Potential for abuse in the VCT counselling room: service provider’s perceptions in Kenya

C Hamilton,1* D Okoko,2 R Tolhurst,1 N Kilonzo,2 S Theobald1,3 and M Taegtmeyer1,2

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The rapid scale-up of HIV counselling and testing programmes in Kenya has led to quality concerns, including the potential for abuse within the private, confidential setting of client-initiated voluntary counselling and testing (VCT).

A qualitative study was conducted in three provinces of Kenya, involving 26 VCT service providers and 13 key informants. First and second hand accounts of emotional, physical and sexual abuse emerged in all three study sites in spite of measures to mitigate such occurrences. Whilst uncommon, abuse was perceived by service providers to be serious and sufficiently widespread to raise significant concerns. Abuse occurred client to counsellor, from counsellor to client and from counsellor to counsellor. In all cases the person suffering the abuse was female.

While the potential for abuse was demonstrated in VCT sites, we argue that experiences of abuse are not confined to VCT and are largely shaped by gender and power relations within the Kenyan cultural context. The international impetus for scale-up of HIV services provides an urgent rationale for the need to address and highlight these difficult issues at multiple levels. International guidelines, policy and methods need adapting in recognition of the potential for abuse. Systems for investigating and deregistering counsellors have been developed in Kenya but require formalizing. Institutions providing VCT should consider unlocked doors, semi-opaque windows and the use of ‘mystery clients’ as a quality assurance measure.

Keywords HIV, VCT, abuse, gender violence, ethics, Kenya

KEY MESSAGES
- Reports of abuse and the potential for abuse are too often swept under the carpet as isolated incidents.
- VCT delivery models need to be culturally sensitive and to protect vulnerable individuals from this potential.

Introduction
Current global efforts to increase access to antiretroviral therapy in resource-poor countries have seen a concomitant increase in efforts to increase access to HIV testing in many different settings (Gilks et al. 2006). Voluntary counselling and testing (VCT) is a behaviour change strategy aimed at the asymptomatic individual who wants to know their HIV status (The Voluntary HIV-1 Counselling and Testing Efficacy Group 2000). VCT is client-initiated and takes place in a number of medical, non-medical and mobile settings.

In Kenya, trained VCT counsellors provide rapid HIV testing with pre- and post-test counselling in one session. The counselling focuses on risk reduction planning and involves the discussion of intimate sexual and personal relations. A number of mechanisms are in place in Kenya to ensure the quality of VCT.
Best practice as laid out in the National VCT Guidelines (Government of Kenya 2001) recommends a minimum training standard and supervisory systems inclusive of counsellor meetings, site visits and counsellor debriefs (either individually or in groups). Some sites also utilize client-exit interviews and ‘mystery clients’ (individuals posing as clients) to provide feedback (Taegtmeyer and Doyle 2003). Counsellors are trained and supported in the maintenance of confidentiality (and/or anonymity). Privacy for clients is ensured, often by locating the centre in an unobtrusive location, and conducting counselling and testing in a room with closed doors where a lack of interruption is guaranteed.

Despite the intimacy of the VCT setting there has been little debate concerning the potential for abuse within the ‘privatized’ environment of the encounter between VCT health care providers and their clients. Given the rapid scale-up of VCT services in overburdened health systems in resource-poor contexts, there is a need for further exploration of the potential for abuse and discussion of appropriate responses. This potential stems from the interaction between two interlinked sets of power relations: those between health care providers and patients, and those between women and men. For the purposes of this paper, a working definition of abuse is a perceived negative or harmful experience stemming from interactions with others.

Ethical prohibitions of sexual misconduct between physicians and their patients date back to the Hippocratic oath in the late 4th century BC (Campbell 1989; Hall 2001). Increasingly in the last 30 years, sexual contact with patients has been outwardly condemned by the medical profession (Dehlendorf and Wolfe 1998; Ferris 2004). Formal ethical codes of conduct for medical professionals now exist in many ‘western’ countries (Council on Ethical and Judicial Affairs, AMA 1991; New Zealand Medical Council 1994; British Association for Counselling and Psychotherapy 2005), and prohibit sexual relationships between health personnel and clientele. Health services in the West also have codes of conduct for the prevention of workplace violence, and train staff (particularly nursing staff) in what to expect (Ferns 2006; Peek-Asa et al. 2007). Resource-poor countries like Kenya, on the other hand, lack formal codes of conduct for the prevention of abuse within health care settings.

