AN EVALUATION OF THE IMPACT OF VCT TRAININGS IN KENYA: A CASE OF LIVERPOOL VCT CARE AND TREATMENT

BY MUTUA JONATHAN MBULUI

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DECLARATION

This Research paper is my original work and has not been submitted for a degree in any other university.

02/09/2008

Mutua, Jonathan Mbului **DATE**

This Research paper has been submitted with the approval of the university supervisors.

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Professor Macharia, David, EBS **DATE**

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Dr. Lillian Otieno **DATE**

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DEDICATION

This work is dedicated to my wife, *Eunice Munyilu Mbului* and our son *Timothy Muuo Mbului*. Thank you for your sacrifice and support to see me through the study. God bless you.

ABSTRACT

This research sought to evaluate Voluntary Counseling and Testing (VCT) trainings in Kenya by taking Liverpool VCT Care and Treatment (LVCT) three-week VCT trainings carried out between 2003 and 2006 as a case study. The Kirkpatrick model of training evaluation was used. The model promotes the evaluation of training from the trainees' reaction to the training, learning, learning transfer and the impact of the training.

The study adopted a survey design. Purposive sampling was used to choose a sample of thirty three respondents from the former trainees, all drawn from Nairobi. Questionnaires were used to collect primary data from the respondents. A combination of qualitative and quantitative techniques was utilized.

The study findings revealed that the knowledge and skills acquired at the training are relevant to the trainees and majority of the respondents are able to carry out VCT tasks. Respondents indicated their training expectations were met to a great extent. Fifty seven percent (57.6%) of the respondents argued the training to a great extent contained appropriate information on VCT counselling. Nevertheless, the training did not enable the trainees to set up referral systems, familiarize them with counselling theories, keep VCT records, carry out community mobilization or provide sufficient theoretical learning to a great extent.

All the respondents, (100%) indicated that they are able to apply the knowledge and skills learnt at the workplace. The training had a positive impact on the respondents and their organizations. Overall, the study concluded that the LVCT training had a positive impact both at the individual and the organizational level.

LIST OF ABBREVIATIONS

ADAPT^{IT}:	Advanced Design Approaches for Personalized Training-Interactive Tools
AIDS:	Acquired Immune Deficiency Syndrome
ASTD:	American Society for Training and Development
CIPP:	Context, Input, Process, Product
FBOs:	Faith based organizations
CDC	Centre for Disease Control
GOK:	Government of Kenya
HIV:	Human Immunodeficiency Virus
ID:	Instructional Design
IiP:	Investors in People (UK)
ISD:	Instructional System Development
KCPE:	Kenya Certificate of Secondary Education
KSHs:	Kenya shillings
LVCT:	Liverpool VCT Care and Treatment
MSM:	Men who have sex with men
NACC:	National AIDS Coordinating Council
NASCOP:	National AIDS and STD control Program
NQAT:	National Quality Assurance Team
PAVE:	Promoting Added Value through Evaluation
PMTCT	Prevention of Mother To Child Transmission
RFF:	Requests for Funding
ROI:	Return on Investment
SPSS:	Statistical Packages for Social Sciences
TOT:	Training of Trainers
TVS:	Training Validation System
VCT:	Voluntary Counseling and Testing

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1.0 CHAPTER ONE: INTRODUCTION

1.1 Introduction.

This chapter is organized into the background of the study, statement of the problem, the purpose of the study, the research objectives, research questions, significance of the study and the scope of the study. The chapter also contains the definition of significant terms.

1.2 Background of the Study

HIV/AIDS remains a major health and developmental challenge facing Kenya today. Kenya has an average annual infection rate of 7%. The Ministry of Health estimates that there are 14,000 AIDS deaths (adults) and 86,000 new infections each year. (Kenya. Ministry of Health. National Aids and STI Control Program. 2005). To mitigate the HIV/AIDS scourge, Voluntary Counseling and Testing (VCT) was introduced to the public health care system in the Ministry of Health Strategic Plan of 1999-2004. Prior to this, it had been realized that most of the people who were infected were not aware of their HIV status. Research in other countries had shown that people who knew their sero-status, whether HIV positive or HIV negative, drastically changed their behavior (Kenya. Ministry of Health. National AIDS and STD control Program, 2001). VCT was therefore adopted by the Government of Kenya to target those not yet infected and identify early those who are infected for proper care services. To achieve those goals, the Ministry of Health recognized the need for comprehensive and standardized VCT operations in Kenya. As a result, the Kenya National manual for training VCT Counselors was launched in 2002 by the Ministry of Health with support from the Centre for Disease Control (CDC), United States of America International Development (USAID), Family Health International (FHI) and Department for International Development (DFID) United Kingdom.

The training manual was divided into eight modules as follows:

A. Module one: Self awareness
B. Module two: Psychological Theories of Counseling
C. Module three: Process and Practice of Counseling
D. Module four: HIV/AIDS information
E. Module five: HIV/AIDS Counseling
F. Module six: Psycho-Social Issues in Counseling
G. Module seven: Supervision and Stress Management
H. Module eight: Operational Procedures

According to the National AIDS and STD control Programme (2002), the overall goal of the training was to produce professional HIV/AIDS VCT Counselors. The training would equip trainees with skills and knowledge to help VCT clients lead healthy and satisfying lives by helping them deal with the clients difficulty life issues. The trainees would be provided with the opportunity to develop caring trusting and supportive relationships, practice self exploration, explore relationships with others and apply the knowledge of theoretical foundations of counseling. The trainees would also develop counseling skills, gain or update knowledge about HIV/AIDS, gain knowledge and skills about HIV/AIDS testing and VCT, develop skills on pre and post counseling and ongoing counseling, gain knowledge on professional issues in counseling such as ethics and supervision as well as skills in community mobilization.

The training manual outlines the counselors specific responsibilities as: to create awareness in the community about the existence of VCT services, prepare clients to take the HIV test by carrying out pretest counseling, carry out HIV testing where applicable, carry out post-test where applicable, provide on-going counseling to clients and make referrals for on-going support such as Home-Based Care, Medical Clinics, TB clinics, Support Groups and Post-Test Clubs. Other responsibilities include raising awareness about VCT services among colleagues at the VCT sites, ensuring quality of

VCT services, collecting client data and transmit the same to higher levels, record keeping, promotion and distribution of condoms.

Liverpool VCT Care and Treatment (LVCT) seized the opportunity and initiated the training of VCT counselors by offering a three-week residential training followed by three days observed practice. The organization has so far trained over 1700 VCT counselors since 2001.

Discussions with LVCT have revealed that no research has been undertaken to evaluate its trainings which justifies the need for this study. This section outlines the problem statement, purpose of study, research question, research objectives, significance and scope of study.

1.3 Statement of the Problem

Evaluation of a training course is a key component of any systematic approach to training (Sloman, 1994). A training evaluation enables the training manager not only to get the feelings of the trainees about the program but also the impact of the training to the individuals and the organizations they work for. LVCT has been carrying out three-week VCT trainings for over five years which is adequate time for impact to be realized (Kirkpartrick, 1976). Lack of a study on the impact of the LVCT three-week training should be a major concern to the LVCT management and the training program sponsors. In line with other development donors, results based planning is the sine qua non in modern day financing. Knowing the impact of the training (positive or negative) could help the training program developers with useful information to reduce any negative impact and accentuate the positive impact.

