

M.A RESEARCH PROJECT

DETERMINANTS OF HEALTH SEEKING BEHAVIOUR AMONG YOUNG WOMEN: A  
CASE STUDY OF VOLUNTARY COUNSELLING AND HIV TESTING PRACTICE IN  
NAIROBI, KENYA. 9

BY:

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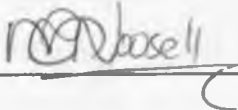


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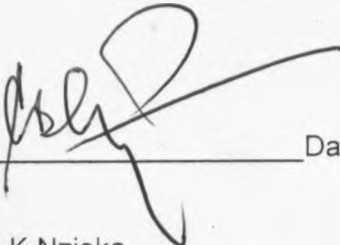
## DECLARATION

The project paper is my original work and has not been submitted for examination in any other university.

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## DEDICATION

This work is dedicated to my husband Peter L'parnoi Lengewa, our children Silantoi Suzanne and Lemayian Shallom for their love, encouragement, patience and support.

It is also dedicated to two exceptional people, my parents Elizabeth and Francis Nooseli who initiated this prolific journey of edification in my life.

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Special tribute goes to Jesus Christ our Lord, the designer and maker of human potential and in whom all wisdom and knowledge is found. And without whom this would be a chasing after the wind.

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## **Abstract**

In Kenya, 80 –90% of infections are among the young people aged 15 to 49 years. 60% of new HIV/AIDS infections worldwide occur among girls and young women aged 15-24 years. (AIDSCAP/FHI, 1996) Women risk becoming infected at a much younger age than do boys. They are vulnerable to HIV biologically, socially, and economically. Gender inequality fuels the HIV crisis among women. (Overall, C and Zion, W 1991)

Based on the current trends and dynamics of the HIV/AIDS virus, all sectors of the society face the challenge of controlling and reducing HIV prevalence. The high level of new infections among young women and their vulnerability is an area of growing concern. This study was occasioned by the reality of the increasing infection in young women, which is not reflected in the policy and program responses. The study undertook to analyse the determinants of health seeking behaviour and VCT practice as they relate the young women.

Due to the high prevalence of HIV infection in young women, the following areas were examined; young women and susceptibility, the HIV/AIDS and STIs risk perception of young women and factors increasing the rate of HIV infection in young women. The issues that were scanned in regard to VCT and young women are issues of demand for VCT, factors that influence the uptake of VCT and possible outcomes and effects of VCT uptake.

Voluntary counselling and HIV testing as a preventive and care strategy and vulnerability of young women, was the focus of this study. The study sought to provide a better understanding of the issues of motivation, knowledge and attitudes of young women on VCT and perceived possible outcomes of the VCT test. While several studies have shown the efficacy of VCT, many questions remain unanswered regarding motivation, how to attract more people to the sites and specifically this high-risk category of young women. Realising that there is a growing tendency for HIV/AIDS programs to focus on VCT it is essential to get accurate and reliable information relating to demand.

The findings reveal that there is a shift from the previous studies that portrayed young women to demonstrate a lack of understanding about key aspects of HIV/AIDS. Contrary

to this their knowledge level is very high and their HIV risk perception is similarly high which has brought about the increase in VCT uptake among this category.

The study further established that increased VCT uptake is determined by high knowledge level about HIV/AIDS and VCT. Availability of care and support services will correspondingly motivate more young women to take up VCT services.

The study found out that the VCT personalised approach with the counselling offered is a motivating factor which needs to be reinforced and further used as a tool for addressing specific issues like family planning, STI services, PMTCT, Condom distribution and other issues as they relate to young women.

The study confirmed that a high level perceived discriminative outcomes of VCT HIV positive results would lead to decreased uptake of service. The study further concluded that VCT uptake among young women increased because of the favourable opinion about the benefits of VCT. Of great significance is that VCT uptake is an effective intervention taken voluntarily by the young women, not for normal HIV diagnostic purposes but as a prevention strategy.



## CHAPTER 1: INTRODUCTION

### 1.1 Background To The Problem

AIDS has become a tragedy of devastating proportions globally. HIV/AIDS affects the productivity and profitability of businesses, with likely economic implications extending well into the future. AIDS creates unique demands at all levels of the society it is a multi dimensional problem. (AIDSCAP/FHI, 1996) It affects individuals during their most economically productive years, and at an age they are most responsible for raising children. By the end of the year 2000, it is estimated that 36.1 million people were living with HIV/AIDS globally. Out of 36.1 million people, 25.3 million live in Sub-Saharan Africa. 2 million are found in Kenya. (NACC, 2000) It is estimated that globally the number of adults and children newly infected with HIV during the year 2000 is a staggering 5.3 million. Statistics reveal that about 15,000 new infections a day occurred in the same year, more than 95% of the cases are in developing countries. (UNAIDS, 2001)

Similarly the global death estimates due to HIV/AIDS, in the year 2000 are estimated to be 3 million. AIDS is responsible for the deaths of 1.5 million Kenyans since the early 1980's, and which left behind 1 million orphans. The cumulative deaths due to HIV/AIDS may rise to 2.6 million by the end of 2005. (NACC, 2000) On the prevalence and spread, the Kenya National Strategic Plan further reiterates that HIV/AIDS spreads rapidly in Kenya mainly through sexual contact, which accounts for 90% of infections. The findings further state that today 47% of the 36.1 million people living with HIV worldwide are women and this proportion is growing.

It is estimated that 7000 young people aged 10-24 get infected with HIV every day globally, that is five young persons every minute. About 1.7 million young people in Africa get infected with HIV every year. Close to 700 000 young people get infected with HIV every year in Asia and the Pacific. (UNAIDS, 2001) In Kenya, 80 –90% of infections are among the young people aged 15 to 49 years. 60% of new HIV/AIDS infections worldwide occur among girls and young women aged 15-24 years. (AIDSCAP/FHI, 1996) Women risk becoming infected at a much younger age than do boys. They are

vulnerable to HIV biologically, socially, and economically. Gender inequality fuels the HIV crisis among women. (Overall, C and Zion, W 1991)

Based on the current trends and dynamics of the HIV/AIDS virus, all sectors of the society face the challenge of controlling and reducing HIV prevalence. The high level of new infections among young women and their vulnerability is an area of growing concern. A number of comprehensive, integrated interventions that would offer the best means of HIV/AIDS control have sprung up. One of these preventive and care strategies, include voluntary counselling and HIV testing, which is the focus of my study.

By knowing ones HIV status, VCT provides people with the skills and knowledge to either remain HIV negative or to prevent further spread of the virus. It involves a pre-test counselling session, the HIV antibody test, a post-test counselling session and an optional follow-up counselling. It is argued, "knowledge is power" (UNAIDS, 1999). If people know their serostatus and are informed about HIV/AIDS, they will prevent themselves from acquiring and transmitting the virus. They will also access care and support services early.

Voluntary counselling and testing has been identified internationally as a priority tool for HIV/AIDS prevention and care. This is according to the UNAIDS top five (5) global priorities. VCT for HIV is now acknowledged within the international arena and in Kenya as an efficacious and pivotal strategy for both HIV/AIDS prevention and care. VCT is included in the National Strategic Framework for the prevention of HIV/AIDS in Kenya, and the Government is fully steadfast to encouraging the provision of VCT services throughout Kenya.

The UNAIDS, 2001 reports that the proportion of people living with HIV who are unaware that they are infected is highest in countries worst affected by the pandemic. It is estimated that two thirds of HIV infections in Africa occur in young people aged 24 years and younger. The report estimates that in Sub-Saharan countries less than 10% of persons infected with HIV are aware of their infections. As a result people unknowingly living with HIV are further spreading the infection unknowingly, and are less likely to adopt behaviours that would reduce further transmission of HIV. They are therefore unable to access care and support services in the early stages of the HIV infection.

HIV/AIDS is now an avoidable fact for Kenya and most Sub-Saharan countries. Majority of Africans infected with HIV have not been tested for HIV and do not know they are living with HIV. (Marum, E., et al, 1997)

The National guidelines for VCT has been developed to standardize the delivery of this service and to assure its high quality and confidentiality. VCT can have broad and specific impacts on the pandemic. According to findings of a study conducted in Kenya, Trinidad, and Tanzania, strong evidence has been provided to support the tenet that VCT is both cost effective and effective as a strategy for facilitating behaviour change. VCT is also an entry point for care and support services. (The VCT efficacy study group 2000)

## 1.2 Problem Statement

Past studies reveal that there is need to address the issue of young women vulnerability to HIV/AIDS. These studies have ignored to understand the issues of demand with regard to VCT and young women. According to the studies the young women's perception of risk of acquiring HIV is very low they correspondingly demonstrate a lack of understanding about key aspects of HIV/AIDS pandemic. It has been identified that most studies have laid more emphasis on the efficacy of VCT but not the factors that have influenced the young women's decision to go for VCT. This is the knowledge gap that has been identified and is the focus of this study.

Another knowledge gap that has been identified is that a lot of emphasis has been laid on adoption of VCT as a preventive strategy. Such studies have not related the preventive aspect of VCT, with the uptake of VCT services, knowledge and attitudes of young women and VCT. A critical analysis of the studies done reveal that increasing numbers of persons want to learn their HIV status. However, do the individuals seeking the test have knowledge of personal risk behaviour which they see a need for change?. The gap identified here is the prevention aspect of VCT vis-a-vis VCT being used for normal HIV diagnostic purposes.

