Using gender analysis to build voluntary counselling and testing responses in Kenya

M. Taegtmeyer a,b,* , N. Kilonzo a, L. Mung’ala a, G. Morgan c, S. Theobald b

a Liverpool VCT Centre, Nairobi, Kenya
b HIV and STI Knowledge Programme, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool, UK
c Population Services International, Nairobi, Kenya

Received 24 August 2004; received in revised form 8 June 2005; accepted 9 June 2005

KEYWORDS
HIV; AIDS; VCT; Gender; Equity; Kenya

Summary The rapid expansion of voluntary counselling and testing (VCT) for HIV in sub-Saharan Africa has led to concerns over the quality and equity of the services. Kenya has seen an unprecedented scale-up of VCT, and valuable lessons have been learnt at national as well as at district and community levels. We combined quantitative and qualitative research methodology and showed how the results of gender analysis can be used to develop equity in VCT scale-up. A gender-disaggregated analysis of VCT client data was conducted for the first 8 months of 2003. These quantitative data revealed that despite an increased vulnerability to HIV, women are underrepresented in VCT sites in all settings in Kenya. Our data also showed that women were also less likely to use condoms or to take home condoms after a VCT visit than their male counterparts. Further exploration through in-depth qualitative work with women and men allowed a better understanding of the reasons behind gender differences in Kenyan VCT sites and helped to develop strategies to address gender inequity. We conclude that there is an ongoing need to mainstream gender in monitoring and evaluation strategies to ensure services meet the needs and priorities of all groups.

© 2005 Published by Elsevier Ltd on behalf of Royal Society of Tropical Medicine and Hygiene.

1. Introduction

1.1. HIV and gender in Kenya

The Kenya National HIV/AIDS Strategic Plan 2000–2005 (Government of Kenya, 2000) was developed to provide an HIV policy and institutional framework to implement HIV/AIDS prevention and control interventions. A key aspect of this large-
scale effort is the opening of accessible and affordable testing centres that provide a high quality of service. The establishment of such voluntary counselling and testing (VCT) centres for HIV testing every district of Kenya is a priority in the government’s response to HIV/AIDS, with a commitment to open five sites in every district by the end of 2004.

HIV disproportionately affects women in Kenya, with an estimated 1.8 women infected for every 1 man (Government of Kenya, 2002, 2004). "Gender differences are most striking in young people" (Government of Kenya, 2004). In the 15–19-year-old age group, seven times as many women were infected as men (Government of Kenya, 2004). Economic imbalances, high rates of sexual violence and limited negotiating power around sex and condom use in relationships all contribute to these increased infection rates (Dunkle et al., 2004).

In 2002 the Kenyan National AIDS Control Council disseminated a plan for mainstreaming gender into the National HIV/AIDS Strategic Plan (Government of Kenya, 2002). This additional step has made a key contribution by highlighting the vulnerability of women and the contribution of sexual violence to HIV/AIDS in Kenya. Other HIV services, including VCT, have a responsibility to integrate gender considerations into programmes and interventions.

1.2. VCT in Kenya

VCT is largely aimed at the asymptomatic individual who wants to know his or her HIV status. Those who wish to be tested for HIV go to a site voluntarily and are offered pre-test counselling, on-site rapid HIV testing and post-test counselling. VCT services have been recognised for preventing the transmission of HIV through education, promotion of behaviour change, and as an entry point to care for those who find out they are infected with HIV (The Voluntary HIV-1 Counselling and Testing Efficacy Group, 2000).

The commitment of the Kenyan government to scale-up VCT has been unprecedented in sub-Saharan Africa. At national level, a VCT task force was convened to address issues of writing guidelines, advocacy, site registration, logistics and quality. The National Guidelines for VCT (Government of Kenya, 2001) are used as a basis for setting minimum standards for VCT services. Sites wishing to access free test kits procured by the government must meet these standards and receive a registration code before opening. In the year 2000 only three sites were operational. In June 2002 a mass media campaign was launched to promote services, and by September 2003 over 250 VCT sites had been registered with the National AIDS and STD Control Programme in six provinces in Kenya. The expansion of access to antiretroviral therapy in Kenya, combined with the mass media campaigns, have led to a further rapid expansion of VCT services in early 2004 and in turn to concerns about whether quality and equity objectives are being maintained.