1.4 Purpose of Study

The purpose of the study was to evaluate LVCT's trainings carried out between 2003 and 2006 and determine the impact to the trainees, the workplace, the organization and beyond.

1.5 Research Objectives

The research had three objectives as stated below:

1. To appraise LVCT three-week VCT trainings
2. To establish the impact of LVCT three-week VCT training to the individual, workplace and beyond and
3. To find out the lessons learnt from the 2003 to 2006 LVCT three-week VCT trainees.

1.6 Research Questions

The study sought to answer the following questions:

1. What is the fit between the LVCT three week VCT training program, the job and strategic contexts?
2. What is the nature, frequency and extent of training program application to the job?
3. What is the degree and demonstrations of training impact to the trainees, the organizations and beyond?
4. What lessons can be learnt from the 2003 and 2006 trainees to improve the VCT trainings?

1.7 Significance of Study

The assessment would be useful to the Kenya's Ministry of Health (MoH), National AIDS and Sexually Diseases Control Program (NASCOP), National AIDS Coordinating

Council (NACC) and LVCT who would be able to receive an impact report and lessons learnt from the three-week VCT trainings. It would also be useful to LVCT's development partners as they will be able to get a documented report on the outcome of their input to the VCT trainings and qualitatively assess the return on investment (ROI). The results can be utilized to assist in future modification of the trainings and in support of future requests for funding (RFF).

1.8 Scope of Study

The study focused on all three week LVCT graduates between 1st January 2003 and 31st December 2006. The assessment therefore covered all the 1569 VCT counselors trained within that period living in Nairobi.

1.9 Limitations of the study

The list of former trainees obtained from LVCT proved ineffective in tracking down the former trainees. Most telephone numbers given during the training were either not functional or had a different user. Due to this challenge, it was not possible to carry out random sampling as expected. The research therefore resulted to snow balling which could have introduced a bias for practicing VCT counselors. The geographical expanse of the study area, inadequate financial resources and time constraints reduced chances of conducting reaching more respondents.

The above limitations were addressed by ensuring that, in the selection of the purposive sample, piloting and careful scrutiny of the perceived parameters of measurement in all the target institution. Questionnaire data was triangulated by interview with the trainee supervisors to help attain maximum information. This was useful in reducing financial and time constraints which could have made the study unaffordable.

1.10 Definition of Significant Terms

Voluntary Counseling and Testing - Self initiated decision to know one's own sero-status which involves counseling before drawing of a blood sample, informed decision to know the results of the blood test and counseling after knowing the sero-status.

Impact - The description by former trainees of LVCT of the lasting or significant changes, positive or negative, intended or not in their lives brought about by LVCT's training as described by the trainees and their supervisors.

Evaluation - Evaluation refers to the assessment (usually at the end) of a project or program or several years later, of its impact, effectiveness, efficiency, relevance and sustainability. In this case evaluation specifically refers to the assessment of the total value of a training system, training program in descriptive terms.

Trainees - People who attended a three-week VCT training at LVCT and graduated as VCT counselors irrespective of whether they are practicing as VCT counselors or not.

Training - Training is the investing in people to enable them perform better and make the best of their natural abilities. In this research, the definition is used to include a planned program to improve the performance and to bring about measurable changes in knowledge and skills to a targeted group.

Three-week VCT training - The training program in which the trainees undergo a residential training followed by three days of observed practice

Fit - The word fit refers to how the LVCT training is suitable or is in agreement with the training objective and the strategy adopted by the government of Kenya in response to HIV/AIDS.

2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter consists of a review of relevant literature to the study. The chapter begins with a critical presentation of training evaluation practice in the United States of America the Great Britain, Kenya and LVCT. The chapter also the meaning and importance of evaluation, different models of training evaluation with more emphasis on the Kirkpatrick model which is used in the study. The chapter ends with a discussion on LVCT input on the fight against HIV/AIDS.

2.2General view of training evaluation practice

Evaluation of a training course is a necessary weapon in a training manager's armoury (Sloman, 1994). Sloman (1994) goes on to say that evaluation is a key component of any systematic approach to training. In the United Kingdom, those who require recognition for their training effort must take effective evaluation to demonstrate tangible results to the trainees. It is difficult to discuss evaluation without a full understanding of training which is discussed below.

Training has been referred as the systematic modification of behavior through learning which occurs as a result of education, instruction, development and planned experience (Bass, 1966). The particular objectives of training are to: develop the competences of employees and improve their performance, ensure people become fully competent as quickly and as economically as possible and to help people learn to ensure future human resources can be met (Bass, 1966). Bass goes on to say that, effective training can minimize learning costs, improve individual, team and corporate performance in terms of output, quality, speed and overall productivity. Training can also improve operational flexibility by extending the range of skills by trainees.

Research found that 80% of establishments in Great Britain make no attempt to assess the benefits they gain from undertaking training (Sloman, 1994). In the United States, a report by Carnvale and Schulz (1990) for the American Society for Training and Development (ASTD) on the return on investment in training also painted a bleak picture. In its conclusion, the report said: "When it comes to investment in training and development, subjective decisions prevail" (P.148).

In another study, ASTD found that 45 percent of surveyed organizations evaluated trainings by only gauging trainees' reactions to courses (Bassi and van Buren, 1999). Overall, the study found, 93% of training courses are evaluated at the reaction level, 52% of the courses at the learning level, 31% of the courses at the behavioural and 28% of the courses at the results level. These data clearly represent a bias in the area of evaluation for simple and superficial analysis.

This situation is not different in Europe as evident in two European Commission projects that collected data exploring evaluation practices in Europe. The first one is the Promoting Added Value through Evaluation (PAVE) project (Donoghue, 1999). The study examined a sample of organizations (small, medium, and large), which had signalled some commitment to training and evaluation by embarking on the UK's Investors in People (IiP) standard (Sadler-Smith et al., 1999). Analysis of the responses to surveys by these organizations suggested that formative and summative evaluations were not widely used. On the other hand, immediate and context (needs analysis) evaluations are more widely used. In majority of the cases the responsibility for evaluation was that of managers and the most frequently used methods were informal feedback and questionnaires. The majority of respondents claimed to assess the impact on employee performance (the 'learning' level). Less than one-third of the respondents claimed to assess the impact of training on organization (the 'results' level). Operational reasons for evaluating training were cited more frequently than strategic ones. However, information derived from evaluations was used mostly for feedback to

individuals, less to revise the training process, and rarely for return on investment decisions. There were some statistically significant effects of organizational size on evaluation practice. Small firms are constrained in the extent to which they can evaluate their training by the internal resources of the firm. Managers are probably responsible for all aspects of training (Sadler-Smith et al., 1999).

The second study was conducted under the Advanced Design Approaches for Personalized Training-Interactive Tools (ADAPT^{IT}) project. ADAPT^{IT} is a European project within the Information Society Technologies program that provides design methods and tools to guide a training designer according to the latest cognitive science and standardisation principles (Eseryel and Spector, 2000). The study found no systematic and planned evaluation in practice or distinction between formative and summative evaluation. The most common activities of evaluation were the evaluation of student performance (i.e. assessment) and not enough evidence that evaluation results of any type were used to revise the training design (Eseryel et al., 2001).