Abuse against women exists in almost all societies and within every profession (van der Straten et al. 1998; de Bruyn and Paxton 2005; Paxton et al. 2005). In many countries women’s subordination constrains their participation in public life (Kibwana 2000), opening them to abuse within environments where they should be able to expect safety. Unequal power relations are reflected in the sexual harassment of women by men in superior positions (Maman et al. 2000), including health professionals who are in a privileged and powerful position in relation to their clientele (Jewkes et al. 1998; d’Oliviera et al. 2002). Published literature reporting sexual violence and abuse in Kenya is limited. However, in the 2003 Kenya Demographic and Health Survey, 13% of women aged 20–29 years reported experiencing sexual violence in the year preceding the study (Government of Kenya 2004). Kilonzo et al. (2008) argue that vulnerability to sexual violence and abuse is rooted in unequal gender power relations in the Kenyan context.

**Background to the study**

In 2005, when this study was undertaken, VCT was being provided in over 600 centres in Kenya (Government of Kenya 2005), by a mix of governmental and non-governmental service providers and through a variety of models including stand-alone sites, sites within health care facilities and mobile services, all of which are governed by the National VCT Guidelines (Government of Kenya 2001). Quality assurance checks as outlined above are in place in all registered VCT sites. Counsellors in Kenya are both male and female. Due to staff shortages and waiting times, few, if any, VCT sites offer clients the option of a counsellor of the same gender as themselves. Additionally, clients are rarely empowered sufficiently to request same-sex counselling should they prefer it. This research was conducted in response to concerns about the potential for abuse, and set out to rigorously explore, assess and document the potential for abuse, within the context of the voluntary counselling and testing (VCT) setting.

**Methods**

Interviewers explored the potential for abuse through discussions on VCT service providers’ counselling experiences and perceptions of abuse. A qualitative research methodology was chosen as sensitivity surrounds issues related to HIV/AIDS, VCT, sexual, gender and power norms, and abuse (Lewis 2003). This allowed researchers to respond flexibly to service providers’ viewpoints and gave space for them to explore and discuss their experiences, limiting the potential for social harm (Ringheim 1995). A decision was made to employ paired or triad interviews providing a balance between the in-depth interview and the group discussion, through provision of a livelier environment where service providers interviewed could feel safe without the intensity of an individual interview or the possibility of intimidation from a larger and unfamiliar group. Semi-structured in-depth interviews, key informant interviews, observation and vignettes were also employed as outlined in Table 1.

**Table 1 Summary of participants**

<table>
<thead>
<tr>
<th>Method</th>
<th>Participant type</th>
<th>Number</th>
<th>Gender</th>
<th>Level/location/ interview description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key informant interviews</td>
<td>Key stakeholders</td>
<td>13</td>
<td>8 female</td>
<td>National level: 4</td>
</tr>
<tr>
<td></td>
<td>(VCT programme directors and managers, VCT counselor supervisors, VCT counsellors)</td>
<td></td>
<td>5 male</td>
<td>District level: 6</td>
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<tr>
<td></td>
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<td></td>
<td>Kisumu 2</td>
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<td></td>
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<td></td>
<td></td>
<td>Malindi 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nairobi 1</td>
</tr>
<tr>
<td>Semi-structured interviews</td>
<td>VCT service providers</td>
<td>26</td>
<td>18 female</td>
<td>Nairobi: 3 in-depth</td>
</tr>
<tr>
<td></td>
<td>(VCT programme managers, VCT supervisors, VCT counsellors)</td>
<td></td>
<td>8 male</td>
<td>1 paired</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kisumu: 6 in-depth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Malindi: 2 in-depth</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>3 paired</td>
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<tr>
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<td>2 paired</td>
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<td></td>
<td></td>
<td></td>
<td>1 triad</td>
</tr>
</tbody>
</table>
The study setting

The research was conducted in Kenya between November 2004 and April 2005, in three geographically distinct provinces with a high concentration of VCT clinics: Western (Kisumu), Coast (Malindi) and Central (Nairobi) (CIA 2006). The study locations represent a diverse social, cultural and religious cross-section of rural and urban communities and their corresponding VCT sites. Well-established stand-alone, health facility and mobile VCT sites were identified that represented a wide variety of service providers from both the government and non-governmental sectors.

