

RESEARCH TOPIC

FACTORS DETERMINING THE UTILIZATION OF HIV VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES AMONG THE YOUTH IN NAKURU DISTRICT: A CASE STUDY OF THE RIFT VALLEY PROVINCIAL GENERAL HOSPITAL.

A Research Project submitted in partial fulfillment of the requirements for the award of Masters of Arts Degree in Sociology.

**BY UNIVERSITY OF NAIROBI
EAST AFRICANA COLLECTION**

MARY EVERLYN AYUGI

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CSO 698 PROJECT PROPOSAL

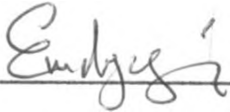


**UNIVERSITY OF NAIROBI
FACULTY OF ARTS
DEPARTMENT OF SOCIOLOGY**

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DECLARATION

This Research Project is my original work and has not been presented for examinations at any other institution.

Sign 

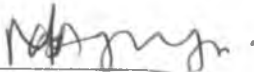
Date 27/9/2005

Mary Everlyn Ayugi

C/50/P/8957/2001

Supervisors

1. Prof. C. Odegi Awuondo Sign  Date 30/9/05

2. Dr. Benson Agaya Sign  Date 28/9/2005

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MAY GOD BLESS YOU ALL

DEDICATION

To my father, Mr. Dalmas Ayugi and mother, Mrs. Fransisca Ayugi

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drugs
ELISA	Enzyme Linked Immunosorbant
FHI	Family Health International
HIV	Human Immunodeficiency Virus
KANCO	Kenya Aids NGO's Consortium
KDHS	Kenya Demographic and Health Survey
RH	Reproductive Health
NASCOP	National Aids and Sexually Transmitted Diseases Control Programme
NGOs	Non Governmental Organizations
STI	Sexually Transmitted Infections
SPSS	Statistical Package of Social Sciences
UNAIDS	Joint United Nations Programmes on HIV/AIDS
UNICEF	United Nations International Children's Fund
USA	United States of America
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

SUMMARY

Recent health and demographic studies reveal that in Kenya, young people, aged 15-24 years face a greater risk of HIV infection than any other age group. The question of whether the youth have access to and utilize proper/quality health services and other prevention programmes such as VCT is becoming critically important. A lack of timely action can have grave consequences. This work sought to examine the factors determining the utilization of HIV voluntary counseling and testing services, as a strategy in prevention and control of HIV/AIDS among youth, aged 15 – 24 years at the Rift Valley Provincial General Hospital, Nakuru District. More specifically, the study attempted to establish the socio-demographic and economic factors influencing **access** to VCT services among the youth. It also attempted to identify the **experiences/perceptions** (social, psychological, emotional) that would motivate or hinder youth receiving HIV counseling and testing on site and to determine the **extent of VCT service utilization** among the age group of 15 – 24 years. The study also investigated the extent to which the VCT center has addressed / met the counseling and other reproduction health needs of the youth. The study finally attempted to investigate the relationship between these factors and VCT service utilization by testing the hypothesis; Youth attitudes towards the utilization of VCT services are influenced by both community level factors (socio-demographic, economic factors) and clinic level factors (organization, quality, and availability of VCT services and facilities).

To achieve the stated objectives, a descriptive cross sectional survey research combining both quantitative and qualitative methods was adopted. The study population consisted of 100 respondents. They were young men and women purposively selected using convenience sampling method. To obtain additional information, 4 key informants were purposively selected. The selection was also guided by the respondents and key informants willingness to participate in the interview process whose main tools of data collection were the questionnaire and interview guide respectively. The 100 respondents and 4 key informants, who were also the unit of analysis in the study were interviewed. Of the 100 respondents, 60 were interviewed on exit from the VCT center and 40 non-VCT users were interviewed while queuing for other medial services within the Provincial General Hospital during the research period.

The findings revealed that awareness of VCT was high with the main source of information for majority, 28.5% of the respondents being television/radio. Although 46% of the respondents indicated that they would wish to know their HIV status, only 11% knew their HIV status – indicating the extent of the reluctance by many to be tested for HIV. Of the 58 respondents who received full VCT services during the study period, majority, 52.6% indicated that they were simply **motivated** by the need to know their HIV status, a variable which the study established to have the most significant relationship with the use of VCT services. This was followed by planning for the future mentioned by 26.2% of the 58 respondents as the main reason for HIV testing. The hypothesis tested further confirmed that there is significant association between VCT services utilization and other community level factors such as, occupation, marital status, residence and feelings/consideration about service charges.

Following such findings, it has been concluded that there is low utilization though there is high demand. A significant proportion of young people are in need of VCT services, but that utilization depends not only on tangible community level socio – economic factors to a large extent, but that it is also limited by social, psychological and cultural perceptions. The study's recommendations mainly revolve around efforts aimed at reducing obstacles by addressing the root causes of low service utilization such as, the socio-economic hurdles facing the youth. The success of this intervention will ultimately depend on a supportive environment which guarantees access and availability of its services.

CHAPTER ONE

1.0 BACKGROUND

The world is now sustaining the largest number of youth in human history. There are nearly 1.1 billion young people of whom nearly half are less than 25 years with 85% of them in developing countries and their reproductive health needs are of increasing concern in part because of the recognition that the HIV/AIDS crisis is disproportionately affecting young people (United Nation Aids Programmes – UNAIDS, 2004, Family Health International – FHI, 2002:2). Alarming HIV/AIDS rates are emerging with an estimated 11.8 million young people aged 15 – 24 years living with HIV/AIDS (UNAIDS, 2002:6). Each day, nearly 7000 young people aged 15 – 24 years are newly infected with HIV virus throughout the world (UNAIDS, 2001:31). In Africa alone, an estimated 1.7 million young people are infected annually (FHI, 2002:1). People in the age group 15 – 24 years account for more than 50% of all HIV infections worldwide (UNAIDS, 2003:52, FHI, 2002:1). These are young men and women entering their most productive years.

Kenya is among the countries adversely affected by the HIV/AIDS epidemic in Africa. As elsewhere in Sub-Saharan Africa, among the factors driving the epidemic in Kenya are persistently high levels of risky sexual behaviour among young people (Nganga et al, 1997: 1-5). Preventing HIV/AIDS among the Youth is particularly urgent in Kenya based among other reasons on the fact that demographically the youth comprise 60% out of the 30 million Kenyans (Kenya Population Census, 1999) and the general HIV prevalence rates often exceed 10% (FHI, 2002:1, Southern African Aids Bulletin – Saf Aids, 2002:122).

The escalating numbers of young Kenyans living with and dying from AIDS has contributed to growing awareness of the pandemic but not to corresponding levels of sexual behaviour change. One reason for this paradox is the lack of suitable HIV Counseling and Testing Services – VCT (FHI, 2004:VII). Various studies have demonstrated that knowledge of ones HIV status by undergoing VCT plays the most significant role in modifying sexual behaviour to either remain uninfected or prevent infecting current or future partners, (Healthlink, 1999, FHI, 2002:2, Population Council, 2001: 1-2). A study in Kenya on the efficacy of VCT supported by

UNAIDS and USAID demonstrated a 40% reduction in the number of unprotected sex acts with non-primary partners among those who received VCT. These trends were associated with knowledge of HIV status, quality counseling and provision of condoms, (Sangiwa et al, 1998, Population Council, 1999:4). At Majengo Clinic, Nairobi, the prevalence of sexually transmitted infections (STIs) disappeared altogether following the interventions which included counseling, testing, treatment of STIs and use of condoms (Population Council, 1999:4). A randomized clinical trial of VCT versus basic health conducted in Kenya, Tanzania and Trinidad by FHI, UNAIDS and WHO, provided strong evidence supporting VCT as both an effective and cost effective strategy for facilitating behaviour change (Lancet, 2000: 356 – 103 – 12). Further, the scope of HIV testing has evolved from purely diagnostic functions to a dynamic component of HIV prevention efforts resulting in a paradigm of new opportunities. Care, support, treatment, decreased stigma / discrimination and healthier lives presents new opportunities associated with taking an HIV test.

There is a fairly extensive network of VCT centres in Kenya established by various government and non-governmental organizations which are highly varied in model and target audience. National Aids and STI Control Programme (NAS COP) places the number of VCTs in Kenya at over 230 by June, 2003. The inventory of HIV, VCT services in Kenya (Population Council, 1999: 1-9) has 36 entries which offer a full range of HIV VCT services mostly in clinical settings such as, Nairobi City Council Clinic, Dandora, University of Nairobi Health Services and Kenyatta National Hospital (KNH). However, relatively few services are targeted to the youth, a population group at high risk of HIV infection. Less than 5 of these centres offer full VCT to the youth. These include the KNH Adolescence Counseling Clinic and Rift Valley Provincial General Hospital Youth VCT. Two others offering services to the youth closed down due to lack of funding (Population Council, 2001:7). There is so little information about youth VCTs and therefore it may be concluded that not all young people are benefiting from these efforts. No large scale or national studies have been undertaken and existing data has been derived primarily from baseline research. Similarly, there is a lack of clarity about the nature and extent of utilization and also a lack of understanding as to the factors influencing the provision and use of VCT services. There are however some indications of weakness associated with national policies on HIV/AIDS, the institutional procedures as well as attitudes of individual staff at the existing facilities. At the same time information to guide planners on the quality and impact of

existing VCT centres for youth is generally limited. Currently, however, experiences at several VCT sites reveal that Youth actually seek and receive HIV VCT even though the VCT services available have not been designed for them. Exploratory research conducted by Horizons Agency in 2000, (Population Council, 2001:7) revealed that most of the VCT facilities provide services to fewer than 10 young clients per month. Only 4 serve more than 20 young people on average per month while 2 see an average of 500 female and 800 male clients of all ages per month. The research also found that 75% of young respondents in Kenya said they would like to be targeted but were disappointed with counseling services in Kenya, where few facilities provide truly voluntary services and good counseling. "Good Counseling" according to the youth constitutes a confidential dialogue where the service provider gives ample time (20 – 30 minutes), attention and respect to facilitate the passing on of accurate information and psychological support. Young people said they would also be attracted to VCT centres if the services were confidential and inexpensive. Many expressed concerns with poor access and delivery. There clearly exists a need to research and address gaps in services provided to the youth. There is a lack of information on whether current services are adequately accessible or of good quality, and whether clients are being treated ethically with informed consent, confidentiality and offered care and support.

Young people have a broad range of HIV/AIDS related needs. Services, must therefore be developed to respond to these needs. Some needs may be best met by counseling, though the needs of others are better met through access to comprehensive reproductive health education and services and social support. (UNAIDS, 2000:14, Verkuhlin, 1998: 6(2) 10 – 11, UNAIDS, 2001:34-35). The VCT approach is highly recommended for the youth (FHI, 2003:10), given that the objective of this intervention is to promote safer sexual behaviours by providing accurate reproductive health information and increasing the use of care and support services. In view of this critical role that HIV VCT centres are likely to play in helping contain the HIV/AIDS epidemic, finding ways to get these clinical services to the youth is a high priority.

1.1 PROBLEM STATEMENT

The burden of HIV/AIDS continues to pose a major challenge to Kenya's Health Care Systems reversing gains achieved earlier in health standards, life expectancy and mortality reduction. Relatively high prevalence rates are reported among adults population and significantly higher rates among the youth (The Kenya Demographic and Health Survey – KDHS, 2003: 183). It is estimated that 2.2 million Kenyans are infected with the virus (Ministry of Health, 2001:V). The virus is killing about 500 Kenyans per day, leading to a total of 1.5 million Aids deaths so far (National Aids Control Council – NACC, 2000:2). The Ministry of Health in Kenya (2001: vii) estimates that 1 out of every 8 adults in rural Kenya is infected. While in urban areas, nearly 1 out of every 5 adults is infected. HIV infection rates among the people aged 15 – 24 years continue to rise steadily. According to KDHS (2003), the Kenyan HIV prevalence rates for the 15 – 24 years age group is the highest in the country where 25% of the youth are thought to be infected with the HIV virus. 80 – 90% of infection are among youthful people aged 15 – 49 years. Highest infection level for women is within the 20 – 24 age group where 18% of women are infected within 2 years of becoming sexually active (Ministry of Health, 2001:8)

Unless things change, more than 25% of these young people living in Kenya will contract HIV and the cumulative number of death due to HIV/AIDS may rise to 2.6 million by end of 2005 (NACC, 2000:2). AIDS is silently stealing Kenya's future and thus preventing HIV transmission among the youth is an urgent priority. The KDHS (2003) indicates that awareness about HIV/AIDS is over 90%, but despite the relatively high levels of knowledge among the youth about HIV/STIs, majority engage in risky behaviour and only a small proportion take action to protect themselves. It seems that creating awareness and advocating for abstinence, faithfulness and condoms (ABC) are useful in sensitizing the youth in the short run. However, they are not very effective in terms of achieving sustained changes in attitude and sexual behaviour. The realities of risky behaviours are reflected not only in the HIV prevalence rates among the Youth, but also in high levels of teenage pregnancy and abortion. A National Study found that 47% of young girls who become pregnant while still at school had induced abortions estimated to total over 250,000 annually. Abortion is also recognized to be the second major cause of maternal mortality in the country (AIDS Care, 2003). In addition, through limited testing for STI in Kenya, it was found that 36% of youth had one or more STIs (FIII, 1993). A situation like this

demands an alternative and effective tool for behaviour change as well as caring and supportive services within the health care systems.

Age is one of the variables representing important differences between people that can be correlated with health. The period of adolescence / youth for example, is characterized by experimentation, risk taking and low levels of awareness of sexual and the potential consequences of unprotected sex. The KDHS (1998:145) reveals that 80% of youth within 15 – 19 year age range do not consider themselves as being at high risk of contracting HIV virus, whereas 70% of them engage in unprotected sex and less than 10% use any form of modern contraceptive. The long latency period for AIDS is known to obscure the fact that many people who are becoming sick now were infected during their teens. The World Health Organization (WHO) estimates that half the people infected with HIV acquired the infection between the ages of 15 – 24 (FHI, 1993:16, UNAIDS, 2001:29 Caldwell, 2000:41). These numbers clearly indicate the magnitude of the sexual and reproductive health needs and concerns among the youth. However, the current services are either scarce, fragmented or non-existent.

There is some evidence suggesting that young people would use reproductive health services including VCTs if they had increased access to them. From the behavioural perspective, the youth may not have social skills to ensure that sexual experiences are safe, while from the health care delivery perspective, youth often do not have access to settings where they feel comfortable enough to discuss and seek reproductive health services. It is also observed that often healthcare providers and the community in general are reluctant to address reproductive health issues among the youth resulting in lower patterns of clinic service utilization among them. What is of sociological interest is that two decades into the Aids pandemic, and numerous documentation of the special vulnerability of young people, little has been done to systematically expose youth to HIV information and services because of societal beliefs and norms that treat sexuality as a taboo subject. Issues such as age of consent for VCT for young people, parental involvement in decision – making to test, confidentiality and coercion to testing, vary and need careful consideration in many settings. Inconsistency between government policy and practices create an atmosphere of uncertainty so that young people do not know whether they can obtain contraceptive services and service providers are unsure as to whether providing services to the youth is appropriate. Consequently, their reproductive health needs remain largely unaddressed.

Caldwell (2000:147) observes that he is impressed by advances in support systems of HIV/AIDS sufferers and their families but depressed by the insufficiency of action taken to change high risk sexual behaviour. The population council of Kenya (1997: XIV) notes that only a few sites supply condoms to clients. Further, frequent shortages of HIV test kits, drugs and long distance to services locations creates additional access barriers to VCT, (UNAIDS, 2002: 124 – 125). Most young people also find it difficult to access VCT because of the cost involved. The cost of an HIV test range from Ksh.500 – 1000 for ELISA and Kshs.5300 for Western blot (Population Council of Kenya, 1999:26). To reach most young people VCT must therefore be free.

The Nakuru District population growth rate of 3.4% stands above the National average of 2.4%. This very high population growth rate has created a predominantly youthful population with about 54.8% out of 1.4 million people less than 20 years of age and about 74.4% of the population less than 30 years (Nakuru District Development Plan, 2002 – 2008:20). The implication of a large youthful population is that it will exert pressure on the district to provide facilities and services to meet their basic needs including health. Lack of funds however has affected the implementation of projects and programmes in the health sub-sector. The average distance to the nearest health center is 8 km. NASCOP, June 2003 lists a total of 10 VCTs in Nakuru out of which only one, located at the Provincial General Hospital offers full VCT services to the youth. At the moment these efforts do not match the districts HIV epidemic in scale and pace. Urgent and dramatic headway is required on all these fronts. The impact of the pandemic has been felt at all levels of the district economic and social circles and has contributed significantly to high levels of poverty in the district. Already Nakuru town has more than 15 children homes and majority of the children are HIV/AIDS orphans. The current Assistant Minister of Gender and Sports, Alicen Chelaite raised the alarm over increasing cases of pregnancies in Primary schools in Nakuru where a total of 28 girls had dropped out of school due to pregnancy between 2003 – 2004. Cases of abortion involving girls aged 12 – 14 are also rampant (East African Standard, 21, 2004).

Of all the mind-numbing statistics about HIV and AIDS, the most staggering and important is that often 90% of all those infected do not know they are harbouring the most deadly virus in History and therefore unwittingly spread it (KDHS, 2003:197, UNAIDS, 2002:31). Further, knowledge of VCT is quite widespread but the majority of those aware have not used the

services. Only 15% of women and 16% of men say that they have ever been tested for HIV in Kenya (KDHS, 2003, 197). It should be noted that no amount of money will be enough to bring the disease under control until there is focus on testing, the missing front in the battle against Aids. Taking into consideration the cost of antiretroviral drugs, many of the interventions in Kenya will continue to focus on behaviour change as well as promoting VCT services. Studies have shown that young people have a strong interest in knowing their HIV status (UNAIDS, 2002). The complex factors or determinants operating at the individual, family, community and societal levels that motivate or inhibit utilization of VCT services among the Youth aged 15 – 24 years need to be explored and are the main concerns of this study.

1.2 STUDY PURPOSE/RESEARCH QUESTIONS

This study was considered within the spectrum of HIV/AIDS Primary Prevention efforts and sought to establish factors that influence utilization of HIV VCT services among the youth. The study also examined and determined knowledge, attitudes and practice/experience (KAP) of VCT services among the target population. More specifically, the study was guided by the following research questions:

1. What socio-demographic and economic factors influence (Inhibit/Motivate) *access* to VCT services among the youth?
2. What are the social, psychological and emotional *experiences/perceptions* of the youth about HIV counseling and testing at VCT sites?
3. What is the *extent of utilization* of HIV/AIDS VCT services at the Rift Valley Provincial General Hospital among the age group 15 – 24 years?
4. To what extent has this particular VCT facility been able to meet/address the counseling and other reproductive health needs of the youth?

1.3 OBJECTIVES OF THE STUDY

The primary goal of this study was to determine and assess the determinants of HIV/VCT services utilization among youth aged 15-24 years at the Rift Valley Provincial General Hospital, Nakuru District.

The Specific Objectives were:-

1. To establish the socio-demographic and economic factors that influence *access* to VCT services among the youth.
2. To examine the range of social, psychological, emotional experience and perception of the youth as they undergo HIV counseling and testing on this particular VCT site.
3. To determine the *extent of VCT service utilization* in the target population.
4. Investigate the extent to which this VCT center has addressed / met the counseling and other reproductive health needs of the youth.

