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## Sources of VCT Information and Reasons for Use or Non Use of VCT Services by Young People in Selected Rural Locations in Kenya

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### Abstract

This study investigated the sources of VCT information and reasons why young people used or failed to use VCT services in selected rural VCT locations. A total of 110 participants (Male= 66; Female= 44), with an average age of 24.9 years (Male=24.9; Female=25.0) were involved. An exploratory descriptive survey design was used. Results indicate that media and friends are the major sources of VCT information, and that majority of the young people made their own decision to seek VCT services. Young people identified quest to know one's HIV status, illness, pregnancy and encouragement from friends as major reasons for using VCT. Fear of positive results, lack of youth-friendly services and not feeling at risk were given as the main reasons for not using the existing VCT services. Social support and increased use of internet- based arenas are suggested to help in translating awareness of VCT into action among young people.

**Keywords:** VCT information, use, young people, rural VCT locations.

## 1. Introduction

Worldwide, adolescents and youth are considered a high-risk population for HIV infection because it is within this age group that high-risk behaviours are initiated (Banerjee & Baer, 2006). It is estimated that 1.4 million Kenyans aged 15-49 years are infected with HIV/AIDS with about 1 million living in rural and 400,000 urban residents infected (National AIDS/STD control Programme, NASCOP; 2009). The high prevalence rates in the continent have brought about urgency in designing HIV prevention strategies that can work for all segments of the population. Since most of the approaches to HIV prevention, treatment and care require that people know their HIV status, Voluntary Counselling and Testing (VCT) has become a critical component of HIV/AIDS prevention approaches in different countries.

The on-going expansion of VCT services in Kenya has increased the number of registered VCT points from 650 in 2005 to 900 in 2007 countrywide (Ministry of Health, MOH, Kenya, 2007). It is still not clear whether the ambitious expansion of VCT has led to increased uptake of the services or assurance of quality of services that will create demand from young people (UNAIDS, 2000). In fact, there is an increasing doubt among Kenyan young people as to whether the current VCT services are meant for them (Muga et al. 2004).

Factors that influence the uptake of VCT services by young people in Kenya, especially those outside Nairobi, have not been adequately investigated and well understood specifically from their perceptions. Studies conducted among majority of young people in some parts of Kenya and in other countries reveal a wide range of barriers to VCT for youth (Horizons Programme, 2001; Munthali, Chimbili & Zulu, 2004; Oshi, Ezugwu, Oshi, Dimkpa, Korie & Okperi 2007; Yonder & Matinga, 2004). Existing behavioural change programmes have been developed based on this information. However, there is still neither a great improvement in number of young people accessing these services nor an increase in the number of VCT facilities designed for youth. It is unclear what young people attribute to their uptake of VCT in the Central province of Kenya.

Studies among African youth have shown that even when youth are aware of HIV/AIDS and of the existing VCT sites, and even when a majority of the youth have a strong interest in knowing their HIV status, only a few go for the actual HIV testing. The reasons established for not going for testing are mostly stigma and discrimination (Adedemeji, 2003 Horizons Programme, 2001; Maluwa & Kawala, 2003). Despite the fact that the 2008-09 Kenya Demographic Health Survey (KDHS) established that rural populations in Kenya are more willing to be tested for HIV/AIDS than their urban counterparts, limited research on how and why young people come for testing in the rural areas of Kenya is currently available

A study among Kenyan and Ugandan youth revealed that a majority of the untested youth - more than eight out of ten in the three samples - could correctly name at least one facility that provides HIV testing services. However, even these do not always name the nearest site or sites that provide youth friendly services. Additionally, many untested youth assumed that large health facilities like hospitals automatically provide HIV testing and counselling among their services. This assumption may or may not be the case (Horizons Programme, 2001). The same study also established that young people seek HIV test while healthy and that their greatest motivation to seek VCT was to know their HIV status. However, the study established that in Kenya, 7% of the sample reported that the decision to have a test was not theirs but a parent's or doctor's and several said they were not informed they had been tested for HIV. It was further established that Kenyan youth think that testing is only for the sick and that the community's perception is that young people seek tests only when ill (Horizons Programme, 2001). Majority of studies on VCT uptake recommend that a better understanding of what factors bring young people for testing would be useful for planning the expansion of testing and/or VCT centres (Yonder & Matinga, 2004; Munthali et al. 2004; Oshi et al. 2007).