Full ethical clearance for the study was granted by the Kenyatta National Hospital Review Committee in Kenya and the Liverpool School of Tropical Medicine Ethics Committee in the UK prior to commencement of the study. All interviews were conducted with free and informed consent and ensured privacy and confidentiality.

Participants

Participants were recruited by the research team from among VCT service providers. This included VCT programme directors, managers, supervisors and counsellors. Non-probability, purposive sampling (Ritchie et al. 2003) was employed in sample selection of all participants upon arrival at various study sites. The participants were chosen from a predefined population of VCT service providers based on sex, experience and location, giving careful consideration to sexual negotiation and gender within the local context. The service providers interviewed varied from counsellors with direct first-hand experiences of client interaction to counsellor supervisors and programme directors with second-hand supervisory reports of counselling experiences. They had a combined experience of an estimated 100,000 client interactions. Thirty-one interviews were conducted and are summarized in Table 1.

Analysis

Data analysis was a continuous process (Patton 2002), allowing issues of relevance which emerged from interviews, observation and vignettes to be included in subsequent interviews. A ‘framework’ approach was used for analysis (Spencer et al. 2003). This was applied through combining the use of WinMAX software and manual techniques. Using the framework approach, the identification of key themes and sub-themes fed into the development of a thematic framework, which was systematically applied to sort the data. This ‘charting’ process enabled the authors to understand and interpret connections in the data.

A variety of quality assurance mechanisms (Pretty 1993) were employed to enhance and assure the trustworthiness and ensure transparency. Pilot-testing of topic guides assured that they generated the depth, scope and clarity of data sought. Interviews were audio-taped, translated into English (if in Kswhahili or Dholuo), and transcribed as soon as possible to ensure accuracy and facilitate recall. Confirming meaning through respondent validation helped to improve the clarity and precision of the notes and transcripts, which were triangulated with context summary sheets and notes taken during the interviews. The use of different interviewers and analysts from varied professional backgrounds and language abilities enabled additional quality assurance checks.

Results

The themes derived from the research data are interlinked and presented as: (1) perceptions of abuse; (2) perceptions of the causes of abuse; (3) experiences of abuse, both first and second hand; and (4) responding to abuse and the application of ethical and VCT guidelines.

(1) Perceptions of abuse

All participants expressed abuse as a negative action or attitude which could cause harm to someone else. Some participants added the element of mistreatment of either the counsellor or client within the counselling context. For example:

“Abuse in counselling, harassment…and you find that a counsellor is attracted by the client and wants to have sex with a client or a client wants to have sex with a counsellor, and that has happened.” (Malindi/female)

Service providers and key informants confirmed these perceptions and several expanded further with descriptions of unethical practice within VCT:

“Abuse is when you go against the ethics of counselling…and you have broken confidentiality…You are imposing your values on the client. You are giving some clients priority over others.” (Kisumu/male)

(2) Perceptions of the causes of abuse

Most participants related causes of abuse to gender and power imbalances bound up within cultural norms. Consequently, they stressed the vulnerability of women in either the counsellor or client role within the counselling setting.

“…because in the counselling room, usually the counsellor is considered, is a powerful person in that room so it’s very rare that you find the client making advances to the counsellor, it’s usually the counsellor making advances towards clients and that has happened quite a lot.” (Kisumu/female)

“…the counsellors need to be in touch with their issues, what they feel. But most ladies are vulnerable in the community, be it a counsellor or client.” (Kisumu/male)

Service providers also stressed client-related issues (such as their inability to accept test results and/or the challenges of dealing with difficult issues in their lives) as causes of abusive behaviour in clients.

“…some clients are very furious, they come talking very nicely but deep in their heart you don’t know what somebody holds.” (Kisumu/male)

“…we hear incidents where clients will come once again and again and again with different issues seeking this particular counsellor.” (Nairobi/female)

Interviews with service providers identified cases of counsellor incompetence, burn-out, stress, lack of training, inadequate
support and supervision of counsellors, and emphasized them as potential causes for abuse in VCT.

“I think there is the risk of a great deal of personal distress and anxiety and burn-out on the part of VCT counsellors, especially if they see too many clients or don’t get appropriate support supervision…” (Nairobi/female VCT counsellor)

“It would be a source of risk, if the counsellor is not too competent and am saying as a counsellor has just come from training. The counsellor might be very young and is not able to detect such issues and maybe the client can be a risk to him in that room.” (Malindi/male VCT counsellor)

Structural issues, particularly concerning the safety of those in private counselling rooms, were also raised.

