Exploration of Attitudes Individuals Hold towards HIV Testing and Treatment in the Use of Antiretroviral Therapy (ART) in Kisii Central Sub-County, Kisii County, Kenya

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Abstract: Recent studies indicate that the HIV incidence in Kenya just like in many countries of the world is generally either stabilizing or declining due to implementation of strategies which have shown potency to control the pandemic. However, in certain regions of Kenya which include Kisii Central Sub-county, the HIV incidence is still on the increase. This study, therefore, attempted to investigate the correlation between demographic factors and willingness to test and start treatment for HIV; To address the research problem, the study adopted a descriptive survey design and employed three research instruments—a questionnaire to collect data. The study was conducted in Kisii Central Sub-County between June and October 2016. To achieve the objectives, the study employed triangulation of data sources. Using multiple stage sampling strategies, 407 participants were sampled from the population. Reliability was determined through the test-re-test method in a pilot study while validity of the data collection instrument was established by the two supervisors. Both qualitative and quantitative methods were employed in analyzing data. Quantitative data was analyzed using inferential statistics by the help of the Statistical Package for Social Sciences version 20.0. The study found that females were more likely than males to hold favorable attitudes towards HIV testing and treatment and that majority of the participants preferred employing professional counsellors and peer mentors for better life outcomes. Arising from the findings and conclusion reached, the study recommends a need in undertaking further work in determining why individuals are willing to test for HIV but unwilling to start treatment early.

Keywords: HIV/AIDS, attitude, treatment, testing, prevention

1. Background to the Study

In 2018, 770 000 people died from HIV-related causes globally. There were approximately 37.9 million people living with HIV at the end of 2018 with 1.7 million people becoming newly infected in 2017 globally. 62% of adults and 54% of children living with HIV were receiving lifelong antiretroviral therapy (ART) in 2018 (WHO, 2018).

According to UNAIDS (2016) more than 78 million people have contracted HIV in the past 40 years; about half (35 million), of whom have died of AIDS related illnesses. In addition, the pandemic has orphaned approximately 17 million children having lost one or both parents and currently about 3.4 million children aged 15 years and below are living with the virus. The pandemic has further resulted in an alarming dependence burden especially considering that those dying constitute the most active segment of the population.

Virtually no country in the whole world has, in one way or another, escaped the impact of the HIV pandemic – implying a global presence for the pandemic (UNAIDS, 2016). Yet, in terms of distribution and spread, HIV shows a notable regional variability. For example, in 2015, Sub-Saharan Africa (SSA) was home to 22.5 (61.3%) million people out of 36.7 million people infected with HIV globally. UNAIDS further notes that majority of these people lack access to medicines.

Health psychology, sociology and social psychology boast of several theories that can be employed to explain the relationship between knowledge, attitudes, skills, and social and environmental influences on one hand and behaviour on the other. For example, to explain how an individual succeeds in changing behaviour, the health belief model theories posit that an individual must first believe that behaviour change is not only possible but also beneficial. In addition, the individual must believe that the advantages of making behaviour change counterbalance any implied disadvantages (Rosenstock, Strecher, & Becker, 1988).

Apart from belief, one needs to consider one’s source of influence since there are a number of sources. Generally, sources of influences for behavior change are divided into two: internal and external. In this context, internal influences include knowledge and attitudes whereas external influences include social and environmental factors (Luszczynska & Schwarzer, 2005). For example, social cognitive theories posit that social factors such as parental views on drug abuse, drug taking habits of peers, availability of economic resources to purchase drugs as well as environmental factors might play a key role in influencing adolescent adopting drug abuse behaviors. Therefore, researchers utilize such principles of behaviour change theories to identify personal and social correlations of drug abuse habits as well as physical activity behaviors.

Considering that self-efficacy is among key determinants of behaviour change; to promote it, researchers recommend the use of motivational education techniques (Bakracevic & Licardo, 2010). As a result, behaviour change support
that HIV testing and counselling (HTC) is a critical requirement for those infected to seek health care services and treatment.