Currently, VCT is offered in many settings, including larger non-governmental organisations (NGO), small community-based organisations, mission hospitals, government hospitals and health centres. Sites located in health facilities that actively make and receive referrals to other health services in the facility are sometimes called 'integrated sites', as without the referral pattern they would merely be 'co-located'. Sites set in a non-medical environment such as residential areas, a shopping arcade or religious building are often called 'stand-alone sites'. All sites are linked by referral to care services and services may increasingly be combined with an HIV specialist care clinic.

A national VCT data form is filled in by VCT counsellors for each client regardless of whether the client is tested for HIV. Each client is issued with a unique client code and 20 multiple response questions are answered on pre-prepared data forms. Basic demographics, services required, risk behaviour and HIV test results (if applicable) are recorded. Additional questions focus on how the client heard about the service and why they came. To ensure accuracy in collecting client data, the number of forms is verified against the number of tests used and the on-site records.

The largest non-government provider of VCT in Kenya is the Kenyan NGO, Liverpool VCT. It currently implements VCT services in 12 stand-alone VCT sites and also gives technical assistance to governmental and other partners in establishing and maintaining over 150 VCT centres. It has worked to ensure that VCT expansion is accompanied by the scale-up of comprehensive quality assurance systems. Facilities are supported to collect and conduct an ongoing review of VCT data broken down by gender. As a result of its work, a national system of quality assurance has grown that is robust and well validated in the resource-poor setting (Taegtmeyer and Doyle, 2003). Data from the Liverpool VCT programme are used in this paper.

1.3. Community mobilisation for VCT

The government, with technical assistance from Population Services International, launched the
Using gender analysis to build responses in Kenya

2. Materials and methods

2.1. Combining quantitative and qualitative approaches to data analysis

All data were drawn from Liverpool VCT project areas with well established VCT sites, using the national VCT data form, registers and monthly summary sheets from the first 8 months of 2003. (All sites therefore reflect a consistent presentation of a wide range of social, cultural and geographical characteristics as well as their varying geographical characteristics as well as their varying HIV prevalence rates. The studies on perceptions of testing and gender-based violence included participants from Nairobi, Central, Coast and Nyanza Provinces, whereas the study on condom negotiation and disclosure included participants from Nairobi and Central Provinces only.

Service users were interviewed in pre-existing groups such as the support groups and in post-test clubs linked to VCT sites. By contrast, potential (or non-) users were sampled and groups were divided by sex and age. Individual interviews were conducted with service providers such as counsellors and healthcare workers, and with opinion leaders such as pastors, Muslim leaders and teachers. Different studies required different participant groups (purposive sampling). For example, users of gender-based violence services were not brought together in a group interview as this would compromise confidentiality and hence raises ethical concerns. In total, 52 group interviews and 87 in-depth individual interviews were conducted (Table 1).

Throughout the fieldwork, flexibility in tools and questions was maintained to maximise the discovery of participants’ own perspectives. Structured topic guides were used to elicit information both from focus groups and in-depth interviews. Examples of key questions from each of the studies are contained in Table 2. Transcripts of focus group discussions (FGD) and individual interviews were re-analysed for similarities and differences among and between the study populations. All three studies undertook a gender analysis (WHO Department of Gender and Women’s Health, 2003) and common themes are presented below.

2.2. Quantitative data

Data were analysed from the national VCT client data form. Client data were drawn from 46 sites—26 located in health facilities and community-based organisations in rural areas and 20 in urban areas. The urban areas included the capital, Nairobi, and the towns of Thika, Malindi, Kitui, Embu, Naivasha and Oyugis. Data from routine client records from January–September 2003 were entered and analysed using Epi 2002 (CDC, Atlanta, GA, USA).

