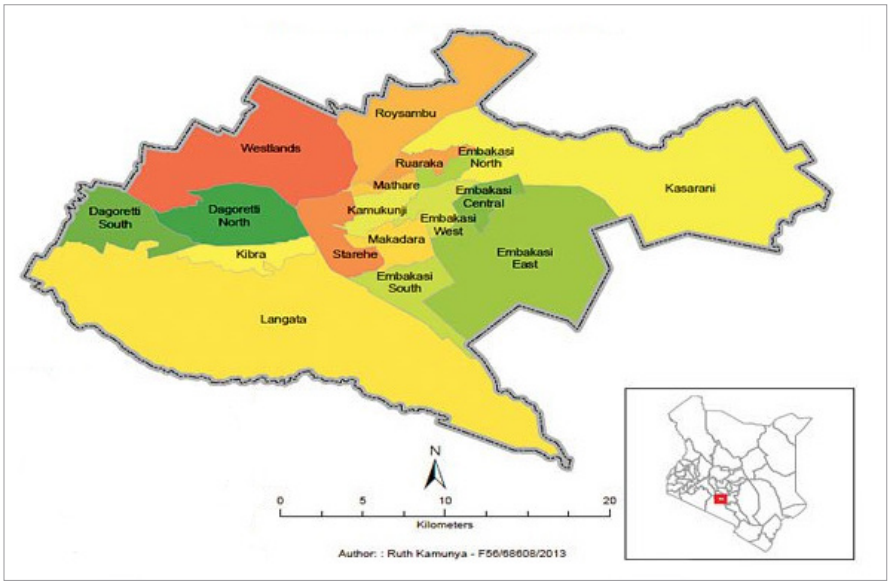
results brief

Improving men's uptake of HIV testing services: Findings from a health facility assessment in Nairobi, Kenya

The 2018 International AIDS Conference called attention to men's low uptake of HIV testing services (HTS) and the need for greater efforts to ensure men know their status and link to treatment if they test positive for HIV.



Project SOAR conducted a health facility assessment across 17 sub counties in Nairobi to learn more about site-specific characteristics that contribute to bringing in male clients for HIV testing.

Project SOAR in collaboration with the Kenya National AIDS & STI Control Program (NASCOP) is building needed evidence to improve uptake of HTS among Kenyan men. Although HIV testing has increased in Kenya, men are less likely than women to get tested. In Nairobi, for example, less than half as many men as women had undergone HIV testing in the 12 months prior to the 2014 Kenya Demographic and Health Survey. Understanding how and why certain men elect to be tested can provide important insights in designing strategies to improve uptake and expansion of HTS among males.

Critical to this process is knowing more about site-specific characteristics that contribute to bringing in male clients for HIV testing. This brief summarizes key findings from a health facility assessment conducted across 17 sub counties in Nairobi (see map).

METHODS

In consultation with NASCOP and county health officials, we purposively selected 124 health facilities from a total of 381 providing HTS in Nairobi. We used the following criteria in our selection process to obtain a cross-section of

KEY MESSAGES

- Only one-fourth of facilities were high-male-volume sites.
- High-male-volume sites were more likely to cater to male members of key populations.
- High-male-volume sites tended to be open longer than low-male-volume sites.
- Almost two-thirds of all sites reported making some effort within the facility to bring in male clients for HIV testing.

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facilities with distinct characteristics: i) client load, ii) total number of male versus female testers, iii) catchment area and, iv) HTS type (i.e., sites where antiretroviral therapy is offered versus standalone HTS sites).

From December 2017 to March 2018, we collected data from the 124 health facilities by interviewing primarily facility administrators/in-charges, HIV testing counsellors, nurses, and, to a lesser extent, clinical officers and lab technicians. We also reviewed service statistics for the four quarters of 2017.

In this brief, we examine site-specific characteristics of high-male-volume (HMV) sites compared to low-male-volume (LMV) sites in Nairobi County. Sites were categorized as HMV sites if the proportion of male clients accessing HTS was greater than 45 percent for each quarter during 2017.

What types of health facilities participated in the study?

All facilities provided standard HIV testing and counselling services based on existing national guidance. At the time of the study, only 4 percent (n=5) of facilities were providing oral HIV self-testing.

RESULTS

Only one-fourth of facilities were HMV sites.

Men made up more than 45 percent of the total clientele at just 33 health facilities out of the total sample of 124 (27 percent).