The need to study and understand young people's perceptions of factors influencing their uptake of VCT has been emphasized by different researchers. Denison, Lungu, Dunnett-Dagg, McCauley and Sweat (2006) recommend that having the knowledge of the many risk and protective factors common to various sexual and reproductive health behaviours of adolescents will allow policy makers and programme managers to develop effective interventions that target those factors. Admashu and Fitaw (2006) state that identifying factors associated with VCT acceptance among different community groups is essential in promoting the service.

The current study investigated young peoples' sexual experience, sexual experiences, perceived incentives, barriers and preferences as factors that influence their uptake of VCT services in selected VCT locations of Central Province Kenya. The factors identified could be used to improve VCT service delivery to youth and to motivate more young people to go for VCT if incorporated in future policies. Emphasis is put on young adults because according to NASCOP (2009) success in combating HIV/AIDS must be measured by its impact on children and young people.

This study focused on the following objectives:

- To establish the major source of VCT information for young people in the selected VCT locations of Central Province.
- To establish whether age and sexual experiences of young people are factors in their uptake of VCT services in the selected VCT locations in Central Province.
- To establish the reasons given by young people for their use or failure to use VCT services in the selected twelve VCT locations in Central Province.
- To establish the incentives identified by young people as motivating them to seek VCT in the selected VCT locations.

## **2. Methodology**

### **2.1 Design**

The study used an exploratory descriptive survey design.

### **2.2 Location Of The Study**

The study was conducted in twelve VCT locations in four districts of Central Province of Kenya namely: Nyeri, Murang'a, Kiambu and Kirinyaga districts. The selected districts are largely rural though they have some peri-urban and semi-urban areas. Three VCT locations were systematically selected per district after reviewing all the VCTs in each of the four selected districts yielding a total of twelve. The VCT sites locations were selected on the criteria of catchments area (strategically positioned to serve large rural populations) and facility type (whether, stand-alone, integrated or youth VCT). The study was conducted in the catchment areas of the selected VCT sites. Ministry of health has indicated that a catchment area of a basic health facility covers an 8-10 kilometres radius of the facility (MOH, 2007). The following sites were involved: Kerugoya District Hospital, Difathas Health Centre and Mwea Mission Hospital in Kirinyaga District; Karatina District Hospital, Nyeri Youth Health Centre and Nyeri Town Health Centre in Nyeri District; Murang'a District Hospital, Marie Stopes, and Kiriaini Mission Hospital in Murang'a District; Kiambu District Hospital, Nazareth Hospital and Limuru Health Centre in Kiambu District. These VCT locations were purposely selected in order to reflect variations in social practices, HIV/AIDS prevalence rates and access to HIV/AIDS testing and counselling services among the people living in Central Province. The VCT locations selected were meant to be illustrative of the social context of the uptake of VCT services among people in Central province of Kenya and not to be statistically representative. Therefore, no attempts are made to generalise the results of this study to wider Kenyan population.

### **2.3 Sample Characteristics**

Convenience sampling was used in this study because there was no information available of all the young people residing in the areas where data were collected which would have formed a sampling frame, or census. A total of 110 participants (Male= 66; Female= 44), with an average age of 24.9 years (Male=24.9; Female=25.0) took part in the study. Majority (51%) of the participants were single, and 10% were cohabiting. 40% of the participants had attained secondary education and 41% stayed with their parents. Importantly, most of the participants (58%) were members of youth groups (Table 1 summarizes the socio-demographic characteristics of the sample).

### **2.4 Data Collection Instruments**

The study used written structured questionnaires with many items based on the UNAIDS (2000) tools for evaluating VCT. The draft questionnaire was discussed with statisticians knowledgeable about the construction of structured questionnaires and people familiar with substantive content of VCT. Afterwards, a pilot study was conducted with 30 young people drawn from three VCT locations in Nyeri and Kirinyaga districts. Areas needing revisions were revised after the pre-test and then the instrument was finalized.

The final questionnaire used in this study contain related to socio-demographic characteristics of the participants; sources of VCT information; uptake of VCT services and decision-making; preferences for VCT sites, counsellor characteristics and interventions for increased VCT uptake by young people.