The study therefore seeks to provide a better understanding of the issues of motivation, the attitudes of young women on VCT and perceived possible outcomes of the VCT test. While several studies have shown the efficacy of VCT, many questions remain unanswered regarding motivation, how to attract more people to the sites and specifically this high-risk category of young women. Realising that there is a growing tendency for HIV/AIDS programs to focus on VCT it is essential to get accurate and reliable information relating to demand. The results of the study should provide an understanding of the issues of demand and perceived potential outcomes so that effective programs targeted to the young vulnerable women are designed.

### **1.3 Objectives To The Study**

#### **Broad Objective**

The overall objective of this study is to investigate the determinants of health seeking behaviour in regard to VCT among the vulnerable young women.

#### **Specific Objectives**

1. To establish young women's knowledge and attitudes on VCT uptake.
2. To establish factors which influence the uptake of VCT among young women
3. To understand the possible perceived outcomes /effects of VCT uptake on young women.

### **1.4 Justification Of The Study**

The findings from this study will be used to provide policy recommendations. This is in line with the report by AIDSCAP/FHI, 1996, which indicates that the reality of the increasing infection in young women is not yet reflected in the policy and program responses. According to the literature reviewed it is clear that past studies have focussed on the increased desire to seek HIV tests. There exists scanty literature about demand for VCT in the Sub-Saharan countries where general awareness and public acceptance of the HIV virus is lower. It is clear that the demand for VCT is increasingly becoming popular as HIV infection rates continue to rise. Several studies have shown the efficacy of VCT. However, the question that remains unanswered is the issue of motivation. What motivates young women to seek their HIV status, despite the potential negative social consequences of VCT?

The desire to take the HIV test is evident. More critical however are the underlying factors that prompt this behaviour. The study proposes to add to the limited stock of knowledge on VCT practice in Kenya by documenting the findings. Most studies reviewed have not emphasised on the importance of VCT counselling to address the specific needs of the young women. The study proposes to go beyond what is available and explore the specific issues as they relate to the young women and VCT. This

personalised approach is essential such that young women feel able to participate, that their insights and analysis are valued and listened to and the external factors, the socio-economic and political climate that creates the conditions, which increase women's vulnerability to infection, can be addressed.

Since VCT seeks to personalize the process of risk assessment, establishing the reasons for VCT uptake among young women would be critical so that they can be helped to reduce their vulnerability. Responding to the factors that motivate the young women to take up the test would be crucial factors in enabling them receive prevention counselling which personalises their risk perception. Correspondingly, barriers to the uptake of VCT service and factors that deter young women from accessing the services will be highlighted. This study proposes to provide practical insights into attracting more young women for VCT services so that they receive personalised HIV prevention counselling.

The study will seek to provide an understanding of the issues of demand and perceived potential outcomes so that effective programs targeted to the young women are designed.

The study will also be expected to contribute to research methodology that other scholars and researchers can adopt for future research

## **1.5 Operational Definition Of Key Concepts**

### **Voluntary Counselling And Testing**

VCT is the process by which a person undergoes counselling to enable him to cope with stress and make informed choices about HIV testing. Confidentiality of counselling sessions, test results, and voluntary choice to test are emphasized. It is a client motivated practice, designed for healthy people. Therefore it is not used for diagnostic purposes. It involves a pre-test counselling session, the HIV antibody test, a post-test counselling session and follow-up. Voluntary counselling and testing (VCT) is by definition optional and client motivated. Counselling and testing, based on the centre for disease prevention (CDC) and World Health Organisation (WHO) models, provides an opportunity for people to personalize HIV/AIDS information and to develop individualized risk reduction plans

## **Young Women**

This is a category of females not advanced in age between 15 years to 24 years.

## **HIV Positive Test Result**

This HIV test results where whole blood samples have been tested and antibodies to HIV have been found. The VCT testing procedures do not directly look for the virus.

## **HIV Negative Test Result**

This is HIV test result where whole blood samples have been tested and antibodies to HIV have not been found.

## **Vulnerability**

This is used to denote a position where one can be hurt, harmed or attacked easily. The young women are especially vulnerable because they are found to be weak, and disadvantaged culturally, socially and economically.

## **Attitudes**

These are mental sets, habitual ways of thinking and perceiving persons and events. They incorporate the young women's self image and beliefs about people and things.

## **Risk Behaviour**

This is exposure to dangerous or full possibility of failure, loss or bad happening and the possibility of injuring oneself in regard to exposure and possibility of acquiring HIV. Such happenings may include:

- Unprotected sex with a person whose HIV status is unknown
- Unprotected anal sex
- Practicing commercial sex
- Having many sex partners
- Having sex with someone who has many sex partners

Using shared and contaminated needles and syringes.

## **Uptake Of Service**

This is the act of utilization/consumption/usage of VCT services.

## **Confidentiality**

Confidentiality is when personal information about clients, whether obtained directly or indirectly, is not revealed without the client's permission. This information includes biographical details that may permit the client and the client's HIV test result to be identified.

## **CHAPTER 2; LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

### **2.1 Introduction**

This chapter presents a review of the literature and theoretical framework. The literature review shows demand for VCT, young women's vulnerability to HIV/AIDS, their HIV/AIDS knowledge level, and attitudes on VCT. Factors that influence the uptake of VCT and potential outcomes or effects of VCT have also been discussed. The literature review is derived mainly from studies conducted in Africa.

### **2.2 Demand for VCT**

According to the KDHS, 1998, more than 90% of the Kenyan population is aware of AIDS and knowledge of risk factors, and as a result, there are increasing numbers of persons who want to learn whether or not they have been infected. E. Marum et al, 1997, reveal that 63% of women and 66% of men surveyed indicated a desire for HIV testing. A recent study conducted in May 2000, by the, HORIZONS program, found out that 77% of untested youth indicate a desire for HIV testing in future. The KDHS 1998 reveals that 60.7% of the age brackets 15-19 among those not tested for HIV have expressed a desire to be tested. While 66.3% of the ages 20-24 of those not tested have also expressed the same desire.

Similarly, there is increasing pressure on families and the clergy to request pre-marital HIV test. HIV testing has also gained root among the insurance companies and potential employers. In a presentation made at the proceedings of the consultative technical meeting on HIV VCT in September 2000, it was noted that a survey carried out in Kenya, in 1998, showed that 14% of women and 17% of men reported to have been tested. Two thirds of those who had not been tested reported a willingness to do so.



In countries in Africa with high HIV prevalence, the need for people to learn HIV test results is of extreme importance, both for prevention and for early access to care. (Coates et al 98) It is advocated on the grounds that it provides an opportunity for education and behaviour change. The opportunity for education and behaviour change through VCT would be an important intervention for the young women.

Knowledge of serostatus allows individuals to plan, make important life decisions, and seeks care and support. (Coates et al 1998)

As the prevalence of HIV infection rises in Kenya, and requests for HIV testing increase in the context of clinical care, employment and social institutions, other concerns will arise. The aspect of 'voluntary' will be put to question. That is VCT in relation to fear, prevention, care and support. Likewise, an abuse of testing might arise where VCT could easily be equated to the normal clinical diagnosis of antibody detection the enzyme linked immunosorbent assay (ELISA) test, whose objective is not to trigger behaviour change and make reference to care and support services.

According to the publication by FHI on HIV VCT, the above findings have boosted interest and support for VCT as a valuable component of a comprehensive HIV/AIDS program among International Organisations including the National AIDS program of many countries and donors. The goals of VCT in Africa are to enable individuals and couples to learn the test result voluntarily and in a setting in which confidentiality is strictly maintained. In contrast to HIV testing done for diagnostic purposes, in which a doctor or health worker orders the test, VCT services are often characterised as client-centred, in the sense that individuals request the test voluntarily, often for non-medical reasons, and counselling session is tailored to the clients unique risk issues, rather than a medical discussion of symptoms and treatment (E. Murrain et al 1997).

### **2.3 Young Women And Susceptibility**

Women are becoming infected at a significantly younger age than men: on average, women become infected 5-10 years earlier than men. Proportionally more girls and

young women in their teens and early twenties are becoming infected than women in any other age group. (UNDP) There appears to be a biological susceptibility in women, which changes with age. This publication which was intended to raise issues of importance to the global understanding of the HIV pandemic and the required responses continues to indicate that one in four women aged 20 – 25 attending ante-natal clinics in Lusaka Zambia were infected with HIV. It further revealed that in Zaire the diagnosed women were in average 10 years younger than the men, that there was a sharp peak in AIDS cases in younger women, 20-29years old. Anne Chao; 1991 provides illustrations of the vulnerability of young women when they become sexually active early in life. Anne chaos data from Rwanda observes that the younger the age of first pregnancy or first sexual intercourse the higher the incidence of HIV infection: over 25% of young women pregnant at age 17 or younger are infected and about 17% of those 17 or younger at first sexual intercourse are infected.

The same trend can be observed in the data sets recorded in Kenya (Republic of Kenya, NACC, 2000) which indicates that the prevalence of HIV infection is highest in young women aged 15-25 and peaks in men 5-10years later in the 25-35 age groups. The findings from (PSI, 2001) whose objective was to investigate the motivation and strategies underlying cross generational sexual behaviour revealed that sexual relations among older men and young women (15-19 sexually experienced) were a very common practice in Kenya. It continued to point out that young women engage in sexual relationships with older men in exchange for money to be able to achieve and maintain an upscale lifestyle. The highest perceived risk in this context was the man's wife finding out about the relationship, followed by pregnancy and STIs (syphilis, gonorrhoea). There was little discussion on HIV/AIDS.