2.3. Qualitative data

Three separate qualitative research studies conducted by Liverpool VCT staff in the year 2003 all contribute to this paper. The studies investigated perceptions of HIV testing, gender-based violence, and attitudes to condom negotiation and HIV status disclosure, respectively (N. Kilonzo et al., M. Taegtmeyer et al., and L. Mung’ala and Y. Mutsunghi, unpublished reports).

Trustworthiness was ensured through the use of different methods for data collection and triangulation of data. For each of the three studies, group interviews and semi-structured individual interviews were performed. The study areas were selected on the basis of their combined representation of a wide range of social, cultural and geographical characteristics as well as their varying HIV prevalence rates. The studies on perceptions of testing and gender-based violence included participants from Nairobi, Central, Coast and Nyanza Provinces, whereas the study on condom negotiation and disclosure included participants from Nairobi and Central Provinces only.

Service users were interviewed in pre-existing groups such as the support groups and in post-test clubs linked to VCT sites. By contrast, potential (or non-) users were sampled and groups were divided by sex and age. Individual interviews were conducted with service providers such as counsellors and healthcare workers, and with opinion leaders such as pastors, Muslim leaders and teachers. Different studies required different participant groups (purposive sampling). For example, users of gender-based violence services were not brought together in a group interview as this would compromise confidentiality and hence raises ethical concerns. In total, 52 group interviews and 87 in-depth individual interviews were conducted (Table 1).

Throughout the fieldwork, flexibility in tools and questions was maintained to maximise the discovery of participants’ own perspectives. Structured topic guides were used to elicit information both from focus groups and in-depth interviews. Examples of key questions from each of the studies are contained in Table 2. Transcripts of focus group discussions (FGD) and individual interviews were re-analysed for similarities and differences among and between the study populations. All three studies undertook a gender analysis (WHO Department of Gender and Women’s Health, 2003) and common themes are presented below.
Table 1 Summary of group and individual interviews

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Perceptions of testing</th>
<th>Gender-based violence</th>
<th>Condom negotiation and disclosure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group interviews</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential users</td>
<td>16</td>
<td>18</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Users</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Service providers</td>
<td>11</td>
<td>0</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>18</td>
<td>4</td>
<td>52</td>
</tr>
<tr>
<td><strong>Semi-structured individual interviews</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service providers</td>
<td>21</td>
<td>36</td>
<td>7</td>
<td>64</td>
</tr>
<tr>
<td>Opinion leaders</td>
<td>18</td>
<td>5</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>41</td>
<td>7</td>
<td>87</td>
</tr>
</tbody>
</table>

Table 2 Examples of questions in group interviews

<table>
<thead>
<tr>
<th>Perceptions of HIV testing</th>
<th>Sexual violence</th>
<th>Condom negotiation, female condoms and disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is VCT?</td>
<td>What does rape mean to you?</td>
<td>What do you think of condoms?</td>
</tr>
<tr>
<td>Do you think it is useful? If so, how?</td>
<td>Is there such a thing as rape in marriage? Why?</td>
<td>Who is responsible for using condoms in a relationship? Why?</td>
</tr>
<tr>
<td>What problems exist in your community in accessing VCT services?</td>
<td>Where can one get help after rape?</td>
<td>Who is responsible for initiating sex? Why?</td>
</tr>
<tr>
<td>Is it easier for some people to come for VCT than others? Why?</td>
<td>Is there a link between rape and HIV? Between rape and VCT?</td>
<td>How are decisions made about sex?</td>
</tr>
</tbody>
</table>

3. Results

3.1. Quantitative data: women are less likely than men to access VCT, to use condoms or to take home condoms

In total, 28,942 records were analysed. 13,073 visits were by women clients (45%) compared with 15,868 by men (55%). Over 20% fewer women attended VCT sites than men both in rural and urban areas. Stand-alone sites in particular attracted a higher proportion of men (odds ratio (OR) 1.28, 95% CI 1.22—1.35), but even health centres, the traditional sanctum of maternal child health and antenatal care, attracted more men than women for VCT services. In total, 93% of attendances were for full VCT (including HIV testing) and 17% of women and 7.5% of men tested HIV positive (OR 2.5, 95% CI 2.3—2.7).

