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**FACTORS INFLUENCING THE USER-CHOICE OF INTEGRATED  
AND STAND-ALONE VOLUNTARY COUNSELLING AND  
TESTING SITES IN NAIROBI PROVINCE, KENYA** //

**BY**

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**MARCH, 2005**

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**DECLARATION**

This thesis is my original work and has not been presented for a degree or any other award in any other university or any other award.

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## DEDICATION

This work is dedicated to my family and my workmates who supported and encouraged me through the course; giving me all the necessary support especially when I needed it most.

## TABLE OF CONTENTS

<b>DECLARATION</b> .....	ii
<b>DEDICATION</b> .....	iii
<b>TABLE OF CONTENTS</b> .....	iv
<b>LIST OF FIGURES</b> .....	vi
<b>LIST OF TABLES</b> .....	vi
<b>ABBREVIATIONS USED IN THIS THESIS</b> .....	vii
<b>DEFINITION OF OPERATIONAL TERMS</b> .....	viii
<b>ACKNOWLEDGMENTS</b> .....	ix
<b>ABSTRACT</b> .....	x
<b>CHAPTER 1: INTRODUCTION</b> .....	1
1.1 BACKGROUND INFORMATION .....	1
1.2 RATIONALE OF THE STUDY .....	2
1.2.1 Statement of the problem .....	2
1.2.2 Research questions.....	3
1.2.3 Justification of the study .....	3
1.3 NULL HYPOTHESES .....	4
1.4 OBJECTIVES OF THE STUDY .....	4
1.4.1 General objective .....	4
1.4.2 Specific objectives .....	4
<b>CHAPTER 2: LITERATURE REVIEW</b> .....	6
2.1 Counselling and behaviour change .....	6
2.2 Voluntary Counselling and Testing Services.....	7
2.3 Models in Voluntary counselling and testing .....	10
<b>CHAPTER 3: MATERIALS AND METHODS</b> .....	11
3.1 THE STUDY AREA.....	11
3.2 THE STUDY POPULATION .....	13
3.2.1 Inclusion Criteria .....	13
3.2.2 Exclusion criteria .....	13
3.2.4 Ethical considerations .....	13
3.3 STUDY DESIGN.....	14
3.3.1 Sampling method .....	14
3.4 METHODS OF DATA COLLECTION AND RESEARCH INSTRUMENTS ....	15
3.4.1 Administration of Questionnaires .....	15
3.5 DATA MANAGEMENT.....	16
3.5.1 Storage and retrieval of data .....	16
3.5.2 Statistical analysis.....	16
<b>CHAPTER 4: RESULTS</b> .....	17
4.1 DEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS .....	17
4.1.1 Distribution of the study subject based on sex.....	17
4.1.2 Distribution of the study subjects based on age.....	18
4.1.3 Distribution based on highest level of education.....	19
4.1.4 Distribution of respondents based on Religion.....	20
4.1.5 Distribution of respondents based on marital status .....	22
4.1.6 Distribution of respondents based on occupation .....	23

4.2 BEHAVIOURAL PSYCHOLOGICAL ASPECTS OF THE CLIENTS .....	24
4.2.1 Plan for children if HIV Positive .....	24
4.2.2 Plans for contraceptives if HIV test is positive.....	24
4.2.3 Sexual activities of the respondents.....	24
4.2.4 Number of sexual partners in the last 12 months.....	24
4.2.5 Distribution based on Knowledge of STDs .....	25
4.2.6 Use of condoms in the last sexual contact .....	26
4.2.7 Distribution based on source of information .....	28
4.2.8 When the client decided to have a HIV test.....	29
4.2.9 Clients who have previously had VCT services .....	31
4.2.10 Reasons for having taken up VCT services today .....	33
4.2.11 Knowledge on partner HIV status.....	34
4.2.12 Discussing HIV testing with partner.....	34
4.2.13 Reasons for choosing the site for VCT services .....	35
<b>CHAPTER 5: DISCUSSION</b> .....	36
5.1 DEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS .....	36
5.1.1 Distribution of the study subjects based on gender .....	36
5.1.2 Distribution of the study subjects based on age.....	37
5.1.3 Distribution based on highest level of education completed .....	37
5.1.4 Distribution of respondents based on Religion.....	37
5.1.5 Marital status of the VCT clients.....	38
5.1.6 Distribution of respondents based on occupation .....	38
5.2 BEHAVIOURAL PSYCHOLOGICAL ASPECTS OF THE CLIENTS .....	39
5.2.1 Plan for children if HIV Positive .....	39
5.2.2 Change plans of contraceptives if HIV test is positive.....	39
5.2.3 Sexual activities of the respondents.....	40
5.2.4 Number of sexual partners in the last 12 months.....	40
5.2.5 Knowledge of STDs in the different sites.....	40
5.2.6 Use of condoms in the last sexual contact .....	41
5.2.7 Distribution based on source of information .....	41
5.2.8 When the client decided to have a HIV test.....	42
5.2.9 Clients who have previously had VCT services .....	42
5.2.10 Reasons for having taken up VCT services today .....	42
5.2.11 Knowledge on partner HIV status.....	43
5.2.12 Discussing HIV testing with partner.....	43
5.2.13 Reasons for choosing the site for VCT services .....	44
<b>CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS</b> .....	45
6.1 CONCLUSIONS.....	45
6.2 RECOMMENDATIONS.....	46
6.3 SUGGESTIONS OF FUTURE RESEARCH WORK .....	48
<b>REFERENCES</b> .....	49
<b>APPENDICES</b> .....	53
APPENDIX I: RESEARCH INSTRUMENTS .....	53
APPENDIX 2: ETHICAL CLEARANCE DOCUMENTS.....	60
APPENDIX 3: ABSTRACT FOR SEMINARS AND CONFERENCES.....	61

## LIST OF FIGURES

Figure 1: Map of Nairobi Showing Study Area.....	12
Figure 2: Distribution of the study subjects based on sex .....	18
Figure 3: Distribution of respondents based on highest level of education.....	20
Figure 4: Distribution of respondents based on religion.....	21
Figure 5: Distribution of Respondents based on marital status .....	22
Figure 7: Number of sexual partners in the last 12 months .....	25
Figure 8: Use of condoms in the last sexual contact.....	27
Figure 9: Sources of information on VCT .....	28
Figure 10: Time client decided to have HIV counselling and testing.....	30
Figure 11: Clients who have ever had VCT services.....	32
Figure 12: Reasons for taking VCT services today .....	33
Figure 13: Discussing HIV testing with partner .....	34

## LIST OF TABLES

Table 1: Distribution of respondents based on age.....	19
Table 2: Reasons for choosing VCT site .....	35

## **ABBREVIATIONS USED IN THIS THESIS**

<b>AIDS:</b>	Acquired Immune Deficiency Syndrome.
<b>BSS:</b>	Behavioural Sentinel Surveillance
<b>GoK:</b>	Government of Kenya.
<b>HIV:</b>	Human Immunodeficiency Virus
<b>KICOSHEP:</b>	Kibera Community Self Help Project
<b>MOH:</b>	Ministry of Health.
<b>NACC:</b>	National AIDS Control Council.
<b>NASCOP:</b>	National AIDS/STD Control Programme.
<b>NCPD:</b>	National Council for Population and Development.
<b>NGO:</b>	Non-Governmental Organization
<b>PMTCT:</b>	Prevention of Mother-to-Child Transmission
<b>SPSS:</b>	Statistical Package for Social Sciences.
<b>STDs:</b>	Sexually Transmitted Diseases.
<b>STIs:</b>	Sexually Transmitted Infections.
<b>UNAIDS:</b>	Joint United Nations Programme for AIDS.
<b>VCT:</b>	Voluntary Counselling and Testing
<b>WHO:</b>	World Health Organization

## DEFINITION OF OPERATIONAL TERMS

**VCT:** This refers to the process whereby an individual or couple undergoes counselling to help him/her/them make an informed decision on being tested for HIV/AIDS.

**Integrated model:** This refers to the model of VCT where by a VCT center is put together with other health services like in a hospital or clinic.

**Stand-alone model:** This refers to the model whereby a VCT center is outside a health facility and VCT services are the primary services offered

**Counselling:** HIV counselling is a confidential and supportive dialogue between a person and a trained counselor. It should focus on both the-physical and emotional wellbeing of the person, and help them to make the decisions that are right for them.

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## ABSTRACT

The HIV/AIDS has been and remains the most important public health problem affecting the world with over 40 million people infected, 70% of whom were living in the Sub-Saharan Africa as at the end of the year 2003. In Kenya, it is estimated that 1.2 million people out of a population of 31 million are living with HIV/AIDS (KDHS, 2003). The pandemic has caused over 1.5 million deaths in Kenya since the early 1980s leaving behind many orphans. Voluntary counselling and testing (VCT) has become an integral part of programmes in many countries in the control and management of HIV/AIDS. It is not only a key component of both HIV prevention and care programmes, but is the gateway to prevention and care. It leads to development of effective and accessible medical and supportive interventions for people living with HIV/AIDS (PLWHA). It has also been incorporated as part the primary health care package in many countries. The general objective of this study was to determine the factors influencing the choice of integrated and stand-alone VCT sites in Nairobi Province, Kenya. The data was collected using semi-structured questionnaires. A sample of 406 (203 in integrated, 203 in stand-alone site) was collected from clients seeking VCT services in two integrated and two stand-alone sites in Nairobi Province. All data from the study was coded and entered in a computer cleaned and analyzed using the statistical package for social sciences (SPSS). Chi-square was used to test for the relationship between the variables determining the selection of VCT site. From the findings of this study, it was realized that one of the major factors influencing the choice of VCT site was sex, with more women (68%) using the integrated model may because they accessed it while undergoing Maternal and Child health services. Education level also influenced the choice with more educated (47%) people using the stand-alone. The sexual history of the respondents also influenced the choice with results indicating that 80% of those who had many sexual partners in the past seeking VCT at stand-alone sites due to the perception of vulnerability. The findings of this study have policy implications in the distribution and accreditation of VCT sites to promote increased utilization of VCT use as a strategy for the prevention and control of HIV/AIDS since it is beneficial to both those with a positive as well as those with negative results. This may also be used in advocating for behaviour change among the people at the greatest risk of contracting HIV/AIDS.

## **CHAPTER 1: INTRODUCTION**

### **1.1 BACKGROUND INFORMATION**

The spread of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in the world is devastating, with nearly 40 million people living with the HIV/AIDS (UNAIDS, 2003). The HIV/AIDS epidemic is not only the most important public health problem affecting large parts of sub-Saharan Africa where 30 million are infected, but also an unprecedented threat to the development of this region.

In Kenya, 1.2 million people out of a population of 31 million are infected with HIV/AIDS (KDHS, 2003). The epidemic occurs in every district of Kenya and has been responsible for the deaths of about 2.5 million Kenyans since the early 1980s. These deaths have left behind more than one million orphans (ROK., 2001a).

With no cure or vaccine currently available, the only options are to prevent further spread of the epidemic, minimize its impact and provide care and compassion for those infected and affected. This crisis calls for an expanded and intensified response to mobilise governments, civil society, the private sector and the international community to take action, increase resources and build capacity to sustain efforts that will slow the spread of the epidemic (NACC, 2001).

Voluntary counselling and testing (VCT) services have a role in HIV/AIDS control and provide an entry point for behaviour change and care for people with HIV infection. VCT provides people with an opportunity to learn and accept their HIV sero -status in a confidential environment with counselling and referral for on-going emotional support and medical care (UNAIDS, 2000a). In many high prevalence countries, VCT is not widely available and people are often afraid of knowing their sero-status because of the

stigma and fatalism associated with HIV/AIDS and the fact that there is little care and support in place following testing.

In countries where HIV prevalence is high and numerous deaths are attributed to HIV/AIDS related illness, people may develop feelings of hopelessness and a misperception that behavioural change is futile. In these settings, the power of positive behavioural change messages may be reinforced by effective HIV/AIDS counselling and testing services. VCT services can be offered through either an integrated model whereby it is put together with other health services or a stand-alone model whereby the services are exclusively offered. The goals of VCT services are to enable individuals and couples to know their HIV status voluntarily and in a setting in which confidentiality is strictly maintained. To choose a VCT model to access the services; clients knowledge, perception and attitude, are crucial. Within Africa, the debate has been which is the most feasible, acceptable and cost effective model (UNAIDS, 2001). In Kenya voluntary counselling and testing is a major strategy in the intervention of HIV/AIDS as defined in the Sessional paper No.4 of 1997 on HIV/AIDS (MOH, 1994).

## 1.2 RATIONALE OF THE STUDY

### 1.2.1 Statement of the problem

As the HIV/AIDS pandemic spreads in Africa, there has been much debate about how best to incorporate HIV counselling and testing services into HIV/ AIDS prevention, care and support programmes in the region.

The establishment of VCT is not seen as a priority because of cost, lack of laboratory, medical infrastructure and trained personnel thus limiting the access of VCT to most people in high prevalence countries (UNAIDS, 2000a).