In Kenya, like in many other parts of the world, evaluation is mainly limited to post-training/evaluation surveys or attitude questionnaires which barely assess the participants' reaction to the training and the increase in knowledge, skills and intellectual capability. These evaluations cannot be relied upon to judge learner's capability of performance. Little effort has been made to assess the extent to which trainees are able to apply what has been learnt in the actual work environment and its effect to the individuals or the organization.

LVCT is no exception to the Kenyan situation. No evaluation has so far been done to assess the impact of its trainings to the individuals, workplace and beyond in spite of more than five years of training. Hence the assessment could not have come at a better time since its findings will be able to provide LVCT with unbiased evidence of the impact of its trainings.

2.3 What is Evaluation?

The thesaurus defines evaluation as assessment, estimate, appraisal valuation, costing or estimation. Traditionally evaluation refers to the assessment (usually at the end) of a project or program or several years later, of its impact, effectiveness, efficiency, relevance and sustainability. It has emphasis on outcomes and impact and on learning for future broader and policy purposes beyond the particular project or program being assessed (Roche, 1999).

In training, evaluation specifically refers to the assessment of the total value of a training system, training program in social as well as financial terms (Sloman, 1994). This is different from validation which specifically looks at the achievement of laid-down training objectives. Evaluation is an integral part of most Instructional Design (ID) models. Evaluation tools and methodologies help determine the effectiveness of instructional interventions.

Despite its importance, there is evidence that evaluations of training programs are often inconsistent or missing (Carnevale and Schulz, 1990; Holcomb, 1993; McMahon and Carter, 1990). Possible explanations for inadequate evaluations include: insufficient budget allocated; insufficient time allocated; lack of expertise; blind trust in training solutions; or lack of methods and tools (see, for example, McEvoy, G. M., and Buller, P. F. (August, 1990). Sloman, (1994) adds three more reasons: the absence of straightforward practical techniques of evaluation which are readily understandable and capable of easy implementation, lack of self-discipline on the part of the trainer as well as confusion about what is meant by evaluation.

Part of the explanation may be the complexity of evaluation process. Evaluating training interventions with regard to learning, transfer, and organizational impact involves a number of complexity factors. These factors are associated with the dynamic

and ongoing interactions of the various dimensions and attributes of organizational and training goals, trainees, training situations, and instructional technologies. Evaluation goals involve multiple purposes at different levels. These purposes include evaluation of student learning, evaluation of instructional materials, transfer of training and return on investment. Attaining these multiple purposes may require the collaboration of different people in different parts of an organization. Furthermore, not all goals may be well-defined and some may change. In the following section, two approaches to evaluation and associated models are discussed.

2.4 Models of Evaluation

Models of evaluation define the parameters of an evaluation; what concepts to study, processes and methods that may be used. Commonly used approaches to training evaluation have their roots in systematic approaches to the design of training. They are typified by the Instructional System Development (ISD) methodologies, which emerged in the USA in the 1950s and 1960s and are represented in the works of Gagné and Briggs (1974) and Goldstein (1993).

Six general approaches to training evaluation can be identified (Bramley, 1991; Worthen and Sanders, 1987), as follows: Goal-based evaluation, Goal-free evaluation, Responsive evaluation, Systems evaluation, Professional review and Quasi-legal. Goal-based and systems-based approaches are predominantly used in the evaluation of training (Phillips, 1991). Various frameworks for evaluation of training programs have been proposed under the influence of these two approaches. Under the goal-based approach, the most influential framework has come from Kirkpatrick (Carnevale and Schulz, 1990; Gordon, 1991; Philips, 1991). The Kirkpatrick's model (1959) is based on four simple questions that translate into four levels of evaluation. These four levels are widely known as reaction, learning, behaviour and results.

Under the systems approach, the most influential models include: Context, Input, Process, Product (CIPP) Model (Worthen and Sanders, 1987); Training Validation System (TVS) Approach (Fitz-Enz, 1994); and Input, Process, Output, Outcome (IPO) Model (Bushnell, 1990). Two models were considered for this research; the four-level Donarld Kirkpatrick model and the Context, Input, Process and Product (CIPP) evaluation model developed by Daniel stufflebeam in 1966. In an overview and assessment of evaluation studies, about the CIPP model, Stufflebeam, (1983) stated: "Fundamentally, the use of the CIPP Model is intended to promote growth to help the responsible leadership and staff of an institution systematically obtain and use feedback so as to excel in meeting important needs, or at least, to do the best they can with the available resources. (p. 118)." In short, the CIPP Model places a premium on information that can be used proactively to improve a program. The CIPP model uses both quantitative and qualitative procedures with emphasis on proactive evaluation model.

As Stufflebeam (1983) noted, values-oriented studies aimed at assessing the overall merit or worth of a program are overly ambitious "for it is virtually impossible to assess the true worth of any object" (p. 18). Systems-based models like CIPP seem to be more useful in terms of thinking about the overall context and situation thus providing an excellent framework for approaching the multitude of possible variables in program evaluation but they may not provide sufficient granularity. The models may not represent the dynamic interactions between the design and the evaluation of training. Few of these models provide detailed descriptions of the processes involved in each step nor tools for evaluation. Furthermore, these models do not address the collaborative process of evaluation, that is, the different roles and responsibilities that people may play during an evaluation process. The four-level approach to training evaluation (Kirkpartrick, 1976) is by far the most popular approach to the evaluation of training in organizations today. Kirkpatrick's four 'levels' (Kirkpatrick, 1994) of

training evaluation model delineates four levels of training outcomes: reaction, learning, behaviour, and results.

Levels one and two are conducted at the time of the program offering and typically involve post course satisfaction questionnaires (level I), as well as pre and post competency testing (level II). Levels III and IV are normally conducted 6 months to two years post program. This allows time for the participants to use the new skills and knowledge, and for potential impacts to have been realized.

2.5 The popularity of the four-level Kirkpatrick Model

The Kirkpatrick model has served as the primary organizing design for training evaluations in for-profit organizations for over thirty years. The overwhelming popularity of the model can be traced to several factors.

First, the model addressed the need of training professionals to understand training evaluation in a systematic way (Shelton, 1993). The model has provided straightforward system or language for talking about training outcomes and the kinds of information that can be provided to assess the extent to which training programs have achieved certain objectives.

Secondly, Kirkpatrick (1994) insisted that information about level four outcomes is perhaps the most valuable or descriptive information about training that can be obtained. For training professionals in organizations, this bottom-line focus is seen as a good fit with the competitive profit orientation of their sponsors. The four-level model has therefore provided a means for trainers in organizations to couch the results of what they do in business terms. Many see this as critical if the training function is to become a true business partner and be seen as an active contributor to organizational success.

Finally, the popularity of the four-level model is also a function of its potential for simplifying the complex process of training evaluation. The model does this in several ways. First, the model represents a straightforward guide about the kinds of questions that should be asked and the criteria that may be appropriate. Secondly, the model reduces the measurement demands for training evaluation. Since the model focuses the evaluation process on four classes of outcome data that are generally collected after the training has been completed it eliminates the need for-or at least implies-that pre-course measures of learning or job performance measures are not essential for determining program effectiveness. In addition, because conclusions about training effectiveness are based solely on outcome measures, the model greatly reduces the number of variables with which training evaluators need to be concerned. In effect, the model eliminates the need to measure or account for the complex network of factors that surround and interact with the training process.