Sexually active women were significantly less likely than men to have used a condom the last time they had sex (OR 0.73, 95% CI 0.68—0.78) and significantly less likely than men to take condoms home after a VCT session (OR 0.7, 95% CI 0.66—0.74). Only 1.5% reported rape to VCT counsellors, consistent with low levels of reported rape in Kenya (FIDA, 2002).

The reasons behind women being less likely to use or take home condoms and to access VCT are explored in turn, using qualitative data.

3.2. Gender and equity insights from the qualitative data

3.2.1. Insights on sexual negotiations and vulnerability to HIV

Most married female clients reported that they would have to obtain permission from their spouses before making any type of sexual decisions such as when, where or how to have sex:

"For me an African woman is not supposed to do those things. It is the role of the man" (married woman, FGD, Nairobi).

Making a decision about condom use is also construed as a male role. Taking home condoms from a VCT session was seen as acceptable for male clients, especially if they had multiple sexual partners. For married women it was quite different:

"Most women would risk having unprotected sex rather than offend their partners by taking home condoms—especially the married ones..."
Using gender analysis to build responses in Kenya

3.2.2. Insights on the barriers to women accessing VCT

A number of themes emerged from the analysis of the qualitative data that can help explain women's lower access to VCT.

3.2.2.1. Asymmetry in decision-making between partners. Gender norms govern the ways in which couples make decisions about accessing VCT. A typical quote follows:

"The woman usually brings the message of VCT home. Like in my case. Then I'll keep asking let's go for a test but we will never go unless he thinks we need to. Once he makes up his mind we go he can even order me out of the house, even if I am in the toilet, and we go there and then." (married woman, FGD, Nairobi).

3.2.2.2. VCT not associated with post-rape care. Whilst there was agreement in all groups in the gender-based violence study that rape is a problem in Kenya and that HIV is sexually transmitted, there were few group participants who explicitly made the link between rape and the benefits of VCT after rape. Rape was associated with a sense of helplessness and withdrawal:

"rape is usually very painful and it takes time to forget and even to lead a normal life." (female adult, FGD, Thika).

"VCT counselling is for HIV not for rape, it would be like telling raped person that they have HIV." (male adolescent, FGD, Thika).

VCT has great potential to be an integral part of post-rape care and a gateway to access post-exposure prophylaxis and ongoing counselling and support. Whilst VCT is not perceived as appropriate for people who have been raped, women and men may miss many opportunities for follow-up care.

3.2.2.3. Married women perceive themselves as 'low risk'. One reason for not being tested was a perception by many potential users that those who go for testing have been involved in risky activities. Married women in particular felt that they were not at risk. A female member of a youth group explained:

"Fear, yeah, but when you know that you have not indulged in some of the habits that lead to HIV contraction you don't need to go for the test." (female adolescent, FGD, Malindi).

3.2.2.4. Gender and stigma: ‘VCT is for prostitutes’. A further obstacle was the association people made between visiting the site and being HIV positive; visiting the centre, regardless of the result, was seen as stigmatising. Some reported that they associated HIV testing with prostitutes and did not want to give people the wrong idea.

One woman shared:

"It's a secret and many people fear to think about their status because of stigma. Someone should go for the result, was seen as stigmatising. Some reported that they associated HIV testing with prostitutes and did not want to give people the wrong idea.

One woman shared:

"It's a secret and many people fear to think about their status because of stigma. Someone should go for the test" (female adult, FGD, Thika).

3.2.2.5. Gender and geographical bias in VCT mobilisation campaigns. The lack of leadership by community members with respect to HIV testing was also noted. Some also reported a lack of female role models. One participant explained:

"Leaders are influential. You see now many of them do not talk about HIV/AIDS to others because they have not gone [for testing] themselves. So I think if the leaders will go the others will choose to go. But then again most of them are men." (male youth, FGD, Nairobi).