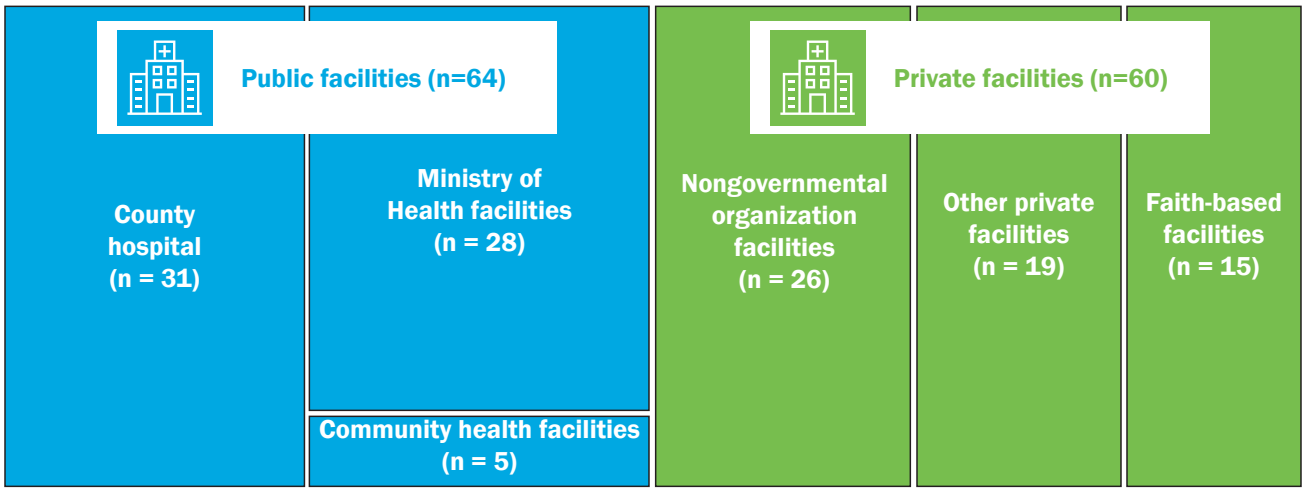
HMV sites were more likely to cater to male members of key populations.

About a third (34 percent) of all facilities reported offering services specifically targeted to key populations, including male members of these populations. But HMV sites were more likely to provide these services, such as to injecting drug users (54 vs. 27 percent, $p<0.01$), men who have sex with men (60 vs. 35 percent, $p=0.01$), and male sex workers (48 vs. 28 percent, $p=0.03$). Yet they were less likely than LMV sites to provide prevention of mother-to-child transmission (PMTCT) services (57 vs. 85 percent, $p=0.001$).

There was no difference between public and private facilities in the proportion of sites that were HMV.

About half of each type of facility was characterized as HMV.

Figure 1 Types of facilities that participated in the study (n=124)



HMV sites tended to be open longer than LMV sites.

Most (57 percent) of the 124 facilities that participated in the study provided services five days per week, with the remainder open six days or more per week. Notably, over half of the HMV facilities (52 percent) offered services six days or more per week compared to 40 percent of the LMV ones.

A greater proportion of these HMV sites that open longer were private facilities compared to LMV sites.

Almost two-thirds of all sites reported making some effort to bring in male clients for HIV testing.

Overall, 64.5 percent (80/124 facilities) of health facilities reported trying to bring in male clients, but there was no significant difference between LMV and HMV sites (67 vs. 58 percent). About one-third (34 percent) of sites (42/124) reported conducting or offering specific activities or services within their facilities.

There were differences in the types of male targeted services offered within HMV facilities versus LMV facilities (Table 1). HMV sites were more likely to distribute male-focused, information, education, and communication (IEC) materials around testing than LMV sites. But they were less likely to target men via antenatal care or via PMTCT clients who test positive. Furthermore, of all 124 facilities surveyed, only 8 percent of either type allocated male staff members to consult male clients.

The most common community-based strategies used by health facilities to bring in men for HIV testing were community awareness programs and other outreach services. The least reported strategies were conducting awareness programs through youth clubs, schools or colleges, and police or army camps as well as by promoting the availability of voluntary medical male circumcision. HMV facilities fared better than LMV sites at targeting men through school or college programs (37 vs. 11 percent, p<.01).

Table 1 Reaching male clients

Services targeting men in health facilities	Total (N=42)	Male volume: Low (n=27)	Male volume: High (n=15)
Services for male partners accessing non-ANC services (such as ART)*	42.8 (18)	55.5 (15)	20.0 (3)
Services for male partners of ANC attendees***	52.4 (22)	74.1 (20)	13.3 (2)
Services to promote male involvement in PMTCT**	54.8 (23)	74.1 (20)	20.0 (3)
IEC materials targeted to men	35.7 (15)	25.9 (7)	53.3 (8)

*p<0.05; **p<0.01; ***p<0.001

CONCLUSIONS AND RECOMMENDATIONS

HTS facilities that had higher representation of male clients were more likely to provide targeted services for male members of key populations and provide HTS for more hours per day and for six or more days per week. It is evident that key and priority populations seek targeted services at specific health facilities. LMV facilities were more likely to be those providing services to male partners of women testing positive through PMTCT or antenatal care services.

HIV prevention programs should sustain access to HIV testing in the general population while targeting men at substantial risk such as men who have sex with men, male sex workers, and men who use drugs. Multiple opportunities for HIV testing should be made available for men as they seek both general and HTS services at the facilities. Awareness programs that highlight the availability of a variety of friendly and non-stigmatizing services based on client preference are critical. Prevention programs should emphasize friendly and non-stigmatizing HIV testing for key and priority populations at both community and health facility levels.

NEXT STEPS

These findings will be used to complement quantitative and qualitative data we are collecting from a variety of informants to better understand men's motivations and drivers for getting tested. These informants consist of:

- Men seeking HIV testing at HTS centers
- HIV-positive men who were and were not diagnosed early
- HTS counsellors

Together, the research will provide needed information to help Kenya and other countries to develop effective strategies for increasing uptake of HTS among men.

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Population Council leads the Project SOAR consortium in collaboration with Avenir Health, Elizabeth Glaser Pediatric AIDS Foundation, the Johns Hopkins University, Palladium, and The University of North Carolina at Chapel Hill.

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