There is no doubt that Kirkpatrick's model has made valuable contributions to training evaluation thinking and practice. It has helped focus training evaluation practice on outcomes (Newstrom, 1995). Newstrom, (1995) fostered the recognition that single outcome measures cannot adequately reflect the complexity of organizational training programs, and underscored the importance of examining multiple measures of training effectiveness. The distinction between learning (level two) and behaviour (level three) has drawn increased attention to the importance of the learning transfer process in making training truly effective. The model has also served as a useful-if preliminary-heuristic for training evaluators (Alliger, 1989) and has been the seed from which a number of other evaluation models have germinated (Holton, 1996). It is for these reasons that the Kirkpatrick model was selected for this process.

2.6 Theoretical Framework

The evaluation approach was based on the Kirkpatrick model for training evaluation (Kirkpartrick, 1976), modified to fit the dimensions of LVCT's trainings. The model promotes the evaluation of training from four hierarchical levels: reaction, learning, learning transfer and the impact levels. It is the most widely used approach for evaluating training and aspects of the model are already embedded in LVCT.

Levels one and two are carried out at the time of the training program offering and typically involve post course satisfaction questionnaires as well as pre and post competency testing. Levels III and IV are normally conducted six months to two years post program. This allows time for the participants to use the new skills and knowledge, and for potential impacts to have been realized. LVCT has a practice of carrying out pre and post evaluation which capture level one and two of Kirkpatrick's evaluation model. As stated earlier, this evaluation whose main focus is learning transfer (level three) and results (level four) will be the missing link in the LVCT training evaluation chain.

2.7 Liverpool VCT Care and Treatment

Liverpool VCT Care and Treatment (LVCT) was first established in Kenya in 1998 and registered as a Kenyan NGO in 2001. Since then, LVCT has partnered with the Government of Kenya, through the Ministry of Health's National AIDS and STD control Program (NASCOP) in scaling up quality assured counseling and testing services in resource-poor settings throughout Kenya. LVCT also serves as the secretariat for NASCOP's National Quality Assurance Team (NQAT) for counseling and testing and has been central to the development of standards and guidelines for Voluntary Counseling and Testing (VCT) as well as the legal basis for registration, licensure and accreditation of VCT sites.

Of the roughly 700 VCT sites in Kenya, LVCT has helped to establish over 250. Through capacity-building of local partners, 150 of these have been "graduated" to be managed by the government of Kenya (GOK), community based organizations (CBOs) and/or faith based organizations (FBOs). For the remaining 100 on their way to being graduated, LVCT provides staff, basic training, refresher training, supervision and quality assurance guidance. LVCT has also trained over 70% of all the VCT counselors in Kenya. (Liverpool VCT Care and treatment, 2007).

Through its strong operations research program, LVCT contributes to evidence-based policy formulation and programming in Kenya by sitting on many of the task forces of NASCOP as well as the Interagency Coordinating Committee (ICC) of the National AIDS Coordinating Council (NACC). LVCT has also spearheaded gender equitable provision of HIV/AIDS prevention, care and treatment services with particular emphasis on improving access to services for groups with special needs including, inter alia: victims of sexual violence, the deaf and men who have sex with men (MSM).

LVCT offers a range of high quality residential courses for people wishing to work in counseling and testing (CT), care and treatment services. Courses offered include: Three week VCT Training, Couple HIV Counselling and Testing Training, Post Rape Care Management Training, Trauma Counselling Training, MSM services Training, ART and Opportunistic Infections Management Training, Community Mobilizers Training, Diagnostic Counseling and Testing Training, Adherence Counseling Training, Quality Assurance Training as well as Training of Trainers (TOT) on adherence counseling training, HIV related courses and laboratory technicians for counseling and testing. The overall goal for LVCT's trainings is to deliver the highest quality and cost effective training services, locally and internationally.

The three Week VCT Training course which is the focus of this research follows the Kenya National VCT Training Manual's curriculum for training of VCT counselors

(Kenya. Ministry of Health. National AIDS and STD control Program, 2001). It comprises a of a three-week taught course and three-days observed practice at a recognized VCT site as recommended by the Kenya National VCT Training Manual. Participants are expected to be committed in working in the field of VCT and priority for training is given to those who will actively work in VCT sites after the training. Participants must have good mastery of English and must be educated above Form 4 with a minimum grade of C in the Kenya Certificate of Secondary Education (KCPE).

Table 2.1: LVCT'S graduates between 2001 and 2006

Year of training	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**TOTAL**
Three week VCT Training	45	140	299	366	518	386	**1754**

Source: (Liverpool VCT and care and treatment, 2007)

As seen above, LVCT trained 1754 VCT counselors between 2001 and 2006. From the table, it can be seen that 1,569 VCT counselors were trained between 2003 and 2006. There was a general increase in the number of VCT counselors trained between 2001 and 2005. The number however dropped in 2006 due increased number of institutions offering VCT training. All respondents reported that they knew of the training through word of mouth. To maintain its status as the leading trainer of VCT counselors in Kenya, LVCT will have to diversify its method of advertising to include the print and the electronic media.

3.0 CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This section outlines the research design, population of the study, sampling design, data collection procedure, data analysis, work plan and the budget. First, a justification of the chosen methodological approach, a mix of qualitative and quantitative approach is presented. The methodological approach: the survey design is presented next, a very effective method for this type of study. The triangulation method, used to validate data collection techniques and verify the authenticity of information sources, is then presented together with the main data collection instruments. Following that, the planned strategies for data collection and analysis are presented. The main procedural steps of the research and the budget bring to conclusion the chapter on methodology.

3.2 Research design

The study used survey design to collect primary data. A survey design is useful in collecting opinions and responses to a given set of questions. A combination of qualitative and quantitative approach was adopted. Qualitative research design allowed respondents to give direct description about their experiences, opinions, feelings and knowledge. A descriptive and in-depth approach was applied to give a narrative justification of all concepts in an elaborate form. Both closed and open-ended questionnaires were used.

3.3 Target population

The research focused on a finite homogenous population of 1569 qualified LVCT trained counselors trained between 2003 and 2006. This category of trainees was chosen because adequate time has elapsed for any impact from the training to have been realized (Kirkpartrick, 1976). Secondly, it was easier to get the contacts of these trainees due to improved data management at LVCT during that duration.

3.4 Sample Size and Sampling Design

The research used purposive sampling to obtain a sample size of thirty three. A non-probability sample was used because the focus was in-depth information and not making inferences or generalizations. The sample selection was based on characteristics such as participation on LVCT trainings between 2003 and 2006, the ability to locate the former trainee and successful completion of the training including award of the VCT certificate. After thirty three completed questionnaires, a point of saturation had been reached and collection of data stopped. Majority of telephone numbers listed in the former LVCT's contact list were non functional so the researcher snowballed to get majority of respondents.

3.5 Research Instruments

Questionnaires were used to collect data. The questionnaires comprised both closed and open-ended questions. The open-ended questions were used to encourage the respondents to give an in-depth and felt response without feeling held back in revealing any information. This enabled collection of both quantitative and qualitative data.

3.6 Data Collection Procedure

A list of the 1,569 trained VCT counselors was obtained from LVCT. Before proceeding to the field, telephone calls were made to establish the exact physical location of the former trainees to enable delivery of questionnaires. Once contact was established, the questionnaires were hand delivered and filled in his presence of the researcher. Filled data collection instruments were edited to ensure they were completely filled. Quantitative data was coded and entered in excel sheets for analysis while textural data was typed for content analysis.