Objectives (2), (3), and (4) required measuring of the following variables, which are critical indicators of the efficacy of VCT services. **QUALITY INDICATORS** was captured in client perceptions of the services (whether satisfied or dissatisfied). Attitudes, skills and qualification of service providers was used to gauge the level of professionalism. Availability of tests kits and other essential commodities such as drugs for STIs, condoms and accurate test results was also investigated. **EFFICIENCY INDICATORS** were gauged by client waiting time, utilization of services or numbers of clients seen per day and the extent to which confidentiality / privacy was enforced in counseling services, staffing levels and record keeping. **EFFECTIVENESS** of the intervention was depicted in return visits and attitude / behavioural changes as captured by questionnaires and key informant interviews. The achievement of objective (1) required the measuring of socio-demographic variables such as age, sex, educational level, employment / occupational categories, social class / residence, marital status, sources of information on VCT and reasons for visiting VCT.

1.4 STUDY SIGNIFICANCE / JUSTIFICATION

The WHO, major International Public Health Organizations and Governments have recognized the urgency and the need to rapidly increase access to information and knowledge of individuals' HIV status as a primary prevention tool particularly among vulnerable groups such as the youth (FHI, 2003:8, UNAIDS, 2002:12). The 2001 United Nations Declaration of Commitment on HIV/AIDS reinforced this by specifically requiring that by 2005, 90% of young people (15 – 24 years) should have access to services and information on prevention including services to develop the life skills needed to reduce vulnerability to HIV infection (UNAIDS, 2003:53).

In this regard, the Kenya government has set a goal of reducing HIV prevalence in Kenya by 20 – 30% among the 15 – 24 year olds by 2005 (NACC, 2000:1). If current trends continue, the Kenya government will fall short of these targets. In the hardest hit regions of Kenya, such as Nakuru District, few people have access to prevention programmes which reach fewer than 1 in 5 people who need them (UNAIDS, 2004). Given the contentious nature of reproductive health services among the youth, few studies have paid adequate attention to perceptions and acceptance of VCT and other HIV prevention efforts as well as barriers that the young people face in seeking those services. This research is significant because it draws attention to a

hitherto neglected issue of special reproductive health care needs and concerns of the young people. Documenting the youth health seeking behaviours, their experiences and the benefits they derive from VCT services is important as it will provide relevant empirical evidence to facilitate and improve action by the government and other agencies towards guaranteeing availability and accessibility of VCT services to the youth. More importantly, youth friendly health services should be designed on the basis of knowledge of youth health seeking behaviour derived from scientific research. This study aims to provide data to enable leaders and other social actors at all levels to confront the facts and renew their commitment towards fighting HIV/AIDS.

1.5 SCOPE AND LIMITATION OF STUDY

Due to time and resource constraints, this study limited itself to the Rift Valley Provincial General Hospital in Nakuru District and interviewed respondents who met the eligibility criteria on site. Given that the selection of the site was purposive, the representativeness of the study results may be reduced. The study also focused more on the demand for services than on service delivery which would have given a complete assessment of VCT services in Nakuru.

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter analyzes the findings of various scholars on HIV VCT Services and the youth. It is organized into the following themes which are pertinent to the research topic: **Youth, Risk factors and HIV/AIDS, Evolution and Utilization of HIV testing and Counseling, Relevance of VCTs in the control of AIDS and Access and availability of VCT services.**

Although the HIV/AIDS situation in Africa is so much talked about, few books are written on HIV VCT and the Youth and there is very limited information on this Topic and especially in relation to Sub-Saharan Africa and Kenya in particular. Most published works come from the developed countries where much of the research on youth sexual and reproductive behaviour has been focusing on negative forces or factors that particularly place teenagers at risk. Most of the literature on HIV VCT mostly concern statements of professional views on HIV VCT services or the technical aspects of HIV VCT services in terms of procedures for HIV testing, quality control of HIV testing, cost of a HIV test and cost effectiveness of HIV VCT services. Many articles and reports deal with issues such as the possible objectives and benefits of testing. Few studies have been carried out in selected vulnerable populations such as the youth and even less in rural communities by examining their views on HIV VCT or their perceptions, demands and needs for those services. Whereas data on HIV/AIDS are subject to various biases and limitations and the representativeness of selected sites/samples of the country/wider population is “doubtful”, information is never-the-less required in order to plan HIV VCT Services for entire populations and to make them relevant and acceptable to clients.

Two main lines of arguments are presented on the relevance of HIV VCTs as an essential component of HIV prevention efforts. There are compelling arguments for the provision of HIV VCT globally. First, individuals have a right to know their infection statuses in order to protect themselves and others from infection and also so that they can plan for the future. Second, VCT may enable people to cope with the anxiety associated with HIV serostatus. Third, early detection of HIV may improve the effectiveness of medical and psychological support for HIV infected individuals. Finally, HIV VCT promotes sexual behaviour change (FHI, 2003: 8-10,

Safais 2002:188). However, in developing countries the role of HIV VCT services in a comprehensive HIV/AIDS control programme is increasingly being questioned. Some scholars have noted a higher risk for the spread of HIV by those who have learned that they are HIV positive and stress that in contrast with the “doubtful benefits” of HIV VCT services, the social risks to the tested individuals are real such as loss of employment, health insurance, abandonment and destruction of marriage (Aids Care, 2002, Jurgens, 1998: 11-12).

It is recognized that the HIV/AIDS issue is a constantly changing field with ongoing lessons to be learnt and increasing field experiences to draw on. There is need for further research on how the general population view HIV VCT services and clients expectations and satisfactions with regard to HIV VCT. This may clarify the role of HIV VCT services within a comprehensive HIV/AIDS control programme and may provide new arguments for or against the establishment of widely offered HIV VCT services.

2.1 YOUTH, RISK FACTORS AND HIV/AIDS

Youth is the transition stage from childhood to adulthood marked by profound physical, emotional, mental and social changes. *Their needs are therefore often misunderstood, unrecognized and under-estimated.* Young people (between 15 – 24 years) are exposed to HIV in different ways. In high – prevalence Sub-Saharan Africa, the main mode of transmission is through unprotected heterosexual intercourse. This region contains almost two thirds of all young people living with HIV/AIDS, that is, 6.2 million people, 75% of whom are female. Unlike women in other regions in the world, African women are at least 1.2 times more likely than men to be infected with HIV. This ratio is higher among young women aged 15 – 24 years who are found to be two and a half times as likely to be HIV infected than their male counterpart (Nzioka, 2001: 71, UNAIDS 2004: 77). In Eastern Europe and Central Asia, HIV prevalence in young people is rising due to drug injecting with contaminated equipment (UNAIDS, 2004:84). They may also be at risk of HIV infection from exposure to contaminated blood and blood products or unsterilised skin – piercing procedures such as tattooing. Sexuality/sexual activity begins in adolescents for the majority of the people. Recent surveys of boys aged 15 – 19 in Kenya, Brazil and Hungary for example found that more than a quarter reported having sex before they were 15 years old (UNAIDS, 2002:13) and indeed one girl in twelve was already

infected by her 15th birthday (UNAIDS, 2000: 47 – 49). In rural districts of Kenya, researchers from the Center for African Family Studies found in 1994, that 75% of girls had their first sexual intercourse before the age of 16 years and 27% before 15 years of age. Among the latter, 15% had become sexually active before the age of 12. The study also found that 3% of young men reported having more than 5 partners (Nganga and Ngugi, 1997:1-5). The impact of HIV/AIDS on the lives of young people and their families is no doubt devastating. Contracting and then developing Aids while young means the end of many deeply cherished hopes and ambitions. Young people are returning home to die in the care of their parents. They entrust their children to their own aged parents or other family members who may not be able to take proper care of them.

Patterns of sexual behaviour in a population are determined by much wider factors than individual morality, personal choice and private decisions about risks. Socio-economic, cultural, religious, political and legal factors are all important in creating the “*risk environment*” in which people live and young people view sexual issues in the context of the larger social, cultural and economic climate in which they live.

Antecedents of teen sexual behaviour and teen pregnancy have been studied extensively. Kirby for example in (Journal of Adolescent Health, 2004, V34, No.5) categorizes these risk factors that place young people at the center of HIV vulnerability into *Community disadvantage, family structure, economic advantage, family peer, partner attitudes and behaviours, characteristics of the teens themselves including biology, emotional distress, sexual attitudes and skills*. According to a UNAIDS Global Report (2004:93-98) a variety of factors place young people at the center of HIV vulnerability – *lack of HIV information, Education and services, the gambles many must take in order to survive and the risks that accompany adolescent experimentation and curiosity. Others are urbanization, poverty and breakdown in traditional values*. In the past, many traditional communities in Kenya effectively discouraged pre-marital sex through a combination of strict social sanctions and early marriages. Information about sexuality and reproduction was passed on not by parents but by grandparents, aunts, uncles and community leaders often in association with initiation ceremonies. These traditional pattern of sex education have been disrupted by socio-economic changes, rapid urbanization, increased mobility and rapid population growth. Young people however still need adult assistance to deal with the

thoughts, feelings and experiences that accompany maturity precisely because young people are less likely than adults to seek proper information, and treatment due to fear, ignorance, shyness and inexperience. Young people are victims of the belief that they are HIV – free and as a result, they not only engage in unsafe sexual practices but male adults are in constant pursuit of young girls. Male adults seeking sexual liaisons with young girls, “Sugar daddies”, often convince the girls to have sex by giving them money, gifts, and occasionally paying school fees.

The basis of such risk is therefore complex and derives from a combination of biological factors, poverty, and lack of access to healthcare. Further, according to Caldwell (2000:40), at a proximate level, African Youth are at increased risk due to risky sexual practices like early initiation of intercourse, low contraceptive/condom use, multiple partners and poor sexual negotiation skills.

The youth are a heterogeneous group and differ in terms of context, demographic characteristics, living conditions, socio-cultural and educational characteristics. *What is of sociological significance is the complex relationship between social factors and the level of health characteristics of various groups and societies.* Social factors play a critical role in determining the health of individual groups. Social conditions / situations not only promote the possibility of illness but also enhance prospects for disease prevention and health maintenance. Social factors are also important in influencing the manner in which societies organize their resources to cope with health hazards (Cockerham, 2001: 28-35). *AIDS is therefore a disease of society in the most profound sense because of its link to specific ways of life. What makes AIDS a disease of society is that it is clearly grounded in the conduct of social life and its potential for changing norms, values, sex habits and lifestyles worldwide is enormous.*

Some countries now acknowledge the importance of targeting youth in their HIV prevention and care strategies and include VCT for youth in their agenda. Draft National Guidelines for Ghana state that it shall “seek to ensure the expansion of the access of young people to youth – friendly facilities and services including HIV and STI prevention, management, testing and the provision of care and support services” (FHI, 2002:2).

motivation or persuading uninfected persons to avoid exposure to HIV or HIV positive person to avoid re-exposure to HIV and other harmful agents. In contrast, potential harmful consequences included the fact that the discovery of positive status could result in grave psychological stress for the person being tested. In addition, an HIV positive person could also be at risk of losing friends, employment and insurance. Further, some persons being tested could be labeled as being positive when not infected (false positive) and some persons could be labeled as negative when infected with HIV (false negative).

1989 – 1992

The attitude discouraging the use of HIV test changed around 1989, when treatment first became available for some of the opportunistic diseases associated with HIV infection. It was not until 1989 that researchers reported that HIV-positive people and not just patients with full-blown Aids might benefit from the Azidotymidine Zidovudine/retrovir (AZT). There now existed clear benefits from testing particularly for individuals. Now there was a good reason to be tested. The rationale for diagnostic testing changed from clinical confirmation of suspected HIV disease to the potential for prevention and care afforded by knowing one's HIV status. With increased access to drugs for treatment of HIV diseases and for prevention of mother to child transmission in the 1990s, benefits of knowing ones serostatus increased dramatically. As a result many people at risk began to seek out HIV testing and related treatment.

In 1991, Higgins and colleagues (Jurgens: 1998:13) examined fifty studies that indicated that men who tested HIV positive were less likely to engage in high-risk sexual practices. *Testing in itself is not a preventive measure it could in principle aid prevention in other settings only if it succeeds in motivating individuals to adopt or maintain safe behaviours.* As the cost per client of VCT declined, VCT was considered a basic prevention strategy, resulting in increased donor and government support. The CDC guidelines were revised in 1993 to focus on a model of interactive personalized risk reduction and again in 1994 with an emphasis on linking standard VCT procedures with treatment goals.

Current Thinking

When it comes to the HIV/AIDS Virus, knowledge is power. The syndrome commonly involves a lengthy period between infection and the development of symptoms. People who know they are infected can be monitored for changes in their condition and for possible treatment even before symptoms appear. There is growing amount of medical research showing that combinations of anti-HIV drugs improve the health of many people with HIV and reduce mortality and delay progression of disease. If initiated shortly after infection aggressive treatment may even be able to completely eliminate any traces of HIV in the blood of the client.

Development of VCT in Kenya

HIV VCT are in various stages of development in Kenya. Services tend to be of limited quality and coverage and conducted as a collaborative effort among the host government, development partners (donors) and local and international organizations. VCT services are run independently or jointly by public and private sector organizations, including Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs).

The first VCT was established in Uganda over 14 years ago in 1990. By 2001, there were over fifty one sites which reported testing over half a million people (UNAIDS, 2002:124, Saf Aids, 2002: 190). The first counseling services for HIV-infected persons in Kenya was set up in 1989 by Kenya Red Cross (KRC) in response to the need to provide support to infected people with tests sent to Kenya Medical Research Institute (KEMRI) until 1990s. At this stage of epidemic most people who came for counseling were those with HIV/AIDS symptoms and the HIV Test was not routinely offered as a service. Many of the services were located in high income areas and tended to attract a middle class clientele. HIV testing was at first primarily carried out as a confirmatory diagnosis for patients showing symptoms of advanced HIV infection or AIDS, at hospital or other medical facilities. As the epidemic grew, however, those seeking HIV-testing expanded to include the "worried well" (particularly those at high risk) and influenced by the policy in some churches involving those considering marriage. In addition, employers and health insurance companies began to demand HIV-Testing as a pre-condition for employment or insurance coverage. At the same time, from the mid-1990s, services began to be provided to

low-income and slum populations by NGOs and CBOs in response to the continuing spread of the epidemic and the growing need for services in low-income areas. In Kenya, the Ministry of Health responded by setting up health delivery points as patient support centers and by training a national network of counselors in the early 1990s. These centers still function successfully in Nakuru, Kitale, Nyeri, Kitui and Kenyatta National Hospital.

In 1998, Kenya had a mere four operational sites but by mid 2002 there were fifty two in the public and NGO sectors reporting having tested over fifty thousand clients (FHI 2003, 3:1). The Directory of Aids Services Organization working in Kenya, (2003: 100 – 101) lists over sixty one VCTs in the NGO sector, while NASCOP, June 2003 lists a total of over 230 VCTs currently operating in Kenya. Out of this total less than five are specifically designed for the youth. It is reported that over 80,000 clients have been served at these VCT centers countrywide. Most VCT sites are integrated in the health care services. Some of these sites are linked with tuberculosis (TB) and prevention of mother to child transmission (PMTCT) and less than 4 are stand alone models. On February 1, 2001, the Adolescent Counseling and Recreation Centre was launched by the Kenya Association of Professional Counselors (KAPC), in response to youth VCT needs. KAPC felt the youth needed a non-medical youth friendly, affordable, accessible and confidential center supported by trained counselors who are sensitive and non-judgmental toward youth issues.

During the same year, 2001, the National VCT task force was formed under National Aids and STI Control Programme (NASCOP) with partners from Non-Governmental Organization such as Family Health International. The joint efforts of these stakeholders resulted in the publication of the first national VCT guidelines during the same year followed by the quality assurance curriculum. The current Ministry of Health response to the HIV epidemic in its national strategic plan (1999-2004) includes the introduction of VCT into public health care system (Ministry of Health, 2001:V). VCT services found a low response in the early days. People did not want to be tested because of a combination of hopelessness, stigma and denial. Also, HIV testing was initially provided without quality VCT and support. Overtime as people became more aware of HIV/AIDS, attendance of VCT centers has generally increased.

2.3 RELEVANCE OF VCTS SERVICES IN THE CONTROL OF AIDS

African nations like Botswana, South Africa and Namibia have the highest rates of HIV/AIDS infections in the world. Anywhere from 20-35% of the population is HIV-infected. Both population growth and life expectancy are falling. In Botswana, for example the average life expectancy has fallen from 61 years in 1993 to 47 in 1998 and it is projected to drop to 41 years by 2005! (Cockerham, 2001: 31-32). Despite these alarming statistics, it is estimated that approximately 90% in Africa are unaware of their serostatus (UNAIDS, 2002:31). Most of the 34.3 million people now living with HIV do not know they are carrying the virus (UNAIDS, 2000:78). Thus Aids carriers can unknowingly continue infecting other people for years. The only way to determine whether a person is HIV-infected in the absence of symptoms is through a blood test.

Young people have very few sources of information about sexuality and HIV/AIDS, and really value the information they get during counseling. A study conducted among a sample of 14 – 21 years olds in Kenya and Uganda found that 20% of the young people who undertook VCT reported that they were not sexually active but still wanted counseling and accurate information (Horizons, 2001: 10-29). Equipping young people with enough knowledge (technical, sex education), moral standards (good role models) and materials (pills, condoms, STI clinics), is one approach to helping them stay safe (Verkhul, 1998, 6(2): 10-11). Verkhul argues that this approach is “sensible” and can work.

Core Principles of HIV VCT

The primary aim of VCT is preventive – to help people change their sexual behaviour. *According to UNAIDS, VCT can reduce the likelihood of engaging in risky sexual behaviour by up to 35% (UNAIDS, 2001:16).* The core principles, objectives and activities of most VCT centers are clearly geared towards achieving sustained behaviour change. Further HIV testing and counseling are entry points to HIV related care and prevention services (FHI, 2003:8-10).

HIV testing should be voluntary, with informed consent and confidentiality must be protected. WHO (2003: 3:9) stresses that mandatory testing is neither effective nor ethical. Indeed the

client's cooperation is essential in successfully implementing public health measures for AIDS control. Moreover, public health is not dependent upon abrogating rights, but rather requires protecting people's rights and dignity. Elements to ensure true informed consent for HIV Testing include providing pre-test information on purpose of testing and offering information on treatment and support available. Once results are known, ensuring understanding and respecting individual autonomy are essential. Referral and access to a comprehensive range of prevention, care and support is a must according to FHI (2004:3). Continuing care it is noted, tends to encourage participation in ongoing counseling. VCT sites without medical treatment tends not to encourage many clients to return for follow up (Population Council, 1999:12).

Benefits of Testing

HIV Testing for individuals was used at the start of the epidemic, mainly to confirm that someone had HIV disease, now it is often also used by people without symptoms who want to know whether they are infected with HIV. VCT services therefore allow people to determine their HIV status and to choose safe behaviours, whether they are uninfected or infected. This is extremely important especially for young people.

Voluntary counseling and testing (VCT) is also a vital point of entry to other HIV/AIDS services, including prevention and clinical management of HIV-related illness, tuberculosis control, psychological and legal support, and the prevention of mother-to child transmission of HIV. VCT offers benefits to both those who test positive or negative. It alleviates anxiety, increase an individuals perception of their vulnerability to HIV, and assists in reducing stigma in the community. The potential benefits of VCT for the individual include improved health status through good nutritional advice, and more positive attitudes towards living with HIV/AIDS. VCT offers a holistic approach that can address HIV in the broader context of people's lives including the context of poverty and its relationship to risk practice (UNAIDS, 2003:55).

