude consideration of integrating other services, nor does it demand that full family planning services be offered.

Most efforts to integrate reproductive health services have focused on integration of HIV services into existing maternal and child health/family planning (MCH/FP) services (Lush et al., 1999), although the level of actual integration appears to be low. For example, data from situation analyses suggest low availability of STI services at MCH/FP facilities in Ghana, Kenya, Zambia, and South Africa (Mayhew et al., 2002). Even when STI screening is available in family planning services, treatment may not be available (Dehne et al., 2000). There is little understanding of how integration of STI/HIV services in MCH/FP has affected the number of STI cases or condom use (Askew & Maggwa, 2002).

Integrating STI/HIV services into family planning services does not appear to have negatively affected the quality of family planning services. Rather, the strategy appears to increase family planning client satisfaction and quality of care and may even increase acceptance of contraceptive methods (Dehne & Snow, 1999). An example from Jamaica suggests that family planning client satisfaction increased when HIV prevention and safe sex counseling services were integrated (Scott & Becker, 1996). Although providers had concerns that the additional duties would increase the amount of time spent with each client, the training addressed these concerns by reorienting their counseling from an explanation of all contractive methods to an exploration of clients' sexual health needs.

Previous integration efforts have also involved integrating STI services into antenatal care (ANC). Syphilis screening for ANC clients and ocular prophylaxis against gonorrhea among newborns are considered to be more successful than integrating other STI/HIV activities in MCH/FP (Mayhew et al., 2000). However, there is room for improvement. A review conducted in 22 sub-Saharan African countries estimated that 38% of women attending ANC services were screened for syphilis, although 78% attended antenatal care (Gloyd et al., 2001). As reasons for the low implementation Askew and Maggwa (2002) cite vertically organized national health programs, little attention to the problem from international donors, paucity of protocols and guidelines, and ANC staff that are ill-prepared to offer screening and treatment.

Some attempts to expand vertical programs have been stymied because of countries' independent systems for human resources, finance, logistics, and monitoring. For example, Kenya's more volatile political situation has been implicated in encouraging donors to keep a tighter reign on programs and maintaining those programs as vertical (Mayhew et al., 2000). In Ghana, Kenya, and Zambia, high levels of donor support tend to reflect the separate priorities of donors (e.g., family planning, safe motherhood, etc.). This is in contrast to South Africa where the lack of

donors has allowed most services to be delivered through the 'primary health care' route (i.e., this strategy is more integrated).

Integrating family planning into VCT

Because of the relative recent emergence of VCT, precedence for integrating family planning into VCT is rare. In Uganda since 1990, the AIDS Information Center (AIC), a donor funded NGO, has been offering VCT services. Family planning services and STI education and testing are available at all AIDS Information Center (AIC) branches (Alwano-Edyegu & Marum, 1999).

To date, Uganda is the only country that has actively integrated reproductive health services. These efforts are supported at the MOH level; there is a policy of providing integrated services including a position for commissioner for reproductive health services. Supervisors provide support to providers by visiting the sites at least once every two months. Integrated IEC messages (through brochures and video) and a referral system (consisting of an assessment form, referral slips, and a referral directory) exist. AIC implemented an 'integration assessment card' to help the provider guide the client to services.

In Uganda since 1993, some family planning services have been offered in VCT, and today FP education is offered to everyone who visits an AIC center (Alwano-Edyegu & Marum, 1999). Post-test club volunteers who have participated in a two-week training offer family planning education to all clients of AIC (A. Berigija, personal communication, May 24, 2002). All AIC counselors have received training and they can distribute pills and condoms. In some cases, the VCT counselor is a medical officer so, in addition to distributing pills and condoms, they can provide other contraceptive methods. Since 1993, 31% of AIC clients have received contraceptive methods through AIC (Alwano-Edyegu & Marum, 1999). Of those VCT clients choosing to practice family planning, 28% practice dual method use. Condoms are the most popular method, and injectables and condoms are the most common dual protection combination.

Study Goals and Objectives

The goal of this study was to gather information about VCT services in Kenya in order to identify and formulate programmatic options for effective integration of family planning into VCT services. Specifically, the study addressed the following questions to inform the development and implementation of a policy and strategy to facilitate the integration of these two services.

- Is there potential demand for family planning services among VCT clients?
- Is the provision of family planning services during VCT sessions acceptable to the clients, providers, and VCT center in-charges?
- What elements of contraceptive counseling and distribution are VCT services in their current form ready to offer?
- Is it feasible to provide family planning services within the VCT service environment?

Study Design and Methods

MOH/NASCOP implemented this study with technical assistance from FHI and AMKENI and in collaboration with other partners.

Formative research methods explored the factors and context that influence effective integration of family planning services in VCT and informed the development of a strategy for integration. Published literature on VCT, family planning, and integrated reproductive health services, and guideline documents in Kenya provided background information. Government of Kenya VCT centers and some non-GOK centers, all receiving funding and/or technical support from FHI IMPACT and/or Centers for Disease Control and Prevention (CDC), served as the study setting. This cross-sectional study of current practices employed both qualitative and quantitative methods including interviews and observations.