At the onset, VCT was primarily used to make a diagnosis of infection in symptomatic people to help medical management, and testing was often accompanied by minimal counselling (UNAIDS, 2000c). In countries where VCT services have been established there has been a reluctance of people seeking the services. This may be because of denial, stigma, fatalism and discrimination that people who test sero-positive may face and the lack of perceived benefits of testing.

A variety of views exists about which approaches of VCT model is most feasible, acceptable and cost effective since most of the countries severely affected by HIV /AIDS are also among the poorest countries in terms of material and human resources.

### **1.2.2 Research questions**

The major research questions that the study intended to answer were

- a) What is the most effective model in the delivery of VCT in Nairobi Province?
- b) What factors influence the choice of VCT model?

### **1.2.3 Justification of the study**

Effective VCT services have been shown to have a significant role in the prevention of HIV transmission and an entry point for care and support, promoting safe behaviour and breaking the vicious cycle of silence and stigma. As the burden of HIV/AIDS continues to pose a major challenge to Kenya and the world in general, the Ministry of Health in its

National Strategic Plan (1999-2004) includes the introduction of voluntary counselling and testing services into the public health-care system (MOH, 2001b).

The expansion of VCT in Kenya will ensure that the services are available, accessible and affordable to Kenyans. This study will describe factors which influence the clients knowledge, perception, attitudes in the uptake of VCT services in either a stand-alone or integrated delivery point, and expected to outline the most feasible, acceptable and cost effective model to deliver the VCT services.

### 1.3 NULL HYPOTHESES

This study was mainly guided by the following null hypothesis

The attitude, knowledge and perceptions of VCT users do not influence the choice of VCT site.

### 1.4 OBJECTIVES OF THE STUDY

#### 1.4.1 General objective

The general objective of the study was to determine client factors that influence the choice of either stand - alone or integrated sites in seeking VCT services.

#### 1.4.2 Specific objectives

The specific objectives were:

- a) To establish the socio-demographic profiles of VCT service users in Nairobi province.

- b) To identify and compare sexual behavioral characteristics of VCT users in stand-alone (Kianda and Mugumoini) and integrated (Riruta and Langata) VCT sites in Nairobi province.
- c) To determine and compare the factors influencing user-choice in stand-alone sites (Kianda and Mugumoini ) and integrated sites (Riruta and Langata ) VCT sites in Nairobi province.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Counselling and behaviour change

Change in behaviour can significantly reduce the spread of HIV/AIDS all over the world. A pilot study on acceptability of voluntary HIV counselling and testing was performed in a rural village in Kagera, Tanzania as a potential intervention against HIV transmission (Killewo *et al.*, 1998). In this study, a significant proportion of participants were willing to volunteer for HIV counselling and test and to receive results, indicating a moderate level of acceptability of HIV counselling and testing. The results also indicated the need for developing innovative ways of enhancing acceptability of voluntary HIV counselling and testing. However, the relationship between knowledge of HIV status and behavioural change is complex and therefore several potential mechanisms may exist by which HIV testing, in combination with counselling, could influence behaviour. For this reason, people should be given the choice of knowing their HIV status since it may constitute a potential mechanism for influencing modes of behaviour that could reduce HIV transmission. The most effective interventions to reduce transmission from mother to child depends upon a woman knowing her HIV status and the availability of quality information, counselling and voluntary testing services (UNAIDS, 1999).

Similarly, a randomized controlled clinical trial carried out in Kenya, Tanzania and Trinidad compared two groups of individuals assigned either VCT services or reproductive health education. A measurable decline in the incidence of sexually transmitted diseases, and remarkable changes in sexual behaviour occurred in the VCT group compared with those in the health education group in three very different social and cultural contexts (Sweat *et al.*, 2000). The findings reinforced the argument for the

inclusion of VCT as part of a standard package in the prevention strategies for less developed countries.

Furthermore, the AIDS Information Center of Uganda conducted an evaluation of its services in Uganda between 1992-1993 where 2,505 clients had been followed up for 6 months after receiving HIV test results. Some 69% of the clients who had learned that they were HIV positive refrained from any sexual activity compared to 45% prior to learning HIV test results (Edyegu *et al.*, 1999).

With about 65% of post-test club members in Uganda, who were HIV negative, adopting and sustaining risk reduction strategies. VCT has become an important base for community dissemination of HIV prevention information (Edyegu *et al.*, 1999).

Similarly, a meta analysis including 27 published studies that provided sexual behaviour data assessing behaviour before and after counselling and testing, revealed change in behaviour and reduction in unprotected sex in HIV sero discordant couples (Weinhardt *et al.*, 1999).

Likewise, in Miami, HIV counselling and testing was associated with a moderate decrease in sexually transmitted diseases among patients who were positive with HIV (Otten *et al.*, 1993).

## **2.2 Voluntary Counselling and Testing Services**

Voluntary HIV counselling and testing is the confidential process by which individuals undergo counselling enabling them to make an informed choice about being tested for HIV. It also involves providing the results to the client as well as counselling them to cope with the results. Human immunodeficiency virus counselling has been defined as a

confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour (WHO/ GPA, 1995).

HIV counselling can be carried out anywhere that provides an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Many people fear to seek HIV testing services because of stigmatization and discrimination from their families and community. Counselling and destigmatization of HIV/AIDS plays an important role in VCT as an intervention.

### **VCT SERVICES IN AFRICA**

A survey carried out among 79 HIV sero-positive women involved in therapeutic trial in Bobo-Dioulasso, Burkina Faso following freely consented prenatal HIV testing, revealed that women were reluctant to inform their partners of their HIV- sero status and feared stigmatization by relatives and friends (Issiaka *et al.*, 2001). This in turn prevents them from accessing care, gaining support and preventing onward transmission. For VCT services to be acceptable, confidentiality must be guaranteed since HIV infection has remained a stigmatizing condition in most countries.

In Zimbabwe, a recent study indicated that common short cuts in counselling (giving brief information before and after HIV testing) were seriously flawed as a strategy to prepare clients for effective coping. However, comprehensive pre-test and post- testing counselling was found to be an essential preparation for coping effectively during and immediately after testing while availability of supportive services beyond the first phase

of counselling is essential to assist clients with needs and problems, which would appear over time (Meursing & Sidindi, 2000).

A study in urban Rwanda among women, where a confidential HIV counselling and testing was administered reported to have an association with an increase in the use of condoms and a reduction in the rate of sexually transmitted infections (Allen *et al.*, 1992a). Similarly in Kigali Hospital in Rwanda, a study involving confidential testing with counselling associated a large increase in condom use and was associated with a lower rate of new HIV infections (Allen *et al.*, 1992b).

### **VCT SERVICES IN KENYA**

In Kenya a national survey carried out in 1998 showed high levels of knowledge of HIV /AIDS among respondents of reproductive age, in which 14% of women and 17% percent of men reported to have been tested for HIV and two-thirds of those who had not been tested were willing to be tested (NCPD, 1998). A study done in Kenyatta Hospital, Nairobi revealed a significant number of patients never had their HIV test results revealed to them due to lack of counselling, over-sight and ignorance of the doctors on counselling and lack of patients' awareness and sensitization (Mulure *et al.*, 2000).

Lack of counselling services could lead to more infections, as persons who are not aware of their HIV sero-status might not take appropriate preventive measures. Accessibility including hours of service, affordability, adequate number and support for counselors, strict quality assurance and supervisory measures, knowledge of a referral network, support for counselors, and an approach focused on sustained health impact will help break the silence which has characterized this epidemic (Gilly *et al.*, 2001).

### **2.3 Models in Voluntary counselling and testing**

There are various models existing in Africa, the stand-alone or free-standing, integrated model and the mobile model. The stand – alone is a model, which offers VCT exclusively- and is not situated within a health facility. The integrated model provides VCT services within an existing hospital or health facility but as a separate service apart from HIV testing done for medical diagnostic reasons.

Stand-alone VCT sites attract large numbers of clients who are not yet ill but may be at the risk of HIV infection. Since all in a stand-alone are requesting for an HIV test, it is less likely for clients to be stigmatized, and confidentiality at these sites is more easily maintained. However, stand-alone sites are heavily dependent on donor funding and the long-term sustainability of these programs is uncertain.

Integrating VCT services within existing health facilities is believed to improve the potential that the services will be sustained over a long period. The approach is also thought to improve the access of other medical services to the clients. However, in Uganda, free-standing model has had more success attracting large numbers of clients compared with integrated sites (Edyegu *et al.*, 1999).

In countries with high HIV prevalence the need for people to learn their HIV test results is of extreme importance, for both prevention and early access to care. The studies cited have not clearly been able to cite reasons that influence the choice of which model to use.

## **CHAPTER 3: MATERIALS AND METHODS**

### **3.1 THE STUDY AREA**

This study was carried out in four VCT centres in Nairobi. The area was purposively chosen because it has many people hence it is expected that there would be many affected and infected by HIV/AIDS. The area also has people with varied social, cultural and economic backgrounds.

#### **a) Physical Description of the study area**

Nairobi is located in the central part of Kenya (Figure 1); the city of Nairobi extends between 36<sup>0</sup>4' and 37<sup>0</sup>10' and between 1<sup>0</sup>9' and 1<sup>0</sup>28' south. It covers an area of 696.1 Km<sup>2</sup>. It shares common borders with Kiambu to the north, Machakos District to the east, and Kajiado District to the south. Administratively it is both a province and a district (National Population census, 1999)

#### **b) Administrative and political units**

Administratively, Nairobi is divided into eight divisions namely Kasarani, Embakasi, Makadara, Kamukunji, Starehe, Westlands, Dagoretti, and Kibera; each under a District Officer. Nairobi has 5 government hospitals, 47 health centers and dispensaries. There are 3 mission hospitals and 15 health centers, 12 company health clinics, 65 private hospitals and health centers (NCPD, 1998). This study was undertaken in four randomly selected sites (two stand-alone and two integrated sites within Nairobi Province). Two VCT health centres are managed by the Nairobi city council (Riruta and Langata) and two VCT sites managed by the Kibera community self help project (Mugumoini and Kianda.)

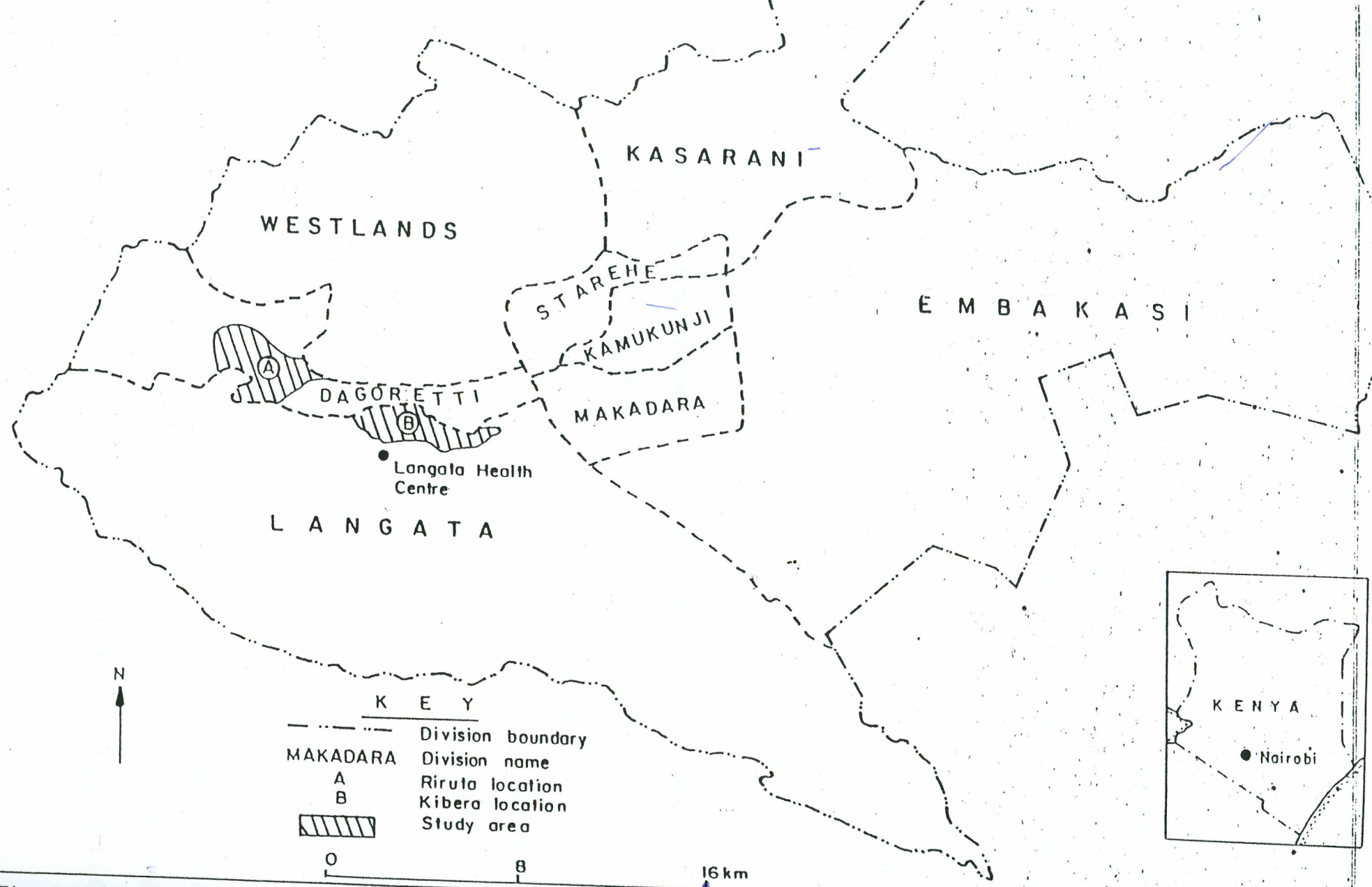


Fig. 1: The location of study area in Nairobi province. (Inset: The position of Nairobi province in Kenya).