Disadvantages of Voluntary HIV Testing

Stigma associated with being seen to visit a VCT center is real with no signs of subsiding and for this reasons, many have advocated for integration of HIV VCT into the existing health services

to reduce the stigma, associated with being seen at a VCT centre. Individuals fear the implications of a positive result and believe that knowing their status will make them get sick and die sooner due to worry, anxiety, shock and even suicidal feelings associated with coping, knowing and accepting results. Stigma, rejection, discrimination / human rights abuses such as losing work or pre-employment testing are still rampant in the society, hence the confidentiality clause. Abandonment, abuse and marital break up are still rife especially following a positive diagnosis.

The window period (the time between a person being infected with HIV and their body producing enough antibodies for a test to detect) can lead to inaccurate test results and with it adverse consequences. The cost of testing which range from 500 – 4000 Kenya shillings is extremely expensive especially for the youth. This expenditure also places a strain on health budget so much so that the benefits of testing, except for blood transfusion, where it is essential, is being carefully considered / reviewed in resource constraint countries.

Reasons for use of VCT by the Youth

A research conducted in Nairobi and Kampala by Horizon Agency using focus group discussions and in-depth interview survey administered to youth and service providers seeking information on young people's experiences and attitude about VCT found that young people were overwhelmingly aware that HIV testing is available to them. Many expressed interest in getting tested. Most tested youth intend to practice safer sex, such as, abstaining, monogamy, condoms and reducing number of sexual partners. Youth said that they greatly appreciated the information and advice they received from counseling, citing counseling most frequently as a feature they liked in their testing experience. Such responses indicate that counseling should be part of any overall strategy for reducing HIV infection among youth.

Young people may have counseling needs for such issues like disclosure and negotiating safety. Counseling is a critical element in HIV/AIDS management as it helps infected and affected people adopt a life style conducive to good health and provide strategies to cope with dying and death. The disease arouses diverse emotional reactions such as fear, denial and suicidal

thoughts. Counseling is meant to meet the physical, psychological, mental and social health and socio-economic needs of clients.

Youth who are sexually active and have engaged in unprotected sexual intercourse visit the VCT centres because of STIs or believing they are already infected due to signs and symptoms. Others go for pre-marital testing or if they want to get intimate with their partners. Others seek testing because they are planning for the future or due to mistrust of partners (Horizons, 2001: 10-29). Traditional VCT approach with its potential for behaviour change is highly recommended for the youth (FHI, 2003:10).

Challenges to HIV VCT Services Uptake

Fear, stigma and denial are major challenges to the uptake of HIV VCT services (Population Council, 2000, UNAIDS 2000:78). In many countries, HIV testing at its worst, is still viewed as an approach to track down and isolate persons living with HIV/AIDS and at its best, people are reluctant to come for counseling and testing because they believe that Aids is inevitably fatal. These personal feelings, perceptions, reactions of hopelessness, lack of faith in the future and lack of perceived benefits of testing contributes to public avoidance of VCT.

Cultural/religious constraints and taboos surrounding sexuality and for that matter HIV/AIDS stigmatizes individuals even if only remotely associated with a positive serostatus. It is widely reflected in many societies and often surprisingly among service providers particularly in their attitudes and behaviors when dealing with such matters particularly with the youth. Adults and policy makers fear that sex education and access to condoms will promote sexual activity or increase promiscuity. Research results suggest that neither fear is well founded. A WHO review of 19 studies has shown that sex education delayed onset of sex (Ngweshemi et al, 1997:164-169). In Kenya for example, on 3 separate occasions efforts by the Ministry of Education to introduce family life education into schools have been defeated by conservative opposition. The issue of condoms has provoked a particularly hostile reaction from many Christian and Muslim leaders, who expressed their feelings by publicly burning a piece of condom in Nairobi in 1996.

Negative attitude is a major deterrent particularly for the youth when seeking VCT services. Findings in Nigeria on sexually transmitted infections (STI) and youth found that 24% went to private or public doctors with the rest preferring to seek help from patent medical dealers; 22% from traditional healers 13%, self administered 8% and no treatment 19%. In a separate study of the 100 counselors interviewed 27 confirmed that they felt uncomfortable counseling about sexually related issues. 19 of them specifically mentioned age as a factor in their comfort level. Some felt that the youth should not engage in sex, some did not approve of giving condoms to those who were not married, while some said that they did not test those under 14 years (WHO, 2000).

VCT operational / logistical issues are posing a major challenge to VCT service provision in most resource constrained countries. To begin with there appears to be either low public awareness / education or inaccurate perceptions concerning VCT services. In rural areas particularly, large numbers of people do not know where to go for treatment of HIV – related illnesses. There is still room for expansion of VCT services in order to ensure availability of services countrywide, especially in rural areas. Adequacy of coverage is still a major challenge but even where VCT services are available, accessibility and quality of service is wanting. There is room for improvement in *technical capacity*. There is often shortage of HIV test kits while quality testing and laboratory procedures which should ensure accurate results are sometimes compromised. *Staff capacity* in terms of numbers, skills, experience, qualification of laboratory staff and counselors has come under increasing scrutiny. *Administrative Capacity* is particularly lacking in the public health sector. Often there is no adequate space for confidential counseling and testing. In fact capacity does not even exist to maintain proper records and systems to ensure confidentiality and to make sure that people are given the correct results. The service providers are constantly overwhelmed by large number of client queues resulting in long waiting time and eventually dilution of services. After individuals have undergone HIV testing and other diagnosis, medical treatment, care and referral support from community groups may still not be adequate. This deeply affects the return rates of VCT clients (FHI, 2002: 1-8).

HIV VCT Efficacy Indicators

Until recently few impact assessments had been taken on HIV VCT services, and their effectiveness have been largely undocumented. In this section an attempt is made to review this emerging body of evidence with the aim of increasing the understanding of “what works” in VCT and any other youth reproductive health programmes in developing countries.

The available evidence on the efficacy/effectiveness of VCT and other reproductive health interventions in developing countries paints a mixed picture. On the positive side, most of the interventions that have been evaluated appear to have had a positive impact on youth sexuality and reproductive health. These are in relation to knowledge and attitudes that often have had a positive behavioural impact. No evidence of increased sexual risk taking behaviour was found in any of the studies. Reviewed as also positive is the extent to which it repudiates the claims of those who contend that providing sexual reproductive health information and services to the youth results in increased levels of sexual activity. Less positive is that behavioural impact was not found in sizeable proportion of the interventions reviewed. There is however much interest in expanding youth VCT although, assessments of youth VCT in other countries have shown mixed results. Studies demonstrate that youth VCT centres reach relatively small numbers of youth and are often not cost-effective. Other studies found that the centres were reaching mostly the youth who are already highly motivated and knowledgeable about reproductive health issues, particularly HIV/AIDS. It is not clear, however, whether all VCT services designed primarily for adult clients are effective and appropriate for young people who account for the majority of all new HIV infections in East and Southern Africa.

The most definitive measure of effectiveness of VCT in reducing HIV transmission is the rate of new HIV infection in people following VCT with the indicator being positive changes in sexual behavioural practices especially undertaken by key groups at risk of infection such as the youth. (UNAIDS, 2001:11). For Sub Saharan Africa, German Agency for Technical Cooperation – GTZ (1999) as cited in (Saf Aids, 2002: 81-134) proposes the following variables as indicators of sexual behavioural change. At a proximate level, variables that affect exposure to intercourse include age at first marriage, the older the age, the later young people are exposed to risk and the gap between age at first sex and age of first marriage which can be a period of considerable sexual risk taking. Risky sexual behavioural practices such as extent of multiple partners as

opposed to monogamy, condom use (measures include “ever used” and “consistent use”) are indicators of attitude and sexual behaviour change. Teenage pregnancies and frequency of STI are clear indications of unprotected sex among the youth.

A case study undertaken in Dar-es-salaam by Muhimbili University College of Health Services (MUCHS) in collaboration with several international organizations as part of a randomized study of efficacy of VCT involving a total of 1427 participants from November, 1994 to January, 1995 was the first randomized trial of the efficacy of VCTs on behaviour change to take place in non-industrialized countries. It provides the strongest evidence to date of the cost-effectiveness and efficacy of VCT as a tool to prevent transmission of HIV based on its findings that individuals visiting VCT sites reported a significant reduction in unprotected intercourse (FHI/UNAIDS, 2001: 100 – 108). This study seeks to contribute to the momentum building internationally in support of VCT programmes in non-industrialized countries. It is however, understandable that VCT will often not have an easily measurable effect because of the complexity of sexual behaviour and relationships and factors which affect these.

2.4 ACCESS AND AVAILABILITY OF VCT SERVICES

Although there are several models/venues of VCT service delivery through which clients can gain access to VCT services, UNAIDS (2004:91) estimates that less than 20% of those in need have access to HIV prevention services. The choice of model or models depends upon a program’s goals, cost-effectiveness, sustainability and affordability, confidentiality and convenience to the client. Models that have been utilized to date include stand – alone sites, Integrated sites within existing health facilities, NGO-based sites, private sectors sites, mobile / outreach services or a combination of these services. It is common in any given country to have a combination of these operating to maximize coverage and ensure accessibility, acceptability and affordability of the VCT services to the entire population. Below are overviews of some of the models that have been employed and the strengths and weakness associated with them.

1) NGO Partnership Model

An existing NGO provides VCT services in public sector/clinic facility where both parties contribute to the management of the VCT services. This model capitalizes on the strengths of both models. The models success depends greatly upon the quality of the partnership. Uganda and Thailand have good examples of NGO's linked with health facilities.

2) *Private sector models*

Perceived as committed to providing high quality of care and services are deemed as private, confidential and responsive to client needs. However, services are inaccessible to poor and uninsured since they have less control over prices and fees, and time consuming counseling does not always fit in this model.

3) *Mobile / Outreach models*

There is limited information on this model. In places where it has been done, it usually involves a "mobile unit", van or caravan offering temporary, rotating services at designated places and dates. They also serve rural or remote areas and "hard-to-reach" groups such as drug users (injecting drug users), sex workers, truck drivers, street boys or individuals who have no fixed addresses. While improving access for "hard-to-reach" and rural populations, this model is expensive and therefore not cost-effective. It is also difficult to keep services confidential and ensure follow up after post-test counseling due to its limited capacity and temporary nature.

4) *Stand alone models*

Stand alone sites are not associated with an existing medical institution and usually have staff fully devoted to VCT. For reasons of cost and cost benefit they are located in high population density areas and where HIV infection rates are high. A good example is the Kenya Association of Professional Counselors (KAPC) Kariobangi Adolescence VCT Centre in Nairobi. This model offers maximum coverage and quality and attracts population groups that would not otherwise attend. Experiences from Uganda, Thailand, Malawi and Zimbabwe has shown that stand alone sites can meet increasing demands. ***Studies have also indicated that young people***

and men do not access VCT services when they are located at medical facilities. It also provides improved accessibility through flexible opening hours and adequate staff. They have linkages with post-test clubs and support groups for people living with HIV/AIDS, which encourages many clients to return for follow-ups. Nevertheless since it is usually not associated with existing medical infrastructure, it is difficult to ensure medical follow-up. Its limited geographical accessibility, coupled with high establishment and operating costs, usually require long standing external support, which has implications for its long term sustainability.

5) *Integrated Models*

Integrated sites are the ones in which VCT is an integral part of other existing/ongoing services, usually public sector health care services such as hospitals, STI clinics, Tuberculosis (TB) clinics, family planning or antenatal clinics or out patient clinics. The antenatal care setting has received special focus since it is integral to prevention of mother-to-child transmission (MTCT) interventions. A good example is the Nakuru Youth VCT Unit located within the Rift Valley Provincial General Hospital. The centre promotes VCT as part of routine health services and by involving health care workers directly in HIV prevention activities, it allows the normalization of HIV/AIDS. The centre also allows direct referral to other relevant care such as management and prevention of opportunistic infections, TB, MTCT, family planning or welfare support. The site usually benefits from the high volume of potential clients who visit the public health facility. This model has high potential for replication and scaling up, due to the ability of staff to provide services beyond the basic HIV counseling typically available at stand-alone sites. Due to the large numbers of clients attending public health facilities however, the quality of VCT service delivery including other medical services is often diluted, because of difficulties in enforcing quality assurance measures. Long waiting times, inconvenient hours of operation and lack of appropriate space for confidential services often leads to negative perception by clients regarding quality of care.

6) *NGO Models*

In this model an NGO either integrates VCT into its other established activities or provides VCT services as its only activity. This model has limited focus enabling better management of

services and ease in enforcement of quality standards. Ultimately it is able to provide VCT services in a private and confidential manner and has the ability to influence waiting time and clinic hours. This model can also be set up within a public health facility (partially stand-alone). However, due to its limited focus, there is limited capacity to scale up and therefore a potential for stigma if one is seen at a facility associated with HIV/AIDS. Similarly, there is a possibility of diversion from NGO's core activities if VCT is integrated with other services. Moreover, their undue dependence upon donor assistance often have implication for their long term sustainability.

In summary this study while focusing on determinants of HIV VCT utilization among the youth, also examines outputs directly associated with VCT health outcomes such as health information, counseling and health services. The problem of an HIV or Aids diagnosis is therefore not just one of accepting or rejecting a disease diagnosis, but also one of accepting the consequences that go with diagnosis and this makes responses to an HIV diagnosis quite unpredictable (Nzioka, 1994:30). It is with this in mind that the research was carried out.

2.5 HYPOTHESIS

In this study, the following hypothesis was tested:

1. Youth attitudes towards the utilization of VCT services are influenced by both community level factors (socio-demographic, economic factors) and clinic level factors (organization, quality, availability of VCT services and facilities).

The study established and prioritized the correlation between the dependent variable (VCT service utilization) and independent variables (community level and clinic level factors)

2.6 OPERATIONAL DEFINITIONS

INDEPENDENT VARIABLES

1. DETERMINANTS

Factors influencing (motivate / inhibit) utilization of VCT services. These are the independent variables in this study. They are the community level and clinic level factors consisting of the following variables:

VARIABLES

INDICATORS /MEASUREMENTS

(Concrete/Instances/signs of variables)

a. Social-demographic factors

Age, sex, educational level, marital status, residence.

b. Economic factors

Marital status, occupational categories, distance to VCT site, cost of VCT services, sources of information on VCT.

c. Social psychological

Wish to know one's status, reasons for requesting for VCT, extent of risk of HIV/AIDS, reasons for not attending VCT, knows peer who requested for VCT services.

d. Cultural

Perception of victims by the community often characterized by stigma, ignorance, ostracism, discrimination and isolation

e. Quality and availability of VCT services

Quality of services measured through client perception of the services (satisfied or dissatisfied), attitudes, skills and numbers of service providers, qualification of service providers (to gauge level of

professionalism) availability of test kits, essential materials such as drug for STIs, condoms, accurate test results

Efficiency Indicators – Client waiting time, confidentiality, staffing levels and record keeping.

Effectiveness of intervention depicted in return visit, attitude/behavioral changes in clients.

2. HIV/AIDS COUNSELING

Is a confidential dialogue between a client and care provider aimed at enabling the client cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of transmitting or acquiring HIV and the facilitation of preventive behaviour.

3. VOLUNTARY COUNSELING AND TESTING (VCT) FOR HIV

The term in this context is used to cover a broad spectrum of interventions that comprise a minimum pre and post-counseling associated with testing. The decision to be tested must be entirely the choice of the individual who must be assured that the process will be confidential. The couple or individual is able to make informed choices after this process. Other interventions offered at VCTs include, family life education, youth seminars and training in health issues, peer education, adolescence high risk clinic and family planning services.

4. YOUTH

The term “Youth”, “Young People” as generally defined by the Agencies of United Nations and as used in this study refers to young men and women between 15 – 24 years of age. The terms are interchangeable and mark the transition from childhood and adolescence to adulthood, marked by profound physical, emotional, mental and social changes.

DEPENDENT VARIABLES

VARIABLES

5. VCT SERVICE UTILIZATION

INDICATORS / MEASUREMENTS

Numbers of clients seen per day, numbers requesting for full VCT services and other services such as counseling and family planning, number of repeat/return visitors.

2.7 THEORETICAL FRAMEWORK

This study was guided by the theories of the Health Belief Model (HBM). The Health Belief Model is widely used in the analysis of health related behaviour in the fields of the Medical Sociology, Social Psychology and Anthropology. It originated in 1952 from the philosophical works of Kert Lewin, who wanted to find out why target populations were not adopting desirable health practices, it was later developed and formulated by Irwin Rosenstock (1966) and his colleagues (Becker, 1974). This theoretical model became so popular in the 1950s and 1960s since it presented the first attempt at a systematic analysis of health preventive behaviour focusing on the relationship between health behaviour and utilization of health services.

The Health Belief Model helped to explain, account for and predict preventive health behaviour in terms of certain cultural / belief patterns by use of socio-psychological variables and approaches. Health Belief Model is therefore defined as the proposition accepted as true by people about causes, signs, and symptoms and remedies related to illness. This model explains what people will do, what goes on, and why some information are not effective in influencing health seeking behaviour

The Health Belief Model has been incorporated within 3 models of behaviour. These are the health behaviour, illness behaviour and the sick role behaviour. Health behaviour is any activity undertaken by a person who believes himself to be healthy for the purpose of preventing / avoiding or detecting disease at a symptomatic stage. Illness behaviour is any activity undertaken by a person who feels ill or perceives themselves to have a health problem for purposes of defining the status of his health and of finding an appropriate remedy (Ward, Mertens et al in East African Medical Journal, 2003, 8 No 2: 61). Sick role behaviour is any action undertaken by those who consider themselves ill, for the purpose of getting well.

Human behaviour within this framework is seen as being dependent upon 2 primary variables:

- i) The value placed by a person upon a particular outcome.
- ii) The person's belief that a given action will result in that outcome.

Accordingly, the HBM suggests that preventive action taken by an individual to avoid disease is due to that particular individual's perception that he is personally susceptible and that the

occurrence of the disease could have at least some severe personal implication. Further, by taking a particular action, susceptibility would be reduced or if the disease occurred severity would be reduced. A person's behaviour, therefore might be viewed as the results of seeking regions that offer the most attractive values or avoidance of personal vulnerabilities.

The perception of the threat posed by disease is affected by *Modifying Factors*. The modifying factors could be both demographic, socio-psychological and structural variables that can influence ones perception and the corresponding *Action cues* necessary to instigate action. Rosenstock notes that *Action cues* are required, because while an individual may perceive that a given action will be effective in reducing the threat of disease, that action may not be taken if it is further defined as too expensive, too unpleasant or painful, too inconvenient or too traumatic (Cockerham, 2001: 113-137).

MODIFYING FACTORS

1. Demographic variables-age, sex, race, tribe, education, occupation, income.
2. Socio-psychological variables-personality, social class, peer group pressure
3. Structural variables-knowledge of disease, prior contact with disease.

CUES TO ACTION

Mass Media Campaigns, Advice from others, illness of family members/friends.

INTERNAL CUES

Perception of bodily states

The interplay of these factors govern the decision making process that precedes the final choice of a care seeking option. This interplay is such that no one option is selected and we may observe a series of options often reflecting a pattern of sort in care seeking. In their early studies, Foster and Anderson (E.A. Medical Journal, 2003, 8 No. 2:61) noted that under - utilization of modern health services is rarely due to the influence of local beliefs or an aversion of western medicine but rather depends on the cost and availability of those services.