The study included a total of 20 VCT centers. VCT centers were purposively selected from a list of existing facilities based on three criteria: type of facility (hospital, stand alone, community-based, or health center), whether they are public or private, and geographic location (district). In some cases we considered information on client characteristics as an extra criterion to help narrow the selection and obtain variation in the populations served by the VCT centers. A team of two research assistants—one trained in VCT and one social scientist—visited each center over the course of one day to gather data. The research assistant trained in VCT made observations of client provider interactions, while the social scientist research assistant conducted exit interviews with clients. Either research assistant conducted interviews with the supervisor in-charge of the VCT center or VCT counselors providing services on the day of the visit. Research assistants obtained informed consent from the participants before conducting the interviews.

In addition, in a sub-set of six VCT centers during three to five days (depending on logistical constraints), a '*time-motion*' study was conducted. The objective of this component was to ascertain how much time providers had to dedicate to family planning counseling and provision. Information on the number and duration of contacts together with information on time expended for other activities was used to determine how much time staff members could shift from other activities to family planning services. In selecting the sub-set of centers for the time motion study, it was decided to include MOH and KICOSHEP (Kibera Community Self Help Program) clinics because most VCT centers are MOH. Kenyatta National Hospital and Kakamega Provincial General Hospital were excluded because this type of facility is uncommon. Further, we chose clinics with the highest client volume for the time motion component. The rationale for choosing the busiest centers was that if providers in these centers had time to provide family planning, then those in less busy centers could certainly provide these services. A third social science research assistant collected data for the time-motion study component.

Activity sampling, which is one type of time motion study, was used to determine how providers spent their time during a full day. Activity sampling provides information on time use for a "sample of time". Observers followed one provider per day and used a stopwatch that "beeped" every three minutes. At the beep, the observer checked off the activity that was being performed using a form with a list of activities. The observer could also add activities to the list. Activities were coded into five categories: with a client, working in other health services, service support

activities, engaging in personal activities, carrying out non-work related activities, and not at the clinic during work hours. Table 1 shows what particular activities are included in each of these categories. The number of times each activity was observed was multiplied by '3' in order to determine the number of minutes or hours spent in these activities over the course of an average day.

Observers obtained data on the number, duration, and type of contacts. Each observer received a watch, and used this to note start and end times for each consultation. The observer also noted the type of client: VCT, family planning, STI, etc. The observer remained outside the consultation room when the provider was with a client.

Table 1. Components of time-use categories for the time-motion study.

Category	Activities
Contact	Time with clients
Other health services	Providing other services in health facility
Service support activities	Completing client record, processing lab sample, equipment preparation, washing hands, work related errand outside of facility, general administrative tasks, gathering personal items at end of day, getting supplies, work meeting, organizing work space, assisting other providers, shift change, work discussion, work telephone call, walking around for work purpose
Personal	Lunch/tea break, toilet
Non-work related activities	Reading newspaper, talking with observer, meeting with personal visitors, chatting about non work matters, personal telephone call, waiting for clients, waiting for cleaning of consultation room, walking around for non work purpose, talking with other clients or relatives/friends of client
Not at the clinic	Not present when shift began, left shift early, absent for personal reason
Unknown	'Other' codes and missing data

Study Results

All 20 VCT center supervisors in-charge (one per center) and 41 counselors approached for interviews consented to participate in the study. According to a logbook count, 141 clients sought VCT services on the day the interviewers were at the VCT centers. VCT counselors served as 'gatekeepers' to clients and sent clients to researchers if clients indicated they might be willing to participate in the study. Researchers had contact with and asked 104 clients for their consent to participate in the study. Of those, 72 agreed to be observed during their consultation with the provider. Three couples attended VCT, thus there are 69 CPI observations. Of the same 104, 84 clients agreed to the exit interviews, although this number would have been greater if several of the clients who had participated in the CPI observation had not had time constraints and thus were unable to participate in the exit interview. Fifty-nine clients participated in both the CPI and exit interview. For the six centers selected for the activity sampling component, there was a total of 25 observation days.

These samples yielded an average of two provider interviews. 3.5 CPI observations, and 4.2 client exit interviews per facility. Table 2 presents the number of VCT centers by type of facility.

Table 2. Number of VCT centers by type of facility.

Facility	N
National or provincial hospital	2
District hospital	3
Stand alone	5
Health center, clinic or dispensary	7
Other	3

Participant characteristics

VCT center in-charges

"In-charges" interviewed for this study were defined as the direct supervisors/managers of the VCT center, but not necessarily supervisors/managers of the entire health facility in the case of larger facilities. Of the 20 in-charges interviewed, the main role for 18 was administrative, 16 provided VCT services, and 14 supervised VCT staff. Twelve in-charges had received training in supervision, while 18 had received training in VCT counseling. No socio-demographic information was collected from in-charges.

VCT center counselors

Researchers interviewed as many counselors working in VCT as they had time for, thus not all counselors in the centers were interviewed. Table 3 summarizes provider characteristics. It should be noted that throughout the text "counselor" or "VCT counselor" refers to all people trained in VCT counseling regardless of their self-reported designation. "Provider" is a term that is used interchangeably with "counselor".

Table 3. Profile of VCT counselors.

