

## ORIGINAL RESEARCH

## UTILIZATION OF VOLUNTARY COUNSELLING AND TESTING SERVICES BY WOMEN IN A KENYAN VILLAGE

MARGARET MUGO<sup>1</sup>, CHARLES KIBACHIO<sup>2</sup>, and JOHN NJUGUNA<sup>2</sup><sup>1</sup>Constituency Aids Control Coordinator, Laikipia West, Nyahururu; and <sup>2</sup>District Public Health Office, Nyandarua, Kenya.Corresponding Author: Mr John Njuguna ([jowanju2002@gmail.com](mailto:jowanju2002@gmail.com))

## ABSTRACT

**Background:** Voluntary HIV Counseling and Testing (VCT) is a key intervention in HIV/AIDS prevention as it serves as an entry point for other key interventions like antiretroviral therapy. **Methods:** A cross-sectional descriptive study was carried out among 138 women of reproductive age in a Kenyan village to determine their perceptions and utilization of VCT services. **Results:** The mean age of participating women was 30.1 years and 74.6% (95%-confidence interval (CI) 66.5 to 81.7) had visited a VCT centre. The key hindrances to women to use VCT services were stigma (38.4%), fear of the unknown (37.7%) and fear of rejection (10.9%). Women in the 15 to 24 year age group were more likely to have visited a VCT centre compared to those in the 25 to 49 age group (Odds-ratio = 2.2; 95% CI 0.95 to 5.3). A majority of respondents (88.4%) stated that those living with HIV/AIDS in their community were stigmatized. **Conclusion:** The study showed that there was a need to engage the community to reduce HIV/AIDS related stigma. Although use of VCT services was already relatively high amongst young women future efforts to increase uptake of services in this sexually active group might be required. These efforts could entail establishing youth friendly VCT services and youth lay counselors.

**KEYWORDS:** Voluntary counseling and testing; Kenya; HIV/AIDS; Africa.**SUBMITTED:** 30 December 2009; **ACCEPTED:** 7 March 2010

## INTRODUCTION

HIV/AIDS is a major public health problem in Kenya. In 2008 the prevalence of HIV/AIDS in Kenya was 7.8% (UNAIDS, 2009). Women were more affected with HIV (8.7%) compared to men (5.6%) (Nascop, 2008). In Kenya Voluntary HIV Counseling and Testing (VCT) is the process whereby an individual or a couple undergoes counseling to enable him/her/them to make an informed choice about being tested for HIV. The decision for testing remains the choice of the individuals and the process is completely confidential. However, VCT is more than drawing and testing blood and offering counseling sessions. It is a vital point of entry to other HIV/AIDS services including prevention and clinical management of HIV related illnesses, control of tuberculosis, psychosocial and legal support, and prevention of mother to child transmission of HIV (Painter, 2001; Sangiwa, 2000).

VCT can also be an effective behavior change intervention. A meta-analysis of the effect of HIV counseling and testing found that HIV positive individuals who used VCT reduced their risk behaviours and had safe sex more frequently (Weinhardt 1999). Despite high initial costs, VCT has been shown to be a cost effective long-term strategy, suggesting VCT to be a feasible public health intervention. A study

conducted in Kenya and Tanzania estimated that the hypothetical cost of VCT was comparable to the cost of sexually transmitted infections (STI) services and childhood immunizations (Sweet 2000). In Kenya, the number of people who have been tested for HIV has increased from 1000 in 2000 to more than 2 million in 2007. This has been partly attributed to an increase in the number of counseling and testing sites from 3 in 2000 to close to 1000 in 2007 (Republic of Kenya, 2008). Most of these VCT sites are client initiated and have certain shortcomings. Transport difficulties and fear of being sighted at a health facility may limit the number of people being tested (Yoder, 2006).

In addition there are factors such as inadequately skilled service providers and inadequate resources (Matovu, 2007) which might hinder the utilization of VCT services. Also, the stigma of HIV/AIDS, fear of negative reactions due to disclosure of being positive, as well as the perception of being at low risk for HIV infection might further restrict the use of VCT (Matovu 2007). Women were found to be particularly disadvantaged as utilization of VCT might expose them to partner violence, and marriage dissolution. In addition their lack of autonomy hinders women in Kenya to use VCT service, even when it is offered free of charge (Pool 2001).

HIV disproportionately affects women in Kenya, with an estimated 1.8 women infected for every man (Republic of Kenya, 2004). Despite the increased uptake of VCT services, nearly two thirds of Kenyans did not know their HIV status, and four out every five HIV positive Kenyans did not know that they were infected (Nascop, 2008). The present study looked at the utilization of VCT services among women in a Kenyan village.

## METHODS

The study area was Maina village which is located in Laikipia West district of the Rift Valley province of Kenya. The district lies on the leeward side of Mt Kenya. It has an annual average rainfall of approximately 700 mm and the area is categorized as semi arid. Communities here comprise of subsistence farmers growing crops, mainly maize and beans, and keeping livestock. Maina village (population about 25,000) was started in 1965 to settle people who had been employed in the settler farms and government service (UN Habitat, 2008). Maina village is bisected by a main road. A government run dispensary provides health care including VCT services. There is also an administrative post, a number of schools and churches. Maina village is not a typical rural Kenyan village but rather a peri-urban area, with residents being able to access VCT services from a number of providers. The dispensary located centrally in the village offers VCT services. Nyahururu town is less than five kilometers away and offers another three VCT centers.