### **2.5 Ethical Considerations**

Authority to conduct the study was sought from Kenya's Ministry of Education, Science and Technology (MOEST). This was done to ensure that the study met the ethical standards of the MOEST. The protection of the rights of the participants was a priority in this study. The respondents were clearly informed about the purpose of the study and that their responses would remain totally anonymous. In addition, to ensure participants' rights to self-determination and full disclosure remained protected, the respondents were asked to voluntarily participate or to discontinue doing so at any point should they wish to without incurring any ill

effects whatsoever. As only structured questionnaires were administered, the participants were never subjected to any harmful effects. However, since talking about VCT might be traumatic to young persons who learned that they were HIV positive as a result of using these VCT services, especially if they were not given enough post-test support, those who felt uncomfortable with the subject were dropped from the research.

### **3. Results**

#### **3.1 Sexual Experiences of Single Participants**

As shown in table 2, most of the single participants ever had sex, while 24 % reportedly never had sex. Out of the 43 single respondents who reported they ever had sex, 31 % had only a single sexual encounter, while 69 % had sex more than once. Of the single young people aged 21 years and above, 88% had more frequent exposure to sex whereas fewer of those aged up to 20 years had been exposed to frequent sexual encounters.

#### **3.2 Uptake of VCT Services**

As shown in table 3, 45% of the participants who had gone for VCT were aged between 26 and 30. Interestingly, participants aged between 20 and 25 years only comprised 29 % of the participants had utilized VCT, while the same age set accounted for the greatest percentage (53%) of the participants who had not utilized VCT services. Only 9% of the participants who had gone for VCT were aged between 16 and 20.

#### **3.3 Respondents Primary Source of VCT Information**

The most common first sources of VCT information among the participants were Media (31%) and Friends (27%). Parents, siblings, teachers and the Internet were also cited as first sources of VCT information, accounting for 32% of the responses (table, 4). Other sources of VCT information mainly included seminars, workshops, posters and churches, all accounting for 10% of the responses.

#### **3.4 Decision to go for VCT**

The participants who had gone for VCT were asked to state whether they made their own decisions to go for VCT or others influenced them. As table 5 shows, the majority of the participants 78% took their own decision to go for VCT while only 22% were influenced by others to go for testing. With respect to age, the tabulation for the data shows that more young people aged between 26 and 35 tended to take personal decisions to go for VCT while younger people aged between 16 and 25 tended to be influenced more by others to reach a decision to go for VCT.

#### **3.5 Reasons for going for VCT**

Those who had sought VCT services were asked to indicate their reasons for going for VCT. 54 % indicated that the main reason for going for VCT stated was just to know their status. Illness, pregnancy and encouragement from friends were the other reasons why young people sought VCT (see table 6) while only 2% of the young people went for VCT out of pressure from family.

#### **3.6 Reasons for not using VCT**

Those participants who had not gone for VCT were asked on the questionnaire to give the reasons for non-utilisation of VCT services. The main reason provided by 40% of the respondents who had not visited VCT for HIV testing for their failure to go for VCT services was fear of positive results (table, 7). Other major reasons cited by young people for not going for VCT were: Lack of youth-friendly services 18%; not feeling at risk 14% and distance of nearest VCT 12%.

### **4. Discussion**

This results shed present an interesting scenario about the uptake of VCT services by young people in the study locations. The finding that majority of the single participants were sexually active was expected going by the findings of the 2008-09 Kenya Demographic and Health Survey (KDHS) that the age of sexual debut among Kenyan adolescents is below 15 years. It is interesting to find that the sexually active young people who had gone for VCT represented all the sampled age groups. This is in agreement with a study in Malawi by Mphaya, (2006) which revealed that young people as young as 14 years sought VCT and that there is a significant difference between age-groups and exposure to sex. This is an encouraging finding because it indicates that younger people, who are not exposed to sexual activity, still seek VCT services. Concerted efforts should be made to repackage VCT for young people in the rural areas as rural population were found to be more acceptable of HIV testing than their urban counterparts during the 2008-09 KDHS. That majority of those who had sought VCT were aged between 26 and 30 could be due to the fact that this is the age that most young people in Kenya get married as per the 2008-09 KDHS. Going for VCT at this age could be a way for a young couple trying to plan for the future (Maman, Mbawambo, Hogan, Kilonzo, & Sweat. 2001). The observation that only a few of those aged up to 20 had gone for testing was expected since few young people within this age group have