If used well, ARTs have a tremendous impact. For instance, Cohen et al., (2011) reported a transmission reduction of up to 96% among HIV discordant couples using ARTs. Moreover, to control the generalized epidemics, universal HIV testing and immediate antiretroviral treatment should be employed (Audet et al., 2012) since it is expected to result in a major impact on the tuberculosis linked to the HIV pandemic (Harries et al., 2010).

Despite HTC playing a crucial role in HIV programming, coverage in the SSA region remains low. For instance, statistics for the SSA region measuring testing coverage in population-based surveys for the period 2007 – 2008 were very wide. Coverage ranged from 3.2% and 4.9% for women and men respectively in Liberia to 56.7% and 43.0% in South Africa (WHO – UNAIDS – UNICEF, 2009). This is an indication that there exists barriers to HTC depending on the settings and stage of the epidemic that include lack of access to free testing and low risk perception (Nakanjako et al., 2006), stigma, discrimination and negative perception of testing services (Kalichman, Cain, & Simbayi, 2010), concerns about confidentiality and shortage of counsellors as well as delays in returning test results (Matovu, 2007), and, cost of transportation (Wanyenze et al., 2006).

Most recently, Kenya has focussed on HTC as a major feature of the HIV response arguing that HIV testing is the gateway to seeking treatment. Towards that end, Kenya has adopted various strategies whose roots can be traced to HTC. Such strategies include the integration of HTC in antenatal care, STIs, sexual and reproductive health services, home-based testing and counselling, provider initiated testing and counselling (PTC), and outreach testing and counselling (OTC) (NACC, 2014).

The impact of these interventions has dramatically increased HIV activities. For example, in the year 2000 there were just three VCT sites compared with over 4,000 sites ten years later. At the same time, whereas 860,000 people tested for HIV in 2008, five years later the number had increased to 6.4 million people (NACC, 2014). It therefore follows that both the number of testing sites and people being tested for HIV had increased greatly. Although, annual testing rates have nearly doubled since 2008, there are still significant gender differences. In 2014 for example, more women (53%) than men (45%) had tested for HIV (KNBS, 2015). Therefore, to improve the testing rates among Kenyans, men in particular, community-based testing programmes need to be implemented as they have proved successful (UNAIDS, 2012).

As a result of implementing HTC, there has been a substantial increase in coverage among both the general population and pregnant women. For example, among pregnant women, testing for HIV increased from 68% in 2009 to 92% in 2013 (NACC, 2014). Similarly, studies examining the relationship between testing and HIV related stigma and discrimination, have come to acknowledge that stigma plays a much bigger role as a barrier to testing uptake than it was thought before (Hesketh, 2005; Sambisa, Curtis,
This is because stigma has the ability of making people hesitant to get tested (Chimoyi et al., 2015), thus,occasioning many infected individuals to likely be unaware of their HIV status thereby putting their sexual partners at risk of contracting the disease.

Besides, stigmatisation can result in detrimental actions and negative thoughts among HIV actors such as governments, health care providers, employers, communities, family members and colleagues (Zierler et al., 2006). But, more importantly, their actions are likely to lead to a number of health consequences for PLWHA; among them, low self-esteem, isolation, loneliness, identity crises and lack of interest in taking preventative measures due to low care seeking behaviours (Altman et al., 2012). Furthermore, lack of participation in VCT is likely to result in many pregnant women for example, ignoring HIV testing (Foner, Denison, Kennedy, Reilley, & Sweat, 2012; Teklehaimanot, Teklehaimanot, Yohannes, & Biratu, 2016)

Another factor affecting HIV testing coverage is the attitudes individuals hold towards testing. In an exploratory study to determine whether attitudinal differences exist between HIV testers and non-testers, Solorio, Forehand, and Simoni (2013) employed qualitative interviews to assess the beliefs and attitudes of 54 Latino immigrants in Seattle, Washington. The study found respondents to be at risk for HIV and delayed diagnosis as over one-third of them had never tested for HIV and that most of the non-testers were more likely to be MSM.