According to my opinion this data is disturbing and a lot of concern about young women and HIV need to be called to challenge and change the dominant course of the pandemic and thus the responses. It is important for VCT counselling to address the specific needs of women. Weinreich, 1998, presents results from a study, which revealed that Zambian women were less likely to seek VCT, than men. In Kenya the opposite proved to be true at the UNAIDS/AIDS CAP study site where more women than men actively sought VCT services. (Balmer, 1998)

The goals of sessional paper No. 4 in Kenya, which was adopted by the Kenyan parliament for implementation in 1997, identifies VCT as a major tool for HIV/AIDS control. The goal of the sessional paper on HIV/AIDS is to provide a policy framework within which HIV/AIDS prevention and control efforts will be undertaken over the next 15 years. VCT is one of the preventive strategies that are expected to change the course of the pandemic in young women also. However, according to my opinion, the greatest challenge would be to motivate this vulnerable group whose perception of risk is very low to take up such vital services.

HIV VCT service is considered to be an effective entry point to other support services, such as legal, welfare and spiritual support within the communities, appropriate medical care services for early management of opportunistic infections, and interventions to reduce mother to-child transmission of HIV. In addition HIV counselling has been proven to be an important factor in promoting safer behaviour, and thus preventing HIV. (UNAIDS, 2001 best practice collection)

## **2.4 Risk Perception**

60% of new HIV/AIDS infections worldwide occur among girls and young women aged 15-24 years. (AIDSCAP/FHI, 1996) Women risk becoming infected at a much younger age than do boys. According to (KDHS, 1998) findings, on young women and AIDS, 45.9% respondents from a total of 1827 in the age bracket 15-19, reported having no risk of being HIV infected. 31.7% of the 1537 respondents in the age bracket 20-24% also did not see themselves at risk of getting HIV/AIDS. It is also stated in the same survey that 1 out of 10 men and women do not think that HIV/AIDS can be prevented. This behaviour is contrary to the expected possible outcome in relation to the prevailing prevalence rate of infection among young women of the same age limit.

According to a Horizon report, 2001, the baseline data from Mexico, South Africa and Thailand reveal a complex picture of attitudes and behaviour among the youth. Sexually experienced youth do not appear to see themselves at higher risk than sexually inactive youth, although sexual activity is the primary risk behaviour among these students. For example, 88% of the Thai group both sexually experienced and inexperienced perceive

themselves to be at no to low risk for HIV. A similar trend of risk perception has been reported in a survey conducted by the KDHS, 1998 in Kenya.

According to data from KDHS, 1998, the respondents under age 20 are more likely than older respondents to demonstrate a lack of understanding about key aspects of AIDS pandemic. For example the young women and men were less likely to know about STD, more likely to hold misconceptions about modes of HIV transmissions, less likely to know about where condoms can be obtained, less likely to report multiple sources for information about HIV/AIDS.

## **2.5 Factors Increasing The Rate Of HIV Infection In Young Women**

HIV prevalence among Zambians between the ages of 15-20 is estimated at about 20%, one of the highest in the world. (Horizons program, 1997). In Kenya 60% of the new infection occur among young women aged 15-24 years. Several factors have contributed to these alarming trends of new infections. They include biological, socio-economic, cultural and environmental aspects. Research shows that the risk of becoming infected with HIV during unprotected sex is 2-4 times higher for women than men. (UNAIDS, October 1997). Younger women are at a greater biological risk. Their physiological immature cervix and scant vaginal secretions put up less of a barrier to HIV. The report continues to reveal that tearing and bleeding during intercourse, whether from 'rough sex', rape or prior genital mutilation multiplies the risk of HIV infection.

Throughout the world women run a similar risk from unprotected anal intercourse, preferred because it preserves virginity and avoids the risk of pregnancy, this form of sex often tears the delicate tissues and affords easy entry to the virus. Untreated STI's, multiplies the risk of HIV transmission by up to 10-fold. Between half and four fifths of STD cases in women go unrecognised. (UNAIDS, October 1997) Age at first intercourse is a prominent factor, which places young women at greater risk of infection acquisition. The KDHS, 1998, reveals that the median age at first sexual intercourse for women has risen slowly in recent years from a median of around 16 years among women age 40-49 to around 17 years among those aged 25-29. In Uganda, 30% of women have had sexual intercourse by the age of 15 and 72% by the age of 18. (DHS, 1995)

The vulnerability of women is exacerbated by historical trends, which have removed men from families for lengthy periods of time, increased the acceptability of male sexual activity outside of marital relations, and sanctioned the behaviour of older men to use their wealth and prestige to seek sex with girls and young women. (AIDSCAP/FHI, 1996) The report discloses that the reality of the increasing infection in young women is not yet reflected in the policy and program responses.

Similarly, millions of young girls are brought up with little understanding of their reproductive system or the mechanics of HIV/STIs transmission and prevention. According to the KDHS, 1998, one of the most important determinants of a woman's social and economic status is her educational level. It discloses that in the age group 15-19, 55.3% drop out of school and in the age group 20-24, 32.6% have had incomplete primary school education. 42% reported that they could not pay for fees and the other prominent reasons include pregnancy and marriage. Others have dropped due to pregnancy. According to the survey adolescents who are already mothers are quoted to be at 17%. That is the proportion of adolescents already on the family formation pathway rises rapidly with age, from 3% at age 15 to 45% at age 19. Rural adolescents and those with less education tend to start child bearing earlier. These factors impact negatively on their socio-economic and health status.

In marriage the young woman's autonomy is crippled, she lacks economic resources of her own, which makes important services in the community inaccessible for her, irrelevant or inapplicable. (Gorna, 1996) Lack of economic independence breeds fear of abandonment or violence on the part of their male partner. They are less likely to leave a risky relationship, and less likely to negotiate protection. Young women's economic dependency increases their vulnerability to HIV.

"Women continue to make strides towards equality with men. Wherever they are educated, able to generate income, enjoy equal protection under the law, they are in a position to have some control over their economic, social and personal life. But for millions of women, these goals are still remote. These are the women who are the most vulnerable to infection with HIV, the virus that results in AIDS."(Gorna, 1996)

Failure to respect the human rights of girls and women in terms of equal access to schooling, training and employment opportunities reinforces their economic dependence on men. The reliance may be a "sugar daddy", a husband, a stable partner; prostitution etc. sex in this case is the 'currency' in which they are expected to pay for life's opportunities. Overall and Zion, 1991; reiterates,

"It is of course naïve to regard women, even those who are wives, as mere helpless and vulnerable victims. But neither are they yet to be the social equals of men. To recognize the ways in which women can be deceived, exploited, and harmed by those to whom they are wed is not to fail to see wives as people, it is to recognize that the heterosexual institution of marriage may not work to the advantage of women in the way it works to the advantage of men"

In a patriarchal culture the issues that concern women particularly with respect to reproductive health and sexuality are regarded as specialised, marginal, and less significant. This is evident in the widespread traditional practices, which harm the reproductive or overall health of young women, including child marriage and sexual exploitation by older men of young women and girls. Consequently men have greater control than women over when, where, and how sex takes place. It expands male sexual freedom, in which case therefore women lack autonomy. At the same time, girls are taught to leave the initiative and decision-making in sex to males, whose needs and demands dominate. There is a culture of silence that surrounds sex that dictates that 'good' women are expected to be ignorant about sex and passive in sexual interactions

Cultural norms may favour early pregnancy, discourage the use of condoms or facilitate intercourse with older men who are more likely to be infected. (UNDP\_) The report continues to state that the ability of young women to protect themselves from infection is a function of power relations between men and women. Therefore " individual families and societies must change how they value girls. The more women are valued, the better they will be fed and nurtured, gain access to health services and education, provided with the skills required for economic autonomy and have their rights honoured, in particular to land and property, especially through inheritance"

Biological vulnerability does not mean unprotectability. Evidence from previous studies on the efficacy of VCT (Coates et al 1998), reveal that behaviour change is possible. To be able to influence the young women to take up VCT services it would important to address the issues of uneven knowledge level about HIV among this group. The information to be disseminated part of it would be an exposition into their biological vulnerability. There is need to highlight on personalization of the process of risk assessment in all interventions targeted to young women in order that their risk perception may be increased. Therefore one of the factors that influence the uptake of VCT is the knowledge level, which contributes to the level of risk perception.

In regard to the above stated factors, it is clear that the uptake of VCT services will be determined by empowerment in areas that include economic resources, and socio-cultural aspects. According to my opinion preventing HIV among young women is particularly urgent in Sub-Saharan Africa.

## **2.6 Factors That Influence The Uptake Of VCT**

The maturity and acceptance of the HIV pandemic may have importance on outcomes. This is particularly true for uptake and return rates. In areas where the pandemic is new, ignorance, denial and stigma may be more closely associated to HIV testing than in countries where the pandemic is better established. The method of reporting and confidentiality is considered as a factor that may deter people from accessing services. Especially where people are worried about confidentiality or belong to groups of people that are marginalized or unsupported. The findings of a study by the Horizons program, 2001 reveal that youth want confidential services and full disclosure of test results. They want private facilities that are convenient and comfortable.

Stigma and societal factors or current events may be important factors in different communities. UNAIDS; 2001 postulates that political commitment to HIV prevention and care have led to less discrimination and hence, higher demand for VCT in Uganda. It continues to say that it has been argued that it is the large number of people who have been tested that is a major factor in promoting normalization and reducing stigma and discrimination associated with HIV. In developing countries lack of ARVs and medical and social support services available for people with HIV is reported as a reason for poor

uptake of VCT. (Baggaley et al., 1995) The simple rapid method of testing used in the VCT centres has been a factor of contention with many people arguing that there is a possibility that people may not have adequate time to make an informed and voluntary decision about testing.