gone for HIV testing in Kenya. This is so because the minimum age for consent for HIV testing is 16 according to the national guidelines for VCT (NASCO, 2001). However, these guidelines allow young people who are sexually active, pregnant or married to give consent for VCT at the age of 13 since they are considered to be mature minors under these circumstances. This explains why there were some respondents younger than 18 who had gone for VCT.

That majority of the participants pointed out to the media and peers as the most common sources of information on VCT for young people corroborate other research findings in Kenya as well as in other countries where media and peers have been found to be young people's primary source of information about a range of reproductive health issues (The Population Council Inc., 2001; Idele, 2002; McCauley, 2004; Dennison et al., 2006; Aarons & Jenkins, 2002, Ben-Zur, 2003). could be due to the fact that in Kenya, currently, there are many radio stations including different vernacular FM stations, TV stations, and newspapers (especially those with youth-targeted pullouts) which provide a lot of information on HIV/AIDS and VCT services. Of these, radio stations and TV stations are the most accessible to both urban and rural populations in Kenya. The radio and TV programmes on VCT are produced and presented by young people in a manner that is interactive through phone-in programmes and Short Message Service (SMS). This could be the reason why more young people listen to such programmes since they are produced and presented in a youth-friendly manner. This also provides the link for peers to act as a source of information on VCT since as much as the information is from the radio and TV; peers are the ones providing most of the information. Therefore it is important to make radios and TVs more available, accessible and affordable to young people to enhance their access to information. In addition, friends play an important role in influencing their peers to access VCT services. It is therefore important to empower young people to provide accurate information to their peers to enable more young people to go for VCT.

Teachers were not identified as the most common source of VCT information for young people. This could be due to the fact that sex education component is minimally incorporated into the education curriculum in Kenya and that it still has not gained full acceptance from all stakeholders especially the church. Although Internet is a powerful source of information on HIV/AIDS and VCT, it is yet to gain more popularity among the young people, especially those in rural areas, due to inaccessibility and high cost. More needs to be done to market the internet as a favourable source of VCT information among adolescents since it has been shown that adolescents use the internet for their own sexual reference displays (Moreno, Brockman, Wasserheit & Christakis, 2012).

The results imply that most young people are already empowered to take their own decisions to go for VCT in the rural locations in the country. This is especially so for those in the older age brackets who are also expected to have started to make own decisions in other aspects of their lives. However, going for VCT is still a sensitive issue, as most young people do not want other people to know that they had used VCT services (Mphaya, 2006). This is more common among young people who fail to go for testing because they would then be perceived as being sexually active (Horizons Programme, 2001). This fear might influence young people to make independent decisions to go for VCT so as to maintain their confidentiality and avoid the possible stigma and discrimination associated with having utilised VCT services.

We found that most young people in lower age brackets (16-25 years) still turned to others when making decisions about using VCT services. This finding corroborates the findings of a study by Horizons (2001) in Kenya and Uganda that established that young people aged 14 to 21 turned to other people especially their peers for information about getting an HIV test. As Muga et al. (2004) point out, supportive relationships for young people may minimise the negative consequences of testing that youth fear including stigma and isolation. The finding also implies that young people may be having a felt need for counselling support services in their quest to utilize VCT services.

It could be that young people already realise the need for them to know their HIV status hence their being motivated to go for VCT. The need to know their HIV status in this study could also be attributed to the fact that the majority of the participants were sexually active. That few respondents went for VCT out of family intervention could be due to the cultural factors that prevent parents and siblings from sharing sexual and VCT information with their children or other siblings (Idele, 2001). These results support the findings of a study conducted in Kenya where it was found that young people went for HIV testing primarily to know their HIV status (Horizons, 2001). It is therefore critical to highlight the importance of knowing one's status during information sessions to young people.