Additionally, the study found out that women had less knowledge about HIV risks and therefore considered their sexual behaviours risk free, thereby deflecting the HIV-related stigma. Furthermore, it was more likely to self-identify testers as gays. It was observed that both the MSM and gays avoided HIV testing for fear of test results turning positive. Moreover, both groups entertained the belief that family members held negative attitudes towards HIV testing and there was a high likelihood for confidentiality to be compromised if a Latino staff served at the HIV testing sites.

To protect themselves from open ridicule, some population groups sometimes prefer testing for HIV using methods that guarantee confidentiality. For example, studies have found preference for rapid HIV home testing method by majority of the gay men and they cite discretion, convenience, accessibility, rapid provision of results, increased privacy, confidentiality, and anonymity as a justification for their choice (Bilardi et al., 2013; Greacen, 2013).

Individuals opposed to this method contend that rapid HIV home testing raises many concerns including lack of immediate professional support in the event the results turn positive (Bilardi et al., 2013), perceived uncertainty about its accuracy (Sharma, Sullivan, & Khosropour, 2011), dissimilarity with a sexual situation and associated costs (Carballo-Dieguez, Frasca, Dolezal, & Balan, 2012). However, the potential for use associated with the approach may include the following factors: high-risk sexual behaviour(s) that require frequent testing (Bavinton et al., 2013; Greacen, 2013; Sharma, Sullivan, & Khosropour, 2011), encouraging the desire for not seeing a doctor for HIV counselling (Bavinton et al., 2013), residing in rural and upcoming urban towns, and the desire for exceptional confidentiality (Chen et al., 2010; Greacen, 2013).

In spite of the method individuals resort to, it seems clear that the greatest consideration is whether the results of the test can be kept confidential. For instance, a study examining PITC for HIV in poor clinical settings found 98% of the women having heard of HIV and AIDS compared with 60% assessed as having good knowledge on risk factors associated with HIV transmission. Despite the good knowledge, 48% of them were unaware of the PMTCT, and 97% considered themselves as being risk free to contracting HIV, thereby resulting in only 57% having tested for HIV. Although, most women (85%) were willing to test for HIV, their primary concern was confidentiality due to the fear of how their husbands, parents and the community would react (Hensen et al., 2012).

While accurate knowledge of the disease increases the chances of testing for HIV, there are other factors that prevent individuals from doing so and they depend on the type of population group one is looking at. For example, studies on HIV testing rates and outcomes have found confidentiality, disclosure and consent issues to be among the most frequently encountered barriers in HIV testing (Hyden, Allegranze, & Cohall, 2014; Peralta, Deeds, Hipszer, & Ghalib, 2007). Similarly, a study that examined the acceptability of voluntary counselling against HIV testing conducted by Ekanem and Gbadegesin, (2004) found a majority (89.9%) of the Nigerian women attending antenatal clinic having good knowledge of transmission pathways, but poor knowledge on PMTCT as well as the relationship between breast milk and HIV transmission by nearly half of the respondents.

Since HIV testing serves as a gateway for people becoming aware of their HIV status, it is also unavoidably the first step towards prevention, care and treatment. Available research evidence shows that HIV-testing brings about behavioural change and reduction of infection risk as well as worry over possible infection. At the same time, testing makes it possible to safely disclose one’s infection status and allow for future planning (Foner et al., 2012; Nunn et al, 2012). The dangers of being ignorant about how one contracts the disease, how to prevent or treat it, how it is transmitted in the community, stigmatization and discrimination poses a higher risk of opportunistic infections which may lead to early death. It is in this context that the study investigated willingness to test and start HIV treatment.

2. Methodology

This study employed a mixed methods approach from a descriptive survey design. Such an approach was adopted because the primary goal was to assess a sample at one specific point in time without manipulating the independent variables. The study preferred a descriptive survey design because it facilitates data collection from a large section of the population fairly quickly and relatively easy, at a given point in time (Westenholz-Bless & Achola, 2007). The choice was also informed by the inherent ability of the
primarily on prior research which had established that the general population in Kenya had a high knowledge of HIV/AIDS (NACC, 2014).