3.7 Pilot Study

Before the actual data collection, the data collection tools were piloted with a sample of ten trainees who were left out of the final research. Piloting was used to establish whether the questions were able to measure what they were intended to measure, whether the respondents interpreted all questions in the same way, whether the wording was clear, if there was researcher bias and rectify any errors. Piloting the study instruments increased their reliability and validity.

3.8 Reliability

Test-retest method was used to free the data collection tools from misinterpretation when administering the instrument in the main study. To ensure consistency, initial responses were used to reword the items. Any items found missing were included and unsuitable ones were discarded.

3.9 Validity

Validity is the accuracy or meaningfulness and technical soundness of the research. It is the degree to which a test measures what it purports to measure (Mugenda O. and Mugenda G, 1999). The data collection tools were reviewed by a team of experts made

up of former course mates, the LVCT research department members and the university course supervisor. At the end, it was agreed that the data collection tools had face validity. Further, a pilot study was conducted and the split half method was used to determine the correlation of the responses. A high correlation of 0.8 was obtained showing high internal consistency.

3.10 Data Analysis

The first step in data analysis involved careful scrutiny of completed questionnaires to ensure they were uniformly completely entered. The data was coded and entered into an excel spreadsheet. Statistical Package for Social Sciences (SPSS) was used to generate frequency distributions using descriptive statistics in order to examine the pattern of the responses. The findings are presented in the form of tables. Textural data obtained was analyzed by thematic and content analysis.

3.11 Ethical Considerations

The research raises several ethical issues. The right to privacy relates to the freedom of the individual to pick and choose for the time and circumstances under which, and most importantly, the extent to which, his attitudes, beliefs, behavior and opinions are to be shared with or withheld from others. To safeguard this right, the research observed anonymity and confidentiality. In the questionnaires, the identification numbers were removed after they are returned. For the personal interviews, no names or other means of identifying participants were acquired from the participants. Further, when preparing the data for analysis, precautions were made to separate identifying information from the data.

Balancing costs and benefits refers to the process of weighing potential contribution of the research project against its cost to the individual participants. Such costs in this case include the participant's time in answering the questionnaire or personal

interviews. The benefits include satisfaction in making a contribution to science and better understanding on the impact of VCT trainings. Though the process of balancing is largely subjective, the researcher is convinced the research project's benefits far outweigh the costs.

There is wide consensus among social science research that research involving human participants should be performed with the informed consent of the participants. This was observed and participants were made aware that they were free to decline participation at any point of the study process.

Liverpool VCT care and treatment reviewed the research proposal and offered input to the research proposal and the data collection instruments. They funded part of the research which would constitute conflict of interest since they are the subject of the evaluation. The researcher was however fully in control of the research process to avoid any biasness arising thereof.

4. CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS.

4.1 Introduction

In this chapter, the results of the study are presented and discussed. The chapter is divided into respondents' profile, learning evaluation, learning transfer evaluation, training impact to the respondents and training impact to the organization.

4.2 Respondents' profile

Table 4.1: Respondents' distribution by sex

Sex	Frequency	Percent
Male	13	39.4
Female	20	60.6
Total	33	100.0

From table 4.1, it can be seen that 60.6% of the respondents were female while 39.4% were male. This shows that more females than males were interviewed.

Table 4.2: Age distribution of respondents

Age	Frequency	Percent
18-24	1	3.0
25-34	14	42.4
35 and above	12	36.4
Total	27	81.8
Missing	6	18.2
Total	33	100.0

Table 4.2 shows that majority of the respondents were aged between 25-34 years. Those aged 35 and above were 12% and only one respondent (3.0%) was aged below 24 years. The age bracket, 25-34 years is notable since it shows the youth who are greatly affected by HIV/AIDS are contributing in the fight to eradicate it.

Table 4.3: Level of education before training

Level of education	Frequency	Percent
Form four	4	12.1
Certificate	13	39.4
Diploma	11	33.3
Bachelors degree and above	5	15.2
Total	33	100.0

Out of the total number of 33 respondents, 12.1% held form four certificates, 15.2% held a bachelors degree or higher training. Majority of the respondents were either certificate holders(39.4%) or diploma holders (33.3%). It is notable that VCT training being a certificate course attracted mainly certificate or diploma holders.

Table 4.4: Year of training.

Year	Frequency	Percent
2003	14	42.4
2004	6	18.2
2005	7	21.2
2006	6	18.2
Total	33	100.0

Table 4.4 above shows that majority of respondents (42.3%) were trained in the year 2003. 18.2 % of respondents were trained in 2006, 21.2 % in 2005 and 18.2% in 2004. These findings show that VCT trained in 2003 were more likely to find employment in Nairobi.

Table 4.5: Whether they are practicing VCT counselors or not.

Practicing VCT	Frequency	Percent
Yes	28	84.8
No	5	15.2
Total	33	100.0

The data above shows that 84.8 % of respondents were practicing VCT counselors. Majority of those practicing also undertake other responsibilities such as coordinating mobile VCT outreaches, counselor supervision, nursing and training. The main reason for not practicing was change of job to areas outside counseling.

Table 4.6: Who paid for their training

Sponsor of training	Frequency	Percent
Trainee	6	18.2
Employer	3	9.1
Scholarship	24	72.7
Total	33	100.0

It was found that 72.7% of the respondents were sponsored. The major sponsors for the training were Centre for Disease Control (CDC) and LVCT. The fee for the rest of the respondents was either paid by employers (9.1%) or self sponsored (18.2 %). Analysis showed that the trend has remained unchanged from 2003 to 2006 showing that the VCT training has remained a donor driven training. All the respondents indicated they knew of the training through word of mouth which would account for the low number of self sponsored trainees.

Table 4.7: Undertaking counseling before the training

Undertaking counseling before	Frequency	Percent
Yes	10	30.3
No	23	69.7
Total	33	100.0

At the time of training only 30.3% of the respondents were practicing counselors before the VCT training. The respondents had diverse backgrounds such as secretarial, nursing, police, research and social work. Others were straight from high school or college. For majority of the respondents who were employed by the time of the training, the information was communicated in their work places.

Hundred percent (100%) of respondents reported that information about the training was by word of mouth. LVCT needs to diversify to other modes of communication to attract increased number of trainees to ensure self sustainance.

4.3 Level two: Evaluation of learning

The tables below represent responses to questions used to evaluate whether the trainees learnt. The discussions follow immediately after.

Table 4.8: Enhancement of knowledge and skills

Knowledge and skills	Frequency	Percent
Great extent	26	78.8
Moderate extent	5	15.2
Small extent	2	6.1
Total	33	100.0

The LVCT three week training greatly enhanced the respondent's knowledge and skills in VCT counseling. Out of the 33 respondents, 78.8% stated that the training to a great extent enhanced their knowledge and skills in VCT counseling. Respondents indicated the training was detailed and professionally facilitated.

Table 4.9: Familiarization with counseling theories

Familiarization with counseling theories	Frequency	Percent
Great extent	12	36.4
Moderate extent	16	48.5
Small extent	5	15.2
Total	33	100.0

Majority of the respondents (48.5%) were of the opinion that the training moderately familiarized them with counseling theories. Only 36.4% felt the training greatly familiarized them with counseling theories. Respondents indicated that the theories

were not covered in depth hence could not remember much about them. A big percentage of the respondents cited short time duration as a possible course for the less than satisfactory coverage of the counselling theories.