According to the HBM, the choice of action taken to prevent oneself from HIV/AIDS infection depends not only on whether the person knows the seriousness of the disease, but also the possible probability that knowledge of one's status will lead to desirable prevention and not fear. The theoretical orientation provided by the HBM considers the individual fear of undergoing VCT as a hindrance in HIV/AIDS control programmes. This fear is likely to slow down the readiness of community members to utilize the VCT services and help in the control measures.

Whereas availability and physical access is important, it has become apparent that client perspectives on the quality of care leading to satisfaction or dissatisfaction, as experienced through the client provider encounter is recognized as playing a major role in health seeking behaviour. Client satisfaction may be described as the *subjective assessment* of quality of services received by the client. A study conducted in Kenya and Zimbabwe concluded that there is not one health seeking behaviour pattern among youth, but rather a complex web of behaviours which vary according to geographical setting, availability of services, profile of the youth (age, sex, school, work status, sexual behaviour) and the need for services. Behaviour patterns also seem to vary from country to country as the study found marked differences between young people in Kenya and Zimbabwe. This diversity implies that there are many different factors at work which influence the youth and thus a range of approaches are needed to encourage them to seek help (WHO, 2000). Young Zimbabweans were asked where they went for sexual Reproductive Health services outside formal health centres, 44% said traditional healers, 32% private clinics, 8% friends (FHI, 2002:6).

From these findings, it can be hypothesized that youth attitudes towards the utilization of VCT services are influenced by both community level factors and clinic – level factors.

The HBM has been successfully employed in preventive health care however its usefulness is limited in that it has been applied mostly to preventive situations in which the behaviour studied is voluntary. Many people however seek health services and are motivated to take action when prompted by the appearance of clear and definite symptoms. Nevertheless, the HBM has been demonstrably relevant in the study of health behaviour. The theory is thus applicable to the youth, service providers, and VCT centres as units of analysis in this study. The merit of the

model is that even when an individual recognizes personal susceptibility, he/she may not take action *unless* the individual also perceives that being ill will result in serious difficulty. Thus the individual's *subjective assessment* of the health situation becomes the critical variable in the utilization of health service. It is also usually the case that a person's *subjective assessment* may be more important than an objective medical diagnosis.

It is over simplification to assume we can isolate a pattern of care seeking behaviour and Mechanic (1978: 199-211) goes on to list more variables. They include the extent to which symptoms disrupt family work, social activities, and frequency of appearance of deviant signs. Nevertheless, prompt health seeking is critical for appropriate management and for this reason, understanding the determinants of health seeking behaviour becomes critical in the bid to provide client oriented services.

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CHAPTER THREE

METHODOLOGY

This chapter gives a description of methods used in this study. It gives a description of the area where the research was conducted, how data was collected, analyzed and presented. The study used various methods of data collection and these are covered in the various themes as follows: **study site, sampling design and procedure, sample size, study design, unit of analysis, data collection and data analysis.**

3.0 STUDY SITE

This study was conducted at the Rift Valley Provincial General Hospital in Nakuru District. The Provincial Hospital houses the only VCT site in Nakuru district which is specifically designed for the youth and is a government of Kenya integrated model which means that VCT is an integral part of existing public sector health care services. The site was purposively chosen as it was representative of Youth VCT centres being implemented by Ministry of Health. It is also among the longest fully operational youth VCT located in a densely populated urban/commercial area and provides services to a sizeable numbers of youth so that an adequate and more representative sample size could be obtained. The site serves the target population and therefore has characteristics required for achieving the stated research objectives.

Background Information on Study Area

Nakuru district is one of the 18 districts constituting the Rift Valley Province, and is one of the most populated districts in Kenya with a total of 1,312,555 people. Nakuru municipality is the most densely populated division where most people live in congested slum areas. The high rate of the population growth coupled with industrialization in Nakuru has put tremendous pressure on existing infrastructure including health. The state/government of Kenya provides public health care services through the Ministry of Health. The Ministry of Health owns and operates a network of public health facilities which deliver services to over 50% of its citizens. The system of public health provision follows a pyramidal structure. At the apex of the structure is a

national hospital called Kenyatta National Hospital in Nairobi, the capital city. It is the largest health facility in the country. It acts as a referral for all the provincial hospitals across the country. The second tier consists of provincial hospitals, one in each of the other eight administration regions/provinces. The provincial hospital is ideally supposed to act as a referral for the smaller and less equipped district hospitals, dispensaries and health centres within its administrative space. Nakuru district has 1 provincial general hospital and 2 district hospitals, 14 health centres and 35 dispensaries. Currently the in-patient and the out-patient services at the provincial hospital are very congested. The Provincial Hospital is also a referral hospital and surveillance station to combat HIV/AIDS for the whole of the Rift Valley Province. The doctor/patient ratio in Nakuru district is estimated at 1:28,000.

Nakuru District Development Plan (2002 – 2003:24) indicates that the HIV prevalence rate had declined from a high of 27.5% in 1998 to an estimated 8% in mid 2004. This could be attributed to the fact that Nakuru was one of the first HIV/AIDS pilot campaign districts. In spite of this decline, HIV/AIDS prevalence rate is still very high if translated in terms of actual numbers against the total population and the socio-economic impact of the pandemic. Further, the youth in Nakuru as in other districts need reproductive health services which are often lacking or inadequate. Increasing cases of pregnancies and abortion among primary school girls has forced The Ministry of Education to dispatch officers to the affected areas in order to bring the situation under control (East African Standard, 21 July, 2004)

3.1 UNIT OF ANALYSIS AND OBSERVATION

This study interviewed young men and women aged 15-24 years, who were coming to receive various medical services at the provincial hospital during the study period. This age category is said to be one of the most sexually active demographic groups. These people participated as both respondents and observation units. There were basically two groups of respondents, one group had actually been counseled and tested while the other group came for other medical services and not VCT services. The other key observation units were the key informants, (service providers) who consisted of two nurses, one peer leader and one clinical officer. The purpose of key informants interviews was to obtain information on theirs' and the clients knowledge, attitude and practice (KAP) regarding HIV/AIDS, VCT services, general utilization of the

facility and to gather information on needs related to sexual and reproductive health programmes among the youth. According to Singleton (1988:69), the unit of analysis is the entity around which the researcher seeks to make generalization. The general unit of analysis for the study are the determinant of VCT services utilization. The study intends to establish how these factors impact on the utilization of the VCT services as a method of controlling the spread of HIV/AIDS. Finally, the services that the youth receive will form part of the unit of analysis.

3.2 SAMPLING DESIGN AND PROCEDURE

Non-probability sampling method was used in this study. The sampling scheme used was the convenience sampling where all subjects who met the eligibility criteria and gave consent were non-randomly selected and included until the predetermined sample size was met. The sampling unit was an individual between 15-24 years receiving VCT and/or other medical services within the Provincial General Hospital, Nakuru District, during the study period. The researcher and two assistants positioned themselves strategically inside the youth VCT centre near the registration desk to observe and screen for potential respondents. Those who qualified in terms of age and gave their consent were then interviewed on exit (exit interview). The interviewers then moved on to those queuing for other medical services at the hospitals' casualty unit. Subjects were similarly approached, screened and interviewed. This method has the advantage of being easy to implement and reduces bias in the survey. In addition this method is recommended in the early stages of investigating a problem, when the objective is to discover and describe a phenomenon (Nechmias and Nechmias, 1992).

Purposive sampling was done for key informants who consisted of two nurses, one peer leader and one clinical officer. There were four key informants in total. A prepared interview guide was used for indepth interview to focus the discussion on selected objectives.

3.3 SAMPLE SIZE

The sample size is the total number of people selected for the interview, which is representative of the target population. The study collected information about factors motivating and/ or inhibiting HIV VCT utilization from 100 subjects, which in this regard constituted the sample.

The non - randomly selected sample size of 100 respondents is considered as a standard size for the validity of the information obtained by the study and also appropriate considering time and resources limitations. The sample consisted of youth of both sexes. The initial intention was to select a sample consisting of 50 VCT users and 50 VCT non-users but the research project yielded 60 VCT user and 40VCT non-users. The aim was to ascertain the reasons for utilization and non-utilization of VCT services. Apart from the set differences, both users and non-users fitted into the age category in which the study was interested.

3.4 STUDY DESIGN

The study was a descriptive cross sectional survey study using both quantitative and qualitative methods. It sought to generate and document information obtained from a sample of the target population on factors determining utilization of HIV VCT services among the youth. According to Singleton (1988:233-237), the survey study enables standardization of the procedures for all the respondents so that the data obtained is highly reliable. In this case the study used a standardized, structured interview schedule to all respondents.

3.5 DATA COLLECTION TECHNIQUES

For the purpose of this study, both primary and secondary sources of data was collected from the field using quantitative methods. The instruments used were mostly self administered questionnaire for the youth. The questionnaire consisted of both open ended and closed ended questions. Studies suggest that self- administered questionnaires may be less biased than face to face interviews (Nechmias & Nechmias, 1992:216). Other supplementary techniques included qualitative methods through indepth interviews with key informants. The instrument used was a structured interview schedule or interview guide. The target of indepth interviews was the key informants or service providers.

Observational methods were also used to gather or corroborate information / facts on quality of the intervention. Secondary data was collected through library research and written reports by various scholars and health organizations, NGOs, and NASCOP. Literature, including journals, government publications and research papers were reviewed. Clinic registers/record on client

demographic characteristic, extent and level of utilization and HIV test results provided a quantitative assessment. Secondary data was used to supplement what might not have been captured by primary methods of data collection. More importantly combining primary and secondary techniques increased accuracy, consistency and kept researcher closer to reality. Quantitative methods ascertained levels of existing access and qualitative research clarified constraints to extending such access.

3.6 DATA COLLECTION

The data was collected from the study population (youth 15 – 24 years) from 10th April to 31st April, 2005. Two research assistants were recruited and trained on how to administer the questionnaires. The need to maintain confidentiality and anonymity was relayed to the assistants.

Eligible participants were asked for consent. After consent was obtained, participants were given a structured questionnaire that required an average of 15 minutes to complete. Confidentiality in this study was protected by assigning a unique identification number to each participant.

3.7 DATA ANALYSIS

The study employed both descriptive and inferential statistics in data analysis and presentation. According to Nechmias & Nechmias, (1992: 340), categorizing variables in a summarized pattern into small meaningful quantities, will enable the researcher to identify the existing relationships and variations between dependent and independent variables of the study. These included percentages, tables, pie charts and bar graphs. Inferential statistics deals with methods of drawing conclusions, inferring the findings of the sample to the general population of the study. The study used inferential statistics to analyze and present quantitative data which contained numerical information from completed questionnaires. The SPSS program was used to feed raw data into the computer, the subsequent computer processing included the Pearson's Chi-Square (χ^2) tests performed to test for significant differences in proportion and to measure

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the strength of association of the socio-demographic, behavioural and service utilization variables so as to test the study's hypothesis.

CHAPTER FOUR

DATA PRESENTATION

4.0 INTRODUCTION

This chapter presents descriptive results / findings of the study based on non-randomly selected sample of 100 respondents, 60 whom were interviewed on exit from the youth voluntary counseling and testing (VCT) center and 40 non-VCT users queuing for other medical services within the Provincial General Hospital, Nakuru District.

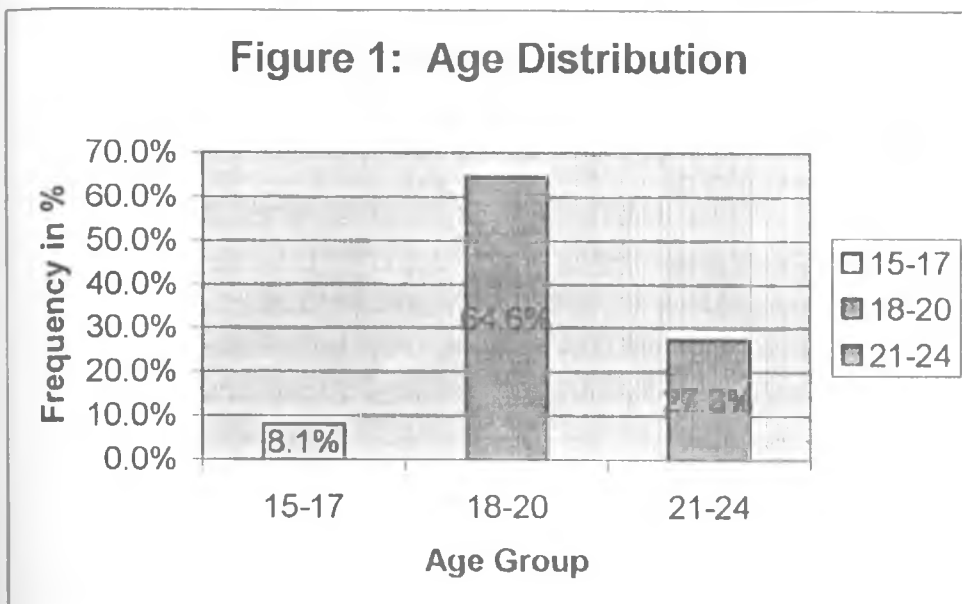
Data is presented in text and statistical illustration form. These illustrations include tables and figures, pie charts and bar graphs. It is sub-divided into 5 sections dwelling on socio-demographic and economic data, utilization of VCT services, access to VCT services and finally, reproductive health needs, experiences and perceptions of the respondents.

4.1 SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS/ATTRIBUTES

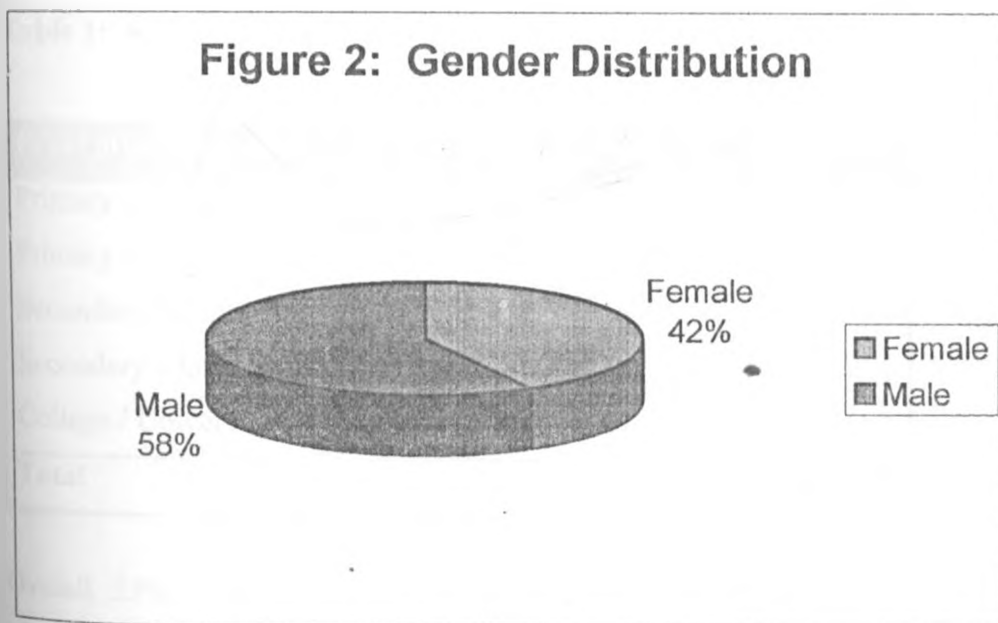
Age of Respondents

The ages of respondents ranged between 15 and 24 years, with a mean age of 21.67 years, the mode was 24 and a standard deviation of 2.395 years. The median age was 22 years.

Figure 1: presents the Age Distribution of the Respondents



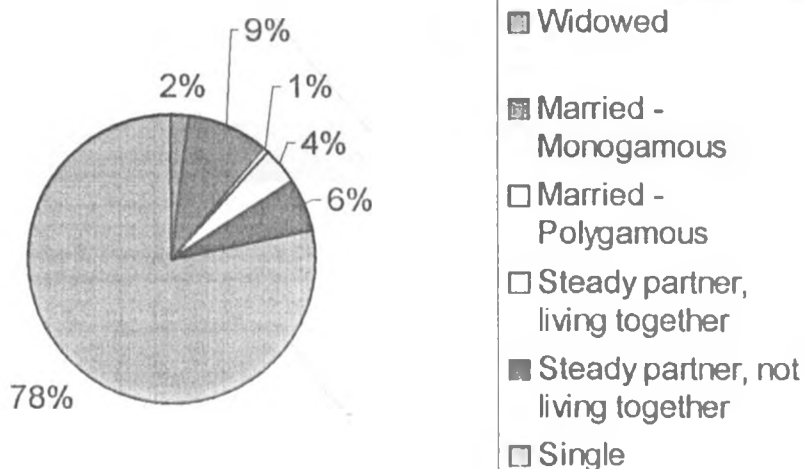
Most, 64.6% of the respondents were between 18 – 20 years of age with only 8.1% being less than 18 years old. Of the 100 respondents, there were more male respondents than females (58% versus 42%) as shown in figure 2 below.



Overall, 78% of the respondents were single, 9% married - monogamous, 1% married - polygamous, steady partner, living together - 4% steady partner, not living together - 6% and 2% widowed. Figure 3 depicts this distribution.

Figure 3: Distribution by Marital Status

Figure 3: Distribution by Marital Status



Educational Attainment

Table 1: Educational Level

Level attained	f	%
Primary incomplete	2	2.0
Primary complete	5	5.0
Secondary incomplete	16	16.0
Secondary complete	33	33.0
College / University	44	44.0
Total	100	100.00

Overall, 55% of the respondents are in school while 45% are out of school / formal education. This reveals that all the respondents had some formal education with 5% having completed primary school, though 2% did not finish primary school, 49% had been to secondary school with 33% of them completing. An overwhelming 44% went up to college/university level. The

respondents are well educated with the greatest concentration, 44% having gone to college/university (Table 1).

Economic Characteristics / Attributes

Table 2: Occupation Categories

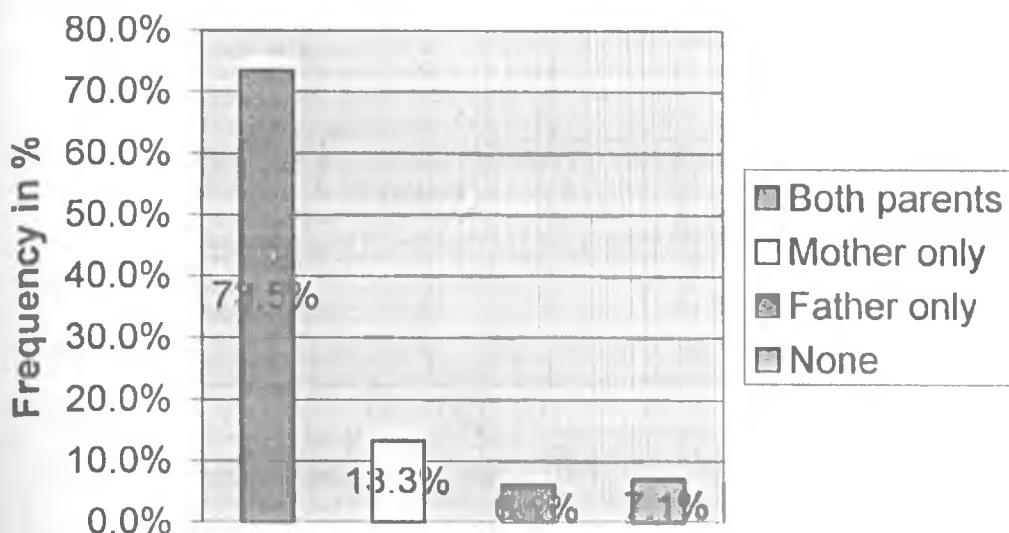
Occupation	f	%
Unemployed	16	16.0
Casual worker	9	9.0
Farmer	3	3.0
Business	6	6.0
Salaried/employed	11	11.0
Student	55	55.0
Total	100	100

The largest category, 55% were student, 16% were unemployed, 11% were in salaried employment, 9% were casual workers, 6% were in business, while the least, 3% were farmers (Table 2). This reveals that the potential clients to this VCT center are students who are mostly dependent on parents / guardians, for their well-being and livelihood.