The study demanded either the making of the assumption or a determination of the participants’ HIV knowledge level since attitudes are more often influenced by the amount of accurate knowledge one has on a subject. The knowledge as well as the attitudes held by an individual about or towards certain behaviours influences them to behave in particular ways. Therefore, being aware of the level of knowledge and attitudes held by the general population provides an understanding of what may motivate individuals to agree to abandon behaviours that are risky and adopt safe ones.

To investigate the participants’ attitude towards HIV testing and treatment, the study asked participants to indicate their willingness to test for HIV and start treatment. The number of responses for each variable investigated varied per the participants’ demographic characteristics. Table 4.18 summarises the number of participants that responded to the two issues based on the demographic characteristics.

Table 4.18: Willingness to Test and Treatment HIV

<table>
<thead>
<tr>
<th>Variable</th>
<th>Test</th>
<th>%</th>
<th>Treat</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>353</td>
<td>96.4</td>
<td>349</td>
<td>95.4</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>354</td>
<td>96.7</td>
<td>350</td>
<td>95.6</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>353</td>
<td>96.4</td>
<td>349</td>
<td>95.4</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>352</td>
<td>96.2</td>
<td>348</td>
<td>95.1</td>
<td></td>
</tr>
<tr>
<td>Income Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>307</td>
<td>83.9</td>
<td>307</td>
<td>83.9</td>
<td></td>
</tr>
<tr>
<td>Residential Location</td>
<td>348</td>
<td>95.1</td>
<td>344</td>
<td>94.0</td>
</tr>
</tbody>
</table>

Table 4.19: Demographic Characteristics versus Test & Treatment Willingness

<table>
<thead>
<tr>
<th>Variables</th>
<th>Demographic Responses</th>
<th>Testing Attitudes</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>N (%)</td>
<td>No.</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 24</td>
<td>172</td>
<td>166 (96.5)</td>
<td>163 (94.8)</td>
</tr>
<tr>
<td>Between 24 &amp; 49</td>
<td>176</td>
<td>171 (97.2)</td>
<td>171 (97.2)</td>
</tr>
<tr>
<td>Over 49</td>
<td>16</td>
<td>16 (100)</td>
<td>15 (93.8)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>154</td>
<td>150 (97.4)</td>
<td>146 (94.8)</td>
</tr>
<tr>
<td>Female</td>
<td>211</td>
<td>204 (96.7)</td>
<td>204 (96.7)</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>182</td>
<td>178 (97.8)</td>
<td>175 (96.2)</td>
</tr>
<tr>
<td>Rural</td>
<td>177</td>
<td>170 (96.0)</td>
<td>169 (95.5)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>184</td>
<td>178(96.7)</td>
<td>172(93.5)</td>
</tr>
<tr>
<td>Married</td>
<td>166</td>
<td>161(97.0)</td>
<td>163(98.2)</td>
</tr>
<tr>
<td>Widow/ Divorced</td>
<td>14</td>
<td>14 (100)</td>
<td>14 (100)</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>21</td>
<td>20 (95.2)</td>
<td>21(100)</td>
</tr>
<tr>
<td>Secondary</td>
<td>130</td>
<td>129 (99.2)</td>
<td>125(96.2)</td>
</tr>
<tr>
<td>Post-Secondary</td>
<td>212</td>
<td>198 (93.4)</td>
<td>199(93.9)</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below Kshs. 24,000</td>
<td>206</td>
<td>198(96.1)</td>
<td>199(96.6)</td>
</tr>
<tr>
<td>Kshs. 24,000-99,000</td>
<td>97</td>
<td>95 (97.9)</td>
<td>95 (97.9)</td>
</tr>
<tr>
<td>Over Kshs. 99,000</td>
<td>14</td>
<td>14 (100)</td>
<td>13 (92.9)</td>
</tr>
</tbody>
</table>

