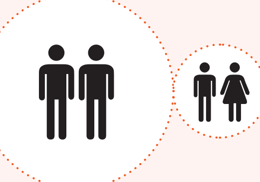
Ministry of Health

HIV SELF-TESTING

Awareness, acceptability and perceptions of HIV self-testing among MSM in Kenya

The HIV prevalence among men who have sex with men (MSM) in Kenya, at 18.2%, **is three times higher** than in the general population [1].



However, the uptake of testing services among MSM in the country remain low [2]. Lack of a perceived risk of HIV infection, fear of a positive test, and stigma and discrimination; healthcare provider attitudes, violence and inadequate access maintain suboptimal testing rates [3]. In this context, HIV self-testing (HIVST) offers the potential to rapidly increase access to and use of HIV testing services among underserved populations. This brief describes the findings from a rapid qualitative assessment of the feasibility of HIVST as an approach among MSM in three counties in Kenya.

What is HIV self-testing?

HIV self-testing (HIVST) is the process by which a person collects his or her own specimen (oral fluid or blood) to perform an HIV diagnostic test. He/she then interprets the result, in private, or in the company of someone they trust. Rapid test kits such as finger stick tests (on whole blood) or mouth swab tests (on oral-fluid) are used to conduct these tests. HIVST does not provide a diagnosis. Negative self-test results are considered negative, but all positive self-test results need to be confirmed according to national algorithms. Existing WHO HIVST guidelines advise individuals who may have been exposed to HIV in the past 6 weeks and those at high ongoing risk (such as key populations) to retest. WHO promotes HIVST as an approach that can help countries meet the UN target of diagnosing 90 percent of all people with HIV by 2020.

Source: http://hivstar.lshtm.ac.uk/publications/

Why do this assessment?

HIVST is considered to have the potential to reach underserved populations, such as MSM, who are not accessing existing services. However, there is little information on the acceptability of HIVST among MSM in Kenya. This rapid qualitative study assessed the awareness, acceptability, and perceptions of HIVST among MSM in Kenya. This assessment was a part of the formative research for a two-year research project on HIVST among MSM in Kenya.

What did the study investigate?

The study assessed the factors that currently limit HIV testing and the feasibility of using self-testing as an approach to improve testing among MSM such as:

- awareness and acceptability of HIVST
- various distribution models
- feasibility of integrating HIVST into existing programmes, and
- linkage of newly diagnosed people living with HIV to HIV care and treatment services

The study team spoke with a total of 60 people in Kisumu, Mombasa and Kiambu counties in Kenya. The facilitators met with MSM community members, peer educators and health care workers to collect data through focus group discussions.

What did the assessment find?

The findings recorded good awareness and favourable attitudes toward HIVST. However, low knowledge of the use of kits, lack of easy access, and fear of receiving a positive HIV test result may undercut the adoption of self-testing among MSM.

Most MSM were aware of HIVST
MSM community members had heard or read about HIVST kits through social media, the news, clinics and hospitals, community-based organisations (CBOs), peers, a pharmacy based HIVST project in coastal Kenya and other projects in Kisumu. However, knowledge of some aspects of the self-testing kits was found to be limited with members expressing lack of clarity on the use of kits and concerns around test accuracy.

"There is low viral concentration in the blood, how do we test for HIV using saliva? Is the kit reusable?"
— (FGD participant from Kisumu)

MSM expressed favourable attitudes to HIVST
Most MSM reported an interest in trying self-testing as they considered it to be a confidential, private, and convenient method. They noted that the method would avoid the risk of public stigma, and was easy, fast, and time-saving to administer.

"I think it is simple and safe to use from what I know. It does not require blood, it offers confidentiality, avoids stigma from health care workers since you and you alone are at liberty to disclose your status."
— (FGD participant from Mombasa)

Favoured distribution sources for the kits varied
Participants identified Drop-in Centres (DICs) within CBOs, hotspots, public health facilities, and dispensaries as preferred locations for getting the HIVST kits. However, for hard-to-reach MSM, they recommended peer workers to distribute the kits.

"There are different classes of MSM including hard to reach MSM. Those in the working class (high end), do not want to and cannot visit the DIC, and they are still our sexual partners and/or close family. We should take the self-testing kits to them so they can know their status."
— (FGD participant from Kiambu)

Peer-led roll out, improved awareness, free availability as enablers of HIVST
All MSM preferred to be reached by their peers with HIVST knowledge and kits. They recommended media driven initiatives for improving awareness on the access points and demonstration on kit use; and the test kits to be made available for free.

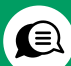
"We should have the peers distribute the kits like they do for condoms and lubricants since they will reach the peers easier than the program can."
— (FGD participant from Kiambu)

Post-test linkage to treatment and care remain a concern
Participants reported that confirmatory testing and subsequent linkage to treatment and care may continue to be limited in the absence of adequate pre- and post-test counselling. They recommended provisions for counselling, in-person or through hotline phone calls, to overcome this barrier.