“In fact, when attempting to say that everything here in VCT in this room is confidential, this man thinks that if he rapes you or do whatever, it still will be confidential, then he will force you to do it…in supervision one of our colleagues brought the issue. She said how it happened…” (Malindi/female VCT counsellor)

“…because they’re vulnerable and it’s a closed room and you don’t know what’s happening in there.” (Nairobi/female VCT counsellor)

Most participants perceived that inadequate prosecution and judiciary systems facilitated and perpetuated the perpetration of abusive behaviours within VCT.

(3) Experiences of abuse
The majority of counsellors related very positive VCT counselling experiences. However, negative experiences and abusive experiences (whether described as first- or second-hand reports) were documented as having occurred in each study area. The providers interviewed felt that these were both serious in nature and more widespread than policy-makers, donors and programmers realised. Detailed descriptive accounts were given by counsellors, their supervisors and programme managers.

“I think the most significant ones have been a spectrum of sexual abuse within the room itself during the VCT session itself and where clients have been raped within the room or have been examined, intimately examined within the room, going against the VCT guidelines and protocol.” (Nairobi/female/programme manager)

First-hand accounts of abuse of VCT counsellors were common
A wide spectrum of abuse in the VCT room was recounted and ranged from the use of abusive words, disorderly conduct, drunkenness and masturbation, to molestation, non-consensual sex and murder threats. Two VCT counsellors discussed their abusive experiences in the following way:

‘‘With] clients who are violent, this has happened before with a colleague. The client wanted to beat her so I had to come in to help out . . . he didn’t want to accept the results.” (Kisumu/male VCT counsellor)

“I had a male client who came in. When I came to the part on the condom demonstration he said, ‘Madam, I hope to show you something.’ He just sat down on that chair and asked me if I can help him with a tissue paper, and he pulled out his penis . . . I asked him why he did that now that he had come for an HIV test. And the client said, ‘If I sit near a woman I feel like having sex.’” (Kisumu/female VCT counsellor)

Confirming that experiences of murder threats have been brought to supervisory sessions, a key informant further suggested a reason for them:

“I’ve heard of experiences whereby counsellors have been threatened with murder or that kind of thing if that client’s information is disclosed.” (Nairobi/female counsellor supervisor)

Second-hand accounts of abuse of VCT clients by counsellors, supervisors and programme directors
The spectrum of abusive experiences detailed by service providers also included counsellor perpetrations against the client. Some programme directors described general accounts of the occurrence of abuse:

“You get counsellors sharing what is happening in sites, of what VCT counsellors have been perpetrating; it has been said that they have not been to training, others were molesting some children or molesting girls who have come for the services.” (Kisumu/male)

“I’ve heard of people making dates in the counselling rooms to meet with people later. I’ve heard of care officers in small rural health centres who actually are watching who is referred to care and watching who isn’t referred and then following those negative girls into the village in the evening and asking them to have sex with them. I’ve heard of people doing community mobilizations and then meeting up with people after them and asking them to have sex with them.” (Nairobi/female)

Others gave specific detailed narratives:

“One of the most difficult experiences I had is when a client phoned me. She said she’d been raped within one of our counselling rooms...she told me she had come to VCT with a friend and...she was called for her finger prick...and then she was told ‘You know there is another test which has to be done with my penis. So then the counsellor put a condom on and he penetrated her and he came...She was so confused now, she was young and she’d never been to a VCT before and didn’t know whether this was true or not true, but she felt it was wrong.” (Nairobi/female)

Counsellor perpetrations against other counsellors or support staff were also reported, for example by a programme director and manager:

“One of the staff members was affected and uh, was being held in one of these rooms against the wall with a counsellor with...
his trousers down telling her that she had to. He was too hot and she had to go on and she had to have sex with him.” (Nairobi/ female)

The experiences of ‘mystery’ clients further confirmed both service provider and key informant descriptions of abusive experiences within the context of VCT.