## **3.2 THE STUDY POPULATION**

According to 1999 census Nairobi has a population of 2,143,254, which accounts for 1,153,828 males and 989,426 females. The total number of households is 649,426 with a population density of 3,079 persons per square km. The age group between 25 and 29 years is highly populated with 299,569 persons. About 63% of the population is within the reproductive age group between 15-49 years (ROK, 1998).

### **3.2.1 Inclusion Criteria**

The inclusion criteria were:

- Those who had given informed consent
- Those who had visited the selected VCT clinics in Nairobi
- Those who have been residents of Nairobi for a period of more than 6 months

### **3.2.2 Exclusion criteria**

Clients seeking VCT services but not willing to participate in the study were not included in the survey.

### **3.2.4 Ethical considerations**

The participation in the study was by verbal informed consent after all the authorities had consented. The data collected were kept confidential and personal identification numbers were used instead of names.

### 3.3 STUDY DESIGN

This was a cross-sectional study, which looked at the characteristics of the clients visiting the two different models of VCT centers and attempt to establish the factors influencing their choice of the model. A structured questionnaire (Appendix 1) was administered to VCT service users who consented before receiving the service.

#### 3.3.1 Sampling method

The study was conducted in collaboration with National AIDS/STD Control Programme (NASCOP). The sites were randomly selected from the registered sites in Nairobi by NASCOP. The selection of the 406 subjects was purposively sampled as they came for the VCT service under a record of sex in each model. 92 males and 111 females from stand-alone sites and 138 females and 65 males from integrated sites. The study was done in two KICOSHEP stand-alone sites (Kianda and Mugumoini) and two integrated sites within Nairobi City Council (Riruta and Langata Health Center).

#### 3.3.2 Sample size determination

The minimum sample size was obtained using the formula as used by Fisher *et al.*, (1998).

$$n = \frac{Z^2 p q D}{d^2}$$

Where:

n -is the desired sample size.

z = normal deviate 1.96) which corresponds to 95% confidence interval

p= proportion of the target population estimated to have desired characteristics

q=1-p

d- degrees of freedom =0.05

D -design effect =2

Thus 
$$n = \frac{1.96^2 \times 0.5 \times 0.5 \times 2}{0.05^2}$$

Approximately 768

However, only a total 406 clients were interviewed due to limitation of time and finances. This was also due to the fact that this study was social in nature and the characteristics were not expected to differ significantly. The sample size was sub-divided into two, 203 subjects from stand alone sites and 203 subjects from integrated sites and the subjects were identified as they come for the VCT service.

### 3.4 METHODS OF DATA COLLECTION AND RESEARCH INSTRUMENTS

#### 3.4.1 Administration of Questionnaires

The purpose of the study was explained to the directors and the VCT counselors at all the study sites. The purpose of the study was also explained to the client before receiving the service. The questionnaire was administered to clients seeking VCT services after consent by the principal investigator and they were allowed to fill the questionnaires.

## 3.5 DATA MANAGEMENT

### **3.5.1 Storage and retrieval of data**

All the collected data were first grouped in sites and then verified before being entered in the computer. A structure for all the data was created in EPI info and all the data was entered by the investigator. After all the data entry was completed it was checked against the original data for any inconsistencies and cleaning was done. The data were transferred into SPSS program for data analysis. The data were stored in a hard disk, a diskette and a hard copy as backups.

### **3.5.2 Statistical analysis**

The frequencies were run to determine the characteristics such as demography, sexual history, perceptions, knowledge, attitudes of VCT users in stand-alone and integrated sites were compared between clients receiving VCT in a stand-alone and an integrated site using proportions and percentages. Fisher's chi - square test applied for relations between characteristics of clients and option of model.

## **CHAPTER 4: RESULTS**

A total of 406 VCT clients responded to the questionnaire before receiving VCT services; 203 subjects from integrated and 203 subjects from stand alone site.

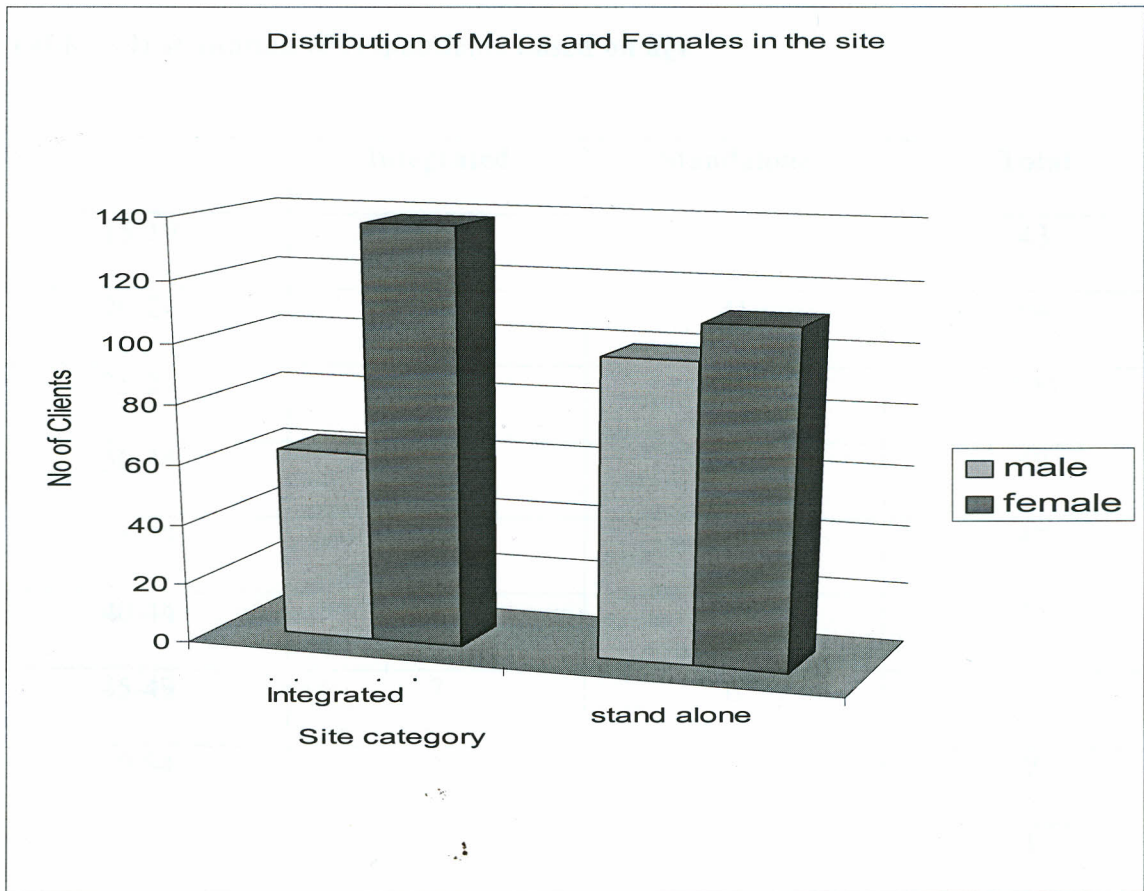
They were interviewed with the aim of identifying the factors that influence the type of site they select for VCT services. The respondents were only got from VCT centres that were sampled i.e. two stand-alone and two integrated sites.

### **4.1 DEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS**

#### **4.1.1 Distribution of the study subject based on sex**

The results indicated that more females used VCT services in both integrated sites (68%) and stand-alone sites (54%). (Figure 2).

**Figure 2: Distribution of the study subjects based on sex**



#### **4.1.2 Distribution of the study subjects based on age**

The ages of the respondents in both sites ranged between 14 to 57 years. The mean age was 27.9 and 29.6 in integrated and stand-alone site respectively. The highest number of VCT clients were aged between 25-29. (Table 1)

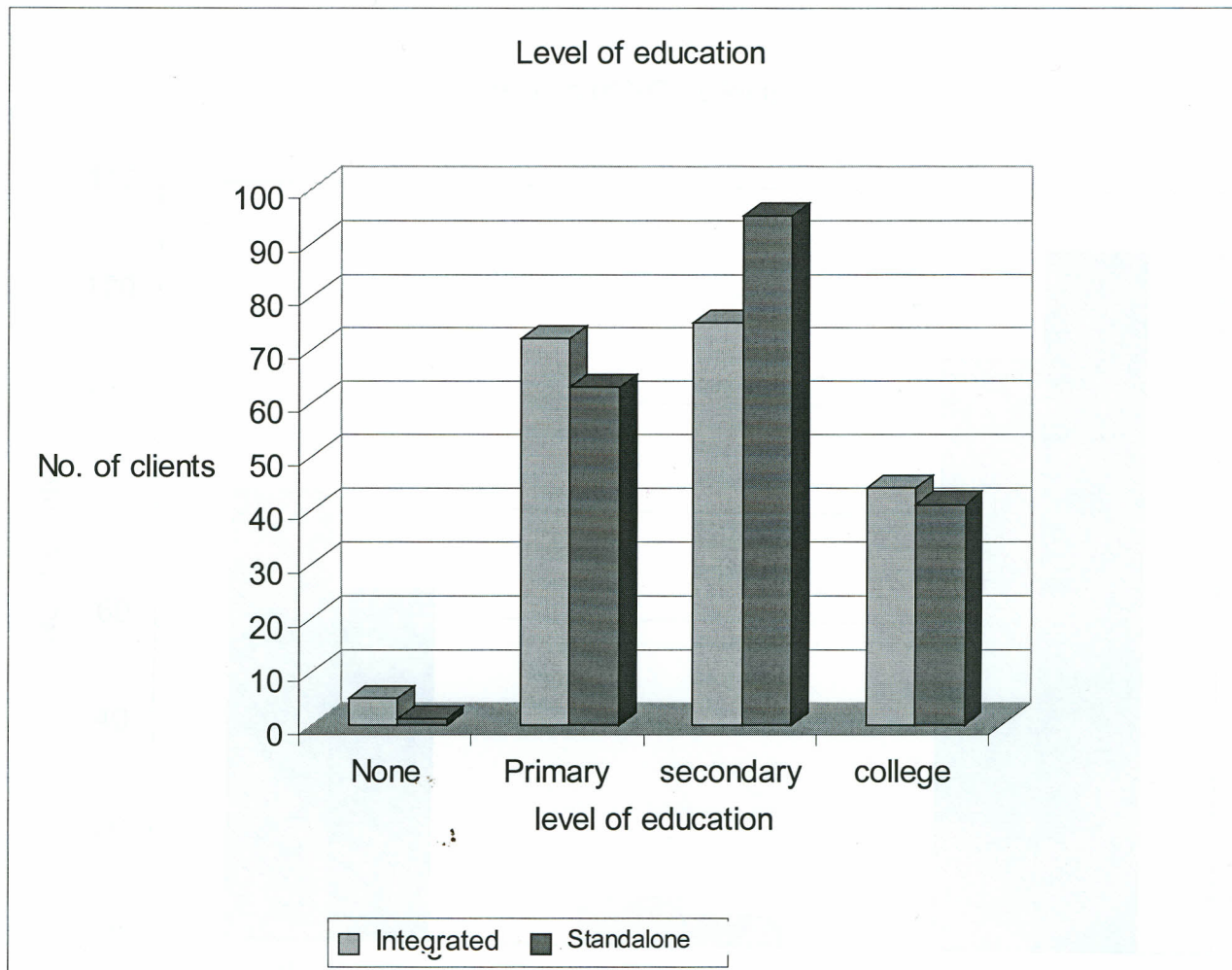
**Table 1: Distribution of respondents based on age**

	<b>Integrated</b>	<b>Standalone</b>	<b>Total</b>
15-19	23	20	43
20-24	55	41	94
25-29	56	49	100
30-34	29	42	68
35-39	21	26	47
40-44	8	15	22
45-49	7	6	13
50-54	3	4	7
55+	1		1

**4.1.3 Distribution based on highest level of education**

Majority of the clients in the stand alone and integrated site had received at least secondary level of education. The study shows that there is no significant relation ship in the level of education and model of VCT services ( $\chi^2 = 5.686$ ;  $df = 3$  and  $P = 0.128$ ) (Figure 3).