Table 4.10: Preparation for counseling work

Familiarization with counseling work	Frequency	Percent
Great extent	26	78.8
Moderate extent	2	6.1
Small extent	1	3.0
No extent	1	3.0
Total	30	90.9
Missing	3	9.1
Total	33	100.0

Seventy eight percent (78.8%) of the respondents said that the observed practice prepared them for counseling work to a great extent. Respondents argued that observed practice offered useful support which helped them gain confidence in the initial work sessions which were said to be challenging and intimidating causing fear and anxiety. The presence of the experienced counselors during the observed practice sessions offered much needed support in the counseling room. This should be encouraged and supported to ensure competence of the VCT counselors.

Fifty seven percent (57.6%) of respontents indicated that the training to a great extent contained appropriate information on VCT counselling. Respondents lauded the training methodology which ensured every trainee had an opportunity to contribute to the training by sharing their own experiences. Participants said they were *"well taken through the VCT protocol."* Some respondents were of the opinion that more time should be allocated to drugs and adolescence counseling.

Sixty nine percent (69.7%) of the respontends said the training to a great extent contained relevant practical application of learning. Major contributors to the practice

were cited as the evening practice and role play sessions, observed practice and the training methodology which is mainly experiential learning. This data suggests residential trainings as much as possible should be encouraged. It should be noted that this will come and a cost and hence imperative that the training venue should be carefully chosen to ensure the training remains affordable. In situations where residential training is not feasible, the need to extend the duration of the training should be explored. Overall, 84.8% of the respontends indicated that their training expectations were met to a great extent .

4.4 Level three: Evaluation of learning tranfer to the work place

This section presents data collected to evaluate learning transfer to the workplace. Reponses were sought concern specific tasks that VCT counsellors are engaged on a day to day basis. The data is presented in the form of tables with discussion following immediately after.

Fourty five percent (45.5%) of the respondents indicated the training to a great enabled the participants to carry out community mobilization while 30.3% indicated they were moderately enabled to carry out community mobilization. Respondents were split with some indicating they have been able to effectively carry out community mobilization. Others argued that little emphasis was placed on it and that the session was not well tackled. The data shows a degree of dissatisfaction and more time should be allocated to this important session in future trainings.

Table 4.11: Ability to keep VCT records

Ability to keep VCT records	Frequency	Percent
Great extent	13	39.4
Moderate extent	13	39.4
Small extent	6	18.2
Total	32	97.0
Missing	1	3.0
Total	33	100.0

The respondents were undecided on whether the training to a great extent or moderately enabled them keep VCT records. An equal number, (39.4%) of the respondents indicated moderate and great extent on the training's ability to enable the participants keep VCT data. Respondents argued that record keeping in the field keeps on changing calling for constant updating by all practicing VCT counselors.

Seventy five percent (75.5%) of the respondents indicated that the training has enabled them to contribute to the VCT counselling profession through presentations and training others. Respondents have facilitated trainings on HIV related issues, set up support groups, offered support supervision and continue to share their information with people in informal settings.

One hundred percent (100%) of the respondents indicated that they are able to apply the knowledge and skills learnt at the workplace. It was evident that whether practicing as VCT counselors or not, all respondents are able to apply the knowledge and skills acquired at the training in their daily life.

Seventy eight percent (78.8%) of respondents indicated they face challenges in applying the knowledge and skills in the workplace. Major challenges include counseling couples (especially discordant couple), alcohol, family planning, drug adherence and youth counseling. This confirms that VCT is an entry point to other care services based on the trainees reporting challenges with service provision beyond HIV/AIDS.

The training promoted peer interaction with 81.1% of the respondents indicating they have been in contact with other LVCT colleagues. Interaction was mainly occurred in peer support and supervision.

Materials provided during the training are frequently used with 81.8% of the respondents indicating they have refered to the LVCT training materials in the course of their work. Respondents mainly refer to clarify and refresh their knowledge.

4.5 Level three: LVCT training impact to the respondents

The questions on this section sought to evaluate whether the training had impact on the former LVCT trainees. Questions were designed to capture both positive and negative impact. Space was provided to capture qualitative data on the variable. The data is presented in the form of tables.

All the respondents (100%) said the training had a positive impact them. Major impact was reported in personal behaviour change, self awareness and improved people skills. Respondents reported improved acceptances of people living with HIV/AIDS (PLWHAs) and increased openness in discussing HIV matters with family members. A few respondents argued the training methodology, which emphasized open sharing exposed them leaving them vulnerable. This argument should be viewed in light of the training objectives which included providing the trainees with an opportunity to develop caring, trusting and supportive relationships.

Ninety percent (90.9%) of the respondents indicated that the training stimulated further training. Areas of further training include VCT training of trainers (TOT), couple VCT, higher Diploma in counseling, trauma counseling, prevention of mother to child transmission (PMTCT) counselor supervision, quality assurance and adherence counseling. Some respondents also reported career progression, growing to head departments in the organizations.

Table 4.12: Change in level of income

Change in level of income	Frequency	Percent
Great extent	7	21.2
Moderate extent	16	48.5
Small extent	4	12.1
No extent	5	15.2
Total	32	97.0
Missing	1	3.0
Total	33	100.0

The training did not result to increased economic benefit for the individual trainees. Only 21.2% of the respondents said that their level of income has increased to a great extent, 48.5% to a moderate extent, 12.1% to a small extent and 15.2% to no extent. Majority of the respondents felt the change in income has been below expectations with the uniformed services deploring the increased responsibilities of counseling without any extra benefit.

4.6 Level four: Training impact to the organization

Ninety seven percent (97%) of the respondents or 100% of those who respondent to the question said that they felt they had made impact in the organizations they work for. Respondents also argue they have provided quality services. In some cases this has led to organizational growth and improved inter personal relationships in the work place. This is supported by 51.5% of the respondents who indicated that their VCTs have received accreditation, a mark of quality.

Ninety seven percent (97.0 %) of the respondents argued that VCT is contributing to the fight against HIV/AIDS and believe that it is a good intervention as knowing ones HIV status translates to behaviour change and ultimately HIV reduction. Majority of the respondents (93.9%) expressed the need to make changes to the VCT training. Some of the changes suggested include; increasing the duration of the training to allocate more time to the counseling theories, the practical session. They also expressed the need to

amalgamate the other small training packages such as PMTCT, CVCT, DCT, PITC, inclusion of more content on drugs, young people, STIs, children and family planning.

5.0 CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to determine the impact of LVCT's three-week VCT trainings carried out between 2003 and 2006 to the trainees, workplace, and organization. This was to help determine the fit between the LVCT three week VCT training program, the job and strategic contexts, determine the nature, frequency and extent of training program application, determine the degree and demonstrations of training impact and learn lessons from the 2003 and 2006 trainees to improve the three-week VCT trainings. This chapter presents a summary of the finding and recommendations.

5.2 The fit between the training, job and strategic context

All respondents indicated that they are able to apply the knowledge and skills in their work. This is a positive response noting that 15.2% are not practicing VCT counsellors. Majority of respondents (97.0%) argued that VCT is contributing to the fight against HIV/AIDS. Eighty one percent (81.1%) of the respondents said they have consulted other LVCT colleagues on work related issues showing good interaction among former trainees. A similar number (81.8%) of the respondents indicated that they refer to the LVCT training materials in the course of their work. From these findings, it can be concluded that the knowledge and skills gained from the training have been applicable to the job and hence the LVCT three week VCT training program should be seen as appropriate and relevant to the VCT work.