“We did a mystery client work and we visited counsellors, we visited different counsellors as different clients. So one of us was sexually abused of being asked to lift up her jersey to check probably if there are any lumps on your breast or groins…” (Nairobi/female)

(4) Responding to abuse and the application of ethical and VCT guidelines

VCT programme directors, managers, and counsellor supervisors demonstrated a general familiarity with the national VCT guidelines and ethics, although the level of understanding varied between institutions. Most participants felt the guidelines could be improved and highlighted the need for more detail, for example, on the regulation of sites and counsellors, and implementation of professional codes of conduct. The necessity to ensure implementation of policy at the community level was repeatedly stressed.

“…maybe as time goes by, this policy will be turned into action point[s] and [we will] be able to see more of it at the community level so that it doesn’t only remain at the national level.” (Nairobi/male)

Counsellors generally expressed their knowledge and practice of ethics in terms of what they had learned in training or what the service-providing institution expected of them, primarily placing emphasis on ethical procedures regarding confidentiality and contracting with the client. Several participants stressed that although standards for VCT practice exist, no one makes sure they are being followed. Codes of conduct and prosecution for misconduct were markedly absent from the majority of ethical discussions. One counsellor stated:

“I don’t know what’s legal and not legal.” (Kisumu/male)

However, the majority of counsellors expressed the importance of ethical guidelines to ensure governance of the counselling process, confirmed their relevance to VCT, and demonstrated their applicability through their response to the vignettes.

“In fact they are really, really applicable and they are all important.” (Kisumu/male)

Discussion

We found that abuse can and does occur within the VCT encounter. Experiences of abuse emerged in each of the three study provinces. It was found to exist in stand-alone, health facility and mobile VCT clinics. The findings provide descriptive accounts, in counsellors’ own words, of the types of abusive experiences which took place within the VCT setting. These included specific experiences of verbal, emotional, sexual and physical abuse. The first- and second-hand narratives of abuse both confirmed that client to service provider abuse takes place. Second-hand accounts and the direct experience of a ‘mystery client’ also highlight the potential for counsellor to client abuse, and one second-hand account reports the occurrence of staff to staff abuse.

These findings concur with evidence in the literature which demonstrates that interpersonal violence occurs within almost all contexts (van der Straten et al. 1998) and furthermore that the perpetrators of gender-based violence are largely men (Randall 1997). In all reports of abuse in this paper (client to counsellor, counsellor to client and counsellor to counsellor) the abuser was male and the person suffering the abuse female. The findings support the argument that gender power relations lie at the root of sexual abuse in health care settings, rendering women potentially vulnerable, regardless of professional status (d’Oliviera et al. 2002).

It is a new and concerning finding that counsellors are subject to abuse within VCT interactions. While violence towards hospital staff is a common finding (Peek-Asa et al. 2007), most literature on abuse within counselling settings has focused on the possible and actual abuse of clients by counselling professionals (Norris 2005). Schneider and Phillips (1997), however, found that contra-power harassment, when the violator does not initially appear to have power over the victim, capitalizes on the power base which is culturally conferred by gender. Our findings concur to indicate that gender is every bit as important as professional power within the Kenyan VCT context.

There were strengths and weaknesses with the methodological approach and sampling frame deployed. A weakness with our sampling frame is that client’s voices are absent. In-depth qualitative research with clients to explore their experiences of the potential for abuse within the VCT setting is an important next step. This is not straightforward as VCT is not only confidential but also anonymous. Hence there is a need for careful methodological consideration around sampling frames, confidentiality and ethics. One possible sampling site could be post-test clubs, although one key informant expressed the possibility that clients who had negative or abusive experiences in VCT were unlikely to join post-test clubs. Another possibility could be through antiretroviral (ARV) clinics, although this would rule out the inclusion of negative clients, who some key informants hinted are particularly sought after by male counsellors seeking sexual interactions. Such a study would likely also generate both first- and second-hand narratives of abuse, which present analytical challenges. First-hand accounts arguably carry more credibility as they are reporting direct experiences. However, it is important to not dismiss second-hand narratives as they feed into the ways in which narratives and understanding of abuse are constructed.

The strength of qualitative interviews—both single and paired/triad (Lewis 2003)—is that they are particularly appropriate in researching a sensitive and stigmatized area of abuse in the ‘privatized’ VCT encounter in Kenya. Interviews with counsellors and key informants enabled the collation of trustworthy and insightful first- and second-hand narratives of abuse in different contexts. The weakness of this approach is
that it does not enable generalization to a wider population, and as such it was not possible to collate rates or prevalence of abuse. Further investigative study with both counsellors and clients across other Kenyan provinces, and in other countries where VCT is operative, would provide information to ascertain and document abuse and vulnerability as it occurs within VCT as a whole, and improve empirical generalization of the study. A similar study within other health care settings, such as the provision of ARVs, would aid in developing an action plan across the health sector.