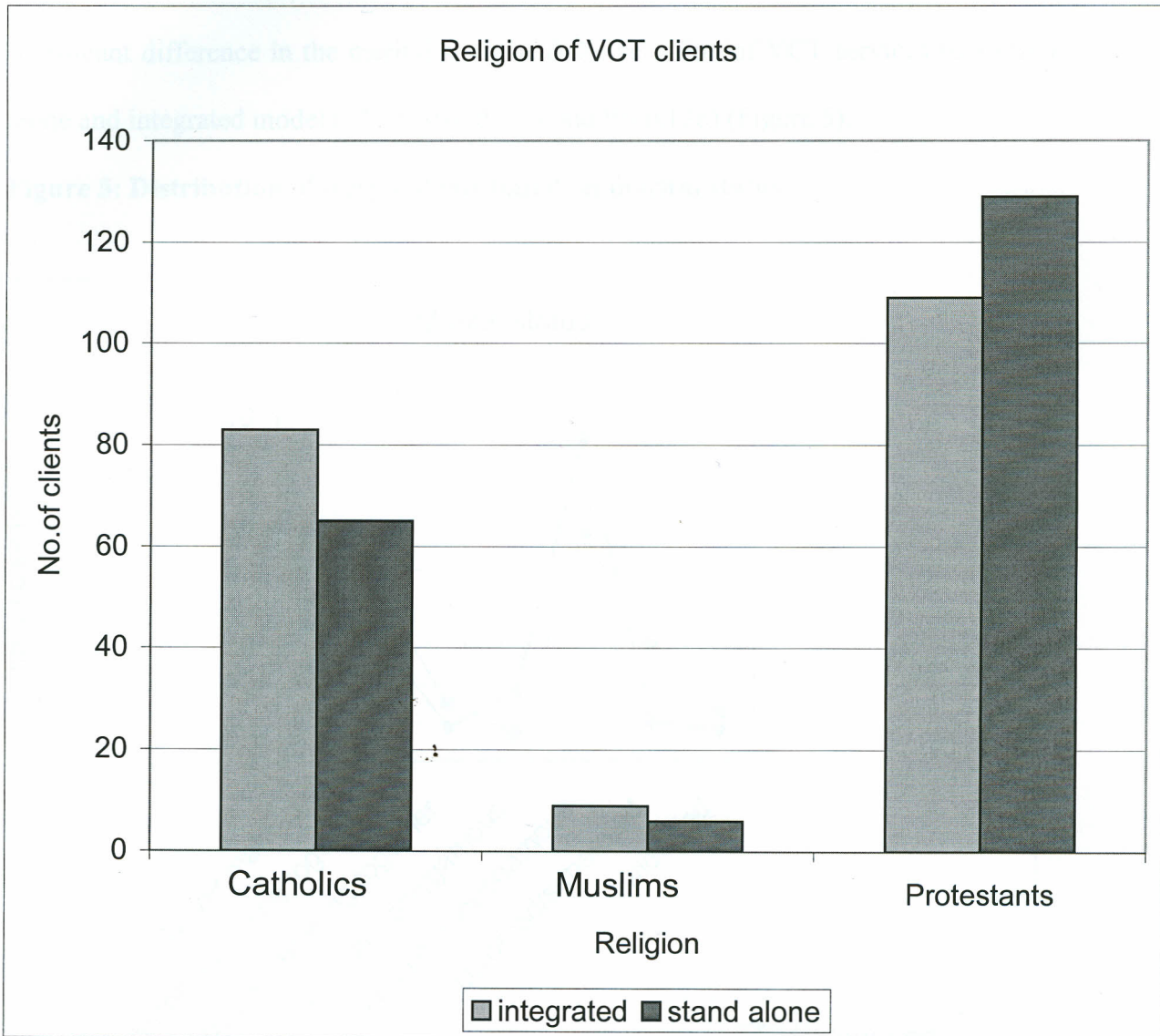
**Figure 3: Distribution of respondents based on highest level of education**



#### 4.1.4 Distribution of respondents based on Religion

Out of 406 respondents, 54% and 63.5% were protestants in the integrated and stand-alone site respectively 406 ( $\chi^2 = 4.467$ ;  $df = 2$  and  $P = 0.107$ ) (Figure 4).

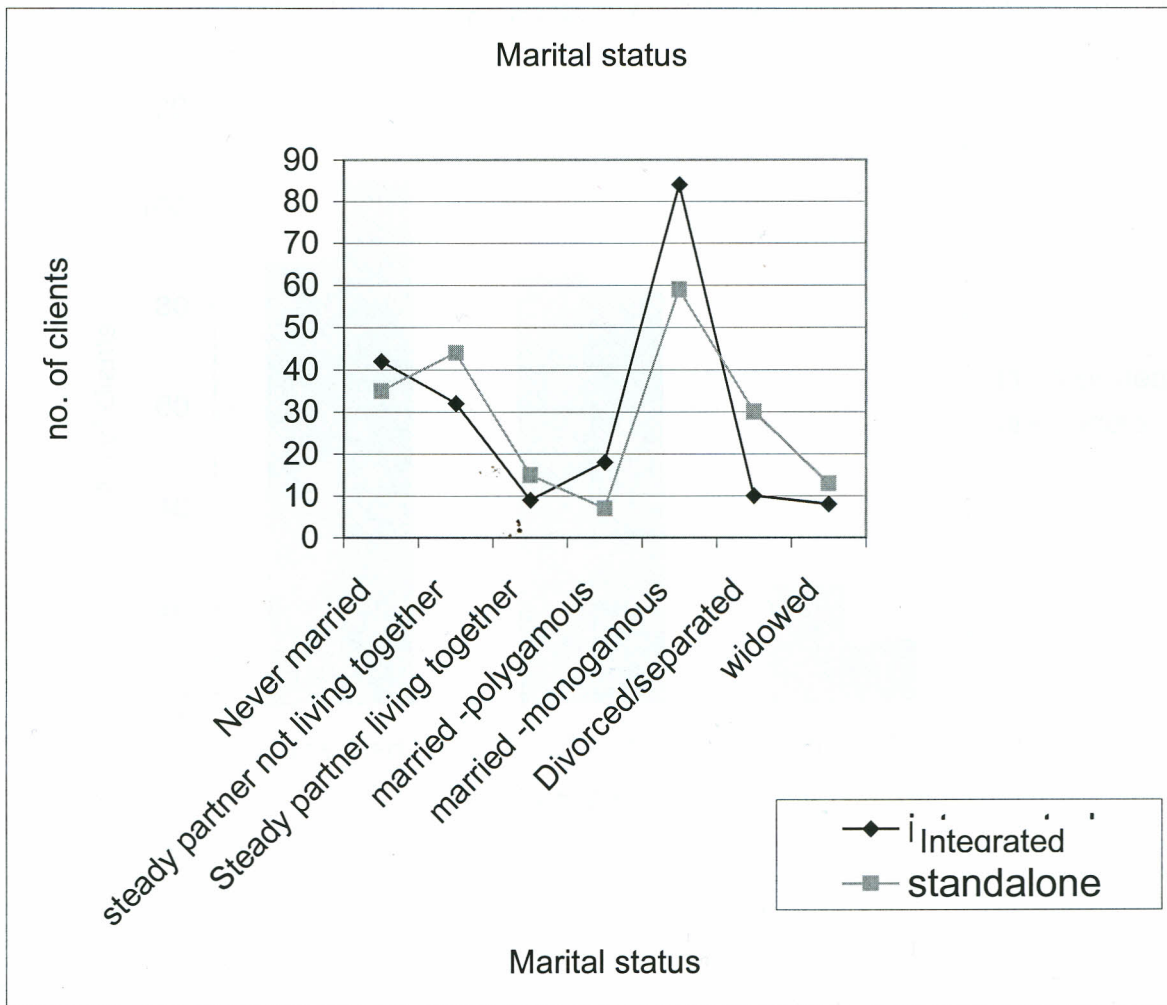
Figure 4: Distribution of respondents based on religion



### 4.1.5 Distribution of respondents based on marital status

In both sites, more married (Monogamous) clients went for the VCT services. Most of the VCT clients had stayed for over one year with their current partner. There was a significant difference in the marital status and the selection of VCT services in a stand-alone and integrated model ( $\chi^2 = 5.686$ ;  $df = 3$  and  $P = 0.128$ ) (Figure 5).

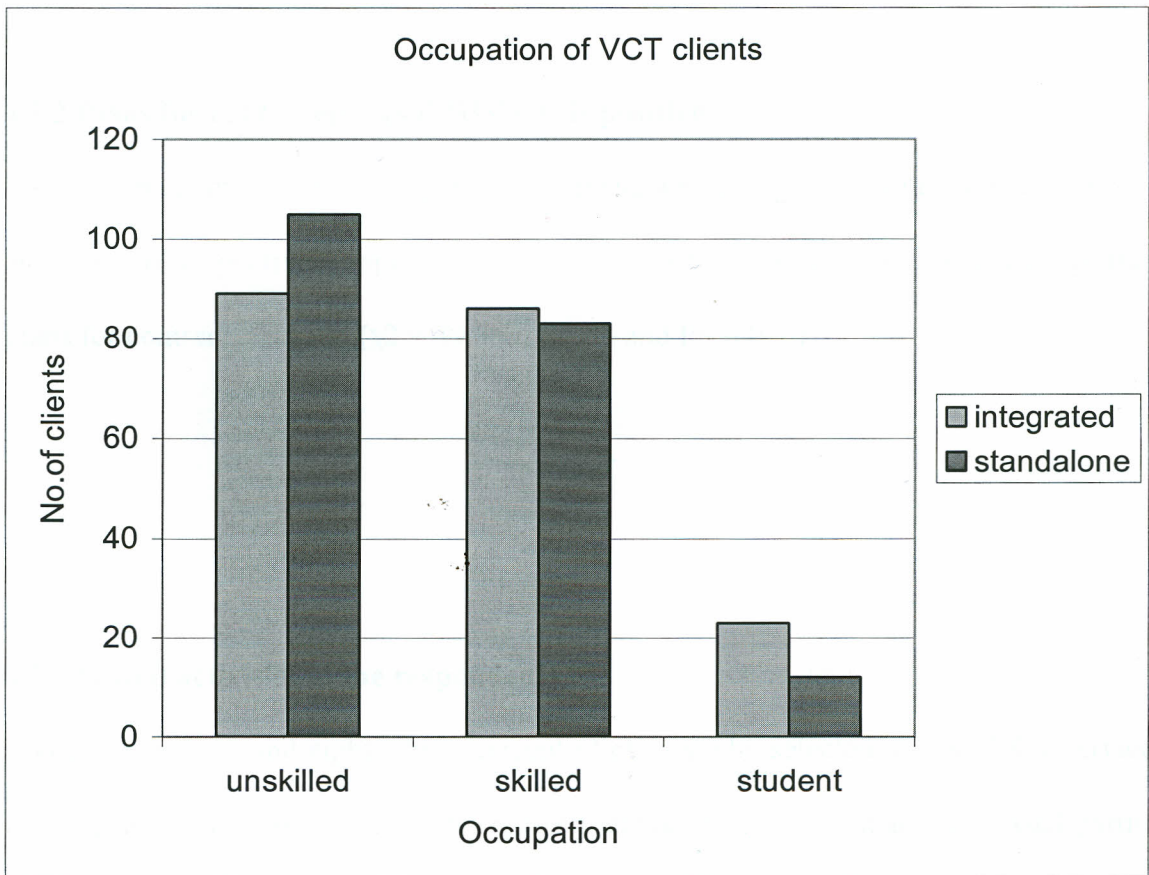
**Figure 5: Distribution of Respondents based on marital status**



#### 4.1.6 Distribution of respondents based on occupation

Fifty one percent and forty three percent of unskilled clients chose to have VCT services in stand-alone and integrated model respectively. ( $\chi^2 = 4.82$ ;  $df = 2$  and  $P = 0.090$ ) (Figure 6).

**Figure 6: Distribution of the respondents based on occupation**



## **4.2 BEHAVIOURAL PSYCHOLOGICAL ASPECTS OF THE CLIENTS**

### **4.2.1 Plan for children if HIV Positive**

Among those who had children 83% and 88.8 % in the integrated and stand-alone sites respectively reported to have had the children with one partner. 73% of clients from integrated site reported that if the HIV test comes out positive, they would not get more children, while 54.7% in stand-alone reported the same ( $\chi^2 = 12.790$ ;  $df = 2$  and  $P = 0.02$ ).

### **4.2.2 Plans for contraceptives if HIV test is positive**

Sixty two percent and forty two percent of clients who chose to use integrated and stand – alone model respectively reported that if HIV test turns positive it would change their plans for contraceptive use ( $\chi^2 = 39.395$ ;  $df = 3$  and  $P = 0.000$ ).