3. Results

A poor attitude towards HIV testing was identified as the fifth factor in influencing the prevalence of HIV. The study found that out of the 366 study participants, 333 (91.2%) had tested for HIV for various reasons. 38 (11.6%) did it for being involved in risky behaviour, 68 (20.7%) for not feeling well, 23 (7.0%) for not trusting their partners, 42 (12.8%) for being advised by the doctor, 154 (47%) as a routine check, and 3 (0.9%) for being forced by their partners. Furthermore, a majority (about 47%) of HIV testers were aged between 24 and 49 years. Considering that this is the most sexually active group within the population, it is expected that the majority would test for HIV especially that in Kenya no one is allowed to enter marriage without testing for HIV.

It is not always true that higher educational attainment automatically translates into better knowledge on all subjects. However, it is true that as one advances in education, they are likely to have more and better knowledge about a specific subject such as the HIV epidemic. Therefore, the study cannot purport to have measured the participants’ knowledge on HIV and AIDS merely by inquiring into their educational attainment. This study assumed that the participants had adequate and accurate knowledge on the HIV pandemic and that they were acutely aware of the transmission pathways, and the risks involved in engaging in unsafe sexual behaviours. This was based primarily on prior research which had established that the
Table 4.19 shows that the more advanced in age individuals became, the more favourable attitudes they developed towards both testing and treatment for HIV. For example, 96.5% of those aged below 24 years held favourable attitudes towards testing for HIV compared to 97.2% of those aged between 24 and 49 years. However, all (100%) of those aged over 49 years indicated having a willingness to test for HIV. Therefore, age is a good predictor of the likelihood of testing for HIV. The findings of this study are consistent with those of some former studies (Mooi, Van Der Maas & De Melker, 2014) on this finding, however, it is inconsistent with other past studies which held the view that persons advanced in age are less likely to test for HIV (Maina et al., 2014; NASCOP, 2009). The likely explanation for this difference could be due to the mean age of the participants in the sample since it was biased towards a younger population.

Despite testing for HIV clearly being the first step towards prevention and provision of appropriate care and treatment (Gardner et al., 2011), there are many factors that influence willingness associated with testing for HIV including perceived risk of contracting HIV such as engaging in sex with CSWs (Wang et al., 2009). However, AIDS related fear and stigma are reportedly major barriers to testing for HIV (Kalichman et al., 2010).

The trend regarding attitudes towards treatment according to the study data is unclear. A majority of the participants in all age categories held favourable attitudes towards HIV treatment. In particular, about 95% of the under 24s held favourable attitude towards HIV treatment compared to 97% of those aged between 24 and 49, and only 94% of the over 49s. Perhaps, lack of clear cut determination of this trend may be due to the bias in the number of over 49s participants included in the study. The sample consists of very few over 49s to make meaningful statistical determination of the trend.

Among some of the most important factors affecting decision making uptake regarding counselling, testing, care, and treatment are HIV related stigma and discrimination (Florom-Smith & De Santis, 2012; Low et al., 2013; Mukolo et al., 2013). Thus, the consequences of HIV related stigma and discrimination on an individual are obvious. They include lack of interest to test for HIV, to seek for care and treatment, and to enhance control and prevention, which would otherwise improve their quality of life (Young & Bendavid, 2010).

A number of studies have recognized the necessity of educating communities on the advantages of testing for HIV. The advantages far outweigh the disadvantages as the consequences of not testing for HIV may imply suffering and eventually facing an early death (Chaudoir et al., 2012; Gilbert & Walker, 2010; Pitpitan et al., 2012).

AIDS will remain a substantial problem if gender inequity is not addressed because vulnerability to contracting HIV was noted to be in the increase where relationships are dominated by gender-power inequity and GBV (UNAIDS, 2009; Decker et al., 2009). Prevalence of gender-power inequity and GBV results from several factors. A study involving Zambian women, for example, demonstrated the limited agency women have in sexual matters. The study found women as virtually lacking the power to either decline unsafe sexual advances or demand the use of a condom to protect themselves. Another factor contributing to the increase in women’s vulnerability to HIV is the age-mixing sexual pattern which encourages older men to engage in sex with young girls (CSO, MOH, University of Zambia, & Measure Evaluation, 2010).