### Study design

The study design was cross-sectional. The study population comprised women of child bearing age between 15 to 49 years. Ethical clearance was obtained from the ethical committee at the Kenya Medical Training College and from the District Health Management Board, Laikipia district.

The public health officer in charge of the village and the local elders introduced the study to the community prior to data collection. The same elders led the researcher and introduced her to the various homes during the actual data collection phase. Most of the interviews were carried out in the privacy of homes and the languages used were English, Swahili and Kikuyu. The latter is a local dialect.

Sampling was not random. Maina village is divided into four areas and two relatively more densely populated areas were allocated a proportionally higher sample size. Eligibility criteria for participants were being female, aged 15 to 49 years, and having lived in the study area for more than six months.

Consent was obtained verbally after the purpose of the study was explained to the women. A semi structured questionnaire was administered, after informed consent had been received. The survey tool included general knowledge questions about HIV/AIDS; questions referring to the availability of VCT services in the local area; the range of services offered; and to stigma related issues. The study

was undertaken during the months of April to May 2008. Data was analyzed using SPSS version 11 (SPSS Inc, Chicago, Illinois).

## RESULTS

All participating women were Christians and had a mean age of 30.1 years. Almost all (98.6%) of them had heard of HIV/AIDS. The source of information was mostly from the radio (44.9%) and the hospital (27.5%). When asked if a woman can transmit the virus to members of her household, 81.2% of respondents said "yes". Women responded that transmission can be through blood (77.5%), shaking hands (0.7%) and eating together (0.7%).

Counseling was cited as the key service offered in a VCT center by 73.2% of respondents. VCT was defined as counseling and testing of HIV by 88.4% of participants. A majority of respondents (63%) had learnt about VCT through the radio and 10% through television. When asked where VCT services were offered in their locality a majority mentioned the health center (54.3%) and dispensary (29%). A majority (72%) reported that the distance to the local VCT provider was less than 5 km.

A majority of respondents (74.6%; 95%-confidence interval (CI) 66.5-81.7) had previously been to a VCT center. The preferred services were counseling (68.8%) and health education (10.9%). The participants perceptions were that women living with HIV/AIDS in the community were stigmatized (61.6%), rejected by parents (8.0%), and divorced by husbands (4.3%). The key hindrances to women utilizing VCT were stigma (38.4%), fear of the unknown (37.7%) and fear of rejection (10.9%). When asked to whom they would disclose test results, the respondents cited husbands (41.3%), partners (32.6%), and relatives (13.8%). A majority of respondents (88.4%) said that partners were being invited to join during VCT sessions.

The statistical analysis of predictors of VCT use showed no significant results. Women aged 15 to 24 years were twice as likely to report using VCT services compared to older women (OR 2.2; 95% CI 0.95-5.3). Women with secondary level education or higher were more likely to report using VCT compared to women with only primary level education (OR 1.3 95% CI 0.89-1.7). Married women were more likely to report using VCT compared to unmarried, widowed or divorced women (OR 1.2 95% CI 0.88-1.6).

## DISCUSSION

A high proportion of respondents of the present study reported the use of VCT services, though the study did not determine whether the responding women had used VCT for testing for HIV/AIDS or counseling. A study from 2004 in the neighboring district of Nakuru, found that 35.9% of respondents had been tested for HIV (Irungu 2008). Preliminary findings of the Kenya AIDS survey from 2007 indicated that about 43.3% of women aged 15 to 49 years had been tested for HIV (Nascop 2008). In Kenya, it is

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estimated that approximately 50% of urban residents have been tested for HIV at least once, compared to 30% in rural areas (Nascop 2008).

The study area was the previous control site for a community driven reproductive health program for young people (Erukka, 2003). The final survey in 2001 showed that 21% of girls had sexual initiation and 30% had had more than three sexual partners in the last three years. It is therefore likely that young women may have perceived themselves to be at risk of contracting HIV and may have used the VCT services of the area. There might be a need to expand access to VCT services for this group of clients given the limitations of the facility based services (Matovu, 2007). Possible options should include starting youth friendly services and using lay counselors to provide community based VCT services. HIV/AIDS related stigma was found to be a major impediment to utilization of VCT services. Strategies must be put in place to reduce stigma, if the uptake of VCT services is to be increased.

Our study showed that younger women had a tendency although not statistically significant to reporting VCT service use more frequent. This result is encouraging as in Kenya, a woman aged 15 to 24 years is estimated to be four times more likely to be HIV positive compared to a man in the same age group (Nascop 2008). In the studied community, young people comprised 27.1% of the population, 14% being female.

Marital status had also a slight but non-significant impact on utilization of VCT services. This is encouraging as marital status is a risk factor for HIV infection (Glynn, 2001). Social norms are more likely to accept sexual activity in marriage, making a visit to the VCT centre less embarrassing. Women who were widowed, single or separated tended to utilize VCT services less frequently. However, in Kenya women in this group have a high HIV prevalence ranging between 17% and 21% (Nascop 2008).

Education also had a positive albeit non-significant impact on the utilization of VCT. Studies have previously demonstrated an increase in VCT with increasing level of education (Wringe, 2008; Sherr, 2007). Arguably people with higher level of education are in general more able to access and comprehend health promotion campaigns.

Limitations of the study included a relatively small sample size and the non-random sampling method used. There is also a possibility of a Hawthorne effect. The respondents may have perceived that ideally they should have used the VCT services. This might have led to an over-estimation of the use of VCT, in particular, as VCT services had extensive coverage in the Kenyan mass media. In addition, some aspects of the study, such as the question "why women did not use the services", might have been better explored using qualitative research methods. This may be an area of possible future studies.

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