Community mobilization and Information, education and communication (IEC) are also considered to be a determining factor in the uptake of VCT services. Unless VCT services are promoted as part of a comprehensive HIV prevention, care and support uptake is likely to be poor. Provision of adequate IEC and community mobilization is thought to be an important element in ensuring uptake of MTCT services associated to MTCT interventions. (UNICEF, 2000) Addressing the plight of young women's vulnerability is key to enforcing the primary prevention for PMTCT.

Poor quality services have been noted to be a factor in the uptake of VCT services. (MOH, Ethiopia, 2000) postulates that there are no private rooms for HIV counselling, the mechanism for quality control is not established, lack trained staff, and majority of sites have shortage of test kits which are delivered to them in shelf short life. It has been noted that the services should match the needs of the target group, including the medical and emotional needs, to maximize client uptake, participation and involvement. There are barriers to changing or modifying sexual behaviour following VCT. It is a complex process that entails interplay of individual, emotional, societal, practical and economic factors. Difficulties may be compounded if people are tested alone and feel unable to share their test results with their partner. (MOH, Kenya. 2001)

Barriers to changing sexual behaviour following VCT as recorded in (UNAIDS, 2001) include aspects like communication difficulties. According to (Dube et al., 2000), without open discussion of HIV status it is difficult to make long-term changes in sexual behaviour to prevent HIV transmission. The difficulties are compounded by the cultural and social taboos surrounding discussions of sexual issues. Young women are often unable to discuss safer sex with their husbands or sexual partners following VCT because of gender imbalances in sexual decision-making.

Many studies have also shown that women have less capacity than men do for making changes in their sexual behaviour. These difficulties arise from factors like the need for



desire to have children, stigma, and economic deprivation. Other factors that may influence the uptake of VCT services include location of services. Young people are more reluctant to seek treatment for STIs for fear of being found out or because the services are unwelcoming. Lack of trust of their sexual partners to remain faithful after having the test is also an issue of contention.

## 2.7 Potential Outcomes And Effects Of VCT

A number of visual and practical consequences of HIV may be important in determining how people perceive their own risk of infection, and hence their willingness to undergo VCT. There are various possible outcomes of VCT both positive and negative. Several positive outcomes of VCT have been presented in the UNAIDS, 2001 report. One of the expected outcomes is prevention of HIV transmission. The successful uptake of VCT will prevent transmission from positive tested to untested or negative partners. It will also prevent mother to child transmission. Similarly it will enable the clients to prevent HIV acquisition by negative tested people from positive or untested partners.

Several studies have been done demonstrating that counselling can reduce sexual risk behaviour significantly. VCT has been found to result in greater behaviour change than health education alone. A multicentre trial in Kenya, Tanzania and Trinidad demonstrated a 40%-46% decrease in reported unprotected sexual intercourse with few adverse psychological effects. In Uganda, at the AIDS information centre (AIC), follow up at 6 months after receiving test results showed a reduction in multiple partners, increased condom use from 10% to 80% and more clients choosing abstinence. In Rwanda, a study of discordant couples showed promising results with the use of condoms increasing from 4% to 57% at one-year follow-up post VCT.

Early and appropriate uptake of services for the positive tested people is another expected outcome of VCT. One of the outcomes is medical care, which comprises the ARV therapies, treatment of opportunistic infections, prevention of opportunistic infections and HIV-associated infections and tumours. Family planning including counselling about reproductive choices is considered to be key to these preventive strategy it is also expected that emotional care will be offered, including individual, couple and family support. The other early and appropriate service to be offered is counselling for positive living, which includes good nutrition, ongoing counselling, disclosure issues and identification of safety networks. Improved coping and planning for the future, legal advice and social support. (UNAIDS, 2001)

For the negative tested people, they will get emotional care, family planning including counselling about reproductive choices and improved coping and planning for the future. Balanced against the advantages following VCT, there are potentially negative social consequences of VCT particularly on women. After a positive test result they may be discriminated against, suffer abuse or abandonment or many serious emotional reactions, psychological distress, stress and depression. According to a study conducted in Nairobi as reported in (Temmerman et al., 1995), seropositive women who received VCT in an antenatal setting reported high levels of negative outcomes. Abandonment and abuse stood out the most in these cases.

Marital break-up was recorded in a study of serodiscordant couples in Kinshasa where couples experienced acute psychological distress, such as threatened suicide, a husband's family chasing the woman from the house and accusations of infidelity. (Kamenga et al., 1991) Several studies have recorded discrimination following VCT particularly for those testing seropositive. Some countries have employment laws that discriminate against people living with HIV. In South Africa the AIDS law project (ALP) acted on behalf of a job applicant who, during 1997, was refused employment by South African Airways as a cabin crew because he was diagnosed of living with HIV.

Discrimination on entry into religious groups and insurance policies is prevalent. In the Education sector some institutions before offering further education require HIV testing. Discrimination in other areas like foreign travel and immigration where some countries require HIV testing prior to issue of visa or entry permit. Discrimination is also imminent in medical treatment. There are several factors that may influence outcomes of VCT intervention. These may include theoretical framework of counselling, content and quality of counselling. (Catalan et al 1995) divulges that "notification of a diagnosis of HIV infection is usually followed by adverse psychological consequences, but the intensity, duration and specific characteristics of the psychological response will vary from person to person, and many factors will influence the development of subsequent emotional reactions and the use of different coping mechanisms"

The number of counselling sessions undertaken and the quality of the counselling sessions is key to influencing positive behaviour change. This may mean that adequate

follow up counselling is essential. Counselling is critical in counteracting the negative effects of positive test result.

Associated support services available to VCT sites are a critical component in this preventive strategy. At times the VCT centres do not have a well-established network for referrals. A VCT centre needs to have referral sites for medical care, social support, emotional support and adjustments, peer support, family planning services, and access to interventions to prevent MTCT.

## **2.8 Theoretical Framework On VCT**

VCT is an approach that has been derived from the body of theories of the 18<sup>th</sup> century psychologists. It is specifically rooted in the cognitive theories. The cognitive theory has shaped the cognitive therapy, which is by definition an active, directive, time limited, structured approach used to help people facing life's challenges. It is based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which he construes the world. (Aaron T. Beck, MD. 1978)

The client learns to master problems and situations that he previously considered insuperable by re-evaluating and correcting his thinking. The pre-test and post-test counselling in VCT is designed to help the client with HIV infection to face the devastating psychological consequences. The VCT counsellor in this case who is a cognitive therapist will assist the client to think more realistically and adaptively in order to make the HIV preventive factor a success.

The systems theory also has a critical role to play in the HIV VCT prevention strategy. A system consists of two or more units that relate to each other in a structural relationship and form an entity whose elements are functionally inter-dependent. It emphasises on the idea of interaction and interdependence of interrelated parts. Thus a system can be viewed as a bundle of relations among interdependent elements that constitute an orderly arrangement characterized by structural integration relational isomorphism. (Talcott parsons)

VCT is specifically targeted to the individuals in the society who are healthy, with no symptoms of HIV. These members of the system who are unaware that they are infected and are unknowingly spreading the infection are interfering with balance in the global system. VCT being a global HIV 5<sup>th</sup> priority preventive strategy has come strongly virtue of the fact that the system cannot function well with AIDS which has become a tragedy of devastating proportions globally.

## 2.9 Hypothesis

The hypothesis as derived from the literature reviewed is as follows:

- A high level knowledge about HIV/AIDS and VCT, including availability of care and support services will lead to increased VCT uptake among young women
- A favourable opinion by young women about the benefits of VCT, and low level of perceived discriminative and adverse effects relating to HIV status may tend to increase the uptake of VCT services within this age group.
- A high level of HIV risk perception among the young women would increase their uptake of VCT services.

## 2.10 Operational Definition Of Variables

At this stage definitions and conceptualisation of variables is important to bring about general agreement about the use of the terms. Conceptualisation is defined as a process through which we specify precisely what we will mean when we use particular terms. The end product of conceptualisation is a specification of a set of indicators. (Barbie, 1995)

Dependent variables

Knowledge and attitudes

Knowledge level refers to a display of facts, information, understanding and skills on HIV/AIDS and VCT this will be measured by presence or absence of correct and accurate information on HIV/AIDS and VCT. Attitudes refer to young women's habitual way of thinking and perceiving VCT uptake. This will be measured by the presence or absence of negative or positive insight on VCT.

Factors that influence the uptake

This will refer to the determinants or influences on an individual on VCT consumption. It will be measured by all factors that motivate a person to use VCT services.

Possible perceived outcomes

These refer to all perceived benefits or shortcomings of VCT consumption by young women. The presence or absence of all benefits and shortcomings of VCT consumption will measure this variable.

Independent variables

VCT uptake

This refers to the act of young women utilizing or using the HIV testing services at VCT centres. The decision to take the HIV test indicates this variable. That is the health seeking behaviour itself.

## **CHAPTER 3: METHODOLOGY**

### **3.1 Introduction**

This chapter focuses on the background to the study area, sampling design and methods of data collection and data analysis. The data used are drawn from a case study of Kibera Self-help Community Program (KICOSHEP), Kenyatta National Hospital VCT clinic (KNH) and four other VCT clinics that were selected at random. These include Langata VCT health clinic, Hurlingham women hospital VCT clinic, Woodly clinic and Masaba clinic. Due to the sensitivity of the research topic the study did not seek to recruit a large sample. It will only focus on the young women because a lot of studies have been done that have indicated their vulnerabilities and urgent policy recommendations and responses need to be adopted to change the course of HIV

infection in young women. The particular method for empirical research depends inter alia on the nature of the research problem and data needed. (Nachmias and Nachmias 92: 198)

### **3.2 Research Site Description and justification**

The study was conducted at Kenyatta National Hospital VCT clinic; Kibera Self-Help Community Program (KICOSHEP), Masaba Hospital VCT clinic, Woodly VCT clinic, Hurlingham Women Hospital VCT clinic, and Langata Health clinic VCT centre.