Residence

Respondents came from as far as Kericho, Gilgil and Molo. Most, 55% - 60% of the respondents reside in 'freehold' or slum areas while the rest reside in stable / middle class residential areas. It emerged that while the VCT site is located within the Provincial General Hospital, which is upper / middle class residence, majority of the clients travel from lower income areas of the District to the site for services. -

Figure 4: Parental Presence in Household



Fortunately, majority of the respondents were living with both parents (73.5%) as depicted on Figure 4 above, however, 7.1% lacked parental presence in their household.

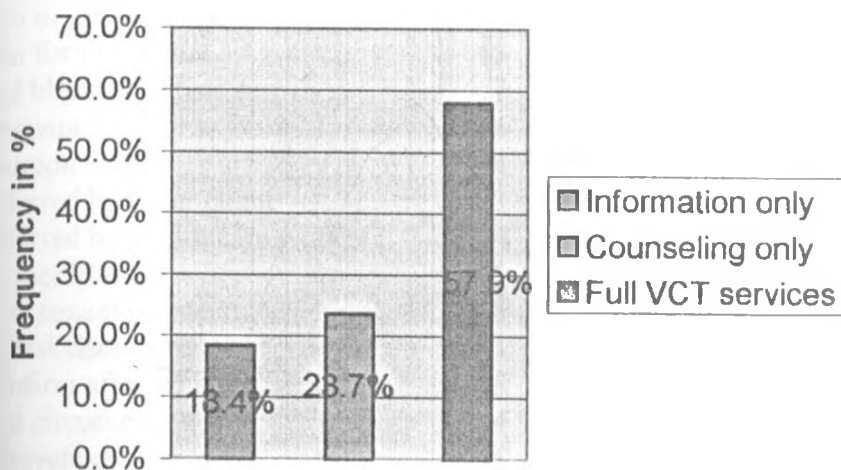
4.2 UTILIZATION OF VCT SERVICES

Table 3: Sources of Information about VCT Centres

Sources	f	% of Responses	% of cases
Television	62	14.4	62.0
Radio	61	14.1	61.0
Newspaper	54	12.5	54.0
Poster/Signpost	57	13.2	57.0
Pamphlets	29	6.7	29.0
Relatives/friends	40	9.3	40.0
Partner/spouse	20	4.6	20.0
Another VCT client	22	5.1	22.0
Church	20	4.6	20.0
Mosque	5	1.2	5.0
Community meeting	13	3.0	13.0
Health worker	13	3.0	13.0
Peer	36	8.3	36.0
Total	432	100.0	432.0

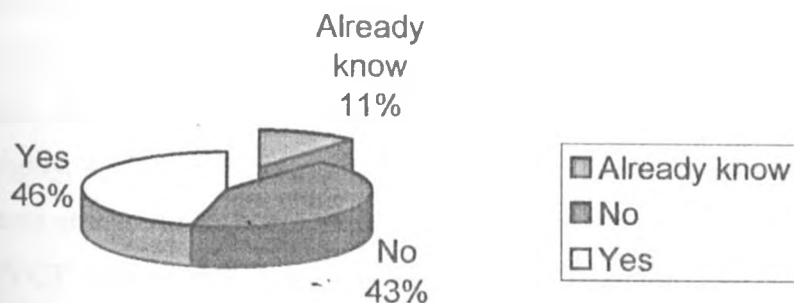
It is encouraging to note that all respondents had received information on VCT from some source. Majority, 14.4% had got information from television, closely followed by radio, 14.1%. Other sources appear on Table 3. The concentration of cases appear to be on electronic and print media. The least, 1.2% got information from the mosque.

Figure 5: VCT Services Required Today



Of the 60 respondents attending VCT clinic, 57.9% requested for full VCT services, 23.7% requested for counseling exclusively and 18.4% sought information only.

Figure 6: Would you like to know your HIV status?



When asked whether they would like to know their HIV status, 46% replied yes, while 43% responded in the negative (No). Only 11% knew their status. This is consistent with other research findings (KDHS;2003:197, UNAIDS, 2002:31).

Table 4: Reasons for Requiring VCT Services today

Reasons	f	% of Responses	% of cases
To ascertain HIV status	33	16.9	44.0
Plan to get married	9	4.6	12.0
Plan to get pregnant	8	4.1	10.7
Plan for the future	46	23.6	61.3
Had blood transfusion	7	3.6	9.3
Pregnant	5	2.6	6.7
Reunion	4	2.1	5.3
Referred by other client	3	1.5	4.0
Referred by health care worker	4	2.1	5.3
Partner ill/died	5	2.6	6.7
New sexual partner	8	4.1	10.7
Tested elsewhere	3	1.5	4.0
Confirm after window period	5	2.6	6.7
Had circumcision	4	2.1	5.3
Intravenous drug use	5	2.6	6.7
My risk behaviour	9	4.6	12.0
Partner risk behaviour	5	2.6	6.7
Feel unwell	13	6.7	17.3
STI symptoms	6	3.1	8.0
HIV related symptoms	7	3.6	9.3
Family planning e.g. condom	6	3.1	8.3
Total	195	100.0	260.0

As indicated on table 4, youth visit VCT centers or require VCT service for multiple reasons. Most, 23.6% of the respondents want to plan for the future, while 16.9% want to ascertain their HIV status. Other notable reasons; 6.7% felt unwell. Acquisition of new sexual partners also scored highly, 4.1%. All reasons had adequate number of cases indicating that VCT services / components are interlinked. For example, the respondents / youth gave the following reasons for visiting VCT center; risk behaviour, 4.6%, STI treatment, 3.1%, pregnancy, 2.6%, family planning/condoms, 3.1%.

Figure 7: Types of visits



Majority, 81% of the youth were paying their first visit, while a good number, 19% were on follow-up visit.

Table 5: What factors motivated you to attend VCT

Factors	f	%
Advertisement and influence from friends	4	3.7
To know my status	27	27.2
For future plan	11	11.1
To assist the already affected ones	3	2.5
The service offered	5	4.9
After circumcision service	1	1.2
Pregnancy	1	1.2
To avoid future infection/change moral behaviour	5	4.9
Not interested, motivated or nothing	22	22.2
Take anti-TB therapy	1	1.2
Fear of being tested	4	3.7
Age	3	2.5
Counseling	11	11.1
Family conflicts	1	1.2
Wanted to marry	1	1.2
Total	100	100.0

As depicted on Table 5, respondents were motivated by various factors to attend VCT center. Most, 27.2% wanted to know their HIV status, followed by a tie, 11.1% for those who were

motivated by need to plan for the future and attend counseling, 11.1%. However, 22.2% indicated they were not interested or motivated to attend VCT.

4.3 ACCESS TO VCT SERVICES

Table 6: How far is this VCT site from your residence

Distance	f	%
Less than 0.5 km	13	13.0
Approximately 1 km	5	5.0
1 – 2 km	21	21.0
3 – 4 km	17	17.0
5 km and above	44	44.0
Total	100	100.0

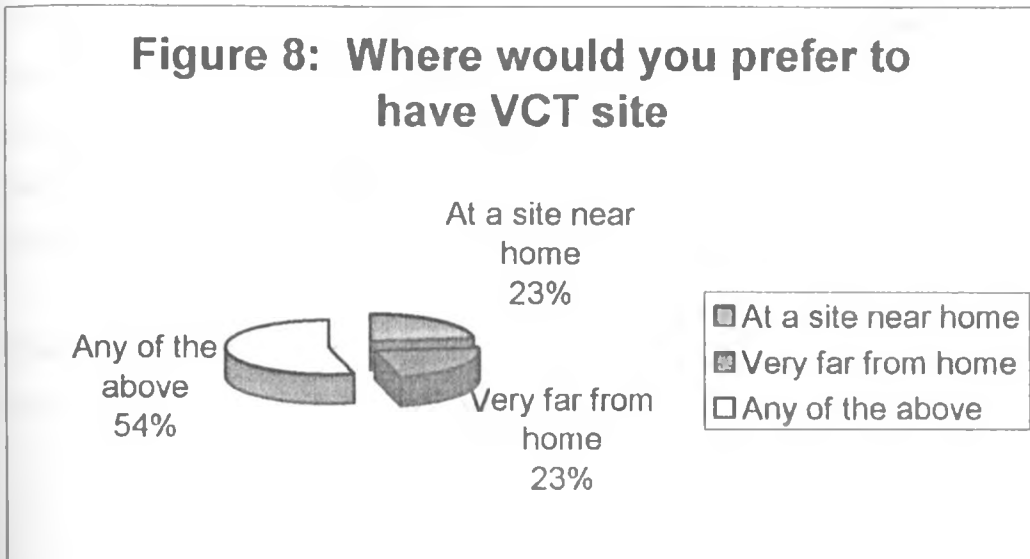
Most of the respondents, 44% reside within 5 kms and above from the site, while 21% and 17% reside within 1 – 2 km and 3 – 4 km respectively from the site. Very few, 18.2% reside within one kilometer and less from site.

When asked whether there were charges for VCT services, most of the respondents, 66% indicated, there were no charges for VCT services, while 25% said charges existed. Only 9% were not aware whether charges for VCT services existed or not.

Among the 25 respondents who indicated that charges existed for VCT services, 24.4% indicated that the charges were between Kshs.100 – 500, 20%, indicated above Kshs 500 and 13.3% indicated less than Kshs.100. As high as 42.3% claimed that although the charges existed, they did not know the actual amounts applied. This ignorance is an access barrier. However, it should be noted that charges vary according to the services requested. On the ground RAPID test for HIV is free while ELISA Test attracts Kshs.200. Consultation with the clinical officer costs Kshs.110/-. The patients also purchases prescribed drugs.

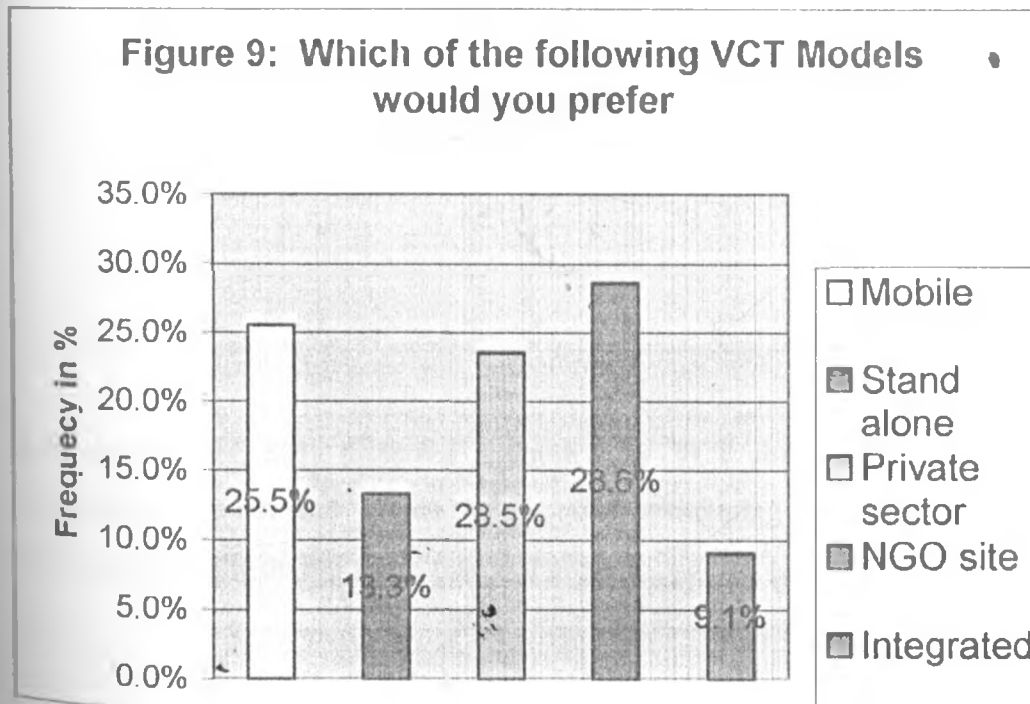
When asked what their feeling were about these charges, most, 43.7% felt that the charges are expensive, 31.3% felt they are fair while 25% said it is cheap.

Figure 8: Where would you prefer to have VCT site



There was a tie for those, preferring a site near home, 23% and those who prefer a site far from home, 23%. Similarly over half, 54% did not mind any of the above. There was no clear preference on distance of site from place of residence.

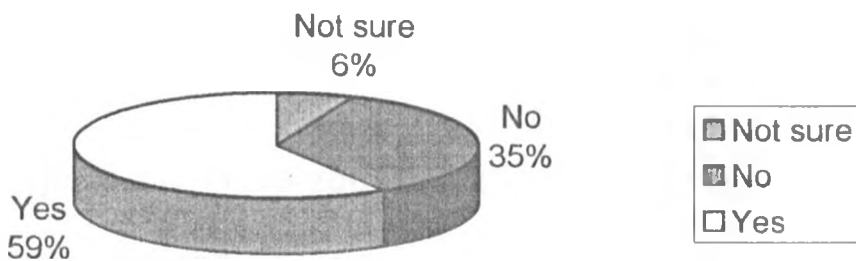
Figure 9: Which of the following VCT Models would you prefer



Again, there was no clear preferences for VCT models with 28.6% preferring NGO model, 25.5% preferring mobile, 23.5% preferred private sector model, 13.3% preferred stand alone model. However, the least preferred with 9.1% was the integrated model, similar to the study site. Reasons for such preferences was also given. Respondents preferred NGO model for high rate of accuracy and commitment. Mobile, for offering services to everybody, private model was preferred for fast and prompt services. Respondents felt stand alone model offered maximum confidentiality while integrated model provided financial support for testing and one had the added advantage of knowing his/her status on site on the same day.

When asked where else they would like to be tested, 62.4% said government hospital clinic, 30.1% said private hospital / clinic, while 7.5% said pharmacy.

Figure 10: Preference to youth only VCT site

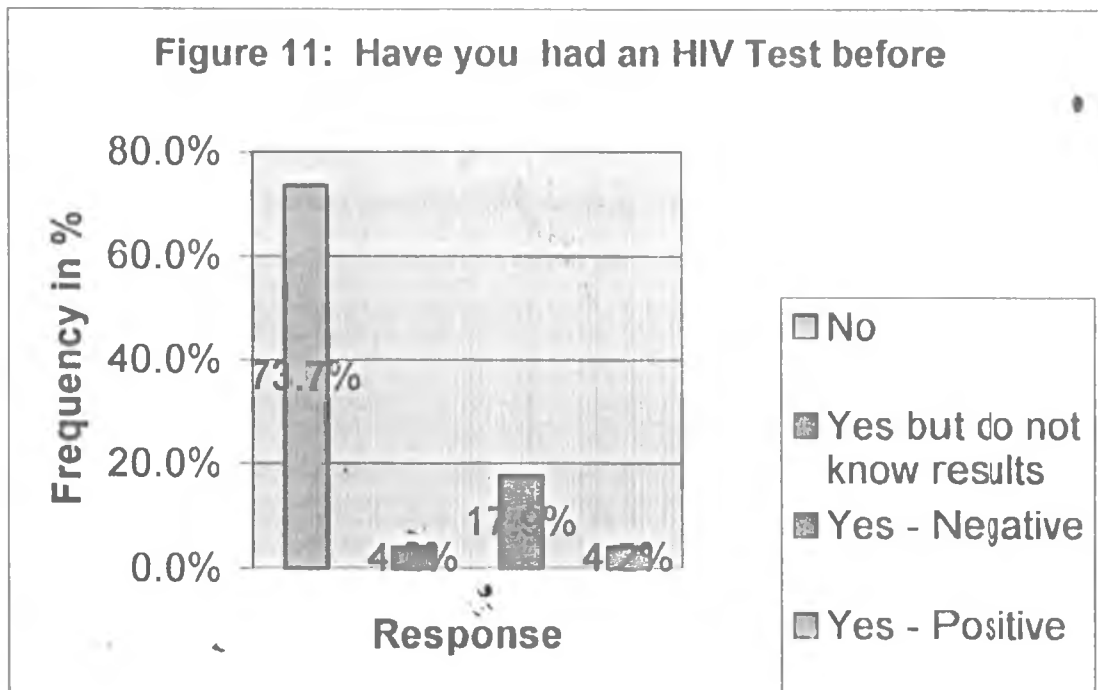


Most respondents, 59% preferred a youth only VCT site, while 35% did not, 6% of the respondents were not sure. Again there is no overwhelming preference for youth only VCT that was expected at the on set of this research project.

Table 7: Why would you prefer a youth only VCT site

Reasons	f	%
You meet with other youth and interact with them	14	14.0
Encourages more youth	16	15.8
Because of generation gap	21	21.0
Youth prefer being offered services alone	31	31.6
To know your status	2	1.8
Technicians know youths situations	6	5.8
It is comfortable	7	7.0
Lack of spouse	3	3.0
Total	100	100

Respondents preferring youth only VCT site gave multiple reasons with the most, 31.6% simply stating that youth prefer being offered services alone, 21% indicated generation gap, while 15.8% mentioned it would encourage more youth. Again no convincing reason was given for preference of youth only VCT. The other reasons for preference of youth only VCT site appear on Table 7 above.



An overwhelming 73.7% confirmed having had no test before, while 17.9% indicated they had a previous test with a negative result. There was a tie, 4.2%, for those who had gone through HIV testing but claimed not to know results and those who had gone through it and had been diagnosed as HIV – positive, 4.2%.

Table 8: Why Not Yet Tested

Reasons	f	% of Responses	% of cases
Am confident that I have not engaged in risk behaviour	37	32.5	44.0
The stress of a positive results	19	16.6	22.6
Other may know my status without permission	7	6.1	8.3
I might be discriminated against	10	8.8	11.9
Changed mind	3	2.6	3.6
Want to test later	7	6.1	8.3
Want to test with a partner	5	4.4	6.0
No test kits available	4	3.5	4.8
Not satisfied with quality of service	2	1.8	2.4
Declined to answer	1	.9	1.2
N/A	19	16.7	22.6
Total	114	100.0	135.7

When asked why they had not gone through HIV testing, most of the respondents, 32.5% felt they had not engaged in risk behaviour, 16.6% mentioned the stress of a positive result as the main reason for not having gone for HIV-testing, while 8.8% had not tested due to fear of being discriminated upon. Other reasons are given on Table 8. It is worth noting that dissatisfaction with quality of service was the least with only 1.8%. One respondent declined to give reasons for not having tested.

Table 9: If yes, what were your reasons for testing?