Characteristic	%
Sex	
Male	47
Female	53
Age (mean)	36
Marital status	
Married, or living as	80
Single, never married	18
Divorced/separated/widowed	3
Children	
None	18
1-3	53
4+	30
Ever tested for HIV	
Yes	76
No	24
Job prior to VCT counselor	
Clinical services	63
Other community based services	24
Other	12
N	**41**

VCT clients

Eighty-four clients participated in the exit interview. These clients were relatively young—over one-third were ages 18 to 23—well educated, and the majority had no children (Table 4). About one-fourth of clients had been tested for HIV before.

To assess representativeness, data collected from CPI study participants' client cards were compared to those of all clients visiting the same facilities during June 2002. At the time this study was conducted there were approximately 60 VCT centers, thus the sample of 20 was about one-third of all VCT centers. Clients in both groups had similar characteristics on gender, marital status, and age, but clients who participated in the CPI were less educated (19.7% had some post-secondary education compared to 32.9% of all clients in the same clinics during the same month). Clients who participated in the CPI were also more likely to report no occupation (39.7% vs. 26.3%) than all clients in the same clinics during the same month.

Table 4. Percent distribution of clients participating in the exit interview by various socio-demographic characteristics.

Characteristic	%
Sex	
Male	49
Female	51
Age	
18-23	36
24-29	36
>29	29
Number of children	
0	56
1-3	30
4+	12
Reading ability	
Not at all	5
With difficulty	16
Easily	80
Highest level of school completed	
<=Primary	42
Secondary	43
Post-secondary	16
Main source of income (self)	
Housewife	13
Small scale farmer	8
Small scale trader	30
Salaried worker	30
Dependent	20
N	**84**

Is there potential demand for family planning services among VCT clients?

One element to consider before introducing family planning services in VCT programs is whether clients will want the service. During the exit interview, clients were asked about their current contraceptive use with their regular partner. Twenty nine percent of clients reported during the exit interview that they did not use a contraceptive method (Table 5), and another 7% reported traditional method use. Twelve percent of respondents reported that they were not sexually active. Clients' understanding of what is meant by 'not sexually active' and the length of this abstinence were not explored.

Just over one-half of those interviewed (52%) reported any modern method use. Condoms were the most frequently mentioned method; 42% of any modern method use was reportedly condoms or condoms in combination with another method. One respondent used condoms in combination with injectable contraceptives, and one used condoms in combination with periodic abstinence.

Reported method use did not vary by client gender. Men and women were equally likely to report that they were not sexually active, using a modern method, or using no method. Five men compared to one woman reported traditional method use.

Table 5. Type of contraceptive method client and regular partner rely on currently.

Method	%
Using modern method	**52**
Condoms	19
Pill	11
Injectable	15
Female sterilization	4
Norplant	1
Dual method (condom + injectable)	1
Dual method (condom + periodic abstinence)	1
Traditional methods	**7**
Natural family planning /periodic abstinence	5
Withdrawal	2
Not sexually active	**12**
None	**29**
Total	**100**
N	83

* This question was open ended; response categories were not offered to the respondent.

Of the 43 clients using modern methods, 35% went to pharmacies, shops, or kiosks to obtain their methods, another 37% reported visiting a public health facility, 19% went to private health facilities, and 9% named another type of facility. Fourteen of the 15 people reporting they went for methods at pharmacies, shops, or kiosks were condom users.

Table 6 suggests that clients are not likely to get information on family planning during a VCT session. In almost all sessions (99%), providers discussed actions that reduce the risk of HIV infection or transmission. The sessions emphasized HIV prevention measures, thus, for example, in almost every session, the provider discussed ways to reduce HIV risk. While in 85% of sessions the provider and client discussed how condoms prevent HIV transmission, providers were less likely to mention that condoms also protect against other STIs (73%) and pregnancy (58%). In less than one-half of observations were other reproductive health issues discussed.

Table 6. Percent of topics discussed during CPI observation, pre- or post-test.

Topic	%
Provider discussed actions to reduce the risk of infection or transmission of HIV	99
Provider and client discuss abstinence	74
Provider discussed how condoms prevent transmission of HIV	85
Provider and client discuss how condoms prevent pregnancy	58
Other contraceptive methods mentioned by provider or client	25
Client asked about family planning/contraception	10
Referral for contraceptive methods made by provider	10
Other reproductive health issues discussed by provider and client	44
Provider makes referral for other reproductive health services (e.g., STI, MCH)	25
N	**69**

Table 6 demonstrates that referrals made during VCT counseling are low. An analysis of client card data from IMPACT study clinics suggests that referral to family planning from VCT was even lower. During June 2002, 1.2% of female VCT clients were referred to family planning services from VCT. An earlier analysis of data from the five CDC supported KICOSHEP sites in Nairobi from March 2001 to March 2002 found similarly low referral rates; 2.7% of VCT clients were referred to family planning services (E Marum and L Nganga, personal communication, 25 April 2002).

Less than one-half of providers offered condoms to clients during the CPI, (45%). However, of those clients offered, 59% accepted the condoms. Although explanations for the low level of condom distribution were not immediately evident, the data did indicate that this was not due to supply shortages.