While a majority of the studies investigating how GBV is related to HIV susceptibility focus on gender inequality and AIDS (Jewkes, Dunkle, Nduna, & Shai, 2010; Jewkes, Sikwefiyia, Morrell, & Dunkle, 2011), a few seem to have explored the impact of GBV on access to care and treatment. More recently, studies based on clinical practice in Zambia have examined women who had suffered GBV. In these studies, it was shown that often women who suffered GBV have greater odds of not seeking for care and treatment services for fear of being abandoned by family or suffer further violence (UNIFEM, 2011; Persson et al., 2011).

Considering that some of these factors influence vulnerability and resistance to seeking treatment and care, this study sought to investigate participants’ attitudes towards testing for HIV. The study found no gender attitudinal differences related to HIV and AIDS since, they were approximately balanced, (97.4 for males compared with 96.7 for females), with less than a percentage point in favour of men.

The process that enables majority of the infected to know their HIV status is through testing. Available evidence shows that testing for HIV results in behavioural change which reduces the risk of HIV infection and anxiety over the likelihood of being infected; as well as enhancing the facilitation of safe disclosure of infection status (Cremin et al., 2010). The dangers of being ignorant about one’s HIV status include continued transmission of HIV in the community and this poses a higher risk of opportunistic infections such as TB (Corless, & Pittman-Linderman, 2014) and cryptococcal meningitis (Park et al., 2009) which can lead to early death.

Furthermore, the study found that more females (96.7%) than males (94.8%) held favourable attitudes towards HIV treatment. This implies that more women than men tend to accept treatment perhaps for the reason that men tend to have a questioning attitude. It is from this point of view that gender inequality has been widely argued to be one of the key drivers of HIV infection (UNAIDS, 2012).

Research evidence shows that more often gender inequalities create vulnerabilities to HIV infection that are specific for women. As a result, studies on the role of gender in mediating HIV vulnerability have, for important reasons, centred on how inequalities act as a barrier for women to seek care and treatment services (Ehrhardt, Sawires, Peacock, & Weston, 2009). Therefore, policies, programmes and donor funding that aim at examining the gender inequality question in the context of HIV have arguably focussed more on women than men (Higgins, Hoffman, & Dworkin, 2010).

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Whenever men have been considered in curbing the epidemic, it is because of their being the problem rather than being affected. Worse still, solutions focus singly on bettering the wellbeing of women (Keeton, 2007). Few studies have focussed on the impact of HIV on men themselves, how to inculcate into men test, care and treatment seeking behaviours or comprehending men’s health-seeking behaviours. Perhaps, this has been described as ‘a major challenge that is poorly recognized’ (Mills, Ford and Mugyenyi, 2009, p.276).

The other issue that the study inquired into was whether being in a marital relationship mediates against risky behaviours. The study found that a majority (96.7%) of those not in a marital relationship (singles) held favourable attitudes towards HIV testing, but fewer (93.5%) indicated a willingness to start treatment if they ever tested positive for HIV.

Likewise, a majority (97%) of the married held favourable attitudes towards testing, however, an even higher number (98.2%) indicated a willingness to start treatment if they ever tested positive for HIV. Lastly, all (100%) widows and divorcees held favourable attitude towards both testing and willingness to start treatment.

Although a majority of the un-married would prefer knowing about their HIV status, less were willing to face the prospect of starting treatment probably due to stigma, the fear of discrimination and desertion by peers, especially if results of the test and treatment would be made public.

Whereas HIV testing serves as the gateway to seeking treatment, care, and prevention, its uptake in the SSA region is very low and painfully slow. For example, by 2015 approximately 60% of the people infected with HIV had known their status. But, out of the total number, men accounted for only 30%. Consequently, men are less likely to test for HIV putting them at higher risk of early death due to lack of treatment (WHO, 2016).