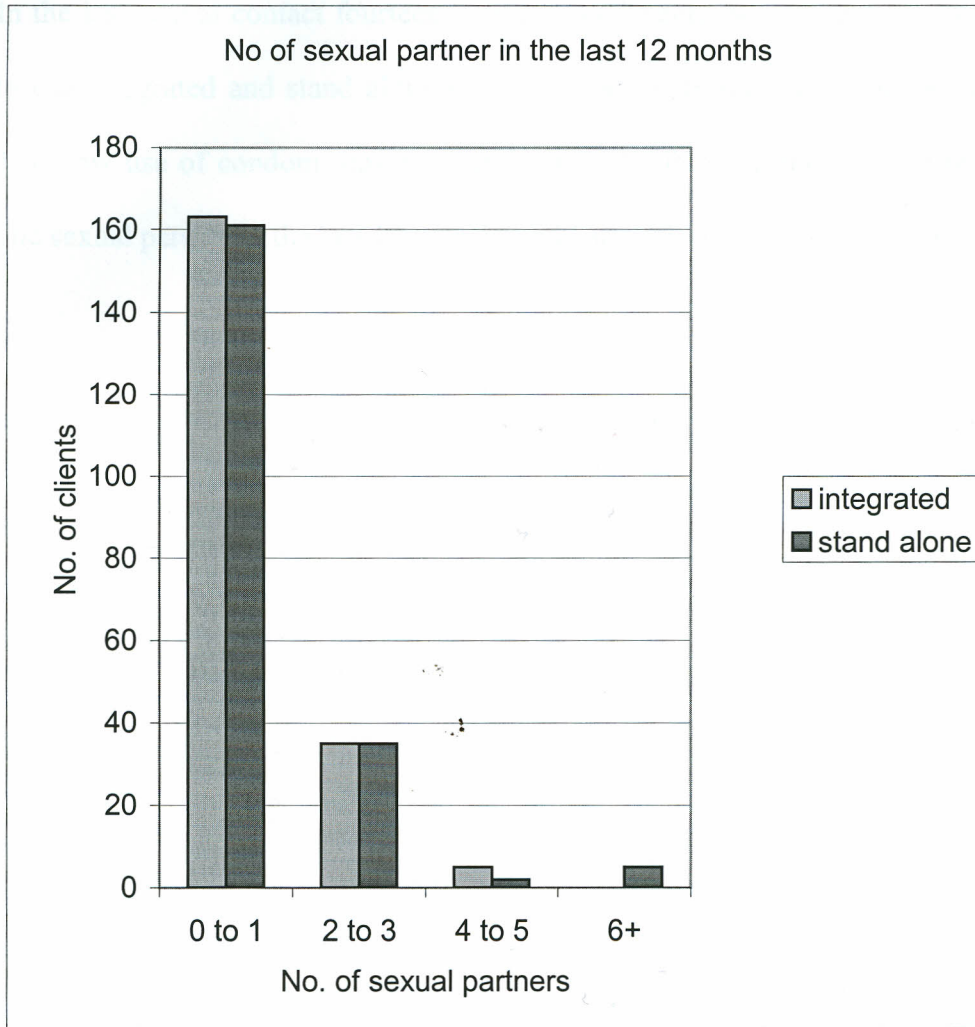
### **4.2.3 Sexual activities of the respondents**

Eighty six percent and eighty three percent of clients who selected to have VCT services in integrated and stand-alone model respectively have had more than one sexual partner in their lifetime

### **4.2.4 Number of sexual partners in the last 12 months**

Eighty percent and seventy nine percent of clients who choose to have VCT services in integrated and stand – alone model respectively reported having one sexual partner in the last 12 months ( $\chi^2 = 16.322$ ;  $df = 10$  and  $P = 0.091$ ) (Figure 7).

**Figure 7: Number of sexual partners in the last 12 months**



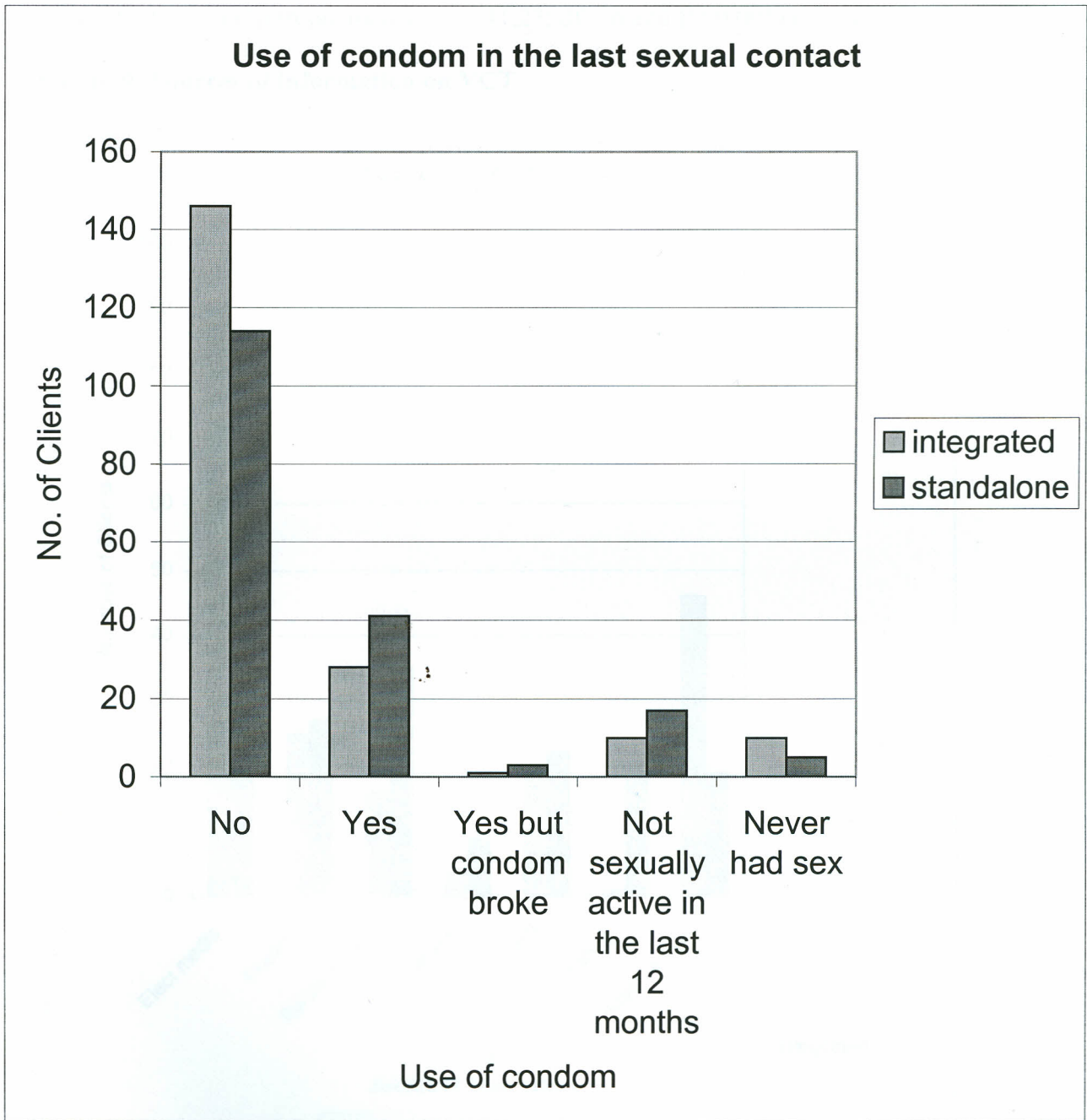
#### **4.2.5 Distribution based on Knowledge of STDs**

The results from the respondents in the integrated model indicated that 94% knew about STD (or were aware of STD existence) while 6 % did not. When the respondents in the stand-alone were asked if they knew of STD, 96% answered in the affirmative while only 4% did not know it.

#### **4.2.6 Use of condoms in the last sexual contact**

In the last sexual contact fourteen- percent and twenty two percent of clients who chose to use integrated and stand alone models respectively reported to have used a condom. This low use of condom may be attributed to the fact that most of the respondents had one sexual partner in the last 12 months and had built trust in them (Figure 8).

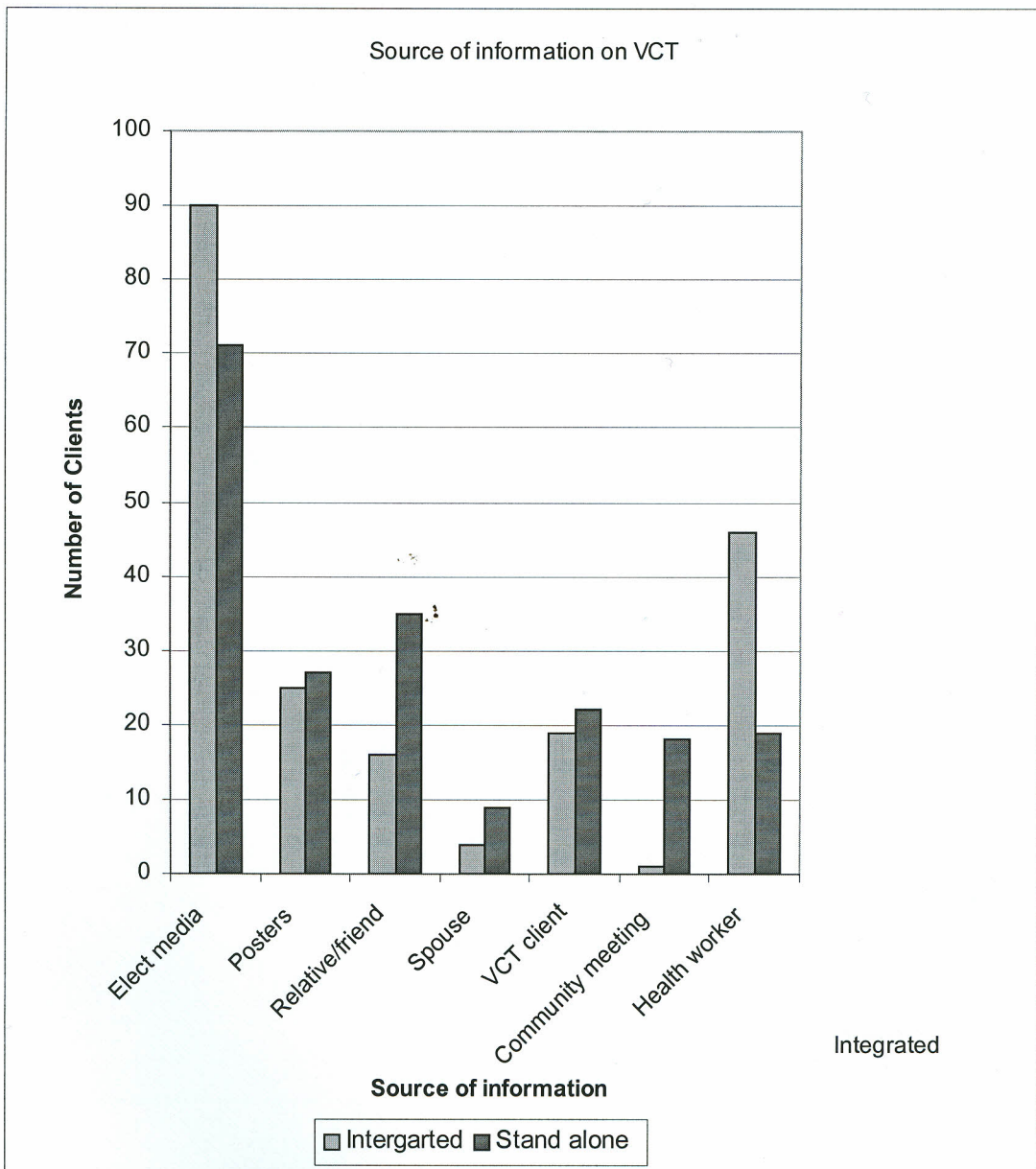
Figure 8: Use of condoms in the last sexual contact



#### 4.2.7 Distribution based on source of information

Forty five percent and thirty five percent of clients who chose to have VCT services in integrated and stand-alone model respectively reported to have had information about the VCT site through electronic media ( $\chi^2 = 41.23$ ;  $df = 6$  and  $P = 0.001$ ) (Figure 9).