Is the provision of family planning services during VCT sessions acceptable to the clients, providers, and center in-charges at VCT centers?

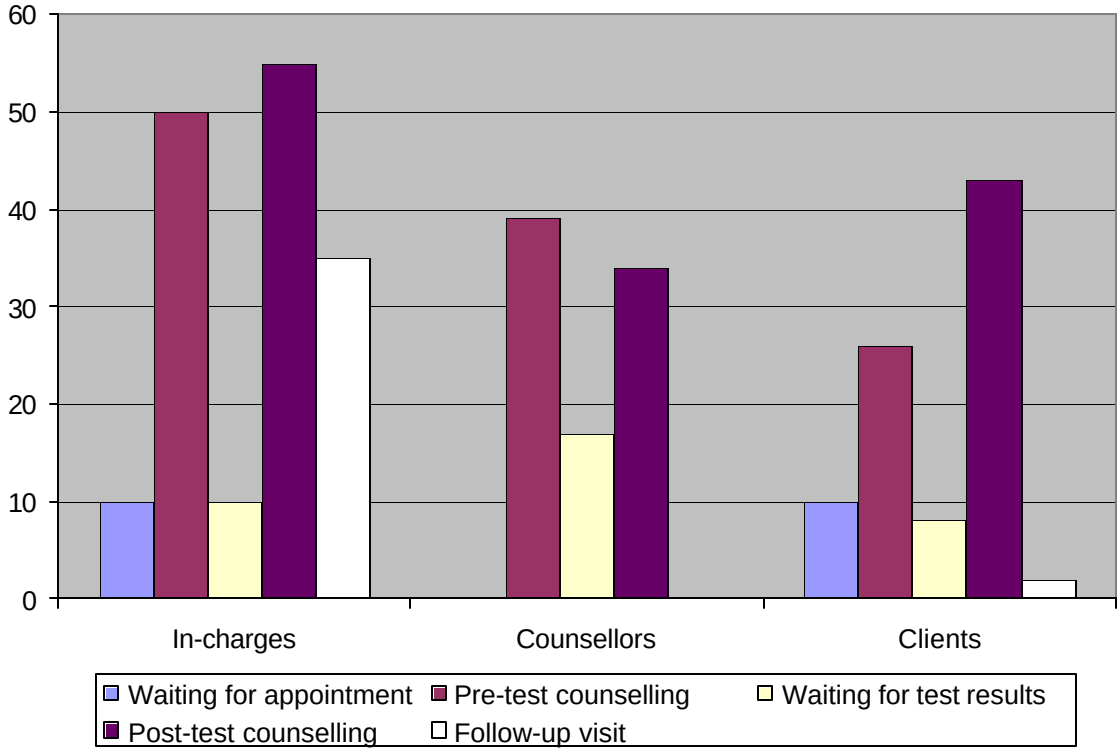
Results from the previous section suggest that there may be latent demand for family planning services among VCT clients, and this section explores the acceptability of offering family planning services during VCT.

All in-charges and all VCT counselors agreed that it was a good idea to provide information and education on family planning to VCT clients. Distribution of IEC materials and referral for family planning was also popular with almost all providers and in-charges (95%). Provision of clinical contraceptive methods was supported by almost two-thirds of in-charges and counselors (60% and 61%). Most clients (89%) felt that it was a good idea to get family planning services during VCT.

When asked to estimate the proportion of VCT clients that would benefit from provision of family planning services, 90% of in-charges responded 'about half' or more of their clients would benefit. Similarly, most providers (88%) thought that 'about half' or more of their clients would benefit from provision of family planning services. The main reason given by providers and in-charges to support their estimates was that most clients were sexually active, of reproductive age, female and/or young.

Figure 1 depicts when in-charges, counselors, and clients reported that family planning services should be offered during the VCT session. Most in-charges and counselors thought that the pre-test session or the post-test session was the most appropriate timing. Clients preferred family planning counseling to follow the HIV test.

Figure 1. Percent of in-charges, counselors, and clients' reports of the most appropriate time to discuss family planning.



What elements of contraceptive counseling and distribution are VCT services ready to offer?

As the idea of family planning in VCT appears acceptable, the next question is to ask what family planning services can VCT services offer? Referral to family planning services is already being carried out. Despite the low level of observed referrals, almost all providers reported ever referring clients to family planning. Most of these referrals (60.5%) were to another room in the same facility.

According to providers, the main limitations with referral for family planning are lack of confidentiality and effectiveness. The most common method of referral is by referral note or by word-of-mouth. VCT providers preferred referral by word-of-mouth because it protects the client's confidentiality. In other words, it is the client's decision to disclose his/her HIV status to the family planning provider. On the other hand, some VCT counselors preferred using a referral note because with that method of referral "the client does not have to explain again their reason for seeking care".

Thirty of the 41 providers (73%) expressed discontent with the current referral system because providers have no way of knowing if clients went or whether clients encounter obstacles to accessing other services. Several providers felt that receiving feedback from the client on the

referral services or the ability to follow up with the other provider for feedback was important, but that this was not currently part of the referral system.