The finding that majority of respondents failed to go for VCT for fear of positive results supports the findings of a study conducted in Kenya by Horizons (2001), on young people who had not gone for testing who reported they were not going for VCT because they feared receiving HIV positive results. Similar findings were reported in a study conducted in Zambia which revealed that 57.0% of boys and 53.0% of girls indicated that they would like to have opportunities of going for HIV tests but the majority of them were not keen to have HIV tests at that

time, as they were worried they might be HIV positive (Baggaley, 2001). The finding that some young people do not feel at risk of HIV infection is consistent with the findings of a study in Nigeria by Oshi et al. (2007) which established that those young people who profess low self-perception of risk least went for HIV screening.

## 5. Conclusion

We conclude that young people may not be utilizing the existing VCT services due to lack of family and school support in their use of these services. We recommend that efforts to popularize the uptake of these services be tailored in such a way that parental support is guaranteed to the young people. Further, the school can be an important arena in transforming knowledge into VCT seeking behaviour. If VCT content were tailored into the current curriculum it may help the adolescents identify themselves as consumers of the VCT services. That peers and media continue to exert important influence among Kenyan rural adolescents should be strengthened by adopting different media as venues for disseminating VCT information. Further research should be carried out among young people in other rural areas to establish if the factors identified in the studied locations are common to all youth. Finally, more robust analytical procedures should be employed in future research to establish how the factors influencing uptake of VCT by young people interrelate and in which direction.

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## TABLES

**Table 1: Socio-demographic characteristics of the participants**

VARIABLE	Frequency (N=110)	Percentage (%)
Gender		
Male	66	60
Female	44	40
Age (Mean= 24.9)		
16-20	13	12
21-25	43	39
26-30	35	32
31-34	19	17
Marital Status		
Single	58	52.7
Married	37	33.6
Cohabiting	11	10
Separated/divorced	4	3.6
Religion		
Christian	79	72
Muslim	14	13
Hindu	-	-
Others	9	15
Educational background		
Primary	9	8
Secondary	45	41
Polytechnic	6	6
Tertiary college	29	26
University	21	19

**Table 2: Sexual experiences of the single participants**

Age Group	Ever had sex		Total
	Yes	No	
16-20	5 (12 %)	8 (58%)	13 (23 %)
21-25	19 (44 %)	3 (25%)	22 (39 %)
26-30	15 (35%)	2 (17%)	17 (30 %)
31-35	4 (9 %)	-	4 (7 %)
Total	43 (100%)	13(100%)	56 (100%)

**Table 3: Participants' uptake of VCT services**

Age Group	Have you ever gone for VCT?			
	Yes		No	
	Frequency	Percentage	Frequency	Percentage
16-20	6	9	7	16
21-25	19	29	24	53
26-30	29	45	6	13
31-35	11	17	8	18
Total	65	100	45	100



**Table 4: Participants' primary source of VCT information.**

Source	Frequency	Percentage
Parents	7	6%
Siblings	13	13%
Internet	9	8%
Media	34	31%
Teachers	6	5%
Friends	30	27%
Others	11	10%
Total	110	100%
Source	Frequency	Percentage
Parents	7	6%
Siblings	13	13%
Internet	9	8%
Media	34	31%
Teachers	6	5%
Friends	30	27%
Others	11	10%
Total	110	100%

**Table 5: Who influenced the decision to go for VCT?**

Age Group	Decision to go for VCT				TOTAL
	Self		Someone else		
	Frequency	%	Frequency	%	
16-20	4	8	2	14	6 (9 %)
21-25	13	25	6	43	19 (29 %)
26-30	24	47	5	36	29 (45 %)
31-35	10	20	1	7	11 (17 %)
<b>Total</b>	51	100	14	100	65 (100 %)

**Table 6: Reasons for going for VCT.**

Reasons	Frequency	%
To know what happens in VCTs	4	6
To know my status	35	54
Pressure from family	1	2
Encouragement by friends	6	9
Pregnancy	9	14
Illness	10	15
<b>Total</b>	65	100

**Table 7: Reasons for not going for VCT**

Reasons for not going for VCT	Frequency	%
Fear of positive results	18	40
Lack of youth-friendly services	8	18
Fear of people finding out	3	6
Don't want to test yet	1	2
Never had sex	4	8
Distance of nearest VCT	5	12
Do not feel at risk	6	14
<b>Total</b>	45	100