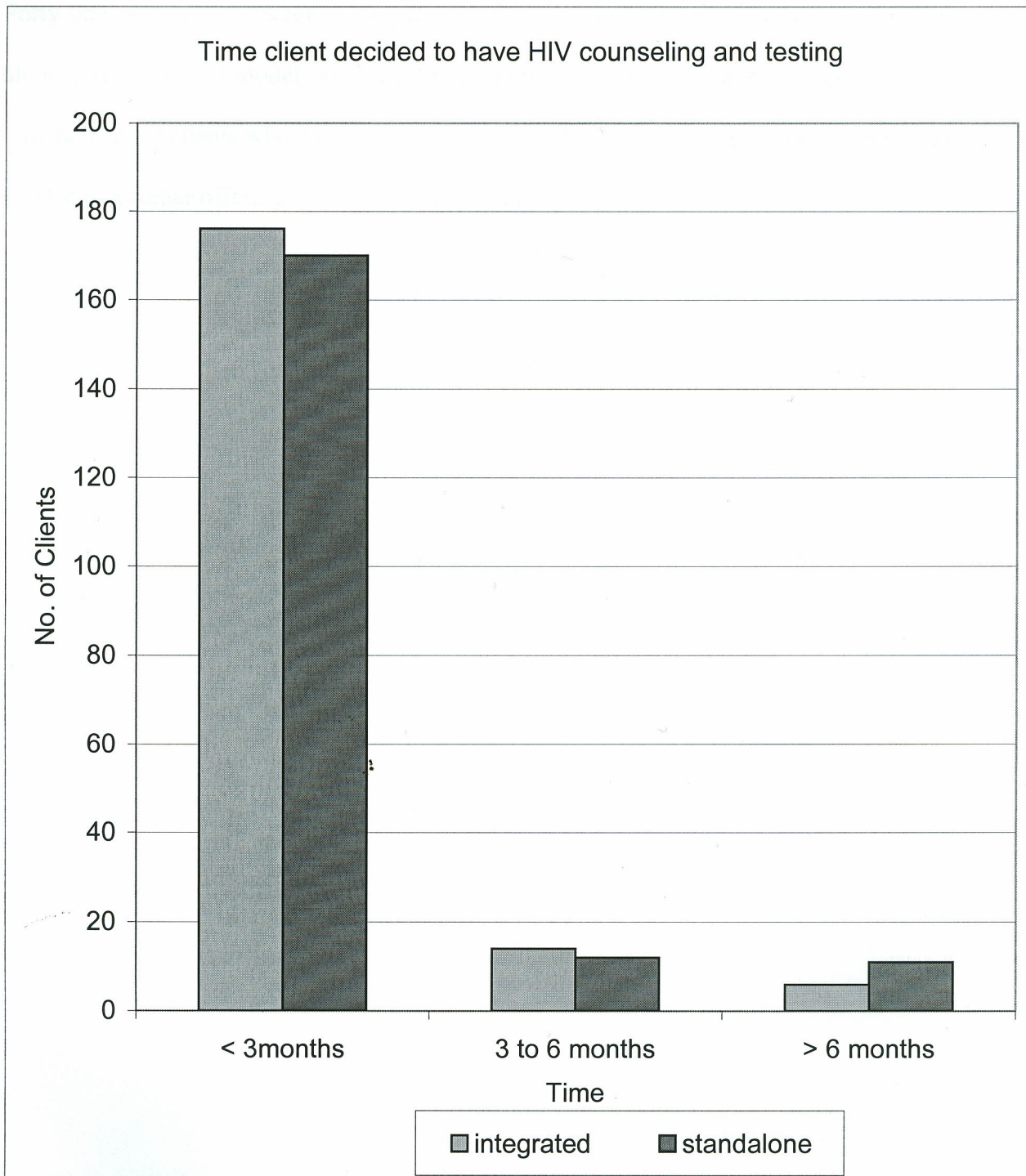
**Figure 9: Sources of information on VCT**



#### 4.2.8 When the client decided to have a HIV test

Eighty nine percent and eighty eight percent of respondents who chose to use integrated and stand-alone models respectively for VCT, decided to have the service 3 months prior to the interview (Figure 10).

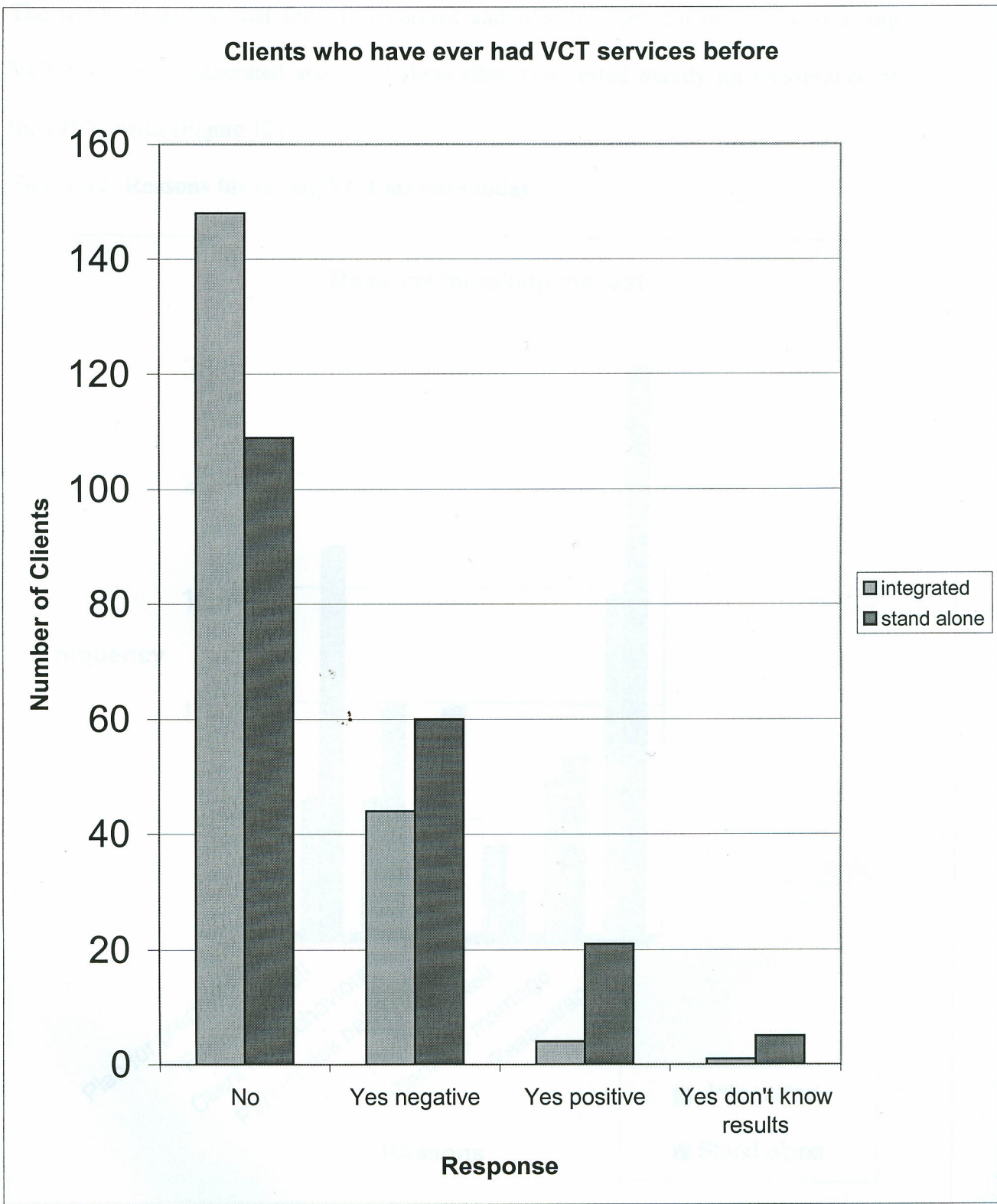
**Figure 10: Time client decided to have HIV counselling and testing**



#### **4.2.9 Clients who have previously had VCT services**

Forty one percent and twenty four percent of the respondents who chose to use stand-alone and integrated model respectively had previously gone through the service. Fifty nine percent of clients who chose to use integrated sites reported to have had the previous service in a center offering only VCT (Figure 11).

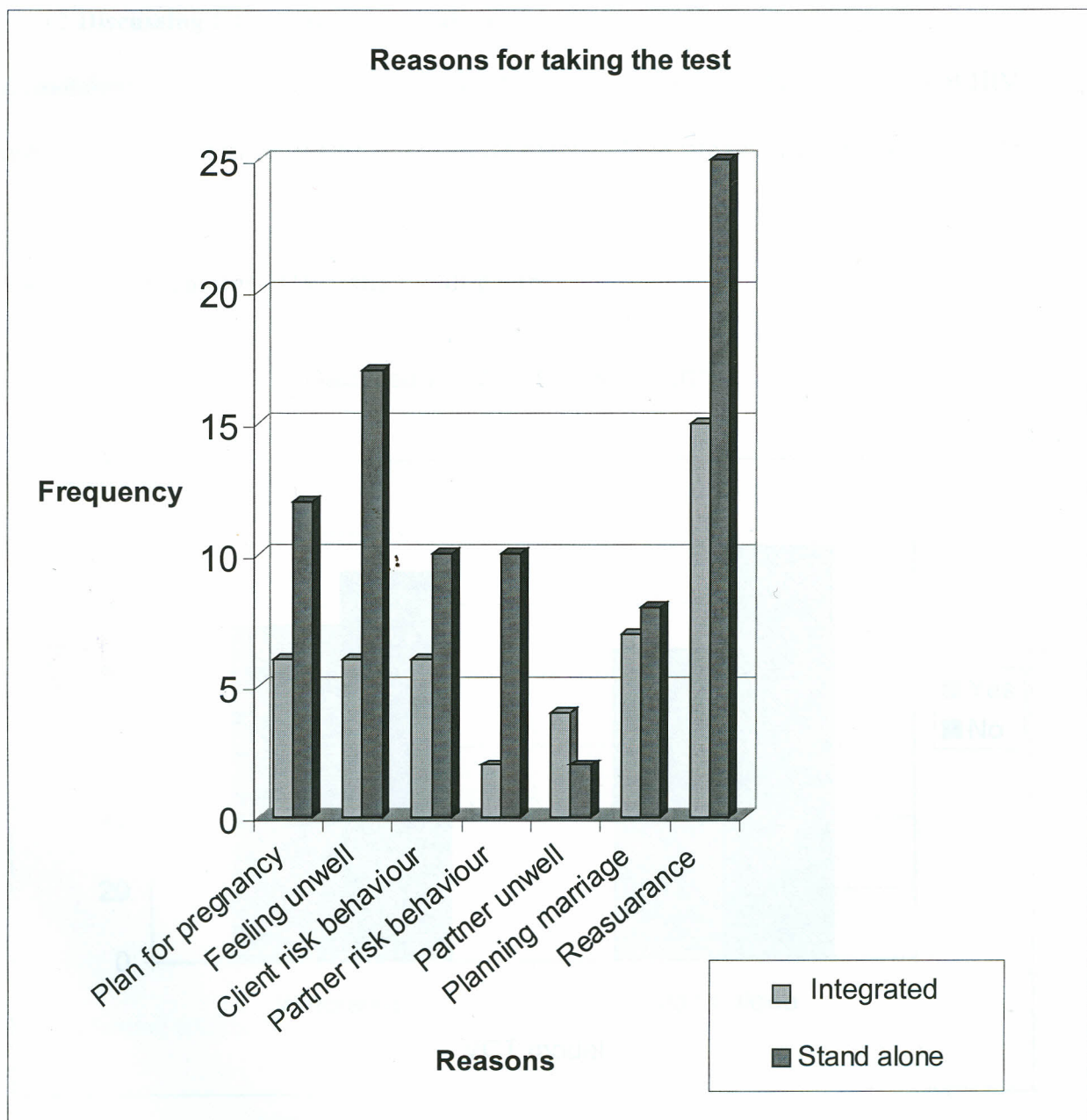
Figure 11: Clients who have ever had VCT services



#### 4.2.10 Reasons for having taken up VCT services today

The results indicated that forty five percent and fifty four percent of clients receiving VCT services in integrated and stand-alone sites were tested mainly for reassurance of their HIV status (Figure 12).