The findings of this study agree with available studies that there is a wide disparity between willingness to test per se and actually testing for HIV. For example, a study of 554 respondents selected from a community in Ghana found that while 83.8% of the respondents were willing to test for HIV, only 45.8% actually tested for HIV (Yawson et al., 2014).

Factors associated with favourable response to HIV screening include confidentiality, presentation of VCT as routine rather than an option, and perceived high risk. However, often willingness fails to translate to testing for HIV largely due to stigmatization. In addition, lacking awareness of the VCT services; the fear of being stigmatized and discriminated; the notion that HIV/AIDS is incurable and therefore pointless to test for HIV; the fear of coping with the results if the test turns positive; high HIV risk perception; divorce and isolation have been identified as the main barriers to the uptake of VCT (Apanga, Akparibo, & Awoonor-Williams, 2015; Meshesha, 2014). Other factors influencing the uptake of HIV testing include the HIV/AIDS-related knowledge, risk perception and practice of confidentiality in handling test results or counselling among patients (Sekoni, Adegbibie, & Akande, 2014).

Another issue that the study explored was whether the level of formal education improves the attitudes held towards HIV testing and treatment. Arising out of the analysis, the study observed that 95.2% of those educated to primary level of education held favourable attitudes towards HIV testing while all (100%) participants held a favourable attitude towards HIV treatment. For those educated to secondary school level, virtually all of them (99.2%) held favourable attitudes towards HIV testing compared with 96.2% with favourable attitudes towards HIV treatment. Finally, 93.4% of the post-secondary graduates held favourable attitude towards HIV testing and roughly a similar number (93.9%) held favourable attitudes towards HIV treatment.

These results concur with findings by prior studies. For example, a study conducted in Kenya revealed that accepting to test for HIV is associated with individual-level factors such as age, location of residence and educational attainment (Byamugisha, Tumwine, Semiyaga, & Tylleskär, 2010). Also, participants with higher formal educational attainment were more likely to have adequate HIV/AIDS knowledge than those with low formal educational attainment (Lliyasu, Abubakar, Kabir, & Aliyu, 2006).

Evidence accumulated from research shows that higher educational attainment correlates with less vulnerability to HIV/AIDS risk-taking (Baker, Leon, & Collins, 2010). As a result, this makes education a critical tool in the war against the epidemic. Although currently AIDS is incurable, it is manageable. It is against this background that the World Bank takes the view that education could possibly be the only substitute vaccine accessible to humans. Accordingly, UNICEF remains adamant in holding the view that for now, education remains the only valuable tool for controlling HIV/AIDS until a more effective remedy is found (WFP, 2013).

To underscore the importance of education and its correlates, Mondal, Rahmann, Rahman, & Akter (2012) assessed the knowledge and awareness of 10,996 women aged between 15 and 49 years against factors enhancing both control and prevention of HIV. The results showed that there were statistically significant correlations between the educational attainment of the participants and their partners against the level of their HIV/AIDS knowledge and awareness. This is perhaps why the World Bank is committed to ensuring that education of children is accorded the highest priority in a world troubled, devastated, and overwhelmed by the pandemic (World Bank, 2013). Such a conviction is grounded in good quality education being ranked among the most successive and cost-effective approaches for combating the scourge.

As a matter of fact, educational attainment correlates positively with knowledge and awareness of HIV/AIDS. In other words, the more-educated one is, the greater the odds for advancing knowledge and awareness of the HIV pandemic. Though this may not be the case since such knowledge can be the basis for changing to unacceptable behaviour.
One other factor that is likely to mediate participants’ attitude towards testing and starting treatment for HIV is perhaps level of income. The study found that majority (96.1%) of those earning less than Kshs. 24,000 per month held favourable attitudes towards HIV testing while a slightly higher proportion (96.6%) held favourable attitude towards treatment. Virtually all (97.9%) of those earning incomes of between Kshs. 24,001 and Kshs. 99,999 held favourable attitude towards both HIV testing and treatment. Finally, all (100%) of those earning over Kshs. 99,999 held favourable attitudes toward HIV testing. However, it was only 92.9% of them that held favourable attitudes toward HIV treatment.