Reasons	f	%
Had sex for the first time	5	5.3
To know my status	53	52.6
New sexual partner	5	5.3
To plan for the future	27	26.2
To donate blood	5	5.3
To quit from risk behaviours	5	5.3
Total	100	100.0

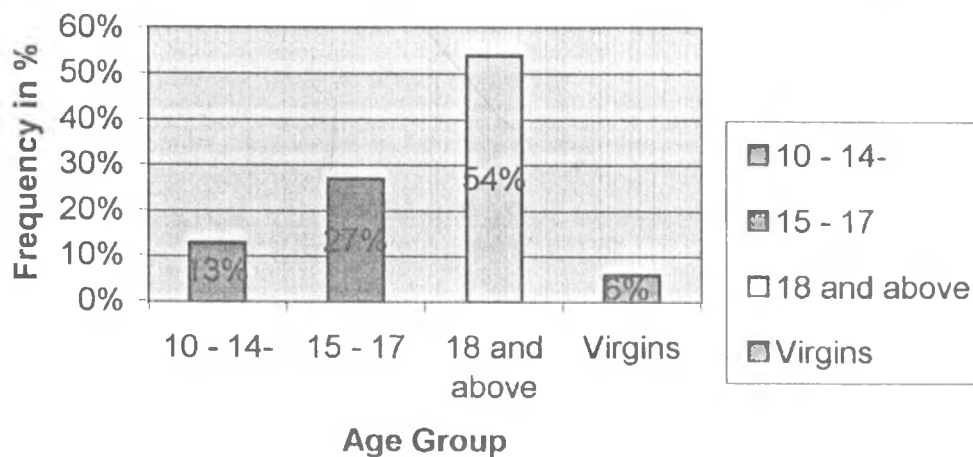
Most, 52.6% of the respondents who had been tested gave the need to know their status as the most important reason for testing, followed by planning for future, 26.2%, there was a tie, 5.3% for the other reasons for testing as depicted on Table 9.

When asked if a friend had requested for VCT services, 44.4% of the respondents had a friend who had requested for the services, 36.4% indicated that none of their friends had requested for the services, 19.2% did not know whether any of their friends had requested for VCT services.

When respondents were asked how many times they had gone through the HIV testing experience, most, 44.5% indicated once (1) followed by 33.3% of the respondents who had been tested twice. There was a tie, for those who had tested thrice, 11.1% and four times, 11.1%. Although few in number, it is encouraging to note that some of the youth receive VCT frequently with some having been tested as many as four times.

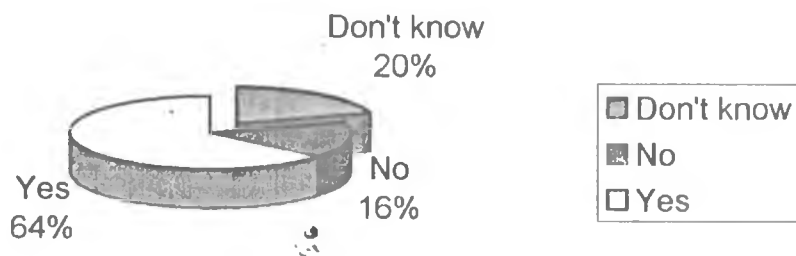
4.4 REPRODUCTIVE HEALTH NEEDS / EXPERIENCES/PERCEPTIONS

Figure 12: Age at First Sex

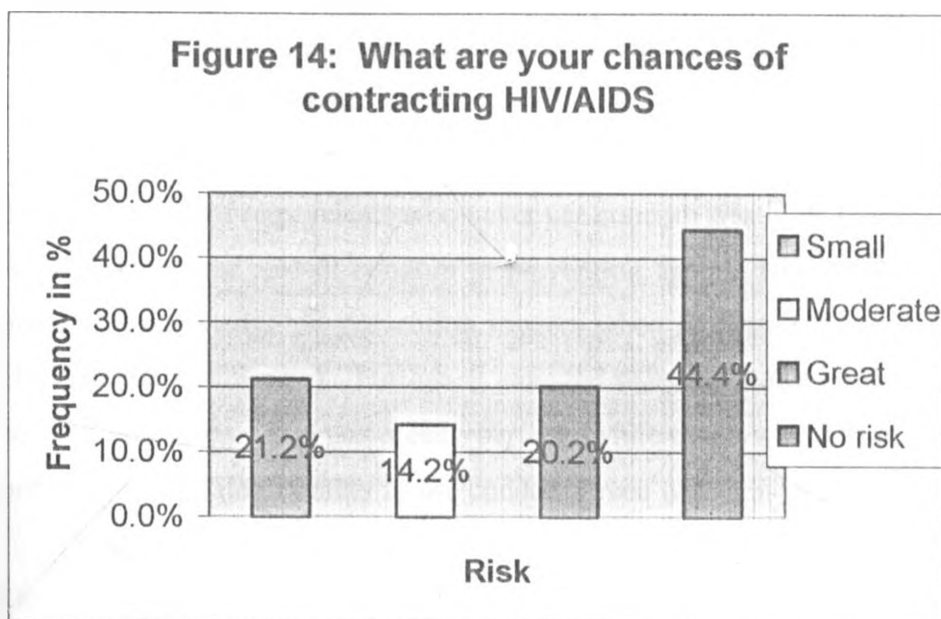


Concentration of cases, 54% are within the over 17 years age group, while 27% fall within the 15 – 17 years age group. The least, 13% fall within the 10 – 14 years age group, which is still substantial considering that these young people are initiating sex when they are barely out of childhood/adolescence and also keeping in mind that some young people might not want to admit they had sex. Almost all the respondents, 94% had initiated sex, only 6% had not initiated intercourse. This finding corroborates other research findings (KDHS, 1998:1-4; Nganga and Ngugi, 1997:1-5).

Figure 13: Can Anyone Below 18 years Freely Request for VCT Services



On the issue of whether those below 18 years could request freely for VCT services, majority, 64% felt that those under 18 qualified for VCT services, 16% felt that youth under 18 years were not eligible for VCT services while 20% could not make up their mind on this issue or did not know. Age of eligibility for VCT services appears to be a contentious issue, even for these respondents in the affected age bracket. Still a good number, 64% in this study, feel these services should be available to youth under 18.



On the question of their chances of contracting HIV/AIDS, most of the respondents, 44.4% indicated they faced no risk, 21.2% indicated small risk, while 20.2% indicated great risk, 14.2% faced moderate risk. Those not at risk of contracting HIV/AIDS gave multiple reasons for this confidence as captured on Table 10 below.

Table 10: Why Not at Risk of HIV/AIDS

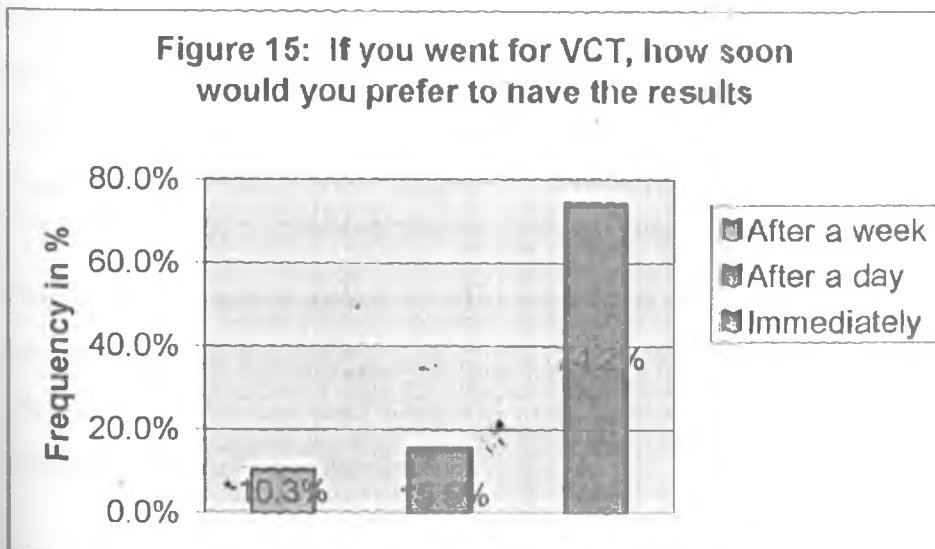
Reasons	f	% of Responses	% of Cases
Tested, know status	16	11.0	27.6
Abstain from sex	39	26.9	67.2
Limited number of sex partners	10	6.9	17.2
Have only one sex partner	15	10.3	25.9
Have regular medical checks	19	13.1	32.8
Protect self using condoms	13	9.0	22.4
No blood transfusion	15	10.3	25.9
Trust my partner	18	12.5	31.0
Total	145	100.0	250.0

Most, 26.9% gave abstinence from sex as the reason, 13.1% indicated that they had regular medical checks, while 11% indicated they had been tested and knew their status.

On condom use in the last 12 months with steady partner, most, 44.2% indicated that they never used condoms, 26.3% indicated that they always used condom, 17.9% used condom sometimes, while 11.6% mentioned that they were not sexually active. The responses remain fairly consistent even with non-steady partners. Most respondents, 42.6% indicated they never used condoms even with non-steady partners, 30.5% always used condoms, 15.9% used sometimes while 11% were not sexually active.

The percentage of respondents who never use condom was high, taking into account that they are fully aware of the role of condom in prevention against HIV/AIDS. (The respondents scored highly on knowledge on prevention matters when requested to mention 2 ways of preventing HIV/AIDS transmission). Further, it emerged that respondents who choose to use condoms do so with both steady and non-steady partners while those who do not use condoms as a rule are not choosy and don't bother to use condoms even with non-steady partners.

On the issue of where they had gone for previous HIV testing, majority, 62% of the respondents who had tested had taken their test at the study site while 14.3% had been tested at Langalanga, another popular government health center. The rest had gone for HIV testing in various private clinics in and around Nakuru.



The majority, 74.2% would prefer to have the results immediately, while 15.5% of them would prefer to have it after a day, the least, 10.3% after a week.

On their experiences at VCT centers, majority, 66% of the respondents found the service providers friendly, while 34% did not. However, it is interesting to note that an overwhelming 76% did not find them respectful, only 24% described them as respectful. However, majority, 86% of the respondents felt service providers were not judgmental. Young people had largely positive experiences, with 64.3% saying that counseling services were adequate while 18.9% indicated they needed improvement. Only 16.8% indicated that they were not satisfied. An overwhelming 91.3% felt that counselors had answered their questions fully, only 8.7% felt that the counselor had not answered questions fully. There was no clear preference for gender of counselors with 56.7% being comfortable with counselors of both sexes, 22.7% were comfortable with female counselors and 20.6% preferred male counselors. As to whether they felt confidentiality was maintained, majority, 70.8% were confident that it was 25% were not sure, only 4.2% felt confidentiality was lacking.

Table 11: What you like about VCT

Service/Qualities	f	% Responses	% of Cases
Confidentiality	58	19.3	61.1
Counseling	68	22.7	71.6
Warm Reception	65	21.7	68.4
Quick Service	49	16.3	51.6
Advice/Information	60	20.0	63.2
Total	300	100.0	315.8

There were multiple responses on what youth liked about VCTs. The most important component for the youth was counseling with 22.7% of the responses, followed by warm reception, 21.7%, advice/information was third with 20% and confidentiality followed with 19.3%. Quick service attracted 16.3% of the responses.

Majority, 83.2% of the respondents confirmed that they were given the services they had requested for and were satisfied, 8.4%, indicated they had not been given the services they had requested for and a similar, 8.4% indicated that although given services that they had requested for, they were dissatisfied with the same.

Table 12: Quality of VCT Services

Services	N	Mean	Mode	Std. Deviation	Min	Max
Counseling	93	9.02	10	1.871	1	10
Confidentiality	89	8.83	10	2.196	1	10
Accurate test results	89	8.81	10	2.215	1	10
Staffing levels	92	8.05	10	2.727	1	10
Test kits available	91	7.99	10	3.028	1	10
Given necessary information/services e.g. condoms, drugs for STI to protect against HIV/AIDS	93	9.08	10	1.818	1	10
Helped me identify ways of my exposure to risk practices	93	9.43	10	1.155	4	10
Changed my sexual behaviour	92	9.13	10	1.787	1	10
Staff was helpful and supportive	93	9.34	10	1.697	1	10
Professionalism (good attitude, skills, qualifications)	93	9.12	10	1.938	1	10
A staff member greeted me within 15 minutes of my arrival (waiting time)	93	7.88	10	3.355	1	10
Overall quality services	92	9.40	10	1.326	3	10
I intend to tell others about this service	93	9.08	10	2.346	1	10

The VCT Centre scored highly on quality of service provided to the respondents as presented in Table 12 above, (The least possible score is 1 and best possible score, 10). The mean score for overall quality service was 9.40. It is encouraging to note that the impact of VCT in helping clients to identify ways of reducing exposure to risk practices received the highest score of 9.43 followed by 9.34 for staff being helpful and supportive. The least scores were 7.99 and 7.88 for availability of test kits and waiting time (that is, staff greeted me within 15 minutes of arrival) respectively.

Table 13: I was Referred To

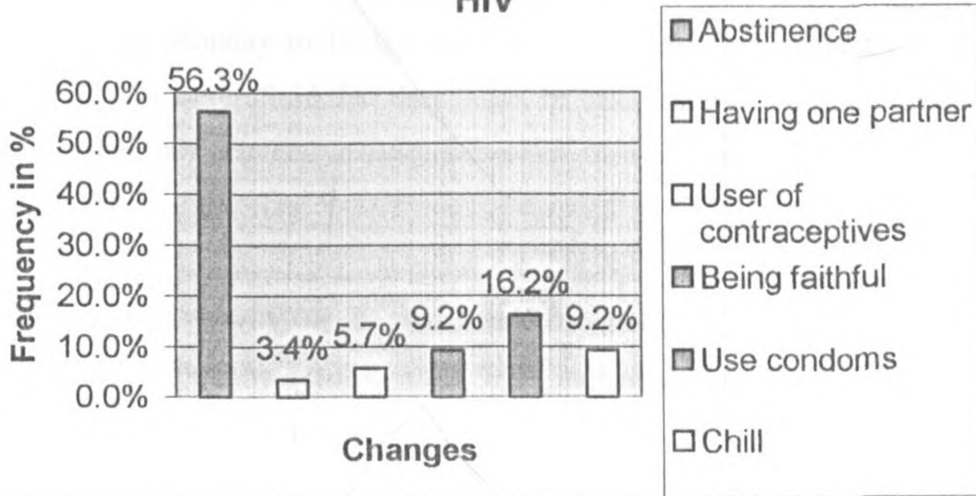
Care and support services	f	% of Responses	% of Cases
Not referred	43	25.6	44.8
HIV clinician	14	8.3	14.6
STI services	12	7.1	12.5
Inpatient services	13	7.7	13.5
TB services	11	6.5	11.5
PMTCT (Prevention of Mother to Child Tr.)	3	1.8	3.1
Family planning	9	5.4	9.4
Home/based family care	6	3.6	6.3
Post-test checks	12	7.1	12.5
Ongoing counseling	30	17.9	31.3
Spiritual support	7	4.2	7.3
PLWA support group (People Living With AIDS)	5	3.0	5.2
Legal services	3	1.8	3.1
Total	168	100.0	175.0

Young people are able to access various prevention or care and support services following VCT as captured on Table 13 with counseling being the component to which respondents were most referred, 17.9% followed by HIV clinician, 8.3%.

On the question of their feelings about taking HIV tests, most, 34.1% were scared or worried of a positive result, 30.8% were confident, 16.5% felt that taking the test enabled one to know his/her status, 6.6% were not interested in the test, another 6.6% lacked trust in counselors, while 5.4% felt they would be stigmatized/discriminated against.

The testing experience had been negative (too much tension) for 27.4% of the respondents, while others, 27.3% indicated they were tense but ready, 22.7% indicated they had never tested anywhere, 18.1% indicated that the testing experience had changed their sex lives, (to be careful, limit sexual partners), while 4.5% indicated that they would never advise a friend to get tested.

Figure 16: What changes have you made to reduce your risk of becoming infected with HIV



Most respondents chose abstinence, 56.3%, followed by condoms, 16.2% to reduce risk of HIV infection.

Table 14: What Factors Inhibits you From Seeking VCT Services

Factors	f	%
Committed in school work	15	15.0
Thinking that you have the right person	1	1.2
Stress from a partner	9	9.3
Fear of stigmatization	12	11.6
Fear of being positive	23	22.1
No risk behaviours	7	7.0
Age/peer	6	5.8
Primitivity	1	1.2
Nothing	4	3.5
Counselors are not serious	6	5.8
Have confidence of myself	2	2.3
Lack of confidentiality	7	7.0
Lack of enough counselors	2	2.3
Looking for a partner	1	1.2
No need of getting tested	1	1.2
Distance	1	1.2
Not afraid	2	2.3
Total	100	100.0

The factors inhibiting respondents from seeking VCT services are presented on Table 14. The Fear of a positive result is mentioned by most of the respondents, (22.1%) while, 15% indicated commitment in school or work – this is probably due to the youth VCT centre working hours, (8 – 5 pm from Monday to Friday only) which are not convenient for students or employees. Others, 11.6% were afraid that they might be discriminated against, others, 7% were confident that they had not engaged in risky behaviour, still others, 7% feared lack of confidentiality at VCT centers.

On the question of why friends were afraid of visiting VCTs, majority, 81.5% again mentioned stress / fear of positive results, while 9.9% indicated lack of commitment by counselor, 8.6% feared discrimination and depression.

Fortunately, more than half, 67% of the respondents indicated that parents provided them with the support which helped them to avoid situations that would otherwise put them at risk. Similar support was also received from friends by 8.2% of the respondents while others included health workers and sex partners.

However, most, 35.6% of the respondents indicated that they talked about personal issues like HIV concerns with close friends / partners while others mentioned counselors and pastors.

When asked about their preferred age group for service providers, majority, 63% indicated 18 – 30 years, while 37% mentioned 30 – 45 years. This reveals that they prefer counselors who are mature and not necessarily those who they consider as peers in the same age group.

Table 15: What didn't you like about VCT

Factors	f	%
Slow/waiting to be tested	31	31.3
How they censor people	15	14.9
They are unfriendly	3	3.4
Language barrier	7	6.9
Not punctual	8	8.0
In confidentiality	11	10.3
VCT structures along the roads	2	2.3
Removal of blood	5	4.6
Lack of enough staffs/lack of commitments	12	11.5
Age	2	2.3
Distance	1	1.1
VCT sites	2	2.3
Interrogating questions	1	1.1
Total	100	100.0

Table 15 presents the various factors that the respondents did not like about VCT with concentration of cases, 31.3% falling on slow/waiting time for testing.

4.5 Table 16: Relationships between various variables and VCT service utilization at 0.05 level of significance (95% level of confidence)

PEARSON CHI-SQUARE TESTS

Variable	Chi-Square Values	Significance (P-Value)	Comment
Marital status	5.505	0.036	S
Education level	4.319	0.365	NS
Occupation	9.16	0.029	S
Distance of VCT from area of residence	6.910	0.041	S
Whether there are charges	2.622	0.270	NS
What are your feelings about these charges	5.878	0.053	S
Where you prefer to have VCT service (near/far from home)	1.618	0.445	NS
Which model do you prefer	1.025	0.906	NS
Do you prefer a youth only VCT	0.884	0.643	NS
Would you like to know your HIV status	36.632	0.000	S
Are there charges for VCT service	8.179	0.025	S
What are your feeling about these charges	4.022	0.403	NS
Where would you prefer to have VCT service	10.186	0.017	S
Which of the following VCT models would you prefer	14.365	0.278	NS
Do you prefer a youth only VCT	7.014	0.320	NS

S - Significant

NS - Not significant

The first 9 variables were cross-tabulated against, **Type of visit (first or follow-up)**, while the last 6 variables were cross tabulated against, **“Have you had an HIV test before?”**

Variables that were found to have significant effect on VCT service utilization were; marital status, occupation, distance, feelings about VCT charges and desire to know ones HIV status.