**Figure 12: Reasons for taking VCT services today**



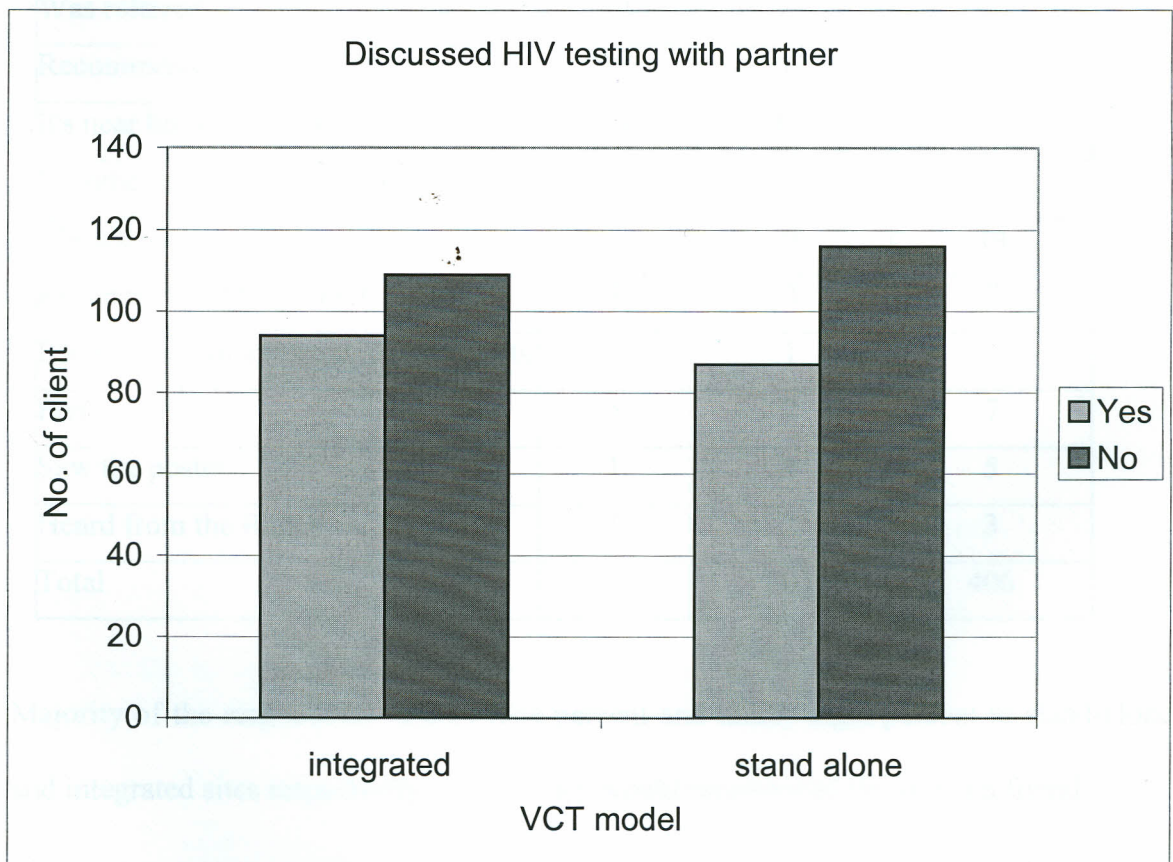
#### 4.2.11 Knowledge on partner HIV status

Sixty two percent and forty nine percent of respondents who chose to use integrated and stand –alone sites respectively reported that their partners did not know their HIV status.

#### 4.2.12 Discussing HIV testing with partner

Respondents who chose to use integrated site, 53.7% reported not having discussed HIV testing with their partner, while 57.1% using stand – alone site reported the same (Figure 13).

**Figure 13: Discussing HIV testing with partner**



#### 4.2.13 Reasons for choosing the site for VCT services

Forty four percent and thirty eight percent of respondents chose to have the services in stand-alone and integrated sites respectively since the site was near their house or place of work (Table 2).

**Table 2: Reasons for choosing VCT site**

	Types of the Site		Total
	Integrated	Stand Alone	
Was referred	49	25	74
Recommended by a friend	57	52	109
It's near house/place of work	74	83	157
No other center offering VCT	7	22	29
Cheaper than others	5	9	14
Recommended by partner	4	3	7
Partner had not agreed with 1st results		1	1
Free	5	2	7
Saw the poster	1	4	5
Heard from the Radio	1	2	3
Total	203	203	406

Majority of the respondents' ninety nine percent and ninety eight percent in stand-alone and integrated sites respectively felt that they would recommend the site to a friend.

## **CHAPTER 5: DISCUSSION**

A total of 406 VCT clients responded to the questionnaire before receiving VCT services; 203 subjects from integrated and 203 subjects from stand alone site. They were interviewed with the aim of identifying the factors that influence the type of site they select for VCT services. The respondents were only got from VCT centres that were sampled i.e. two stand-alone and two integrated sites.

### **5.1 DEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS**

#### **5.1.1 Distribution of the study subjects based on gender**

The results indicated that more females used VCT services in both integrated sites (68%) and stand-alone sites (54%). This therefore shows that there is a significant relationship between the sex of the respondents and the selection of VCT services in both the stand-alone and integrated sites. The results concur with those in a study by Laibuta *et al* (2001) while assessing the youth-friendly uptake of VCT. The high number of females using integrated sites can be attributed to the health-seeking behaviour, since the woman carries the burden of illness to promote health in the family. The other reason for more women using the service may be attributed to the fact that they mostly visit hospitals more than the males for reasons such as Maternal Child health care and family planning (MCHFP).

### **5.1.2 Distribution of the study subjects based on age**

The ages of the respondents in both sites ranged between 14 to 57 years. The mean age was 27.9 and 29.6 in integrated and stand-alone site respectively. High number of VCT clients were categorized in the age groups of 25-29 years. These results concur with those by CDC (2000) who asserted that the group mostly at risk of contracting HIV/AIDS is that of people aged between 15 – 49 years. The mean ages 27.9 and 29.6 may be attributed to the fact that most of the respondents were married as at the time of the study.

### **5.1.3 Distribution based on highest level of education completed**

Majority of the clients in the stand alone and integrated site had received at least secondary level of education. The study shows that there is no significant relationship in the level of education and model of VCT services ( $\chi^2 = 5.686$ ;  $df = 3$  and  $P = 0.128$ ).

Although most of the respondents had at least secondary school level of education, the results indicated a significant relationship between the level of education and the use of VCT services showing that 74% of those who had attained secondary and above level of education tended to use the services more. 47% and 38% of those with secondary level of education selected to have the services in a standalone and integrated site respectively.

### **5.1.4 Distribution of respondents based on Religion**

Out of 406 respondents, 54% and 63.5% were Protestants in the integrated and stand-alone site respectively ( $\chi^2 = 4.467$ ;  $df = 2$  and  $P = 0.107$ ). The study shows a significant difference between religion and selection of VCT services in a stand-alone and integrated model. This may be attributed to the fact that the protestant churches

encourage preventive measures to promote health within their church. This is illustrated in the Health seeking behaviours of the Protestants by encouraging the use of contraceptives and the condom as a preventive commodity. Catholics and Muslims discourage the use of condoms and other forms of family planning as they view it to be like disobeying God who sent them to go and fill the earth.

#### **5.1.5 Marital status of the VCT clients**

In both sites, more married (Monogamous) clients went for the VCT services. Most of the VCT clients had stayed for over one year with their current partner. There was a significance difference in the marital status and the selection of VCT services in a stand alone and integrated model ( $\chi^2 = 5.686$ ;  $df = 3$  and  $P = 0.128$ ). This could be attributed to the fact that in monogamous families people tend to trust each other more, as it is assumed that they have only one sexual partner so that as they go for VCT services and they are not very scared of what the outcome may be.

#### **5.1.6 Distribution of respondents based on occupation**

Fifty one percent and forty three percent of unskilled clients chose to have VCT services in stand-alone and integrated model respectively. The study showed no significant difference in the occupation of those seeking VCT services in a stand-alone or integrated model of VCT. This could be attributed to the fact that the study was undertaken in study sites mainly situated in the slums hence most of the respondents are either jobless or are involved in unskilled labour ( $\chi^2 = 4.82$ ;  $df = 2$  and  $P = 0.090$ ).

## **5.2 BEHAVIOURAL PSYCHOLOGICAL ASPECTS OF THE CLIENTS**

### **5.2.1 Plan for children if HIV Positive**

Among those who had children 83% and 88.8 % in the integrated and stand-alone sites respectively reported to have had the children with one partner.

Seventy three percent of clients in integrated site reported that if the HIV test comes out positive, they will not get more children, while 54.7% in stand-alone reported the same ( $\chi^2 = 12.790$ ;  $df = 2$  and  $P = 0.02$ ). The reason of change of plans for more children if HIV positive in those who choose to have the VCT service in stand-alone and integrated concurs with the BSS survey (MOH, 2003) which reports 80% of the respondents had knowledge on Mother to Child Transmission of HIV/AIDS among youth out of school.

### **5.2.2 Change plans of contraceptives if HIV test is positive**

Sixty two percent and forty two percent of clients who choose to use integrated and stand – alone model respectively reported that if HIV test turns positive it would change their plans for contraceptive use ( $\chi^2 = 39.395$ ;  $df = 3$  and  $P = 0.000$ ).

This may be attributed to the high knowledge of HIV/AIDS among respondents in the reproductive age in KDHS (2003). This knowledge has to be translated to practice to reduce Mother to Child Transmission of HIV/AIDS. In 2000, ten percent of reported AIDS cases in children were under 5 years of age, which 90% of the transmission is attributed to Mother to Child Transmission (MOH, 2002). This is because there are other health education and promotion programs in the health institutions including control of Sexually Transmitted Diseases (STDs).

### **5.2.3 Sexual activities of the respondents**

Eighty six percent and eighty three percent of clients who selected to have VCT services in integrated and stand-alone model have had more than one sexual partner in their lifetime. The study findings showed a significant relationship between the number of life sexual partners and also the number of sexual partners in the last 12 months and the selection of the VCT model, this shows that most of the respondents had been sexually active while in secondary level of schooling, thus HIV/AIDS prevention measures (Abstinence) should be emphasized in high school.

### **5.2.4 Number of sexual partners in the last 12 months**

Eighty percent and seventy nine percent of clients who chose to have VCT services in integrated and stand – alone model respectively reported having one sexual partner in the last 12 months. ( $\chi^2 = 16.322$ ;  $df = 10$  and  $P = 0.091$ ). This implied that most of the respondents had been faithful to one partner may be due to the realization that heterosexual relationships were the major mode of transmission of HIV/AIDS. It is also because those who have had one partner consider themselves less vulnerable to contracting HIV/AIDS and hence have less stigma as pertains to the use of VCT services.

### **5.2.5 Knowledge of STDs in the different sites**

The respondents in the integrated model were asked if they knew of STD and the results indicated that 94% knew while 6 % did not. When the respondents in the stand-alone were asked if they knew of STD, 96% answered in the affirmative while only 4% did not

know it. These results indicated that most of the respondents were aware of the STDs and also coupled with the fact that HIV/AIDS is also sexually transmitted. Twenty percent of respondents receiving VCT services in integrated site had an STD and among them 69.2% had a discharge. Thirty four percent in the stand-alone reported having had an STD and among them 67.2% had a discharge. The study findings showed no significant difference in the in having had an STD and the selection of VCT model

### **5.2.6 Use of condoms in the last sexual contact**

In the last sexual contact fourteen percent and twenty two percent of clients who chose to use integrated and stand alone model respectively reported to have used a condom. This low use of condom may be attributed to the fact that most of the respondents had one sexual partner in the last 12 months and had built trust in them.

### **5.2.7 Distribution based on source of information**

Forty five percent and thirty five percent of clients who chose to have VCT services in integrated and stand-alone model respectively reported to have had information about the VCT site through electronic media ( $\chi^2 = 41.23$ ;  $df = 6$  and  $P = 0.001$ ).

This meant that the most effective method of transmitting HIV/AIDS messages is through the media. These results concur with those of a study by Oyore (2003), which revealed the factors influencing the utilization of VCT services among the youth in Nairobi. The high percentage of people using media as a source of information can be attributed to the population which was within urban and peri-urban area where there is a lot of technological advancement.

### **5.2.8 When the client decided to have a HIV test**

Eighty nine percent and eighty eight percent of respondents who choose to use integrated and stand-alone models respectively for VCT, decided to have the service 3 months prior to the interview. Since most of the respondents decided to have the service within three months of decision this can be attributed to the on going campaign to promote the use of the service in the country.

### **5.2.9 Clients who have previously had VCT services**

Forty one percent and twenty four percent of the respondents who chose to use stand-alone and integrated model respectively had previously gone through the service. Fifty nine percent of clients who chose to use integrated sites reported to have had the previous service in a centre offering only VCT. Fifty percent of the clients who choose to use the stand-alone site reported having had the previous service in a site within a health institution. This may be explained that most of the clients could have come back to confirm that they were actually negative and were not just in the window stage.

### **5.2.10 Reasons for having taken up VCT services today**

The results indicated that forty five percent and fifty four percent of clients receiving VCT services in integrated and stand-alone sites were tested mainly for reassurance of their HIV status. The other reasons for testing included feeling unwell, planning for pregnancy, partner engaged, risky sexual behaviour, partner unwell and planning for marriage. This could be because they have been involved in risky sexual behaviors in the past and they thought that this could have put them at a high risk of contracting HIV so

they wanted to be sure they are safe. This may also be attributed to the communication strategy NASCOP has put in place for VCT. The communication strategy through the 'Chanuka' campaign and also the faith based organizations through the churches have encouraged the population to know their HIV status and take control of their lives.

#### **5.2.11 Knowledge on partner HIV status**

Sixty two percent and forty nine percent of respondents who choose to use integrated and stand –alone sites respectively reported that their partners did not know their HIV status. This result concurs with those in the study by *Issiaka et al., (2001)*. This indicates that the communication strategy should effectively address issues of couple counselling, testing and disclosure. This low knowledge on partner HIV status can be attributed to the fear and stigma following discordant results that may lead to breaking up of families.