As noted earlier, most VCT services have condoms available, although distribution of and counseling on condoms as a pregnancy prevention method is low. When asked what methods would feasible to provide given their current set up, over one-half of providers thought they could provide other methods, specifically pills and/or injectables. Indeed, this study confirmed that there were few VCT centers with the equipment available to offer clinical methods such as the IUCD.

There was wide variation in VCT providers' professional backgrounds. Over 60% of VCT providers came from clinical backgrounds and 37% had participated in family planning in-service trainings prior to or since becoming counselors. This variation was reflected in the variety of responses obtained when asking providers questions about contraception. When asked to identify the two most frequently used methods in Kenya, almost all (90%) VCT providers correctly cited the pill as one of the two, while slightly over one-half (56%) correctly identified the injectable (Table 7). Almost 30% of VCT providers incorrectly identified the condom as one of the two most frequently used contraceptive methods. The majority (59%) of providers were able to define emergency contraception and most (85%) could identify the two goals of dual protection.

Table 7. Percent of VCT providers' reports of the two most frequently used contraceptive methods and their knowledge of emergency contraception and dual protection.

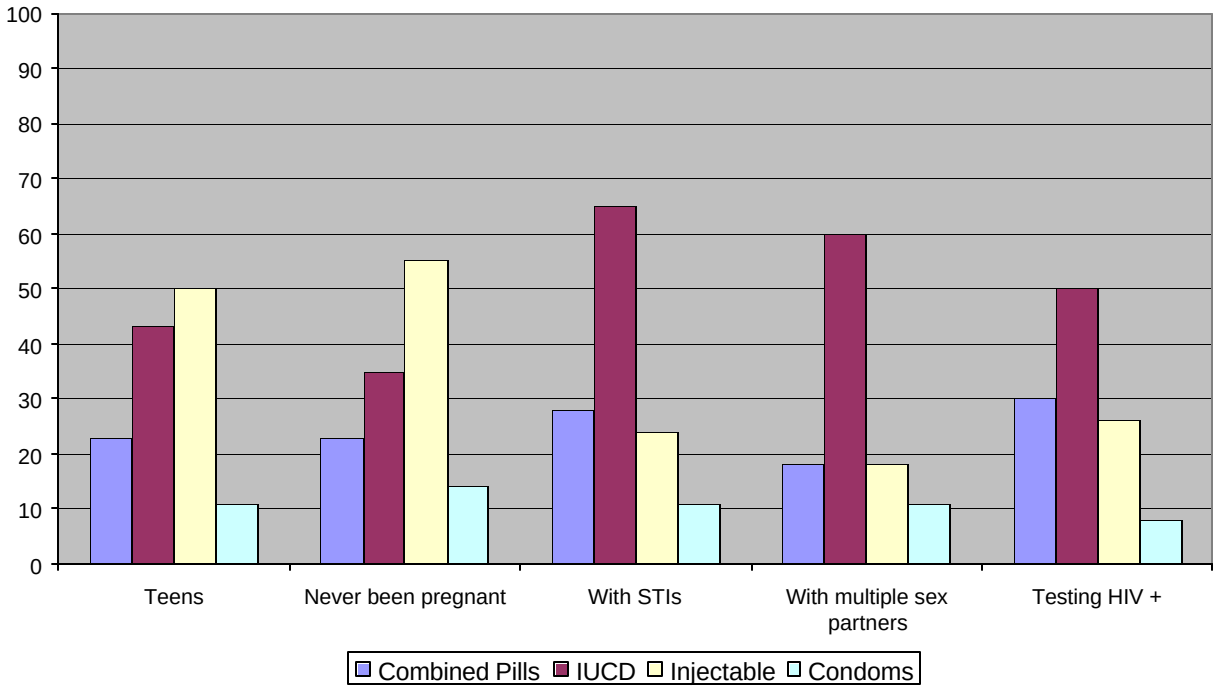
	%
Provider reports of the two most frequently used contraceptive methods in Kenya	
Birth control pill	90
Injectables	56
Condoms	29
IUCD	5
Norplant	15
Definition of emergency contraception	
Oral contraceptive pill	20
Pill taken (immediately/within 72 hours) after unprotected sexual intercourse	59
Don't know	27
Definition of the two goals of dual protection	
Pregnancy prevention and infection/STI/HIV prevention	85
Any other answer	7
Don't know	7
N	**41**

To further assess contraceptive knowledge, VCT counselors answered a series of questions on methods that should *not* be used by women with various characteristics (the term "contraindication" was not used, although this was the sense of the question) (Figure 2). However, the way the question was worded ("which women should not use [method]") may have led providers to respond according to their values. In other words, some providers may think that teenagers, for example, should not be having sex and therefore should not use a method.

The results in Figure 2 suggest significant bias and lack of knowledge among some providers regarding particular methods and certain classes of women. For women testing positive for HIV, there is some reluctance among VCT providers to offer contraception. For example, 30% of providers did not think that HIV positive women should use the pill. Since contraception is necessary to prevent vertical transmission, these finding are troublesome. Fully 50-55% of providers were averse to providing injectable contraception to teens or women who have never had children. In fact, providers are less likely to recommend injectables than IUDs to this group. Providers may mistakenly believe that injectables cause infertility.