"After a client tests positive, we already have a challenge with linkage as it is right now. And that is with people coming into the clinic to test, with counselling and all, so how will we expect people having taken away kits to be linked to care?"
— (FGD participant from Kiambu)

Limited knowledge, accessibility, and fear of a positive test result limit self-testing
Although HIVST was found to be generally acceptable, participants expressed inadequate knowledge on its use and accessibility, kit costs, interpretation of results, a lack of trust on test reliability, and fear of the test result with a tendency to self-harm if testing positive, as barriers to testing.

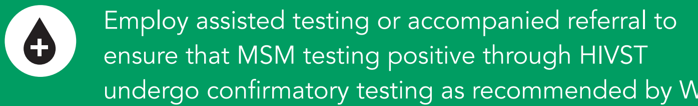
"It might make people commit suicide if they test positive and have not received counselling which is mostly offered in the VCT sites."
— (FGD participant from Kisumu)



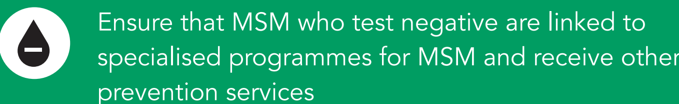
Recommendations

Invest in demand generation activities, to promote HIVST, through various communication channels

- Promote HIVST as a confidential method of testing that adequately addresses the anxieties of MSM around stigma or discrimination from public exposure.
- Improve awareness around the validity and accuracy of test results from HIVST. Emphasize features such as the ease of use, saving of time and free kits.
- Use traditional and new media and Information, Education and Communication (IEC) to provide information on availability of HIVST kits, access points and for demonstrating the method for using the kits.

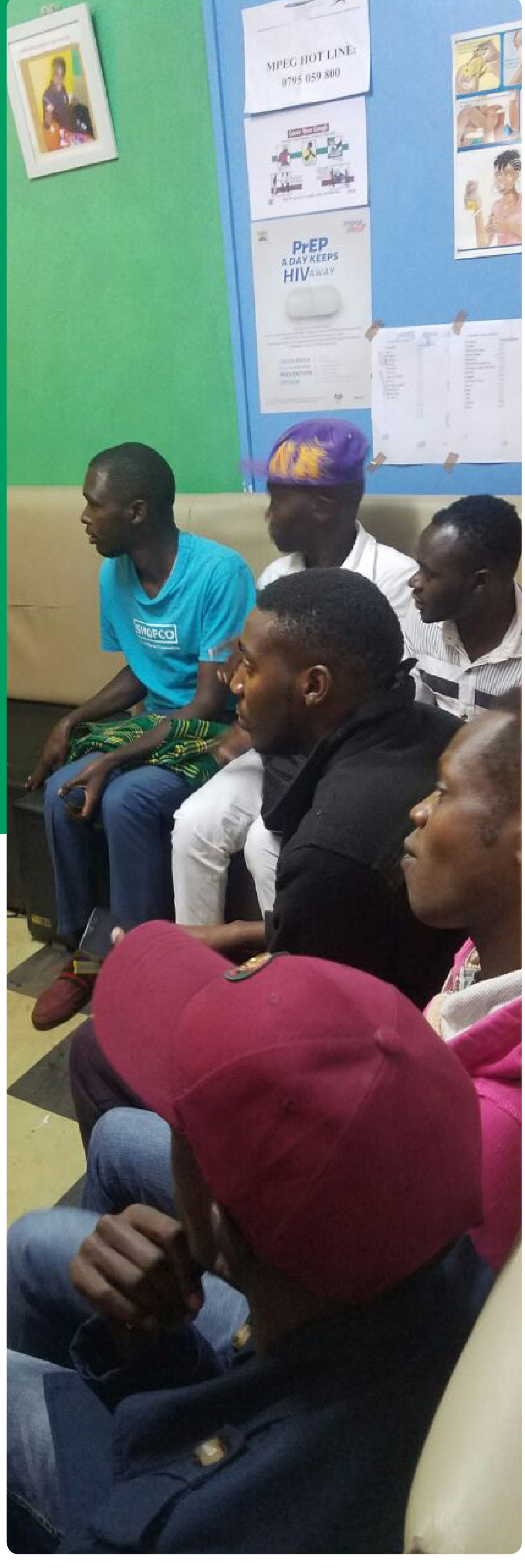


Employ assisted testing or accompanied referral to ensure that MSM testing positive through HIVST undergo confirmatory testing as recommended by WHO



Ensure that MSM who test negative are linked to specialised programmes for MSM and receive other prevention services

Leverage and build on existing peer support systems to promote the uptake of HIVST method among MSM



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References

1. NASCOP, 2010-2011 Integrated Biological and Behavioural Surveillance Survey among key population in Nairobi and Kisumu, Kenya. Nairobi: Government of Kenya, Ministry of Public Health and Sanitation
2. National STI and AIDS Control Programme (NASCOP). Third National Behavioural Assessment of Key Populations in Kenya. Polling Booth Survey Report, September 2018
3. Johnson, C. A. (2007). Off the map. How HIV/AIDS programming is failing same-sex practicing people in Africa. New York, International Lesbian and Gay Human Rights Commission, 2007