5.3 Nature, frequency and extent of training program application

Majority of respondents (78.8%) stated that the training greatly enhanced their knowledge and skills in VCT counseling. The knowledge acquired at the training greatly enabled participants to carry out community mobilization. Study findings show that the training did greatly enable the participants to keep VCT records and moderately familiarized them with counseling theories. Respondents argue the content was rushed due to inadequate time allocation for these sessions.

All respondents (100%) indicated that they are able to apply the knowledge and skills learnt at the workplace. As dicussed earlier, majority of respodents said they have been in contact with former LVCT coleagues and refer to the LVCT training materials in the course of their work. Seventy five percent (75.5%) of the respondents indicated they have contributed to the VCT counselling profession through presentations and training others. These findings demonstrate learning transfer to the work place.

5.4 Degree and demonstrations of training impact

All respodents (100%) indicated that the training had a positive impact on them. A big percentage (90.9%) of the respondents indicated that the training stimulated further training. A hundred percent (100%) of the respondents felt they had positively impacted their organizations. About half (51.5%) of the total respondents indicated the VCTs in which they work for have been accredited, a measure of quality. Ninety seven percent (97.0%) of the respondents felt the VCT is contributing to the fight against HIV/AIDS. About fifty percent (48.5%) of the respondents indicated a moderate increase in personal income. From these findings, it can be concluded that the training had a positive impact at the individual and organizational level although the respondents' level of income did not increase significantly. The findings also reveal an average performance in provision of quality VCT services as shown by the fact that only about half of the VCTs have been accredited.

5.5 Discussion of findings

As discussed in the background section of this study, VCT was adopted by the Government of Kenya as an HIV/AIDS prevention strategy to target those not yet infected and identify early those who are infected for proper care services. The VCT training manual sought to produce professional HIV/AIDS VCT Counselors. (Kenya. Ministry of Health. National AIDS and STD control Program, 2002). The training would equip trainees with skills and knowledge to help VCT clients lead healthy and satisfying lives by helping them deal with the clients difficulty life issues. As discussed in section 5.2, 78.8% of the respondents stated that the training greatly enhanced their knowledge and skills in VCT counseling.

According to the NASOP VCT training manual (2002), the trainees would be provided with the opportunity to develop caring, trusting and supportive relationships. Research findings support the achievement of the objective except for one trainee who felt the training left him vulnerable after sharing personal information during the training. Other objectives of the training were to help trainees practice self exploration, explore relationships with others and apply the knowledge of theoretical foundations of counseling. Evidence of improved interpersonal relationship is reported in section 5.4 above. The training sought to equip VCT counselors with skills in community mobilization. This was well achieved as reported in section 5.3. These finding is in line with the outlined counselors' specific responsibilities of creating awareness in the community about the existence of VCT services, preparing for the HIV test and making referrals for on-going support. Awareness creation, one of the trainees' responsibilities, is reported in section 4.6 where ninety seven percent (97%) of the respondents argued the training has improved inter personal relationships in the work place and that they shared HIV/AIDS information in informal settings in their places of work.

Research findings show the VCT counselors who are charged with the responsibility of ensuring quality of VCT services and record keeping have not performed very well in those areas.

5.6 Conclusions

Conclusions are constrained by a number of factors. The nature of the program precluded unfettered access to sources, which could validate the effects and impacts of the training program reported by respondents. The purposive sample cannot allow for generalizations across LVCT VCT trainee population and the traditional examination of 'organizational impacts' is not appropriate for the highly dispersed and voluntary participation in this program.

In spite of these caveats, the evaluation information is meaningful and engenders a level of confidence about the positive effects of the program on and through the evaluation contributors. There are both repeated and consistent themes in the data and information collected which demonstrate a strong affirmative response to the evaluation questions posed. Survey respondents report using acquired knowledge and skills in their work.

Positive impacts and influences from the program were identified at an individual, work unit and organizational levels. Contributors to this evaluation claim increased self awareness and accreditation of their VCT facilities. Findings from the study show there is demand to increase the duration of the training to cover more content in counseling theories, community mobilization and record keeping. Research findings suggest residential trainings should be encouraged as much as possible. This could come at a price such as time, social costs as well as finances. It is imperative that the training venue be carefully chosen to ensure the training remains affordable. In situations where residential training is not feasible, the need to extend the duration of the training should

be explored. Enthusiasm for the program and the networks forged remain very strong. This is attributed to the rich diversity of the participants.

The VCT training has remained donor driven from 2003 to 2006. Majority of respondents were sponsored. All the respondents indicated they knew of the training through word of mouth which would account for the low number of self sponsored trainees. Overall, critique and suggestions for improvements were soundly outweighed by commentary on the positive effects and impacts of this program. From the above findings, it can be concluded that there LVCT training has had a positive impact to the individuals and the organizations.

5.7 Recommendations

Based on the findings, the study makes the following recommendations:

There is need to increase the duration of the VCT training. Study findings reveal a less than satisfactory coverage of counseling theories, VCT data record keeping and community mobilization.

The content of the training should be expanded to include issues on family planning, alcohol, drugs, counseling young people, STIs, children, family planning and substance abuse. Respondents cited challenge in addressing these issues.

There is need to amalgamate other related training such as PMTCT, CVCT, DCT, and PITC into one packages. There is no doubt that the training packages are all interrelated and contribute to the same objective of repulsing and eradicating the threat of HIV/AIDS.

The training evaluation should be planned at the level of curriculum design. This should include the indicators to be evaluated, when the training will be evaluated and who will

be responsible. Resources including time and finances should be allocated for the evaluation process.

5.8 Suggestions for Further Study

Based on the findings from this study, the research recommends the following areas for further study;

1. An analysis study of the impact made by VCT counselors in other parts of the country.
2. A comparative study on the training methodologies employed by different VCT counseling training institutions.

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APPENDIXES

Appendix 1: LVCT three week VCT training course modules

1. Introduction of training course and course objectives
    a. Pre course Evaluation
    b. Personal Evaluation
2. Module 1: Self Awareness exercises
3. Module 2: Psychological issues in Counselling
    a. Theories of Counselling
    b. Psychoanalytic theory
    c. Behavioural theory
    d. Cognitive Behaviour theory and
    e. Person Centred theory
4. Module 3: Process and Practice of Counselling
    a. What is Counselling?
    b. Egan's Model of Counselling
    c. Decision-Making Skills
    d. Self/Peer Assessment Form
    e. Giving and Receiving Feedback
5. Module 4: HIV and AIDS information
    a. Blood Tests for HIV
    b. Disease Progression
    c. The virology of HIV
    d. HIV replication
    e. Points of action for antiretrovirals
    f. Antiretroviral Therapy
    g. Nutrition
    h. Drug Treatments for HIV
    i. Post Exposure Prophylaxis(1)
    j. Post Exposure Prophylaxis (2)
    k. Mother-to-Child-Transmission
    l. Sexually Transmitted Infections
    m. TB
    n. HIV and Mental Health
    o. HIV and Family Planning
    p. HIV and Gender Issues
6. Module 5: HIV and AIDS Counselling
    a. VCT Protocol Diagram
    b. VCT Protocol Summary
    c. Full VCT Protocol
    d. Waiting for VCT (Picture)

e. Risk Reduction language
f. Pre/Post Test Summary
g. Guide to Conducting Role Plays
h. Couple counselling
i. HIV and Young people
j. Pre and post test guide
k. The VCT protocol narrative