Or this rural woman:

"In rural areas the billboards should not show pictures of rich people from town. Where is the tomato seller in the market who says to her neighbour 'please mind my stall. I want to fetch my husband and we go for VCT'?'" (married woman, FGD, Thika).
This Thika VCT counsellor explained:

"I have issues with mass media depicting couples counselling as only for the few who have big dreams, laptops and MAs (i.e. Masters degrees).

How many of our women have that?" (female VCT counsellor, in-depth interview, Thika).

4. Discussion

The mainstreaming of gender equity in VCT scale-up means being responsive to the issues that emerge from the analysis of gender indicators. Gender disaggregation of data should be built into the reporting cycle, allowing gender disparities to be easily picked up and further explored through rigorous and trustworthy qualitative work in a dynamic interplay.

The complementarity in research approaches used in this paper allows the impact of gender issues in VCT scale-up to be better understood.

Quantitative analysis of data from 46 VCT sites revealed that despite increased vulnerability to HIV infection and higher rates of seropositivity amongst women, they are not attending VCT sites in Kenya as often as their male counterparts. Women are also less likely to take home or to report the use of condoms. These differences are particularly marked when seen in the light of national statistics indicating almost twice as many women as men are infected. The gender disaggregation thus highlighted concerns for the programmer such as "What are the barriers to VCT access for women?"; also "What makes it difficult for women to take home condoms?" and "Are women being targeted appropriately?" Qualitative exploration revealed that stigma, societal norms that dictate how 'good girls' or 'married women' should behave, lack of negotiating power in relationships and rape in marriage are barriers to the uptake of VCT by women in all settings.

The Liverpool VCT Programme has used these results in Kenya to re-examine VCT structure and delivery and to ensure that VCT scale-up is gendered. Counsellors in training discuss the gendered nature of sexual power relations, enabling them to better support clients in strategies for sexual negotiation and condom use through counselling. Since men constitute the larger number of VCT clients, counsellor training can also be seen as an entry point for strategies targeted at men, such as breaking down barriers around sexual communication.

The results have also fed directly into a number of programmatic responses (Garcia-Moreno, 2002; Martin and Curtis, 2004). First, the opening of comprehensive post-rape care services linked to three district hospital VCT sites in Kenya. In Thika District Hospital the rate of reporting rape was 10 times higher in the 3 months following the introduction of comprehensive post-rape care services than reporting of rape to VCT counsellors in the 3 preceding months. Counsellors have also started the active promotion of female condoms through femidom demonstrations in VCT rooms. Twelve VCT sites started free distribution of femidoms, increasing choice and control for female VCT clients (Gollub, 2000). The response so far indicates a need for the active promotion of this female-controlled method through mass media, government commitment and free distribution, as has been the case for male condoms.

5. Conclusion

National policy in Kenya has already accepted the need for developing different service modalities such as health centre-based and mobile services to try to address gender and geographical barriers. However, the lessons learnt from this study about women’s ability to negotiate sex, condom use and disclosure of HIV status are relevant to future mobilisation strategies to improve the uptake of VCT by couples and point to the need for specific promotion campaigns and programmatic responses in Kenya that tackle gendered stigma associated with VCT. The paper has demonstrated that gender analysis can build more responsive and equitable VCT services.

Conflicts of Interest statement

The authors have no conflicts of interest concerning the work reported in this paper.

Acknowledgements

The authors gratefully acknowledge the support and assistance of our colleagues Yonulter Mutsungah of Liverpool VCT Centre and Vicki Doyle of Liverpool Associates in Tropical Health who were involved in aspects of this study and commented on previous drafts. The HIV/AIDS Knowledge Programme, Liverpool School of Tropical Medicine, is a collaborative programme funded by the Department for International Development, UK, to develop ‘knowledge for action’ in the field of HIV/AIDS prevention and care and funded the situation analysis of post-rape care. The Liverpool VCT Centre, Nairobi, through support from CDC, Kenya, and the DFID through Futures...
Group Europe funded all other aspects of the study.

References