#### **Justification**

KICOSHEP is a program located in Mashimoni Village in Kibera. It is an NGO that provides VCT services in its five clinics whose main catchment's area is the Kibera slum. The study will be conducted in the above-mentioned clinics, which are either the integrated type of service or free standing. The rationale following my choice is that the two designs would convey unique and different dimensions of findings to the study. One of KICOSHEP'S mandates is to create awareness about HIV among women and to empower them be able to negotiate safer sex relationships. The study's focus is young women therefore this perspective would enrich the findings. Kibera would be a catchments area for young women who are likely to be unemployed or whose economic status is low, educational level and social class are also likely to be low.

KNH VCT clinic, Langata clinic, Hurlingham, and Masaba VCT clinics are referred to as integrated type of service, which is key in the efforts towards fighting Stigma. Due to less stigma associated to this kind of service more young women are likely to seek services from this centre. Due to the location of the sites they are likely to serve a heterogeneous group with varied educational level, income and social class among other variables that describe heterogeneity.

The sites serve a large and varied group of clientele. Nairobi is a cosmopolitan city; it provides a heterogeneous sample of people and a rich cultural diversity. It has a higher proportion of literate people with HIV/AIDS vis-a-vis the smaller towns and rural areas. This allows easy circumvention of the problem of using interpretations and translators, thus reducing the contamination of the data, and also reducing the prospects of

compromising individual privacy and confidentiality. (Nzioka, 97) Due to time factor and costs involved it was not possible to conduct the study throughout the country or throughout all the VCT centres in Nairobi. Therefore the information received is assumed to be representative of the characteristics of Nairobi.

### **3.3 Sampling Design**

Sampling design refers to that part of the research plan that indicates how cases are to be selected for observation. (Singleton et al 1988) In the research site selection, the study used nonprobability sampling. The respondents were included in the sample through systematic random sampling where every third young woman who falls within the age category of 15-24years is interviewed as they come to the clinics. The age was established after they had gone through the reception process. Recruitment of the 50 respondents was done on voluntary basis. Sampling is taking part of, or a portion of the population as a representative of the population or universe. (Kerlinger, 1964:52) Sampling serves the main purpose of avoiding biases in the selection of the sample and to help achieve a maximum precision for a given outlay of resources. (Barley, 1987)

### **3.4 Methods Of Data Collection**

The study obtained primary data through fieldwork. Both qualitative and quantitative methods of research were used. The two methods of collecting data supplemented and complemented each other because both have strengths and weaknesses. The use of different method enhanced the validity of the research findings. (Nachmias and Nachmias 92). Three methods were used in collecting the data.

#### **Questionnaire**

The major instrument for collecting data was the questionnaire. A questionnaire provided for variation and generalizability of the data collected. It collected information that was used to give important statistics. Quantitative method of research was used and hence the nature of questions was of quantitative kind.

The personal interviews with the young women were conducted in the office of the supervisor in charge of the VCT centres and any other rooms that provided for privacy



and comfort. The interviews were done before the pre-test and post –test counselling because the respondents may be overcome by Psychological reactions which come as a result of HIV diagnosis. And may not be willing to divulge any information to the researcher. The researchers spend a considerable amount of time familiarizing herself with both the personnel and clientele of the clinic to quell any suspicions and find acceptance in the clinic. The collection of data was carried out in English and kiswahili where appropriate.

### **Direct observations**

Direct observations were done and notes made on the observation checklist guide. Observation guides were good in confirming claims made by the respondents. Some sets of information are hard for the respondents to articulate but the researcher can be able to observe.

### **Secondary data**

A review of secondary data was done to supplement primary data. Secondary data captures sets of information that were otherwise not captured by primary sources and which are perceived to be relevant to the unit of analysis. Secondary sources of data was acquired from the Ministry of Health, Non-Governmental Organisations like FHI, population council, John Hopkins, WHO, CDC, PSI journals and other relevant documents. Other secondary data will be obtained from U.O.N Libraries. Like IDS, J.K.M.L and the population studies library.

### **Organization Of The Study**

The primary unit of analysis for the project was health-seeking behaviour among young women on VCT. The young women were the respondents.

This is a multifaceted study, which was implemented in three stages:

#### **Stage one:**

Pre-testing the data collection tool

**Stage two**

Administering the questionnaire to the young women, who are the key respondents for this study.

## CHAPTER 4; DATA ANALYSIS

The data collected was keyed into a computer using statistical package for the social scientists (SPSS). Both the descriptive and inferential statistics was used to present and interpret data.

### 4.1 Descriptive statistics

The procedures of descriptive statistics were used to describe and analyse data thereby enabling the researcher to summarise and organise data in an effective and meaningful way by reducing information to an understandable form. They were applied, as a way of categorising variables by summarising patterns in responses of the respondents. This was done by use of frequency deviations, pie charts, tables and percentages.

#### 4.1.1 Biographical data of the young women

The data below in table 1 on the young women's employment status revealed that 60% of the respondents were unemployed it is important to note that an urgent intervention is required to curb the growing levels of poverty among the young women and create financial stability so that their decision making and negotiation on matters of sexual practice is not influenced by this imbalance and financial status. 28% were found to be students while 46% reside in the sprawling Kibera slum. Only 10% of the respondents were married currently, with 28% having children presently and 40% reported to having ever been pregnant. One of the key issues to note is that only 4% of the respondents have more than one sexual partner, this is a safer sexual behaviour that can be reinforced in HIV prevention designed for young women.

The cluster with the highest formal completed education was secondary level form 3-4 which recorded 26%.

Table 1: Employment status

### Employemnt status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unemployed	30	60.0	60.0	60.0
	Casual employment	11	22.0	22.0	82.0
	Self employed	8	16.0	16.0	98.0
	Decline to answer	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

Table 2: Current marital status

### Current marrital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	5	10.0	10.0	10.0
	Cohabiting	8	16.0	16.0	26.0
	Not married not living together with partner	26	52.0	52.0	78.0
	Not married but have more than one partner	2	4.0	4.0	82.0
	Seperated	3	6.0	6.0	88.0
	Deline to answer	6	12.0	12.0	100.0
	Total	50	100.0	100.0	

#### 4.1.2 Knowledge about VCT service

The study revealed that 36% of the respondents learnt about the VCT services from the media and 26% from the billboards. 72% acknowledged that it is valuable to have VCT centres in the communities. Due to the stigma and discrimination associated to HIV/AIDS, 54% of the respondents chose not to inform anyone when they were going for the service. Though at the same time there is a lot of positive move towards destigmatization, which is indicated by 44% of the responses recording that they informed someone when coming for the service. Table 4, 5, 6 and other tables attached at the appendices provide further details on knowledge about VCT services.

Table 3: knowledge of VCT centre

How did you learn about VCT center

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Media	18	36.0	36.0	36.0
Billboards	13	26.0	26.0	62.0
A clinic	5	10.0	10.0	72.0
A relative	1	2.0	2.0	74.0
Friends	10	20.0	20.0	94.0
Some where	1	2.0	2.0	96.0
Decline to answer	2	4.0	4.0	100.0
Total	50	100.0	100.0	

Table 4: Is it valuable to have VCT centre in the community

Is it valuable to have VCT centre in the community

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	36	72.0	72.0	72.0
No	1	2.0	2.0	74.0
Decline to answer	13	26.0	26.0	100.0
Total	50	100.0	100.0	

Table 5: Did you inform anyone you were coming?

Did you inform any one that you were coming

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	22	44.0	44.0	44.0
No	27	54.0	54.0	98.0
Decline to answer	1	2.0	2.0	100.0
Total	50	100.0	100.0	

The study has found out that 78% of the young women volunteered to know their serostatus for non-medical reasons in contrast to HIV testing done for diagnostic purposes, in which a doctor or health worker orders the test. Planning to have children was rated second with 65% of the responses. The young women's partners past sexual behaviour and their own past sexual behaviour was also a subject of concern with the

former rating at 33% and latter 29%. Developing symptoms of HIV/AIDS had 4%, which was the least rated.

Other additional services that the young women expected to get following the test included counselling which was the highest rated with 94% of the respondents. Family planning services came second with 62% of the respondents expecting to get it. 48% expected to get sexually transmitted infection services. The least rated was Anti retroviral treatment/therapy, which got 12% of the responses.

The data above provides a different dimension from the previous findings, which conclude that availability of treatment and ARVs for people with HIV is considered to be a motivating factor for VCT uptake. The evidence shows that only 12% of the young women expected ARV therapy and thereby putting personalised counselling services as the highest motivator for VCT uptake. Providing other services that would benefit the young women like family planning and STI services may also increase demand.

#### **4.1.3 Risk perception**

This section describes the responses of the young women's perception about the risk they are at of acquiring HIV/AIDS. 70% of the respondents acknowledged that the chances are high that they are highly susceptible to HIV infection. This data indicates that the risk perception of young women is very high. 8% were sure that certainly it would not happen to them. This is a big shift from the previous findings that considered young peoples' perception of risk to be low.

In response to the statement that chances are that you already have the HIV virus, 42% respondents thought it could happen to them. This is another indication that the risk perception is high. Another 42% of the respondents were certain it would not happen to them.

