

**REPRESENTATIONS OF HIV  
AND IMPACT ON CARE SEEKING  
AMONG THE MEN OF HOMA BAY, KENYA**

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Xavier Plaisancie

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supervised by Dr. Jean-Hervé Bradol and sociologist Marc Le Pape

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**Research, investigation, writing:** Xavier Plaisancie -  
**Editorial preparation:** Marc Le Pape, Jean-Hervé Bradol,  
Michael Neuman, Elba Rahmouni - **Translation:** Nina  
Friedman - **Design and layout:** **fcgraphite**

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# FOREWORD

Jean-Hervé Bradol and Marc Le Pape

## **I. Jean Hervé Bradol - Disciplining the sexual behaviour of Homa Bay men: a medical pipe dream?**

Xavier Plaisancie's study – a sociological survey done for his thesis in medicine – looks at “Representations of HIV and their impact on care seeking”. This investigation regarding the male population of Homa Bay, Kenya reveals the difference between public health aims and the concerns of patients being encouraged to change their social behaviour to meet health objectives.

In the case of HIV, success – defined by governments and global health actors like Médecins Sans Frontières – would mean 90% of adults getting tested each year, 90% of those testing positive agreeing to treatment, and 90% of cases adhering to treatment faithfully enough that their viral load becomes undetectable.<sup>1</sup> This would stop person-to-person disease transmission. According to this mathematical model, adopting these virtuous behaviours would control the epidemic by 2020 and eradicate AIDS as a disease by 2030.

And while many institutions (medical, public health, political, religious, educational, and media) are acting locally via recommendations, instructions, and advice, Dr. Plaisancie's survey shows that many of Homa Bay's men are not informed about this policy, although it concerns them most of all. They have other equally legitimate interests besides being virtuous subjects of health policy – having lots of sexual partners (for some of the young men), getting married, having children, and providing for them financially.

More generally, the survey results raise the following question: “Are United Nations public health objectives for combatting HIV achievable?” This is an important question whenever there is strong political will to eradicate a disease, but the medical knowledge and technology needed to achieve such an objective is insufficient. In this instance, the question arises in a context where there is no vaccine or definitive treatment for eliminating HIV from the body. There is little chance, in this case, that changing people's social behaviour can compensate for medicine's shortcomings. The vast majority of men are simply unaware of the goal, and even if they were, they have better things to do than be an HIV patient.

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1. <https://www.unaids.org/en/resources/909090>

## II. Marc Le Pape - What a qualitative survey adds

Xavier Plaisancie did his field work from April to June 2018 in Homa Bay County, Kenya, on the northeastern shore of Lake Victoria. Forty-six men were interviewed and recorded. He employed a number of different of survey methods. In addition to recorded interviews, Plaisancie used informal contacts, meetings, conversations, the scientific literature (in medicine, anthropology, and sociology), and observation of the activities of MSF and other institutions, door-to-door testing, moonlight consultation sessions, formal education sessions, patient advising and monitoring sessions.

I would like to underscore the specific ways in which a qualitative sociological and anthropological survey adds to the medical effort.

1. It relates and situates the actions and discourse of the main agents offering HIV-related recommendations – i.e., medical, religious, and educational institutions. It reveals the tension between what the medical establishment says about HIV, on one hand, and traditional Luo beliefs and practices (levirate marriage and polygamy, in particular<sup>2</sup>), on the other – that is, beliefs that conflict with the messages from institutions involved in fighting HIV. At the same time, consistent with the medical discourse, Christian messages frequently advocate abstinence first and then marriage as a preventive practice. But neither medical discourse nor Christian messages have brought about widespread, unvarying adherence to the normative recommendations or agreement on what constitutes protective behaviour or dangerous attitudes. Plaisancie identified those differences by examining how subjects expressed their sense of risk as a function of their generation, their relationship to tradition and formal education, their susceptibility to family influence, the quality of their relationship to medical professionals, and the intensity of their desires.

2. Dr. Plaisancie shows the influence of reputation as an explanatory factor for many behaviours: sex, marriage, the use of medical facilities (for testing and HIV care), church attendance, etc. He explains the dynamics of social recognition and how they accord or conflict with the recommendations on testing, treatment adherence, and protective sexual behaviour. For each man (teenagers in particular and single men more generally), protecting their reputation means being careful about daily practices – for example, being vigilant about the risk of being stigmatised if they are seen going into a medical facility (dispensary or hospital). If seen, you are suspected of having HIV.