Education level, VCT service charges, whether one would prefer VCT site far or near home, VCT model, youth only VCT, charges, (for those who had gone for more than one test) had no significant effect on VCT service utilization.

The desire / need to know one's HIV status or not has the most significant influence on the use of VCT services. The chi-square value of 36.632 and $P=0.000$ indicate that the need to know or not to know HIV status have a very significant relationship with adoption of VCT services. It implies that the need to know HIV status can influence one's decision to go for VCT services or not.

Whether there are charges for VCT services or not does not determine whether one visits the VCT ones or a second time. In fact it is interesting to note that the respondents do not have problems with the charges of VCT services but their feelings about VCT services charges are significant. This implies that the respondents won't mind paying for the VCT services but the rates charge will have an impact on whether one will visit the VCT once or a second time.

Where you prefer to have VCT services has a significant relationship with whether one has had, HIV test before or not. The most insignificant association was between type of VCT model and VCT service adoption, with a chi-square value of 1.025 and $P=0.906$.

CHAPTER FIVE

ANALYSIS AND DISCUSSION OF THE FINDINGS

5.0 INTRODUCTION

The purpose of this study was to look into the extent to which certain variables influence the utilization of youth voluntary counseling and testing (VCT) services at the Rift Valley Provincial General Hospital, Nakuru District. Based on such an aim, it was hypothesized that youth attitudes towards the utilization of VCT services are influenced by both community level factors (socio-demographic, economic factors) and clinic level factors (organization, quality and availability of VCT services and facilities). The discussion on chapter five is based on statistical analysis and logical reasoning. The background and lifestyles of the youth which in this study is considered as the client profile is described using socio-demographic and economic data collected from site. Though these young people are not necessarily representative of all Kenyan youth, they are effectively potential clients of the Nakuru youth VCT. The performance of the centre is reviewed examining client perceptions and experiences, services received, staff preparedness in the centre and clinic records. Finally, the key informant in-depth interviews technique was used to assess the knowledge, attitude and practice (KAP) of the service providers as they gave insights into the operations of the VCT Centre.

The socio-demographic and economic factors that influence access to VCT services among the youth.

There is increasing evidence that youth physical and mental health is related to the structure of the family, own educational attainment, current economic position and personal, disposal income (Nettleton, 2002; 10:119). . Socio-demographic and economic information must therefore be included when assessing determinants of VCT service utilization among the youth since they play an important role in their health seeking behaviour. The Nakuru Youth VCT Center clients are more likely to be female, with the largest concentration of clients, both male and female, falling in the age group, 18-24 years. There were significantly more single / unmarried people, (78%) than married ones, (10%) who formed the study population (Figure 3). There is demand

for VCT services and it attracts people in this age group who are at relatively high risk of HIV infection since this period is characterized by intense sexual activity and experimentation. Youth attending the VCT Centre tended to be the in school youth, (55%) compared to 45% out of school clients. Out of this, 44% were college educated and above, only 16% were unemployed (Tables 1 and 2). It can be deduced that the District is economically active/progressive with all respondents having had formal education at various levels. This can only mean that it is easy and possible to create awareness on VCT services and its benefits in this community. Indeed knowledge on prevention matters was found to be high and respondents scored highly when asked to mention 2 methods of preventing HIV/AIDS transmission.

Parental presence in households is still very high, with 73.5% of the respondent, living with both parents. This explains the high levels of education, awareness and ultimately VCT service utilization (the centre attends to an average of 15 – 20 clients per day. Source: clinic records). Radio/TV were found to be the most informative media on VCT in Nakuru District with majority mentioning them as their main source of information, (Table 3), which is consistent with urban centres like Nakuru with good network coverage. Few got information from church and even less from mosque. A clear indication that the church/mosque are not putting a lot of effort in informing the community about VCT services despite their moral role in the community. It must be pointed out that information can never be too much and access to information on ones HIV status is a human right as well as a public health measure. People have the right to know their HIV status so they can protect themselves and others from infection, improve their healthcare and plan for the future. Nakuru is a rapidly growing urban centre with one of the highest population growth rates in Kenya. The pressure exerted on social amenities far exceeds the supply. People are forced to live in unplanned settlements surrounding the towns joining the urban marginal population. As such, they are an important risk group for STI and HIV due to lack of accessibility to health services and health education including issues on HIV/AIDS prevention. It emerged that 55% - 60% of the youth attending the study site reside in “free hold” or slum areas. The centre is located in an upper class residential area, yet over 55% of its young clients travel long distances (5kms and above) from the lower income areas of the District to the site for services. More effort should be put towards increasing VCT coverage by bringing its services closer to the marginalized youth who are not only more exposed to risk situations, but

are attracted by the free or highly subsidised cost of services and care offered at government clinics.

Although clients value VCT services and express willingness to pay for it, they do not necessarily have the means to do so, (43.7% of the respondents felt the charges were expensive). The pricing of VCT services must be carefully determined to ensure that people who are in most need of the services are not turned away because of their inability to pay for it. At the study site, for example, the ELISA test for HIV, which can detect HIV within 48 hours of infection is Kshs.200 while consultation cost Kshs.110 and these are considered to be highly subsidized pricing. Another access barrier is miscommunication on the same issue of charges with 43.3% of respondents indicating that they did not know the actual costs for services provided. Information on pricing should similarly be highly publicized and displayed clearly for public consumption.

The experience on the ground established that the legal age of consent for VCT services which is 18, is observed at the Centre with exemptions only on deserving cases such as “mature minors” and rape victims. All the four key informants (service providers) interviewed felt that young people below 18 years old should get parental consent before obtaining reproductive health information or services and in particular HIV testing. A few felt that reproductive health services to youth leads to increased promiscuity. This is in sharp contrast to the young respondents, 64.2% of whom felt that any one below 18 years should be able to access VCT services. Their acknowledgement that people engage in sexual relations at an early age – a compelling factor to want youth access the services at an early age. This general reluctance to support young people under 18 years going for HIV tests and other reproductive health services without consent permeates the whole society and is reflected in our attitudes towards matters such as HIV/AIDS. This is the reason why fear of a positive HIV results (mentioned by 22.1% of the respondents) and consequently, stigma (mentioned by 11.6% of the respondents) are major barriers in the utilization of VCT services (Table 14).

While the demand for VCT is high with 46% of the respondents indicating they would like to know their HIV status voluntarily, many of the correlates of youth sexual activities are not susceptible to change within the societal and economic context of Kenya today, but some may be amenable to policy or pragmatic intervention.

The range of social, psychological and emotional experiences/perceptions of the youth about HIV counseling and testing at the VCT site.

The experiences of youth undergoing HIV counseling and testing on site will determine how closely the testing experience match the recommended VCT model, with its pre-test and post-test counseling plus follow up care and support. The respondents had largely favourable views of the service providers (nurses/counselors) and their interactions with them. The overwhelming majority of clients, 66% found the nurses / counselors friendly. About 86% of the respondents visiting VCT found them non-judgmental. Similarly, the dynamics during counseling which is the distinguishing element of VCT were favourably viewed with 64.2% saying that the counseling services were adequate. Its client – centered counseling approach help tailor the intervention to the needs of each client. Clients liked counseling more than any other component. Majority, 70.8% of the respondents felt that the strict confidentiality maintained and positive relations/warm reception facilitated client trust and confidence in the services provided. Interestingly, however, 76% of the respondents found the services providers disrespectful and felt that some nurses / counselors were embarrassed during the interaction. While three of the key informants/services providers felt that the youth don't open up during counseling, others tell too much and counselors were frustrated when the youth do not return for follow-up or ignore such advice as discontinuing unprotected sex.

On the question of their feelings about taking HIV tests, most felt that it had been largely negative, with 27.4% indicating anxiety /tension, while 4.5% indicated that they would never advise a friend to get tested. Majority of the respondents, 74.2% would however prefer to have the results immediately (Figure 14) probably to reduce the waiting period for the results which can be a period of great anxiety. Youth testing experience at the study site matches the recommended VCT model with 18.1% of the respondents indicating that the testing experience had changed them to the extent that they intend to practice safer sex.

HIV VCT is also meant to be useful in better understanding of HIV/AIDS and promoting less stigmatization of persons with HIV/AIDS, qualities which can only be nurtured by practically going through HIV testing and related services and information. It is also worth noting that

clients who chose not to come back to the centre because of dissatisfaction are not captured in the clinic settings.

The extent of utilization of HIV/AIDS VCT services at the Rift Valley Provincial General Hospital among the age group 15 – 24 years.

The pattern of service utilization measures the level of awareness, exposure and coverage of the VCT centre in the community and is captured / sourced mainly from clinic records. The target age range for the centre is 15-24 years. According to the clinic records, overall, a total of 1054 youth in this age group received services in the year 2004 out of the total Nakuru District youth (15-24 years) population of 313,189, others could have of course sought for the services elsewhere and not at the study site. The population of those requesting for services is nevertheless still too low. According to the clinic records for the year 2004, there were more female visitors, than male, 519 and 468 respectively, out of which 491 female and 451 male went through HIV testing resulting in a total of 942 tests done in the year, 2004. There were a total of 56 HIV positive results, 46 being female and only 10 male. This means that women in Nakuru District aged 15-24 are 2.5 times more likely than their male counterparts to be HIV infected. This is consistent with other research findings (Nzioka, 2001:71, UNAIDS, 2004:77). The females in this age group also have the highest HIV infection rate of 42.3% as compared to the rest. A total of 67 youth were on repeat visit, 41 being female while only 26 were male (source: clinic record for 12 month ending 2004).

The VCT Centre has a wide range of other services apart from HIV counseling and testing such as free general counseling and information, reproduction health information and services, clinical consultations for STI and other diseases, peer group social activities and pre and post test clubs. Figure 5 shows the services young people received at the centre during the study period. Most youth, 57.9% came for full VCT services which is consistent with the clinic records for the last 12 months of the year ending 2004. Counseling exclusively came second with 23.7% of the respondents. Repeat visitors mostly come for counseling only. The numbers of clients seeing the nurse/counselors per day (15-20) shows the level of awareness. Clients are evenly distributed throughout the day with peak attendance between 3pm and 4 pm in the afternoon which roughly coincides with after school hours. The longest consultations are devoted to VCT counseling with

mean length of visits being 30 minutes and a follow up card after 3 months. According to indepth interviews, service providers believe youth seek HIV test because of risk behaviour, distrust of partners, HIV symptoms and to know ones HIV status in that order. The main reason given for not requesting for services was fear of a positive result which is the main draw back in utilization of the services (Table 14)

Coverage is an important aspect of any HIV/AIDS Prevention Programme. This assessment has revealed that the youth centre reaches less than 1% of young people in the areas immediately surrounding it. It is likely that coverage is far lower in areas at a greater distance from site.

The extent to which the Nakuru Youth VCT Centre has been able to meet/address the counseling and other reproductive health needs of the youth.

The Nakuru Youth VCT is an Integrated site/model managed by the government and supported by NAKADA (National Agency for the Campaign Against Drug Abuse). The centre provides specialized Youth VCT services with the main objective of reducing the incidence of HIV among 15-24 year old by 50% over the next 5 years (Source: Clinic Statement, Service providers). The centre is easily accessible with clearly placed signposts, and youth friendly modern physical structures, (Television, posters). The hours of work are from 8.00 a.m. to 5 p.m., Monday to Friday. These hours are not convenient for school going or working clients. There have been numerous requests by clients to have the centre opened over the weekends. (Source: key informants). The current staff capacity of 6 nurses/counselors, 1 clinical officer and 2 peer counselors, is not adequate. With the recommended counseling sessions of a maximum of 3 – 4 clients per day per nurse/counselor for VCT, it is recommended that 2 additional nurses/counselors and 3 clinical officers be recruited to beef up staffing levels (Source: key informants). Otherwise like any other government facility the staff are fully trained, well qualified and experienced. The centre is coping well with the current administrative capacity. There is adequate space for confidential counseling and testing and capacity also exists for proper records and system maintenance ensuring confidentiality and accurate test results. Confidentiality is further reinforced by locked cabinets and restricted access areas. However, with the anticipated increased uptake of VCT services additional counseling rooms may have to be created.

The two most challenging aspects involved in the operations of the centre remain the technical and financial capacities. The centre depends on the government for supply of HIV test kits, gloves and other medical materials. The supply is not sufficient and is sometime irregular resulting in shortages of even up to 3 weeks during certain periods (source: key informants). There is need for reliable supply of HIV test kits in particular to avoid turning away clients and losing opportunities for HIV/AIDS prevention. It is however commendable that with support from NACADA the centre is running a “one-stop” comprehensive VCT programme that includes education, follow-up counseling, care and support. Through referral from the centre, young people diagnosed with HIV /AIDS can receive free medical treatment from either the comprehensive care centre, psychiatry, or prevention of mother to child transmission (PMCTC). – All these units are located within the provincial hospital.

The young respondents outlined what they want from VCT centres on Table 11. They want counseling, information/advice, warm reception, quick service and above all, youth consider privacy and confidentiality to be primary consideration in determining whether and where to go for testing. At the study site, testing is confidential and anonymous-people are never asked their names or addresses but allocated a number to ensure that they remain anonymous. Further, pre – test and post-test counseling follows UNAIDS guidelines. Pre-test counseling session helps to reduce the shock of a positive results as well as helping people decide whether they really want to have the test. Clients are then given their results almost immediately because the centre has found that people are anxious to know. Thereafter, there is confirmatory testing of positive results after three months. The youth is then referred to follow up services for either prevention or support. At each follow up visit clients receives intensive counseling aimed at behaviour modification. The VCT study site is therefore not only well equipped to respond to youth issues but is responding successfully to youth needs/expectations. Young people want confidential services and full disclosure of test results and the centre is providing exactly that. The centre similarly scored highly on quality of services and service providers attitude and skills in counseling and testing (Table 12)

The topic for indepth interviews were related to quality of service with special attention on youth reproductive health. Majority of the service providers were very knowledgeable in matters

concerning youth and VCT. The vast majority held liberal attitudes regarding young peoples' access to reproductive health information and services. However, a number revealed personal biases in particular a bias towards age of consent for HIV Testing. Of the four service providers interviewed, two felt that young people should get parental consent before obtaining reproductive health information and services. In addition, one felt that providing reproductive health services to Youth leads to increased promiscuity. In fact a key informant accused his colleagues, in particular nurses of having negative attitudes. Such personal biases effectively create barriers to reproductive health information and services and would dissuade a young person from pursuing services when they need them. (It should be noted that age of consent for VCT in Kenya is 18, below this age, counselors determines that the young person has sufficient maturity for testing and other services). The responsibility of determining whether a minor is suitable for VCT or not should not be fully left to counselors, understandably they may be apprehensive about consequences arising out of positive test result communicated to a minor in the absence of statutory backing.

VCT for youth is in demand and will continue to be in demand. In this study 46% of untested respondents said they would like to be tested for HIV in future (Figure 6). Young people want to know their HIV status. Further, 6% of youth attending VCT had not initiated sex (Figure 11). The findings suggest that some young people may know little about how HIV is transmitted or that they use VCT services to get accurate information about HIV/AIDS. This corroborates other research findings (Horizons programmes, 2001). More important, in general, young people who participated believed that the likelihood of being infected with HIV was slight, with majority, 44.4% indicating that they were at no risk of contracting HIV/AIDS. (Figure 13) Yet, their reported sexual risk taking behaviour is high with 13% of the respondents having initiated intercourse between the ages of 10-14 (Figure 11). Also, "Never-use" of condom even with non-steady partners is high, with most respondents, 42.6% falling within this bracket. These two variables – Age at first sex and condom use are indicators of behavioural change and in this study they indicate that there is still room for improvement, particularly when considering bias inherent in self reporting data in relation to sexual behaviour and under reporting of sexual practices. The key informants confirm that the period while waiting for results makes one engage in deep thoughts and is bound to make anyone at least consider the possibility of contracting

HIV/AIDS as a result of risk behaviour. In this study, 18.1% of the respondents indicated that the testing experience had changed their sexual behaviour (to be careful, limit sexual partners).

Interestingly, a youth only service which is a hallmark characteristic of youth centre was not rated as highly important compared to other characteristics. The findings further revealed that the age of services providers was not an issue for youth and that friendly staff rated far higher in importance as a criteria for youth friendliness than age or gender of service providers. This study no longer sees the need to select staff of a certain age to provide services and in certain contexts there may be a role for integrated services (similar to study site) in the expansion of youth and adolescent reproductive health initiatives.

5.1 CONCLUSION

The present study established that community level factors had more significant association/correlation to VCT service utilization than clinic level factors, (Table 16). There was for example, significant relationships between occupation, marital status, residence, feelings about charges, with the most significant being the need to know ones HIV status at $P=0.000$. Clinic level factors were found not to have a significant relationship with VCT service utilization. Variables such as, youth only VCT, was not significant in VCT adoption with the most insignificant being model of VCT at $=0.906$. The hypothesis was thus accepted. In this regard it may be concluded that though the level of awareness, availability and quality of VCT is high (clinic level factors), utilization is usually limited by community level factors.

The theories of Health Belief Model (HBM) is used to explain the study's findings - it can be hypothesized that the reason why a more significant relationship was found between community level factors and VCT service utilization (than between clinical level factors, youth friendliness and VCT service utilization) is because the community is where individuals activate their health seeking/care behaviours and therefore issues such as societal perceptions and acceptances become important factors influencing utilization of VCT services and other health care services in general. It is for this reason that fear of positive HIV diagnosis becomes a major barrier in VCT utilization precisely because of the consequences that go with it – stigma, discrimination and ostracism (community level factors). Further, negative beliefs appear to influence young

people away from the professional sector towards the traditional sector often because they believe they offer more **privacy** and have powerful medicine. **Privacy / confidentiality** was found to be a primary consideration in determining whether and where youth will go for testing and other reproductive health services (Table 11).

In summary, the study clearly shows that there is a high demand for HIV VCT services in communities. This needs to be acknowledged and to be considered. These services are not only opportunity for HIV testing but also a reliable source of information on sexual matters. Access to quality sexual and reproductive health services and information are a matter of human rights especially for youth. Their sexual and reproductive health needs must be met despite conservative and cultural resistance.

5.2 RECOMMENDATIONS

One of the most important lessons that has emerged over the years is that a safe and supportive environment is a crucial element in effective HIV prevention – even when individuals know full well how to avoid HIV infections, factors in the immediate and wider environment play an important role in whether or not they can protect themselves. Aids awareness must be matched with sound programmes that ensure those who need drugs, care and support services get them. Prevention nevertheless must remain a priority intervention that goes beyond individual behaviour change to address the root causes of the epidemic - the social and economic factors that make women, men and young people vulnerable. Reducing obstacles to basic education, information on reproductive and sexual health, increasing primary health care and economic opportunities are central elements in HIV/AIDS prevention programmes.

Key strategies to increase youth uptake of VCT are discussed below and require urgent attention. Lessons from industrialized countries suggest that a “one-stop” shopping model of integrated services – reproductive health and HIV – specific case management is desirable. A “one-stop” shopping model has the advantage of minimizing referrals with all its problems. But this may not be realistic or achievable in many contexts. Flexible appointments, attention to payment services and walk in capacity may facilitate better participation in health services. Strengthening the

health sector as a whole is therefore essential to facilitate better implementation of VCT services. This means strengthening other care and support services including referral networks.