Poor physical health among PLWHA is related to both quality of life and unemployment. In these circumstances, income is an excellent predictor for health-related quality of life. Furthermore, food uncertainty is related to treatment interruptions, poor access to treatment and HIV-related mortality. It is an important marker of low income because the cost of HIV medications can be a significant burden despite the government fully covering antiretroviral medications for now. In addition, income for many PLWHA is reduced as the associated health problems lead either to leaving paid employment or being forced to reduce working hours.

Lastly, the study explored whether the location of the participants’ residence has any influence in mediating willingness to both test and start treatment for HIV. The location of residence is important in motivating one to test for HIV and to start treatment if the test turns positive. Arising from the analysis of data, the study noted that 97.8% of the urban dwellers held favourable attitudes towards HIV testing while a slightly lower proportion (96.2%) held favourable attitudes towards HIV treatment. For rural dwellers, a majority (96.0%) held favourable attitude towards HIV testing, but only 95.5% of them held favourable attitude towards starting HIV treatment.

Whereas the study found that gender and education were the best predictors of both willingness to test and to start treatment for HIV, it found level of income being a poor predictor. Although, attitudes towards HIV testing become increasingly favourable with increasing age, income and location of residence attitudes towards treatment are not as favourable.

4. Conclusion

In terms of knowledge and attitudes, this study found no significant attitudinal differences towards HIV testing and treatment based on gender. In fact, males (97.4%) and females (96.7%) held evenly balanced attitudes except for a less than one percentage point advantage in favour of men. But as for age, the study found the more aged holding more favourable attitudes towards testing for HIV, and not regarding attitudes towards treatment which is not clear. This implies that more women, especially the aged, tend to accept testing for HIV and treatment too compared with men making gender inequality one of the key drivers of HIV infection (UNAIDS, 2012).

In addition, the study found that attitudes towards HIV prevention and treatment are positively associated with the level of education, income, and place of residence. It was found that participants with higher formal education were more likely to have adequate knowledge of HIV/AIDS than those with low formal education. Correspondingly, education determines one’s employability making income a good predictor of health-related quality of life for both mental and physical health (Worthington & Krentz, 2005) and in turn, poor physical health-related quality of life is associated with unemployment (Rourke, Tucker, & Bekele, 2010). Nevertheless, the relationship between age and marital status and attitudes towards HIV prevention and treatment was unclear.

Lastly, this study found gender to be the best predictor of willingness to test as well as start treatment for HIV while income was identified as the worst predictor of willingness to test and start treatment for HIV. Whereas HIV testing serves as the gateway to seeking treatment, care, and prevention, its uptake is very low and painfully slow. For example, by 2015 only 60% of the people infected with HIV had known their status and out of the total number, men accounted for only 30%. Consequently, men are less likely to test for HIV putting them at higher risk of early death due to lack of treatment or starting treatment late (WHO, 2016).

However, factors associated with favourable attitudes towards testing for HIV include confidentiality, presentation of VCT as routine rather than an option, and perceived high risk. But, often willingness fails to translate to testing for HIV largely due to stigmatization.

5. Recommendations

The study recommends the institutionalization of HIV/AIDS knowledge. It seems that HIV is like a chronic life-style disease and therefore HIV related programmes should always have a training component or should partner with programmes offering HIV related training by involving either professionals or trained peer mentors. This is because mentorship seems to touch a cord that resonates with the HIV infected persons. It provides a positively re-enforced message that enables one to decide to extricate themselves from risky sexual behaviours. Through promulgation of policies and strategies, an environment that prohibits and if possible criminalizes stigmatization and discrimination of persons infected with HIV should be created. Though discrimination on account of HIV status is punishable by law, it has not been effectively implemented to deter individuals and employment agencies from doing so. Furthermore, policing behaviour by legal means is extremely difficult, therefore, what might work is coming up with a way of changing everyone’s attitudes.

References