Table 6: The chances are that you will get HIV virus

The chances are that you will get HIV virus

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Certainly it will not happen	4	8.0	8.0	8.0
I could happen	35	70.0	70.0	78.0
It probably will happen	8	16.0	16.0	94.0
Declined to answer	3	6.0	6.0	100.0
Total	50	100.0	100.0	

Table 7: The chances are that you already have the HIV virus

The chances are that you already have the HIV virus

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Certainly it will not happen	21	42.0	42.0	42.0
I could happen	21	42.0	42.0	84.0
It probably will happen	6	12.0	12.0	96.0
It almost certainly will happen	1	2.0	2.0	98.0
Declined to answer	1	2.0	2.0	100.0
Total	50	100.0	100.0	

4.1.4 Attitudes on HIV/AIDS and condom use

The responses that follow in the tables below describe the young women's attitudes and beliefs regarding HIV/AIDS. 56% of the respondents disagree with the statement that says people with AIDS are infected because of carelessness. 28% strongly disagree with this statement.

Table 8: People with HIV are infected because of carelessness

People with HIV are infected because of carelessness

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	14	28.0	28.0	28.0
Disagree	28	56.0	56.0	84.0
Agree	6	12.0	12.0	96.0
Strongly agree	2	4.0	4.0	100.0
Total	50	100.0	100.0	

Table 9: whenever you have sex you are the person who suggests using a condom.

**Whenever you have sex you are the person who suggest using condom**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	8	16.0	16.0	16.0
Disagree	10	20.0	20.0	36.0
Agree	15	30.0	30.0	66.0
Strongly agree	12	24.0	24.0	90.0
Decline to answer	5	10.0	10.0	100.0
Total	50	100.0	100.0	

30% of the respondents agreed with the statement that suggests whenever you have sex you are the person who suggests using a condom. 24% strongly agree with the same statement. These findings are very important in informing policies on gender because unlike the common belief that women are powerless, and they cannot make decisions especially in regard to sex, here young women are proving otherwise. In connection to this, 66% of the respondents strongly disagreed with the statement "if your sex partner refuses to use condoms there is little you can do about it". Program responses need to build on this effort of the young women towards self-assertion. 78% of the young women strongly disagreed with the fact that there is little they can do to prevent catching HIV virus. The respondents were further asked if they had any problems rejecting sexual advances from people who do not want to use condoms, 60% strongly agreed that they had no problem at all. 38% indicated that they would have a problem with rejecting sexual advances with people who do not want to use condoms. Many studies have shown that women have less capacity than men do for making changes in sexual behaviour. On the contrary the data above shows a swift focus to solving communication difficulties.



Table 10: If your sex partner refuses to use condoms there is little you can do about it

**If your sex partner refuses to use condoms there is little you can do about it**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	25	50.0	50.0	50.0
	Disagree	8	16.0	16.0	66.0
	Agree	12	24.0	24.0	90.0
	Strongly agree	2	4.0	4.0	94.0
	Decline to answer	3	6.0	6.0	100.0
	Total	50	100.0	100.0	

The findings further revealed that 80% of the respondents agreed that health wise there is much you can do for yourself once you have the virus. 76% of the respondents agreed with the statement that people who always use condoms would not get or give the HIV virus. On the issue of the condom it was found out that 46% of the respondents disagreed with the statement that in the heat of passion they have a difficult time using a condom. However, 50% of the young women agreed that in the heat of passion, they would have a difficult time using a condom.

Table 11: you have no problem rejecting sexual advances from people who use condoms

**You have no problem rejecting sexual advances from people who dont want to use condom**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	14	28.0	28.0	28.0
	Disagree	5	10.0	10.0	38.0
	Agree	15	30.0	30.0	68.0
	Strongly agree	15	30.0	30.0	98.0
	Decline to answer	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

#### 4.1.5 Risk reduction

The following is a summary of HIV/AIDS risk reduction measures taken within two months prior to the study:

## Abstinence

50% abstained from sex in the stated period to reduce their risk or protect themselves from HIV/AIDS. 14% did not abstain from sex and 36% declined to answer.

Table 12: Abstain from sex

		Abstain from sex			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	25	50.0	50.0	50.0
	No	7	14.0	14.0	64.0
	Declined to answer	18	36.0	36.0	100.0
	Total	50	100.0	100.0	

## Condom use

32% used a condom every time they had sex, 10% did not use a condom every time they had sex to protect themselves and 58% declined to answer.

18% agreed that they used condoms more often, with 18% also reporting that they do not use condoms more often. 64% declined to answer. 72% declined to answer if they used a condom for the first time ever. Only 8% used a condom for the first time ever.

Table 13: used condoms every time I have sex

		Used condom every time I have sex			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	32.0	32.0	32.0
	No	5	10.0	10.0	42.0
	Declined to answer	29	58.0	58.0	100.0
	Total	50	100.0	100.0	

## Sexual partner(s)

In an effort towards reducing the risk and protecting themselves from acquiring HIV, 46% of the respondents changed the way they select their sexual partners. Another 46% declined to answer whether they changed or not. 48% reduced or limited the number of sexual partners they have had. 50% of the young women discussed HIV/AIDS with their sexual partner(s). 28% discussed condoms with the sexual partners, 12% did not

discuss and 60% declined to answer. 40% had sex with only one sexual partner. 14% did not have sex with only one sexual partner and likewise 46% declined to answer.

Table 14: changed the way I select my sexual partners

**Changed the way I select my sexual partner**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	23	46.0	46.0	46.0
No	4	8.0	8.0	54.0
Declined to answer	23	46.0	46.0	100.0
Total	50	100.0	100.0	

The indicators above reveal that VCT uptake is important in helping young women reduce risky behaviour and reinforce positive safer behaviour. There is strong evidence that 50% of the respondents abstained from sex as a measure of HIV/AIDS risk reduction. This is an option that can be reinforced in HIV prevention among the young women to reduce their vulnerability. Sexual behaviour change can be promoted to enhance secondary virginity for those who were active sexually. The findings also reveal some significant safer sexual behaviour like limiting and reducing the number of different sexual partners, using a condom every time they had sex, and changing the way they select their sexual partners.

Due to the changes noted it would be important to tailor the information provided to include decision-making skills and other relevant skills to meet specific needs of the young women. Long-term maintenance of behaviour change and consistent reduction in risky sexual behaviour and reinforcement of positive behaviour will be ensured by ongoing counselling and specifically designed support structures that would address specific issues of young women.

#### 4.1.6 Possible Outcomes Of VCT Uptake

##### **Denial, stigma and openness**

It was found out that the young women would not have a problem in disclosing their status if they turn out to be HIV positive. 56% would disclose it to their sexual partners; only 6% will not disclose their serostatus to their partners. 26% will disclose to a spouse

while 24% did not have such a person. 44% will disclose to a brother, 50% to sisters, 36% to relatives and 38% to friends. 38% indicated they would tell a religious leader, 14% an employer, 26% a physician, and 14% a neighbour

#### **4.1.7 Perceived Outcomes of a HIV positive test.**

These findings sought to highlight the possible negative or positive outcomes of a HIV positive result. 38% of the respondents indicated that it would be likely that they will experience physical abuse by sexual partner/spouse. 12% expected break-up in marriage. 28% recorded that they did not expect to be neglected by the family, while at the same time 26% expected to be neglected by their respective families.

Only 10% indicated that the positive result would end up in strengthening of their relationship with spouse/sexual partner. Consequently only 6% of the young women expected to get increased emotional support from employer. 26% expected to get increased emotional support from peers after a positive result, while 30% thought family would disown them.

60% expected increased emotional support from family/relatives. 68% expected a break-up of sexual relations. 74% indicated that peers would estrange them. 26% would face discrimination by employers.

92% were positive that they will seek medical care, 58% would seek counselling for reproductive choices. 94% would seek counselling and positive living while 90% would join support groups. 76% will promote awareness of HIV/AIDS, 50% will abstain from sex and 54% will use condoms every time they have sex.

Denial, stigma and lack of openness about HIV and acceptance of HIV serostatus have previously been acknowledged being major barriers to HIV prevention and VCT uptake. With increased multimedia campaigns on VCT and HIV and availability of VCT services, there is evidence that the young women are more open and able to disclose their HIV status.

Table 15: break up of sexual relations

### Break up of sexual relations

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	34	68.0	68.0	68.0
No	3	6.0	6.0	74.0
Not applicable	5	10.0	10.0	84.0
Declined to answer	8	16.0	16.0	100.0
Total	50	100.0	100.0	

Table 16: Estranged by peers

### Estranged by peers

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	37	74.0	74.0	74.0
No	4	8.0	8.0	82.0
Not applicable	1	2.0	2.0	84.0
Declined to answer	8	16.0	16.0	100.0
Total	50	100.0	100.0	

Table 17: seek medical care

### Seek medical care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	46	92.0	92.0	92.0
Declined to answer	4	8.0	8.0	100.0
Total	50	100.0	100.0	

#### 4.1.8 Perceived outcomes of a HIV/AIDS negative result

The young women had the following responses towards a perceived HIV negative test result.

50% suggested abstinence from sex, 54% would use condoms every time they had sex. 86% indicated that they would ask their sexual partner to come for HIV test to protect himself or herself from acquiring HIV virus. 30% would use condoms more often, 26% would use a condom for the first time ever. 62% showed an indication of changing the way they selected sexual partners. 48% of the respondents will further reduce or limit the number of different sexual partners they will have.

86% will discuss HIV with their sexual partners if they tested HIV negative. 86% will ask their sexual partners to come for VCT HIV test. 72% will discuss condom use with the

sexual partners and 90% will have sex with only one sexual partner. The findings further revealed that 78% would join a support group or posttest clubs.