7. Module 6: Good Laboratory Practice
    a. HIV Testing Procedures
    b. WHO Guidelines
    c. Test Kit Use and Interpretation of Results
8. Module 7: Psycho-social Issues in Counselling
    a. Sexual Organs (Female)
    b. Sexual Organs (Male)
    c. List of Sexual Organs
    d. Condom Use
    e. What is Good Sex?
    f. Safer Injecting Drug Use
    g. Loss and Grief
    h. Post test clubs
    i. Concept of community mobilization
9. Module 8: Supervision and Stress Management
    a. What can we do about stress?
    b. The Aim of Supervision
10. Module 9: Operational Procedures
    a. VCT Counsellors' Job Description
    b. What is VCT?
    c. VCT as an Entry Point
    d. Definition of VCT
    e. Developing a Referral Network
    f. Quality Assurance
    g. Record keeping and Confidentiality
    h. VCT Form Guidelines
    i. National VCT Data Form
    j. VCT Monthly Summary Sheet
    k. Client Exit Interview
    l. Guidelines for Observed Practice
    m. Observed Practice Forms
    n. A guide to observed practice

Appendix 2: Cover Letter

Dear former Liverpool VCT care and treatment trainee,

Good morning/afternoon. My name is Jonathan Mbului, a student at the University of Nairobi. I am working on an evaluation of the three weeks VCT training targeting LVCT trained VCT counselors between 2003 and 2006. The purpose of the evaluation is to determine the impact of the training to the trainees, the workplace, the organization and beyond.

The purpose of this letter is to obtain your consent to participate in this study. There are no wrong or right answers; we are just seeking your opinion. If you agree to participate, please sign the consent form and hand it back to us. Confidentiality will be observed and all responses will be stored in a locked cupboard under the principal investigators' control. Your name, or other identifying information, will not appear anywhere on the interview record.

There are no risks associated with your participation in this study. You will be asked about your perception of the LVCT three-weeks VCT training which you attended, your application of the knowledge and skills in the work place and the organization. Although you will not receive immediate benefit from this research, you may benefit from this research in the future, if it helps to improve the VCT trainings.

You are requested to fill the questionnaire which will take about 20 minutes. Your participation is voluntary. If you do choose to participate but prefer not to answer certain questions, you are free to do so. You are free to ask any questions before signing the form I am giving you. If you have questions during the course of the study, you may contact the following:

Jonathan Mbului
Principle Investigator
University of Nairobi
Tel 0722 702193

I have read the information sheet for the study and voluntarily agree to take part in this study.

Signature.....
Date .....

Appendix 3: Telephone Conversation Protocol

Good morning/ Afternoon/Evening

My name is ..... (*Name of the research assistant*) and I am calling on behalf of Jonathan Mbului of the University of Nairobi.

Jonathan is planning to carry out an evaluation on the 2003 to 2006 LVCT trained VCT counsellors. He would like to find out whether you would voluntarily accept to participate in the study.

If no, thank them and terminate the conversation.

If yes, ask their exact location/ where they can be found to facilitate the delivery of the questionnaire. (Town and exact street and building.)

Thank them and terminate the conversation.

Appendix 4 : Survey Questionnaire for Former LVCT Trainees

SECTION 1: Respondents profile

(*For this section, tick one category that is applicable to you.*)

1. What is your sex?
   - Male ( )
   - Female ( )
2. What is your age?
   - 18-24 Years ( )
   - 25-34 Years ( )
   - 35 years and above ( )
3. What was your highest level of formal education when you attended the LVCT training?
   - Form four ( )
   - Certificate ( )
   - Diploma ( )
   - Bachelor's degree and above ( )
4. I attended LVCT training in the year:
   - 2003 ( )
   - 2004 ( )
   - 2005 ( )
   - 2006 ( )
5. Are you currently practicing as a VCT counsellor
   - Yes ( )
   - No ( )

   Please explain

   ---

6. Who paid for your attendance at LVCT?
   - Myself ( )
   - My Employer ( )
   - Scholarship ( )

   Please explain

Great extent ( )
Moderate extent ( )
Small extent ( )
No extent ( )

14. To what extent do you think the LVCT training contained appropriate information on VCT counselling?
    Great extent ( )
    Moderate extent ( )
    Small extent ( )
    No extent ( )
15. To what extent do you think the LVCT training provided sufficient theoretical learning?
    Great extent ( )
    Moderate extent ( )
    Small extent ( )
    No extent ( )
16. To what extent do you think the LVCT training had relevant practical application of learning?
    Great extent ( )
    Moderate extent ( )
    Small extent ( )
    No extent ( )
17. To what extent do you think the LVCT training met your expectations?
    Great extent ( )
    Moderate extent ( )
    Small extent ( )
    No extent ( )
18. To what extent did the observed practice prepare you for the VCT counselling work?
    Great extent ( )
    Moderate extent ( )
    Small extent ( )
    No extent ( )

SECTION THREE: APPLICATION OF KNOWLEDGE AND SKILLS IN THE WORK PLACE.

19. Can you apply skills and knowledge learned in the VCT training to your work?
    Yes ( )
    No ( )

Please explain?----------
---

20. Do you encounter any challenges in applying the knowledge and skills acquired in the training?
    Yes ( )
    No ( )
    If yes, please explain.----------
    ----

21. Have you ever contacted/been contacted by LVCT colleagues for advice on a work challenge?
    Yes ( )
    No ( )

    If yes, please explain.----------
    ----

22. Have you ever referred to the VCT training materials in the course of your work?
    Yes ( )
    No ( )
    If yes, what made you to refer? ----------

SECTION FOUR: LVCT TRAINING IMPACT ON YOU

23. Has the LVCT three-week training had any positive effect on you?
    Yes ( )
    No ( )

Please explain----------
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24. Has the LVCT three-week training had any negative effect on you?
    Yes ( )
    No ( )

Please explain----------
----

25. Since attending LVCT training, have you had an opportunity to further your knowledge about HIV/AIDS or counselling?
    Yes ( )
    No ( )

Please explain----------
----

26. Since attending LVCT training, have you contributed to the VCT counselling profession through presentations or training others?
    Yes ( )
    No ( )

27. Since attending LVCT training, to what extent has your level of your income changed?

Great extent	( )
Moderate extent	( )
Small extent	( )
No extent	( )

Please explain----------

SECTION FIVE: LVCT TRAINING IMPACT ON YOUR ORGANIZATION

28. Do you feel you have made any impact in your work place as a result of attending the three week VCT training?

Yes	( )
No	( )

Please explain----------
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29. Has your VCT facility received accreditation?

Yes	( )
No	( )
Not Applicable	( )

Please explain----------

SECTION SIX: ADDITIONAL COMMENTS

30. Do you think the VCT training is contributing to the fight against HIV/AIDS?

Yes	( )
No	( )

Please explain----------
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31. Are there any changes you would suggest to be made to the LVCT three weeks VCT training?

Yes	( )
No	( )

Please explain----------