The highest negatives were for the IUD. For women with STIs, HIV, or having multiple sex partners, the risk of pelvic inflammatory disease with the IUCD use may concern providers. Although there is some controversy about giving the IUCD to some women, there are no reasons why women with the characteristics in Figure 2 should not get pills, injectables, or condoms.

Figure 2. Percent of VCT counselors reporting that women with certain characteristics should not use various contraceptive methods.



Is it feasible to provide family planning services within the VCT service environment?

Given that VCT providers can distribute condoms, counsel on condoms, make limited referrals for family planning, and that they have some knowledge of contraceptives, to what extent would VCT services need to change to offer more comprehensive family planning services? In order to offer a full range of family planning services, 58% of counselors thought they would need more equipment, 49% cited a family planning room, and 44% mentioned training in family planning.

Comprehensive family planning services in VCT would probably increase the amount of time providers spend with clients. Information from the time-motion study, including the information on the duration of contacts, is used to determine whether providers can accommodate the extra time into their work-loads.

Table 8 provides information on the type of facility included in the time-motion study, the number of observation days, the average number of VCT clients per day, and the average total number of clients per day. Providers had contact with 121 clients; 114 clients were VCT clients. Mugumoni and Ganjoni had the highest average number of client contacts per provider. These data agree with providers' reports obtained from interviews; providers in all study facilities estimated that they saw an average of 4.4 clients on their last working day.

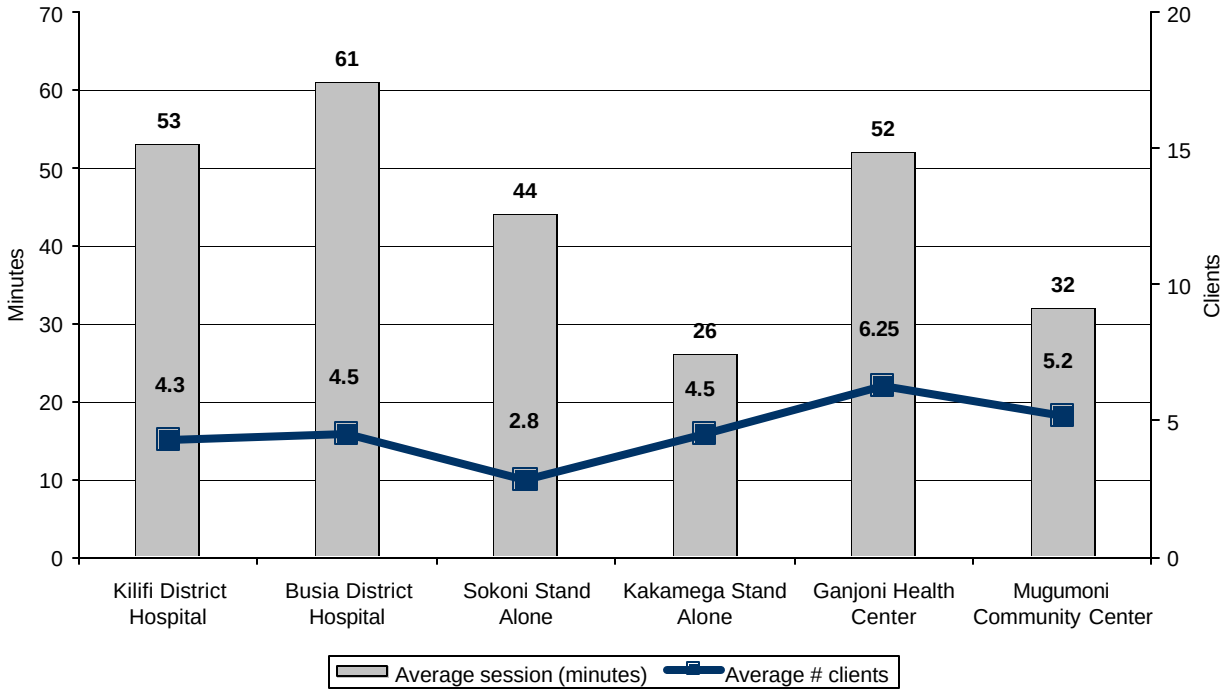
Table 8. Average number of contacts per day per provider by facility.

	Type of facility	# observation days	Average* VCT clients	Average* total clients
Kilifi District Hospital	District hospital	3	4	5
Busia District Hospital	District hospital	4	5	5
Sokoni Stand alone	Stand alone	5	3	3
Kakamega Stand alone	Stand alone	4	5	6
Ganjoni Health center	Health center	4	6	7
Mugumoni community center	Community center	5	5	5

*Calculated by summing the number of contacts for each observed staff member and dividing by the number of observation days

The average VCT contact length by facility ranged from 26 to 61 minutes (Figure 3). Kilifi, Busia, and Ganjoni had the longest visit lengths, and Mugumoni and Kakamega had the shortest visit lengths. Overall, the average observed VCT visit length of 44 minutes for the time motion component was shorter than for the observed CPI session (64 minutes). This discrepancy in session length by source is probably due to the Hawthorne effect; providers may have been more thorough in their counseling when they were observed (researchers remained outside during CPIs that occurred during the time-motion study). Further, results in Figure 3 suggest that client load is not associated with the average session time.