## 4.2 Inferential Statistics

These allow the researcher to make decisions or references about characteristics of the population based on the findings from sample taken from the population. The correlation tools, measures of association and cross tabulations were used in order to compare the relationship between various dependent variables and independent variables of the study.

### 4.2.1 Hypothesis

Tables 18: knowledge level about HIV/AIDS and VCT, level of perception, cross tabulation

Cross tabs

Is it valuable to have VCT centre in the community \* Level of Knowledge about HIV/AIDS and VCT Crosstabulation

			Level of Knowledge about HIV/AIDS and VCT			Total
			Knowledg able	Not knowledgable	Decline to answer	
Is it valuable to have VCT centre in the community	Yes	Count	26	8	2	36
		% within Is it valuable to have VCT centre in the community	72.2%	22.2%	5.6%	100.0%
		% of Total	52.0%	16.0%	4.0%	72.0%
	No	Count		1		1
		% within Is it valuable to have VCT centre in the community		100.0%		100.0%
		% of Total		2.0%		2.0%
	Decline to answer	Count	11	2		13
		% within Is it valuable to have VCT centre in the community	84.6%	15.4%		100.0%
		% of Total	22.0%	4.0%		26.0%
Total	Count	37	11	2	50	
	% within Is it valuable to have VCT centre in the community	74.0%	22.0%	4.0%	100.0%	
	% of Total	74.0%	22.0%	4.0%	100.0%	

### Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.756 <sup>a</sup>	4	.313
Likelihood Ratio	9.757	4	.313
Linear-by-Linear Association	.746	1	.388
N of Valid Cases	50		

<sup>a</sup> 6 cells (66.7%) have expected count less than 5. The minimum expected count is .04.

**The Hypothesis 1 is accepted**

### Frequency Table

#### Level of Knowledge about HIV/AIDs and VCT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Knowledgable	37	74.0	74.0	74.0
	Not knowledgable	11	22.0	22.0	96.0
	Decline to answer	2	4.0	4.0	100.0
	Total	50	100.0	100.0	

#### Level of perception

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Negative perception	1	2.0	2.0	2.0
	Positive perception	49	98.0	98.0	100.0
	Total	50	100.0	100.0	

#### What do you know about the counselling offered in this clinic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No knowledge	5	10.0	10.0	10.0
	Positive opinion	42	84.0	84.0	94.0
	Negative opinion	3	6.0	6.0	100.0
	Total	50	100.0	100.0	

### Cross tabs

#### Hypothesis one

A high level of knowledge about HIV/AIDS and VCT, including availability of care and support services will lead to increased VCT uptake among young women.

As illustrated above in the cross tabulations, the level of knowledge about HIV/AIDS and VCT was considered very high and rated at 74%. The findings further revealed that the young women's level of risk perception was very high rating at 98%. The counselling service offered at the centres was highly rated as well with 84% of the respondents having a positive opinion about it.

The figures below indicate the level of significance and degree of freedom. The details on this table indicate that the hypothesis has been accepted.



### Critical values of chi-square ( $\chi^2$ )

The numbers in the body of the table indicate how large chi-square must be in order for the result to be significant at the 0.05, 0.01, or 0.001 levels of significance. The degrees of freedom (*df*) is (rows - 1) \* (columns - 1).

<b>df</b>	<b>0.050</b>	<b>0.010</b>	<b>0.001</b>
1	3.841	6.635	10.827
2	5.991	9.210	13.815
3	7.815	11.345	16.266
4	9.488	13.277	18.466
5	11.070	15.086	20.515
6	12.592	16.812	22.457
7	14.067	18.475	24.321
8	15.507	20.090	26.124
9	16.919	21.666	27.877
10	18.307	23.209	29.588
11	19.675	24.725	31.264
12	21.026	26.217	32.909
13	22.362	27.688	34.527
14	23.685	29.141	36.124
15	24.996	30.578	37.698
16	26.296	32.000	39.252
17	27.587	33.409	40.791
18	28.869	34.805	42.312
19	30.144	36.191	43.819
20	31.410	37.566	45.314

Table 19: Counselling services offered

What do you know about the counselling offered in this clinic \* Level of Knowledge about HIV/AIDS and VCT Crosstabulation

			Level of Knowledge about HIV/AIDS and VCT			Total
			Knowledgeable	Not knowledgeable	Decline to answer	
What do you know about the counselling offered in this clinic	No knowledge	Count	4	1		5
		% within What do you know about the counselling offered in this clinic	80.0%	20.0%		100.0%
		% of Total	8.0%	2.0%		10.0%
	Positive opinion	Count	32	8	2	42
		% within What do you know about the counselling offered in this clinic	76.2%	19.0%	4.8%	100.0%
		% of Total	64.0%	16.0%	4.0%	84.0%
	Negative opinion	Count	1	2		3
		% within What do you know about the counselling offered in this clinic	33.3%	66.7%		100.0%
		% of Total	2.0%	4.0%		6.0%
Total		Count	37	11	2	50
		% within What do you know about the counselling offered in this clinic	74.0%	22.0%	4.0%	100.0%
		% of Total	74.0%	22.0%	4.0%	100.0%

### Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.999 <sup>a</sup>	4	.406
Likelihood Ratio	3.531	4	.473
Linear-by-Linear Association	.029	1	.865
N of Valid Cases	50		

<sup>a</sup> 7 cells (77.8%) have expected count less than 5. The minimum expected count is .12.

## **Chapter 5: Summary, Conclusions And Recommendations**

### **5.1 Introduction**

The purpose of this chapter is to recapitulate the major findings, draw salient conclusions and make policy recommendations to policy makers and researchers based on the main objectives. Interest in the study was derived from the need of improving the quality of life of the vulnerable young women by designing programs that are responsive to their specific needs, and hence reduce the infection rate of HIV/AIDS among them. The study explored the determinants of health seeking behaviour in regard to VCT among the young women. It focussed on the young women's knowledge and attitudes on VCT uptake, factors that influence the uptake of VCT among young women. It further sought to understand the possible perceived outcomes of VCT uptake among the young women.

### **5.2 Summary**

The study established that high knowledge about HIV/AIDS and VCT, including availability of care and support services will lead to increased VCT uptake. 74% were found to be knowledgeable about HIV/AIDS and VCT.

It was further found out that a favourable opinion by young women about the benefits of VCT would increase the VCT uptake. The study shows that 84% of respondents had positive opinion about the counselling offered in the VCT clinics. 66% paid for the VCT services. 78% of the respondents volunteered to know their serostatus for non-medical reasons contrary to having HIV testing done for diagnostic purposes.

It was revealed that high level of perceived discriminative and adverse effects relating to HIV status would decrease the uptake of VCT within this age group. The indicators reveal that 38% of the respondents expected to experience physical abuse by sexual partner with a positive serostatus. 74% perceived that a positive result would lead to being estranged by peers. 68% expected break up of sexual relations

However to a great extent some of the respondents had low level of perceived discriminative and adverse effects relating to HIV serostatus. 60% expected to experience increased emotional support from families and relatives. 60% perceived increased emotional support from health professionals.

The study also found out that 58% suggested they would seek counselling for reproductive choices, and 94% would seek counselling for positive living, 90% would join support groups.

Of significance also is the fact that 50% of the respondents considered abstinence after a negative serostatus to reduce risk of HIV/STI infection. 78% revealed that they would join HIV support/post test groups. 86% would discuss HIV with their sexual partners if they had negative HIV serostatus. This to a great extent indicates that sexual behaviour change is possible. More emphasis should also be drawn to sexual abstinence not only on condom promotion and distribution.

A high level of HIV risk perception among the young women would increase VCT uptake. The indicators provide evidence to the effect that the young women have internalised risk. Sexual activity is the primary risk behaviour among these women and the data shows that 98% of the respondents have a positive perception. This is to say that they acknowledged that chances are high that they can be infected by the HIV virus.

### **5.3 Conclusions and recommendations**

The counselling offered at VCT centres, which is considered to be a motivating factor should be made flexible and may need specific adoptions to meet pertinent issues as they relate to young women. It should be part of a comprehensive program that provides ongoing HIV prevention education and information, sexual health education, behaviour change and reinforcement of safer sexual behaviour. Various relevant structures can be designed at different contact points specifically to address issues of young women.

For consistent reduction in risk sexual behaviour and reinforcement of positive behaviour change, there is need to encourage and increase positive parental involvement. 60% of the young women perceived they would get increased emotional support from families and relatives if they tested HIV positive. Therefore comprehensive program responses

need to be designed where parents would play a role not only in care and support but also in mitigation aspects.

Availability of ARVs for people with HIV/AIDS is considered to be a motivating factor for VCT uptake and hence resulting in a greater uptake. There is evidence that to a great extent this factor does not influence VCT uptake in this group of people. There is need therefore to ensure quality counselling and frequent review of performance to ensure satisfaction with the service.

Availability of peer support groups and post-test clubs according to data collected, are important motivating factors in VCT uptake among the young women. Evidence indicates that 94% would seek counselling and positive living. 90% would join support groups. These groups would help people cope following VCT by sharing experiences and providing mutual support. Through the same structures ongoing counselling may be important and promotion of awareness of HIV/AIDS. Due to unemployment, this groups would be a forum to address the unemployment problem by re-designing goals to introduce income-generating activities intended to provide financial support to both HIV positive and negative clients.

The study has revealed that the young women are not deficient in communication and negotiation skills. There is evidence that to some extent the existing gender imbalance in sexual decision-making and negotiation difficulties is being challenged. With 50% of the women abstaining from sex, 32% using condoms every time they sex and other factors. There is need to reinforce the skills and behaviour change noted.