The findings are concerning as they provide evidence of abuse against women in the privatized encounter of the VCT experiences in all three study settings. There is nothing particular or peculiar about the structure or the setting of the three study sites that would indicate that abuse was more likely to occur. Hence the findings do not simply indicate occasional aberrations from an otherwise well-functioning system but rather suggest that abuse is potentially widespread. If abuse and violence are happening in VCT in Kenya, which has an exceptional quality assurance system and high levels of supervision, then similar offenses are likely occurring elsewhere within privatized health care encounters. This is particularly relevant within the context of over-stretched health facilities in resource-poor contexts and rapid scale-up of HIV counselling, testing and treatment where comprehensive quality assurance and supervision systems are lacking. The privatized encounter between client and health professional in the context of VCT or ARV provision should not always be assumed to constitute a safe space.

Policy recommendations

*Internationally,* the rapid scale-up of HIV counselling and testing, including client-initiated VCT, necessitates the adoption of international guidelines, policy and methods in recognition of the potential for abuse. Clear, contextualized and gender-sensitive ethical frameworks for best practice in HIV counselling need to be developed and disseminated. International goals of universal access to knowledge of sero-status have led to an increase in HIV counselling and testing in very public hospital settings (provider-initiated) (WHO 2007) and in successful door-to-door programmes (Wolff 2005). Both policies may inadvertently protect patients and people in the home from the potential for abuse, as counselling and testing are conducted in full view of other patients or family members. However, these policies, whilst possibly protecting on the one hand, have been associated with human rights concerns over confidentiality and consent on the other (UNAIDS 2007).

*In Kenya,* the acknowledgement by the Ministry of Health and the National AIDS and STIs Control Programme of the potential for abuse of both counsellors and clients has been fundamental to the enactment of support systems and the development of protective measures. New policies allow for suspension of counsellors during the investigation of allegations of abuse and, in confirmed cases, for the deregistration of counsellors. Increased public awareness, education and information regarding the correct VCT process empowers VCT clients and means they know exactly what to expect in the session. Leaflets, media advertising and an interactive CD-rom on what to expect in the VCT room in Kenya have been issued. Furthermore, radio presenters, MPs and popular entertainers who have visited sites have talked about their experiences in public fora. Pilot projects for door-to-door, home-based testing are reporting high acceptability rates in three districts. There remains a need for further collaboration between the health sector and the criminal justice systems to ensure that when cases do occur they are reviewed through the courts, as no cases have been taken to court.

In *institutions delivering VCT services,* there is a need to stress the importance of quality assurance, standardized service delivery, VCT site regulation, and the enactment of codes of conduct, including prosecution of misconduct by counsellors. Institutions providing VCT should attempt to offer clients the option of same-sex counselling wherever possible. They might also consider structural matters such as windows with semi-transparent glass, unlocked doors and the use of quality assurance measures such as mystery client exercises.

Conclusion

Despite a strong focus on quality assurance mechanisms in many VCT sites in Kenya, abuse against women has been described and documented in the study as occurring client to counsellor, counsellor to client, and counsellor to counsellor regardless of the role held by the women. Together these findings imply that gender and power relations influence and shape the risk of abuse within the privatized setting of the VCT encounter in Kenya. This necessitates definitive action to ensure that the physical and emotional well-being of VCT counsellors and clients is not compromised. The issue carries further implications for protecting the rights of clients and providers, which are imperative both within the VCT context and beyond.

Further debate around this issue and the application of ethical guidelines and codes of conduct are urgently needed to ensure the protection of clients and providers in the scale-up of client-initiated VCT and wider HIV/AIDS treatment and care programmes. To address this issue now is timely, particularly in view of the international impetus to scale-up HIV care and treatment in resource-poor contexts. However, addressing abuse in VCT is not a straightforward process and requires definitive action at numerous levels and by various stakeholders. It is necessary from both rights and gender-based perspectives to ensure that HIV treatment and care services do not infringe on the rights of either clients or providers. The literature has largely been silent on this issue, and it cannot afford to be so any longer. It is our hope that this article will raise awareness and fuel debate in this critical but neglected area.

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

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