Figure 3. Average VCT session length and average number of clients seen by facility in time-motion study.

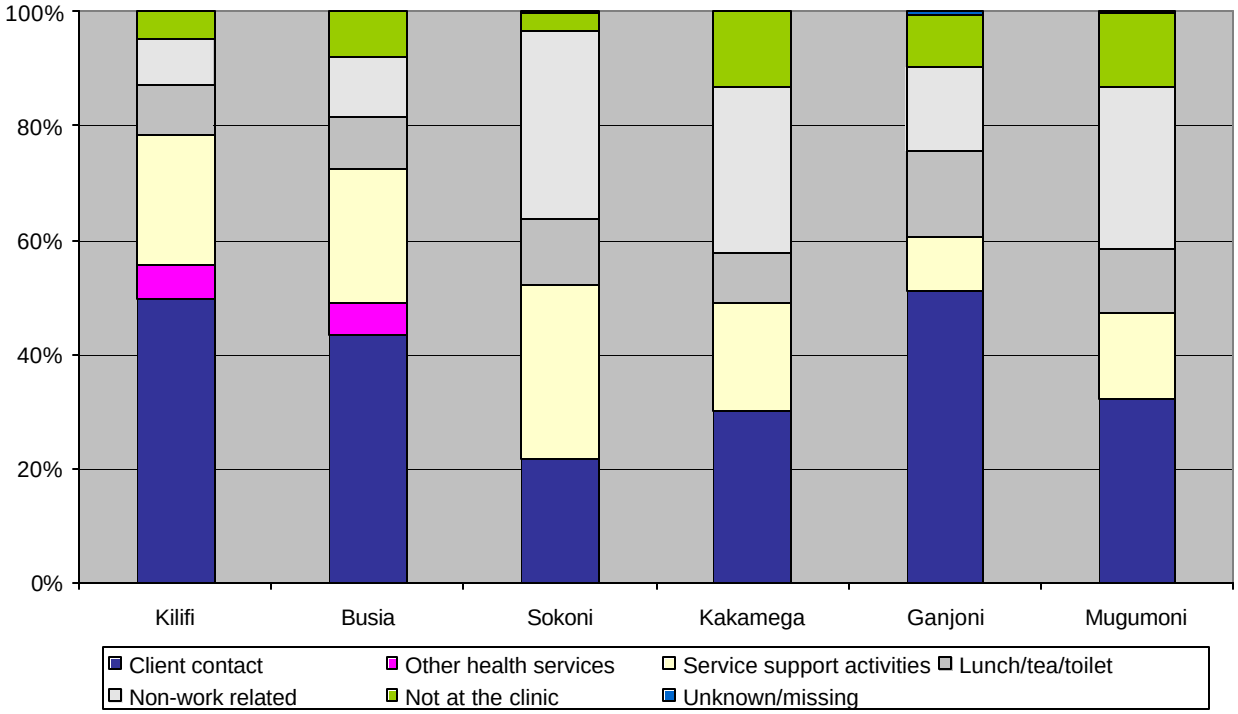


In an effort to explain some of the variation in session times by facility, the mean session times were recalculated after dropping sessions shorter than 21 minutes. It was assumed that sessions shorter than 21 minutes would not include an HIV test as the rapid HIV test usually takes 15 minutes. The implication of this assumption is that sessions shorter than 21 minutes may be informational or pre-test counseling sessions. For all clinics, the average increased by 8.5 minutes when these short sessions were excluded. Average session times in Kakamega increased by 19 minutes (from 26 to 45 minutes). Mugumoni average session times increased by four minutes (from 32 to 36 minutes). While shorter average session time might reflect lower quality of care, it may also be the case that shorter session times are due to a larger percentage of clients who chose to participate in the pre-test counseling session only.

Effect of family planning provision on provider time

Figure 4 shows how providers at the six clinics allocated their time across different activities. Only at Ganjoni did the percentage of time spent with clients equal 50% of the day and it was as low as 22% in Sokoni. Conversely, in some clinics, especially those where the percentage of time spent with clients was low (Sokoni, Kakamega, Mugumoni), the percentage of time not spent in work-related activities was high. Thus, it appears that in some clinics providers have some time that can be redistributed to talk to clients about family planning.

Figure 4. Percent distribution of provider time by facility.



The impact on total client contact time was calculated assuming that providers spent an extra ten minutes on family planning per client. The three busiest clinics (Ganjoni, Kilifi, Busia) served as the hypothetical examples because if providers in busy clinics could accommodate the extra client time into their workloads, then providers in the less busy clinics could certainly do so.

Table 9 provides results of calculations and shows how the extra contact time is gained by reducing various categories of unproductive time. For example, in Ganjoni, the extra contact time per day needed to provide family planning is 62.5 minutes (10 minutes x 6.25 [average number of VCT contacts per day per provider] from Table 8). As shown in the first row of Table 9, most of this time (46 minutes) can be transferred from time providers do not currently spend at the clinic because they come to work late or leave early (9% of an 8.5 hour day). Reducing non-work related time by half, from 15% to 7.4%, adds 38 minutes. In total at Ganjoni, there are 84 minutes that could be added to VCT sessions to integrate family planning services.