## **Limitations Of The Study**

### **Maintaining confidentiality**

Confidentiality is when personal information about clients, whether obtained directly or indirectly, is not revealed without the client's permission. This information includes biographical details that may permit the client and the client's HIV test result to be identified. Confidentiality is critical in VCT sites because it encourages a relationship in which clients can divulge to the counsellor information and feelings normally to themselves, some of which are often taboo. The study will compromise on counsellor client confidentiality.

### **Financial constraints**

Due to lack of resources it is not possible to carry out a large-scale survey including a wider sample

### **Lack of representativeness**

Given the focused area in which the study will occur, the results may not be applicable to other areas within Kenya. Case studies have problems of analytical deductions. Therefore my sample does not permit me to claim representativeness. Generalizability of the data will be hampered.

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## APPENDIX

### List Of Tables

Table	Title
1	Employment status
2	Current marital status
3	Knowledge of VCT centres
4	Is it valuable to have VCT centre in the community
5	Did you inform anyone you were coming
6	The chances are that you will get HIV virus
7	Chances are you already have the virus
8	People with HIV are infected because of carelessness
9	Whenever you have sex you are the person who suggests using a condom
10	If your sex partner refuses to use a condom there is little you can do about it
11	You have no problem rejecting sexual advances from people who do not want to use a condom
12	Abstain from sex
13	Used condoms every time I have sex
14	Changed the way I select my sexual partner
15	Break up of sexual relations
16	Estranged by peers
17	Those who seek medical care
18	Knowledge level about HIV and VCT, level of perception
19	Counselling services

## Questionnaire

Date of interview: \_\_\_\_\_

Language of interview

English 1

Kiswahili 2

### Introduction of the interviewer

Greetings. I am from the Department of Sociology University of Nairobi, undertaking a study on young women and VCT practice. For the purpose of this study you will be identified through a number therefore all the responses to our questions are confidential. All the information that you provide for the study is kept completely confidential. Your participation in the study is completely voluntary. You may skip any question that you prefer not to answer, but we would appreciate your cooperation. You may ask me to clarify questions or decide to stop the interview at any time.

### Section One

#### Biographical details

1) Residence

2) Occupation

3) Employment status;

1. Unemployed
2. Casual employed
3. Self-employed

4) Age

5) What is the highest formal school you completed?

1. No formal education
2. Primary 1-4
3. Primary 5-8
4. Secondary 1-2
5. Secondary 3-4
6. College
7. University
8. Other, specify
99. Declined to answer

6) What is your religion?

1. Muslim
2. Catholic
3. Protestant (e.g Anglican, Pentecostal etc Specify \_\_\_\_\_)
4. Traditional religion
5. None
6. Other. Specify \_\_\_\_\_

99. Declined to answer

7) Are you currently...? (Read list)

1. Married
2. Not married but living with a sexual partner under the same roof (cohabiting)
3. Not married and not living with a sexual partner under the same roof
4. Not married but with more than one sexual partners and not living with any
5. Separated
6. Divorced
7. Widowed
99. Declined to answer

8) Do you have any children?

---

9) Are you pregnant?

1. Yes
2. No

10) Have you ever been pregnant?

1. Yes
2. No

If yes, what happened to the pregnancy?

## SECTION TWO

### Knowledge Of VCT Service

1) How did you learn about the centre? (Check all that apply)

1. Media (Television, radio, newspaper, magazine)
2. Billboards
3. A clinic (doctor's office, or health centre)
4. Your spouse or sexual partner
5. A relative
6. Friends
7. Neighbours
8. Somewhere else

Specify \_\_\_\_\_

1. Declined to answer

2) Do you think it is a valuable service to have a VCT centre in the communities?

Yes

Specify reasons

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---

---

No

Specify reasons

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3) Did you inform anyone that you were coming?

2. Yes

3. No

If yes who?

Specify \_\_\_\_\_

4) Who paid for you to seek these services?

Specify \_\_\_\_\_

5) What do you know about the counselling offered in this clinic?

Specify

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6) Have you ever taken a HIV test?

1. Yes

2. No

7) What were your main reasons for coming to the centre? (Check all that apply)

1. Your own past sexual behaviour
2. Your partners past sexual behaviour
3. Your exposure to HIV at work
4. Had blood transfusion

5. Taking care of people with HIV and AIDS
6. Volunteered wanted to know your serostatus
7. Developed symptoms of AIDS
8. Going to be tested at work
9. Planning to get married
10. Premarital testing required by the church
11. Planning on having children
12. Planning for the future
13. Planning to have children
14. Others

Specify \_\_\_\_\_

99 Declined to answer

8) What other additional services do you expect to get?

1. Family planning
2. ARV therapy
3. STI services
4. Free condoms
5. PMTCT
6. Counselling
7. Others

Specify \_\_\_\_\_

99 Declined to answer

### SECTION THREE

#### Risk Perception

1) People have different perceptions about the risk they are at for HIV/AIDS. What do you think the chances are that each of the following situations might happen to you?

	Certainly it will not happen	It could happen	It probably will happen	It almost certainly will happen	Decline d to answer
--	---------------------------------	--------------------	----------------------------	---------------------------------------	---------------------------

The chances are that you will get the AIDS virus	1	2	3	4	99
The chances are that you already have the AIDS virus	1	2	3	4	99
The chances are that you will eventually develop AIDS	1	2	3	4	99

2) The following questions ask about your beliefs regarding AID. How much do you agree or disagree with each of the following statements?

	Strongly disagree	Disagree	Agree	Strongly agree	Declined to answer
People with AIDS are infected because of carelessness	1	2	3	4	99
Whenever you have sex you are the person who suggest using condoms	1	2	3	4	99
If your sex partner refuses to use condoms there is little you can do about it.	1	2	3	4	99
There is little a person can do to prevent catching AIDS virus	1	2	3	4	99
You have no problem rejecting sexual advances from people who don't want to use condoms	1	2	3	4	99
Health wise, there isn't much you can do for yourself once you have the virus	1	2	3	4	99
People who always use condoms	1	2	3	4	99

won't get or give the AIDS virus					
In the heat of passion you have a difficult time using a condom	1	2	3	4	99

3) In the past 2 months, have you done any of the following to reduce the risk or protect yourself from HIV and AIDS? (tick all that apply)

	YES	NO	Declined to answer
Abstained from sex	1	2	99
Used condoms every time I had sex	1	2	99
Used condoms more often	1	2	99
Used a condom for the first time ever	1	2	99
Changed the way I select my sexual partners	1	2	99
Reduced or limited the number of different sexual partners I have had	1	2	99
Discussed HIV with sexual partner(s)	1	2	99
Discussed condoms with sexual partner(s)	1	2	99
Had sex with only one sexual partner	1	2	99

## SECTION FOUR

### Possible outcomes of VCT

1) If you test positive for HIV, would you tell any of the following individuals about your test results? (tick one)

	Yes	No	No such	Declined
--	-----	----	---------	----------



			person	to answer
Your spouse	1	2	88	99
Your sexual partner(s)	1	2	88	99
Your brothers	1	2	88	99
Your sisters	1	2	88	99
Your other relatives	1	2	88	99
Your friends	1	2	88	99
Your religious leader	1	2	88	99
Your employer	1	2	88	99
Your physician	1	2	88	99
Your neighbour	1	2	88	99
Other	1	2	88	99

2) If you test positive for HIV and choose to disclose your serostatus, how likely is it that the following might happen to you? (tick all that apply)

	Yes	No	Not applicable	Declined to answer
Break --up of marriage	1	2	3	4
Physical abuse by spouse/sexual partner	1	2	3	4
Increased emotional support from employer	1	2	3	4
Neglected by family	1	2	3	4
Strengthening of relationship with spouse/sexual partner	1	2	3	4
Disowned by family	1	2	3	4
Increased emotional support from peers	1	2	3	4
Discrimination by health professionals	1	2	3	4
Increased emotional support from	1	2	3	4

family/relatives				
Break –up of sexual relationships	1	2	3	4
Discrimination by employer	1	2	3	4
Estranged by peers	1	2	3	4
Increased emotional support from health professionals	1	2	3	4
Seek medical care	1	2	3	4
Seek counselling for reproductive choices (F.P, PMTCT)	1	2	3	4
Seek counselling for positive living	1	2	3	4
Join social support group	1	2	3	4
Promote awareness of HIV/AIDS.	1	2	3	4

3) If you test HIV negative would you do the following to protect yourself from acquiring HIV and other STIs?

	Yes	No	Declined to answer
Abstain from sex	1	2	99
Use condoms every time I had sex	1	2	99
Use condoms more often	1	2	99
Use a condom for the first time ever	1	2	99
Change the way I select my sexual partners	1	2	99
Reduce or limit the number of sexual partners I will have	1	2	99
Discuss HIV with sexual partners	1	2	99
Ask my sexual partner to come for HIV test	1	2	99
Discuss condom with sexual partners	1	2	99
Have sex with only one sexual partner	1	2	99
Join HIV support groups/ post test clubs	1	2	99

## Acronyms

HIV - Human immunodeficiency virus

AIDS - Acquired immune deficiency syndrome

VCT - Voluntary counselling and testing

UNAIDS - Joint United Nations body on HIV/AIDS

USAID - United States Agency for international Development

FHI - Family Health International

PSI - Population Services International

WHO - World Health Organisation

CDC - Centre for Disease Control

UNDP - United Nations Development Programme

KDHS - Kenya Demographic Health Survey

STD - Sexually Transmitted Diseases

STI - Sexually Transmitted Infections

ARV - Anti Retroviral drugs

MTCT - Mother To Child Transmission

IEC - Information Education Communication

KNH - Kenyatta National Hospital