VCT centres should adopt better networking with NGO's who would support them in a variety of ways. The Ministry of Education should also be seen as a major partner of youth VCT centres. This would be an opportunity for both partners to send out the same message, support joint projects and develop strategies aimed at improved VCT outreach to schools and youth groups. Partnerships with various sections of the community will help reduce the stigma attached to HIV / AIDS and the youth. This intervention needs to also be culturally sensitive and appropriate to the defined target population. Key informant interviews regarding timing of client visits suggested the need to restructure the services to accommodate attending after school hours. Although, the KAP of service providers is encouraging, there remains a need to address judgmental attitudes, particularly with respect to premarital sex. This should be a priority in staff training. Service providers must in addition make deliberate attempts to create conducive environments for the youth. Key features of Youth-friendly services include; quality services ensuring same day services/results, confidentiality/ anonymous testing and services, (for example, adequate supply of condoms in dispensers), flexible service costs and readily available care and support services. Finally, VCT programmes for young people are in their first generation with little attention having been paid to evaluating their performance and coverage. This assessment underscored the importance of monitoring performance of programmes and understanding who is being reached with what intervention.

5.3 AVENUES FOR FURTHER RESEARCH

VCT is a dynamic field with ongoing lessons to be learnt. There is need for further research on several aspects of this intervention. A systems approach study attempting to analyze the **structures** and **processes** of the VCT centres with the objective of determining what factors enhances success or which ones deflects the system from its goal is guaranteed to offer valuable information necessary for the survival of this intervention. A countrywide study on the impact of VCT focusing on sexual practice and reproductive health knowledge following HIV VCT is long over due. A comparative study of clients and non-clients of VCT centres in terms of safer sexual behaviour over a long period would be interesting. There is also need to explore options for reducing the costs of VCT services.

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APPENDIX 1

Questionnaire to examine factors determining the utilization of HIV voluntary, counseling and testing (VCT) services as a strategy for prevention and control of HIV/AIDS among the youth (15 – 24 years) at the Rift Valley General Provincial Hospital, Nakuru District.

This questionnaire is strictly for learning purposes and the information obtained from the respondents shall be treated with confidentiality.

Respondent No. _____ Date _____
Residential Area _____

INSTRUCTIONS

1. TICK ✓ THE APPROPRIATE ANSWER
2. STATE WHERE APPLICABLE

TYPE OF VISIT: FIRST _____ FOLLOW-UP _____

SOCIAL – DEMOGRAPHIC DATA

1. AGE ___ YEARS _____

3. EDUCATION (*Tick One*)

Currently in school?

- Yes
 No

2. SEX (*Tick One*)

- Male
 Female

4. LEVEL ATTAINED (*Tick One*)

0. None

1. Primary Incomplete
2. Primary Complete
3. Secondary Incomplete
4. Secondary Complete
5. College / University

5. OCCUPATION (Tick One)

0. Unemployed
1. Casual Worker
2. Farmer
3. Business
4. Salaried employee
5. Student
6. Other-please specify
.....
.....

6. MARITAL STATUS (Tick One)

1. Separated / divorced
2. Widowed
3. Married, monogamous
4. Married, polygamous
5. Steady partner, living together
6. Steady partner, not living together
7. Single

7. PARENTAL PRESENCE IN HOUSEHOLD (Tick One)

Living with:

1. Both parents
2. With one parent:
 - Mother
 - Father
3. None of the parents

UTILIZATION OF VCT SERVICES

8. SERVICE REQUIRED TODAY (Tick One)

1. Information only
2. Counseling
3. Full VCT services
4. Other-please specify
.....
.....

9. WOULD YOU LIKE TO KNOW YOUR HIV STATUS (Tick one)

1. Yes
2. No
3. Already know

10. IF VCT SERVICES REQUIRED TODAY. WHY? (Tick all that apply)

- To ascertain HIV status
- Plan to get married
- Plan to get pregnant
- Plan for the future
- Had blood transfusion
- Pregnant
- Reunion
- Referred by other client
- Referred by health care worker
- Partner ill/died
- New sexual partner
- Tested elsewhere
- Confirm after window period
- Had circumcision

- Intravenous drug use
- My risk behaviour
- Partner risk behaviour
- Feel unwell
- STI symptoms
- HIV related symptoms
- Family planning e.g. condoms
- Other – please specify
-
-
-

11. What factors motivated you to attend VCT?

.....

.....

.....

ACCESS TO VCT SERVICES

12. How did you learn about this VCT site? (Tick all that apply)

- Television
- Radio
- Newspaper
- Poster / sign post
- Pamphlets
- Relative / friend
- Partner / spouse
- Another VCT client
- Church
- Mosque
- Community meeting

- Health worker
- Peers
- Other – please specify
-
-
-

13. How far is this site from your residence? (Tick one)

- Less than ½ km
- Approx. 1 km
- Between 1 – 2 km
- Between 3 –4 kms
- 5 Kms and above

14. Are there charges for VCT services? (Tick one)

1. Yes
2. No
3. Don't know

15. If yes, what are the charges (Tick one)

1. Less than Kshs. 100
2. Between Kshs. 100 – 500
3. Above Kshs. 500
4. Don't know
5. Others please specify

.....

.....

.....

16. What are your feelings about these charges? (Tick one)

1. Cheap

- 2. Fair
- 3. Expensive

17. Where would you prefer to have a VCT service (Tick one)

- 1. At a site near home
- 2. Very far from home
- 3. Any of the above
- 4. Other - please specify

.....

18 Which of the following VCT models would you prefer? (Tick one)

- 1. Mobile
- 2. Stand alone
- 3. Private sector
- 4. NGO site
- 5. Integrated

19. Why would you prefer such a site?

.....

20. Do you prefer a YOUTH ONLY VCT site (Tick one)

- 1. Yes
- 2. No
- 3. Not sure

21. If YES why would you prefer such a site?

.....

22. Where else would you like to be tested. (Tick one)

- 1. Government Hospital/ Clinic
- 2. Private Hospital / Clinic
- 3. Pharmacy

23. Have you had an HIV test before (Tick one)

- 0. No
- 1. Yes, do not know results
- 2. Yes, Negative
- 3. Yes, Positive

24. If yes, what were your reasons for testing?

.....

How many times tested?

.....

Where?

.....

25. What are your feelings about taking tests?

.....

26. If you have been tested before what was the experience like for you?

.....

.....
27. What changes have you made to reduce your risk of becoming infected with HIV?
.....
.....

28. If NOT Tested, why not? (Tick all that apply)

- 1. Am confident that I have not engaged in risk behaviour
- 2. The stress of a positive result
- 3. Others may know my status without permission.
- 4. I might be discriminated against
- 5. Cannot afford the services
- 6. Changed mind
- 7. Want to test later
- 8. Want to test with a partner
- 9. No test kits available
- 10. Not satisfied with quality of service
- 11. Declined to answer
- 12. N/A
- 13. Others - please specify

.....
.....

29. What factors inhibits you from seeking VCT services?

.....
.....
.....
.....

30. Has any of your friends requested for VCT services? (Tick one)

- 1. Yes
- 2. No
- 3. Don't know

31. Why are your friends afraid of visiting VCTs?

.....
.....

REPRODUCTIVE HEALTH NEEDS

32. AGE AT 1ST SEX (Tick One)

- 1. 10 – 14
- 2. 15 – 17
- 3. More than 17

33. Can anyone below 18 years old freely request for VCT services? (Tick One)

- 1. Yes
- 2. No
- 3. Don't know

34. Name two (2) ways to prevent HIV/AIDS Transmission

.....
.....
.....

35. Thinking of your own personal sexual behaviour, do you think your chances of getting HIV/AIDS are (Tick one)

- 1. Small

- 2. Moderate
- 3. Great
- 4. No risk

- 2. After a day
- 3. Immediately

If no risk (4) why? (Tick all that apply)

- 1. Tested, know status
- 2. Abstain from sex
- 3. Limited number of sex partners
- 4. Have only one sex partner
- 5. Have regular medical checks
- 6. Protect self using condoms
- 7. No blood transfusion
- 8. Trust my partner

36. Condom use in the last 12 months

(Tick one)

Steady Partner

- 0. Never
- 1. Sometimes
- 2. Always
- 3. Not sexually active

Non-Steady Partner

- 0. Never
- 1. Sometimes
- 2. Always
- 3. Not sexually active

37. If you went for VCT, how soon would you prefer to have the results? (Tick one)

- 1. After a week

38. Is there someone in your life who can provide you support so you can avoid situations that put you at risk.

Explain

.....

39. Who in your life do you talk with about personal issues such as HIV concerns.

.....

40. What is your perception of the service providers (Tick all that apply)

- 1. Friendly
- 2. Respectful
- 3. Judgmental

41. Are counseling services adequate?

(Tick one)

- 1. No
- 2. Need Improvement
- 3. Yes

42. I felt that the counselor answered my questions fully (Tick one)

- 1. No
- 2. Yes

43. I am comfortable with counselors who are: (Tick one)

- 1. Male
- 2. Female
- 3. Any of the above

44. I prefer counselors who are between the ages of

.....

45. Is confidentiality maintained? (Tick One)

- 1. No
- 2. Not sure
- 3. Yes

46. What did you like about VCT in general (Tick all that apply)

- Confidentiality
- Counseling
- Warm reception
- Quick Service
- Advice / Information
- Others please specify
.....
.....
.....

47. What didn't you like about VCT?

.....
.....

48. I was given the services I requested for (Tick One)

- 1. No
- 2. yes, dissatisfied
- 3. Yes, satisfied

49. On a scale of 1 – 10 (where 1 is least and 10 most) how would you rate the performance of VCT on the following:

Counseling

1 2 3 4 5 6 7 8 9 10

Confidentiality

1 2 3 4 5 6 7 8 9 10

Accurate test results

1 2 3 4 5 6 7 8 9 10

Staffing levels

1 2 3 4 5 6 7 8 9 10

Test kits readily available

1 2 3 4 5 6 7 8 9 10

Given necessary information/services e.g. condoms, drugs for STI to protect against HIV/AIDS

1 2 3 4 5 6 7 8 9 10

Helped me identify ways of reducing my exposure to risk practices

1 2 3 4 5 6 7 8 9 10

Changed my sexual behaviour

1 2 3 4 5 6 7 8 9 10

Staff was helpful and supportive

1 2 3 4 5 6 7 8 9 10

Professionalism (good attitude, skills, qualifications)

1 2 3 4 5 6 7 8 9 10

A staff member greeted me within 15 minutes of my arrival (waiting time)

1 2 3 4 5 6 7 8 9 10

Overall quality services

1 2 3 4 5 6 7 8 9 10

I intend to tell others about this service

1 2 3 4 5 6 7 8 9 10

Thank You for Your Cooperation

50. I was referred to: (Tick all that apply)

- Not referred
- HIV clinician
- STI services
- Inpatient services
- TB services
- PMTCT (Prevention Of Mother To Child Transmission)
- Family planning
- Home/based family care
- Post-test checks
- Ongoing counseling
- Spiritual support
- PLWA Support group (People Living With Aids Support Group)
- Legal services
- Others - please specify

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APPENDIX II

KEY INFORMANT INTERVIEW GUIDE

Service Provider Attitudes / Perception of Youth Friendly Services

- Can anyone below 18 years request for full VCT services?
- What are some of your experiences /challenges with issues such as parental consent and involvements in decision to test, age of consent for VCT for young people and confidentiality.

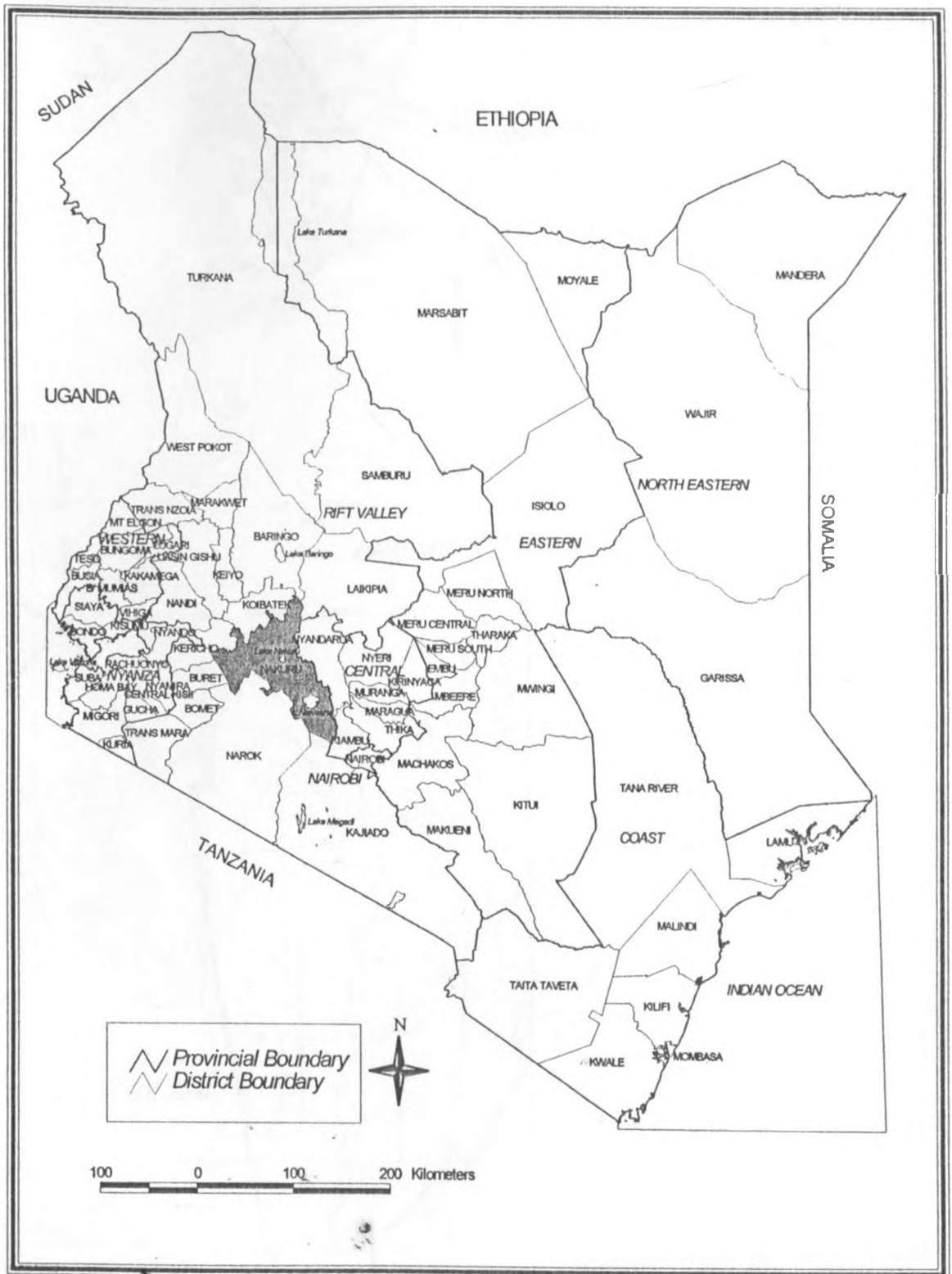
Service Provider Impression Of Same Day Testing

- Describe your experiences when giving same day test results compared to HIV results given several days later.
- What are the challenges and stress associated with giving same day results?
- How confident are your clients in their rapid test results?
 - Acceptance
 - Confidence in test results
 - Impact on behaviour
- Do you believe there is a difference in the risk reduction behaviour following same day results?

Comments about Quality of Service

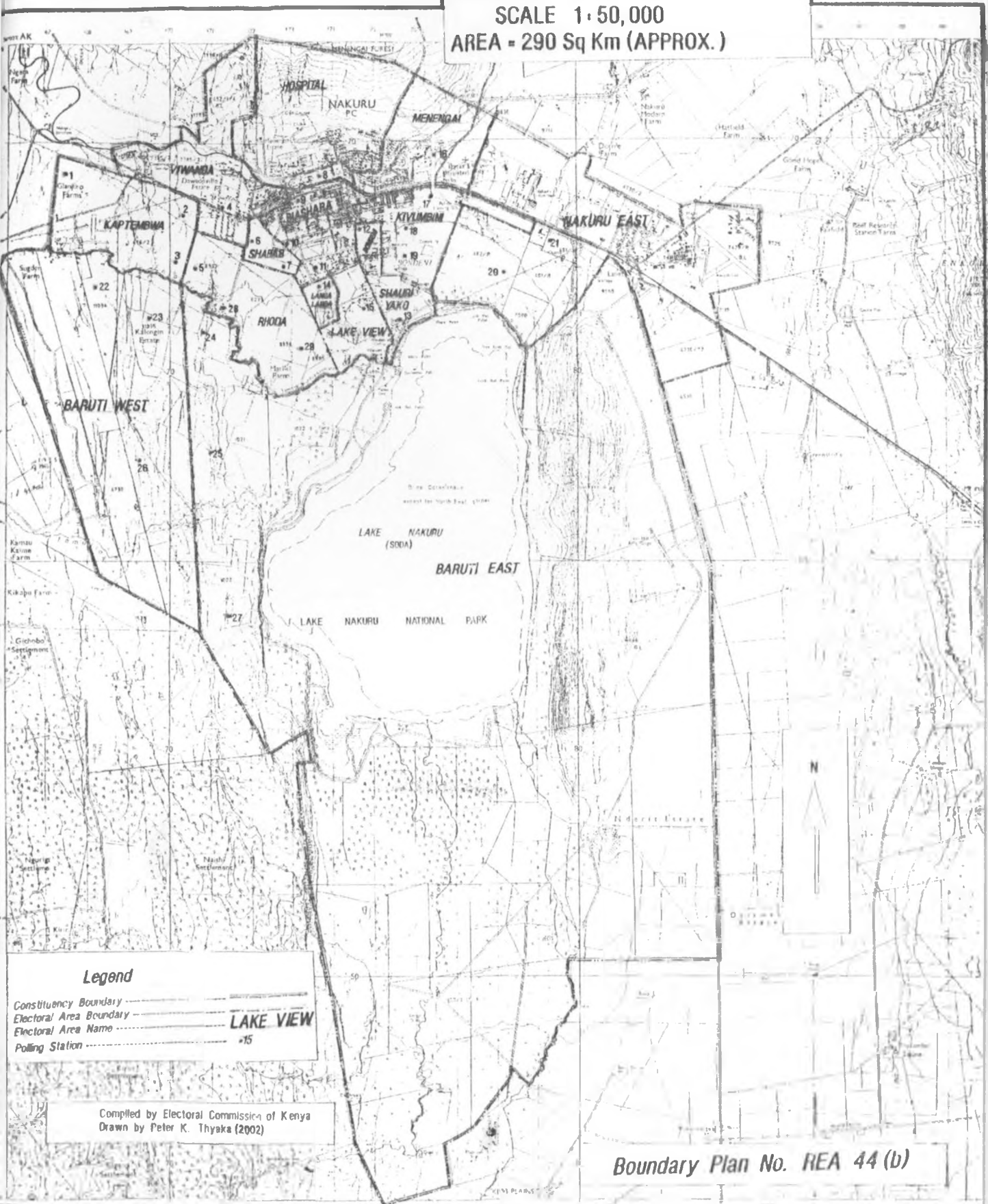
- What concerns do you have about the quality of services at your site.
- How would you enhance the quality of service delivered at your site.

LOCATION OF NAKURU IN KENYA



NAKURU MUNICIPAL COUNCIL

SCALE 1:50,000
AREA = 290 Sq Km (APPROX.)



Legend

- Constituency Boundary ————
- Electoral Area Boundary ————
- Electoral Area Name ———— LAKE VIEW
- Polling Station ———— #15

Compiled by Electoral Commission of Kenya
Drawn by Peter K. Thyaka (2002)

Boundary Plan No. REA 44 (b)



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14
75