#### **5.2.12 Discussing HIV testing with partner**

Of the respondents who chose to use integrated site, 53.7% reported not having discussed HIV testing with their partner, while 57.1% using stand – alone site reported the same. This means that most people do not discuss with their partner since it may be them who have been involved in risky sexual relationships hence imagining that they may be blamed for having brought the scourge in the relationship or family. This result concurs with those in a study by *Issiaka et al (2001)*, reviewing women who were HIV sero positive in a therapeutic trial in Bobo-Dioulasso, Burkina Faso

### **5.2.13 Reasons for choosing the site for VCT services**

Forty four percent and thirty eight percent of respondents chose to have the services in stand-alone and integrated sites respectively since the site was near their house or place of work. Twenty six percent and twenty nine percent in stand-alone and integrated site respectively had the site recommended to them by a friend. Majority of the respondents' ninety nine percent and ninety eight percent in stand-alone and integrated sites respectively felt that they would recommend the site to a friend.

## CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

### 6.1 CONCLUSIONS

- a) Young men and women are vulnerable to HIV infection because they begin sexual activity at an increasingly younger age, 60% of the respondents had been involved in sexual relationships before the age of 18. This contributes to the high prevalence of HIV among the 15-49 age groups.
- b) The lower the knowledge on the dynamics of the disease, the more discriminative they tend to be about HIV infection and affected families and the stronger the stigmatization is evidenced by the fact that most of people went for VCT were only because they wanted to reassure themselves.
- c) The relationship between the knowledge of STD and behaviour change is complex and therefore developing innovative messages to enhance acceptability of VCT Services and combining them with counselling and behaviour change. If behaviour change is to be effective, it should involve the local people in developing appropriate messages and should address socio-economic and cultural realities that influence their sexual behaviour.
- d) Ninety eight percent of the clients who choose either stand alone or integrated site reported they would recommend the site to a friend. This gives an indication that the population has built confidence of the services been offered and can be enhanced through the media since majority of the respondents received information of the services through electronic media.

- e) There is low knowledge on HIV partner status with 62.1% and 49.3 % in integrated and stand-alone respectively. Fifty-three and fifty seven percent of the respondents in integrated and stand-alone sites respectively discuss HIV testing with their partners. This low knowledge may lead to an increase of discordant couples and may lead to disintegration of families.

## 6.2 RECOMMENDATIONS

- a) Information, communication and education messages designed with particular target audiences in mind will be of special importance especially in addressing the varying needs of the various populations who have varying social, economic, psychological, cultural and behavioral differences.
- b) VCT services either offered through integrated or stand-alone model should be available at primary health level.
- c) Stigma and discrimination affect uptake of VCT in different communities. Normalizing testing and increasing the number of people who know their serostatus is an important strategy in reducing stigma and discrimination.
- d) VCT should be linked with support services following testing. These may include post test counselling groups, ongoing psychological, social and clinical care for those HIV positive. Adequate support is also important for HIV affected families in relation to orphans, street kids and children-headed households.
- e) Integration of VCT services at workplace to target more men and increase the participation of men in the HIV/AIDS prevention programmes.

- f) Develop a prevention campaign targeting couples to freely discuss about HIV/AIDS with their partners and their children.
- g) A more youth-friendly HIV/AIDS curriculum to be developed and disseminated to schools to articulate prevention and promote health among the youth.

### 6.3 SUGGESTIONS OF FUTURE RESEARCH WORK

I would like to suggest that other studies be done aimed at answering the following research questions.

- a) How does the family influence and promote behaviour change to reduce risk of HIV transmission?
- b) What impact does integration of HIV interventions in the Reproductive Health and MCH services have in the prevention and control measures of HIV/AIDS in Kenya?
- c) How do family structures influence both health-seeking and care-giving for HIV-infected and HIV-affected individuals in the society?
- d) What impact will reproductive health education in schools have in addressing biological changes in the girl and boy child to enhance delayed onset of sex and encourage use of VCT services?
- e) What are the determinants of HIV-related stigma in Kenya? How are these determinants influenced? Do these determinants differ and, if so, how do they differ, from stigma associated with other diseases? Do they differ by gender, ethnicity, class or age of the individuals stigmatized? What strategies and interventions are effective in reducing stigma?
- f) What is the influence of stigma in programs designed for access to care for people living with AIDS?

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## APPENDICES

### APPENDIX I: RESEARCH INSTRUMENTS

#### STRUCTURED QUESTIONNAIRE

#### SURVEY OF VCT SERVICES IN RIRUTA, LANGATA HEALTH CENTRE AND KICOSHEP SITES: NAIROBI DISTRICT

1. Site name \_\_\_\_\_
2. Subject number \_\_\_\_\_
3. Date of interview (day/month/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
4. Clients place of residence \_\_\_\_\_

#### A: SOCIO DEMOGRAPHIC DATA

5. Date of Birth (day/month/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
6. Age \_\_\_\_\_ years
7. Sex: Male [ ]  
Female [ ]
8. How many years of school did you complete? \_\_\_\_\_ Years
9. Highest education level completed? None [ ]  
Primary [ ]

Secondary [ ]

College [ ]

10. Current marital status (tick one):

Never married Other (specify) \_\_\_\_\_ [ ]

Steady partner, not living together [ ]

Steady partner living together [ ]

Married (polygamous) [ ]

Married (monogamous) (Box 19) [ ]

Divorced/Separated [ ]

Widowed [ ]

11. How many years have you been with your current partner?

Last 5 months [ ]

6 -11 months [ ]

1-5 years [ ]

Over 5 years [ ]

12. What is your occupation?

Unskilled [ ]

Skilled [ ]

Student [ ]

Specify \_\_\_\_\_

13. Client seen as?

Individual [ ]

Couple [ ]

Group [ ]

14. Religion (tick one):

Catholic [ ]

Muslim [ ]

Protestant [ ]

Other (specify) \_\_\_\_\_

15. Do you have children?

Yes [ ]

No [ ] (if no child go to question 19).

16. If yes how many children do you have? \_\_\_\_\_

17. Are they all from one partner? \_\_\_\_\_

18. If you tested HIV positive, would it change your plans for more children?

Yes [ ] No [ ] Don't know [ ]

19. Do you plan to have children?

Yes [ ]

No [ ]

Don't know [ ]

20. If you tested HIV positive, would it change your plans for children?

Yes [ ] No [ ] Don't know [ ]

21. If you tested HIV positive, would it change your plans for the methods of contraceptives.

Yes [ ]

No [ ]

Don't know [ ]

**B: SEXUAL BEHAVIOUR**

22. At what age did you have first sexual contact? \_\_\_\_\_

23. How many sexual partners have you had in the last 12 months?  
\_\_\_\_\_

24. Do you know about STDs?

Yes [ ]

No [ ]

25. Have you ever had an STD (syphilis, gonorrhoea, genital ulcers or warts)? **(if no go to question 28)**

Yes [ ]

No [ ]

26. If Yes what STD?

Ulcerative [ ]

Discharge [ ]

Others \_\_\_\_\_

27. Condom use in the last sexual contact?

No [ ]

Yes [ ]

Yes but condom broke [ ]

Not sexually active in the last 12 months [ ]

Never had sex [ ]

**C: CLIENT PERSPECTIVES/ KNOWLEDGE/ATTITUDES**

28. How did you know VCT services are offered in this site?

- Television [ ]
- Radio [ ]
- Newspapers [ ]
- Posters/Signposts [ ]
- Pamphlets/fliers [ ]
- Relative/friend [ ]
- Sex partner/spouse [ ]
- Another VCT client [ ]
- Church [ ]
- Mosque [ ]
- Temple [ ]
- Community meeting [ ]
- Peer educator [ ]
- Health worker [ ]
- Others (specify) \_\_\_\_\_

29. When did you decide to have HIV counselling and testing today?

- 0-3 months [ ]
- 3months – 6 months ago [ ]
- 6 months and above months ago [ ]

30. Have you ever received VCT services before?

- No [ ]
- Yes, negative [ ]
- Yes, positive [ ]
- Yes, do not know results [ ]

31. If yes, when were you tested?

Less than a month ago [ ]

1-5 months ago [ ]

6 months ago [ ]

32. Where were you tested?

In a health institution [ ]

In a center only offering VCT [ ]

33. Why are you having VCT services today ?

Partner tested [ ]

Plan for pregnancy [ ]

Feeling unwell [ ]

Client risk behavior [ ]

Partner risk behavior [ ]

Partner unwell/ died [ ]

Planning to get married [ ]

For reassurance [ ]

Other (specify) \_\_\_\_\_

34. Does your partner know his/her HIV status?

Yes [ ] No [ ]

35. Had you discussed HIV testing with your partner before coming for the VCT services?

Yes [ ] No [ ]

36. Why did you choose to be tested in this clinic?

I was referred [ ]

- Recommended by a friend [ ]
- It's near my house/place of work [ ]
- No other center offering VCT [ ]
- Cheaper than others [ ]
- Other (specify)\_\_\_\_\_

37. Would you recommend this Center to your friends?

Yes [ ] No [ ]

38. If no, why not?

- Poor location [ ]
- Poor services [ ]
- Staff unfriendly [ ]
- Services take too long [ ]
- Other (specify)\_\_\_\_\_

39. If you had to pay, how much would you be willing to pay in Ksh.\_\_\_\_\_?

APPENDIX 2: ETHICAL CLEARANCE DOCUMENTS

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

Telegrams: "EDUCATION", Nairobi

Telephone: Nairobi 334411

When replying please quote

Ref. No. MOEST 13/001/32C 136/2  
and date



JOGOO HOUSE "B"

HARAMBEE AVENUE

P.O. Box 30040

NAIROBI

30th July 2002

~~Teresia Kyutu Mwikali~~

~~P.O Box 19361~~

~~Nairobi~~

Dear Madam,

RE; RESEARCH AUTHORIZATION

Please refer to your application for authority to conduct research on 'Factors influencing the utilization of Voluntary Counseling and Testing services in Stand alone and Integrated sites in Nairobi province'.

I wish to inform you that you have been authorized to conduct research in Nairobi province for a period ending 30<sup>th</sup> September 2002.

You are advised to pay courtesy calls to the Provincial Commissioner and the Provincial Education Officer, Nairobi before embarking on your stuffy.

You are further expected to deposit two copies of your research findings to this office upon completion of your study

Yours faithfully

A handwritten signature in black ink, appearing to read 'A.G. Kaaria'.

A.G KAARIA

FOR. PERMANENT SECRETARY MINISTRY OF EDUCATION

C.C

The Provincial Commissioner  
Nairobi Province

The Provincial Education Officer  
Nairobi Province

## **APPENDIX 3: ABSTRACT FOR SEMINARS AND CONFERENCES**

**Author:** Teresia Kyulu Mwikali

**Forum:** Department of Zoology, Post-Graduate conference

**Venue:** Kenyatta University, Science Complex

**Date:**

**TITLE: FACTORS INFLUENCING THE USER-CHOICE OF INTEGRATED AND STAND-ALONE VOLUNTARY COUNSELLING AND TESTING SITES IN NAIROBI PROVINCE, KENYA**

**NAME: TERESIA MWIKALI KYULU**

**REG. NUMBER: I56/9127/2000**

### **SUPERVISORS**

1. Prof. Alloys S. S. Orago, PhD., C Biol , MI Biol.
2. Prof. Romanus O Okelo, PhD.
3. Dr Elizabeth Marum PhD.

## **ABSTRACT**

The HIV/AIDS epidemic has been and remains the most important public health problem affecting the world with over 40 million people infected, 70% of whom are living in the sub-Saharan Africa as at the end of the year 2003. In Kenya, it is estimated that 1.2 million people out of a population of 31 million are living with HIV/AIDS (KDHS, 2003). The pandemic has caused over 1.5 million deaths in Kenya since the early 1980s leaving behind many orphans.

Voluntary Counselling and Testing (VCT) has become an integral part of programmes in many countries in the control and management of HIV/AIDS. It is not only a key component of both HIV prevention and care programmes, but is the gateway to prevention and care. It leads to development of effective and accessible medical and supportive interventions for people living with HIV/AIDS (PLWHA). It has also been incorporated as part of the primary health care package in many countries.

The general objective of this study was to determine the factors influencing the choice of integrated and stand-alone VCT sites in Nairobi Province, Kenya. The data was collected using semi-structured questionnaires. A sample of 406 (203 in integrated, 203 in stand-alone site) was collected from clients seeking VCT services in two integrated and two stand-alone sites in Nairobi Province. All data from the study was coded and entered in a computer cleaned and analyzed using the Statistical Package for Social Sciences (SPSS). Chi-square was used to test for the relationship between the variables determining the selection of VCT site.

From the findings of this study, it was realized that one of the major factors influencing the choice of VCT site was gender, with more women (68%) using the integrated model maybe because they accessed it while undergoing Maternal and Child health services. Education level also influenced the choice with more educated (47%) people using the stand-alone. The sexual history of the respondents also influenced the choice with results indicating that 80% of those who had many sexual partners in the past seeking VCT at stand-alone sites due to the perception of vulnerability.

The findings of this study have policy implications in the distribution and accreditation of VCT sites to promote increased utilization of VCT use as a strategy for the prevention and control of HIV/AIDS since it is beneficial to both those with a positive as well as those with negative results. This may also be used in advocating for behaviour change among the people at the greatest risk of contracting HIV/AIDS.