Table 9. Scenarios to determine how non-contact time can be reallocated to FP consultations.

	Time needed for FP consults	Not at the clinic	Non-work related (reduced by half)	Service support activities (reduced by half)	Total
Ganjoni	63	46	38		84
Kilifi	43	24		58 *	82.
Busia	45	42		63*	106

* Potentially utilized time calculated by multiplying percentage by clinic working hours (Ganjori 510 min., Kilifi 510 min., Busia 540 min.)

Busia has an average of 4.5 VCT contacts per provider per day, thus an additional 45 minutes is needed to add family planning (10 minutes per client). Forty-three minutes are gained if providers come to work on time and do not leave early. Another 63 minutes is gained if the time spent on service support activities (currently 23% of the day) is cut in half. This is a reasonable assumption since, in Ganjoni, providers spend only 10% of their day on service support activities and there are more visits to that clinic. Results for Kalifi in Table 9 are similar to those for Busia.

These calculations do not take into account the fact that not all VCT clients will need family planning services or that VCT client visits are unevenly distributed throughout the day. Because clients' arrival times are clustered, clients would spend more time waiting to see a provider since providers would have spent more time with clients that arrived earlier during these busy periods. Thus, a more detailed analysis would be necessary to plan for extra counseling time. It is also important to note that these calculations assume that the number of clients is constant. If VCT centers attract larger numbers of clients, at some point additional staff will need to be hired to meet the demand for services and the financial costs of service delivery will increase.

Conclusions

This study draws from interviews with VCT supervisors in-charge, counselors, and clients; observations of VCT sessions; and provider activity sampling. Although the sampling methodology sought to obtain a representative sample of VCT clinics, rapid scale up activities have resulted in the establishment of many more VCT centers since the time of this study.

Some core elements of VCT—condom use counseling, condom distribution, and referral to services—overlap with those of family planning. However, providers inadequately addressed these areas. Counseling on how condoms prevent HIV transmission was adequate, but providers missed opportunities to counsel on how condoms prevent pregnancy. Further, condom distribution was surprisingly low for a population that is, in theory, at risk for transmitting or acquiring HIV. More information is needed to understand why providers fail to offer condoms to all VCT clients, since at least in Kenya, condom supply appears adequate.

Reported modern method use was relatively high in this study. Condoms were the most frequently cited method; therefore, clients may need information about more effective pregnancy prevention methods and counseling to support dual method use. This is particularly important because dual method was virtually non-existent among clients in this study.

Despite the fact that over one-third of VCT clients were either not using any contraceptive method or were using traditional methods, the observed referral rate to family planning services was low (10%) and client card data suggest that it is even lower (<3%). This finding is of particular concern for those clients who test HIV positive, since they will need effective pregnancy prevention methods to prevent vertical transmission of the virus.

Low referral levels may result partly from providers' dissatisfaction with current referral mechanisms. Despite the fact that vertically organized health services and the stigma associated

with HIV may serve as barriers for seeking family planning services, referral systems should be enhanced to allow VCT clients greater access to these services. Low referral rates may also reflect provider biases against provision of certain methods to certain clients. For example, family planning providers in Kenya and elsewhere are often unwilling to provide injectable contraception to childless women, in the mistaken belief that injectables (such as Depo-Provera) cause permanent infertility. More generally, some providers may be unwilling to refer women whom they feel, for moral reasons, should not be having any sexual relations.

This study found wide variation in VCT provider backgrounds and in VCT service delivery models. VCT providers with clinical and family planning training are more likely to be working in health facilities where family planning services may be more accessible via referral. Given the variables that need to be considered before integrating family planning services, the decision regarding the level of integration is best left to those organizations implementing VCT services. The level of family planning integration in VCT will have to be decided on a facility-by-facility basis to address provider training needs, referral mechanisms, supervision needs, and contraceptive supply channels. VCT provider training curricula in family planning will have to be flexible enough to accommodate a variety of professional backgrounds. Further, all VCT providers will need training on how to counsel using an integrated approach so that providers address the client as a "whole person" and assess her/his risk for pregnancy, STIs, *and* HIV.

It is recommended that possible program inputs for family planning into VCT be conceptualized as a continuum of services, since it is unrealistic at this time to expect VCT services to provide all contraceptive methods. A basic first step would be to assess the client's risk for pregnancy, STIs, and HIV, then provide IEC on methods, counsel on method choice, provide condoms and pills, and refer for other methods. Provision of quality family services at VCT centers will require interventions at multiple levels, significant resources, and cooperation among stakeholders.

VCT is conceptualized as an entry point to care and support, but VCT clients are receiving little in the way of family planning services. Although provision of IEC on contraception was not initially part of the VCT counselor training, a chapter on contraception is being added to the VCT training manual in Kenya. Failure to offer contraceptives to women and men who want to space or limit childbearing results in thousands of unintended pregnancies and therefore HIV transmissions that could otherwise be avoided. Contraception is a primary HIV prevention strategy and VCT is an obvious opportunity to reach individuals who need to prevent unintended pregnancies.

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