3. Lastly, one specific contribution of the qualitative approach is that it reveals alternatives to recommended behaviours. Though rare, they are worth identifying because relating such behaviours serves as a reminder that men do not rely solely upon what the prevailing sources of advice (the medical establishment, religious institutions, the educational system, and their families) tell them.

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2. We should underscore the fact that while levirate marriage is commonly designated as a risk factor, but we do not know how common the practice is or, as a consequence, the actual effectiveness of such traditionalist determinism. Regarding the characteristics of levirate marriage as practiced in 1936, see E. E. Evans-Pritchard, "Marriage Customs of the Luo of Kenya", *Africa. Journal of the International African Institute*, Vol. 20, No. 2, April 1950, pp.140-141. Evans-Pritchard was the first professional anthropologist to study the Luo.

Here is an example. Rejecting sexual competitiveness as a means of social recognition, some teenagers circumvent this reputation problem by prizing other behaviours. Plaisancie cites the case of one student he interviewed in 2017 (V. was born in 1998 and had just finished high school). V. stated:

*“Most of my friends haven’t seen my girlfriend they haven’t seen my girlfriend. They can ask the question why I didn’t have sexual intercourse yet so they could laugh at me.”*

But V. valued asceticism not as Christian respect for virginity before marriage, but as performance. This goes back to what Michel Foucault called “les pratiques de soi” (practices of the self); it is asceticism, “not in the sense of a morality of abnegation, but as an exercise of self over self (exercice de soi sur soi)<sup>3</sup>”.

4. “Community”? There were three people present at the field interviews: the person being interviewed, the interpreter, and the physician/sociologist. The first spoke Luo, the second English and Luo, and the last English. This may have caused some difficulty for the non-Luo-speaking person. The interpreter often chose the term “community” to translate an expression by the Luo speaker. As a French-speaking social science researcher, this piqued my curiosity. To what reality does the term “community”, and its French equivalent “*communauté*”, refer? This is not self-evident, at least to a French-speaking researcher; the term “*communauté*” can refer to several different realities, which can be denoted by words that show the difference between them: household, church (or religious group), group of friends, entourage, loved ones, family circle, socioeconomic group, or village. Whenever such details are left out, the difficulty remains. And this is not specific to Luo – it applies to a lot of commonly-used terms at MSF and elsewhere.

5. In their own way, the accounts that the qualitative researcher collects of the subjects’ experiences and the stories of their journeys give us access to the world in which medical work is done, and to the realities that affect it; it is a world of tension, unequal social relationships, irreconcilable desires, stigmatisation, sexual competition, etc. Through his field work, Dr. Plaisancie has endeavoured to know those realities.

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3. Michel Foucault, “L’éthique du souci de soi comme pratique de la liberté”, texte n° 356, *Dits et écrits IV 1980-1988*, Paris, Gallimard, 1994, p. 709.



# GENERAL INTRODUCTION

After more than thirty years of combating HIV (human immunodeficiency virus) and despite progress in both treatment and reducing the stigmatization of people living with HIV (PLHIV), issues related to the epidemic persist.

The HIV epidemic is still a problem everywhere in the world, but particularly in developing countries, where numerous barriers continue to limit access to information, prevention, and treatment.

The Joint United Nations Program on HIV and AIDS (UNAIDS) has set an ambitious goal of eradicating HIV as a public health threat by 2030, and an intermediate goal known as “90-90-90” (90% of HIV-positive people knowing their status, 90% of HIV-positive patients under treatment, and 90% of treated patients having an undetectable viral load) by 2020 (1) (2).

Sub-Saharan Africa bears the heaviest burden of this epidemic, with 25 million people affected (it accounted for 66% of the world’s HIV-positive population in 2015) and 1,300,000 new cases in 2015 (3). This is a very different situation than in the global North, where the incidence is far lower and mortality well-controlled. And while there has been undeniable progress on all continents with ever-increasing numbers of PLHIV on antiretroviral therapy (ART) – especially in sub-Saharan Africa, where 11 million people now have access to ART – the epidemic is clearly still active.

A number of factors in sub-Saharan Africa hinder access to the kind of HIV care offered in the global North. These include difficulties accessing the latest generation drugs, which are still too expensive; dependence on international AIDS agencies for human, physical, and economic resources; and other humanitarian situations that sometimes complicate public health management of HIV (4).

This is the reality in Nyanza Province, a rural area in western Kenya where this study was conducted. The prevalence in this region of 4.4 million inhabitants is an estimated 15%, and in some districts is as high as 25%. The mortality rate is also very high, due to AIDS (Acquired Immune Deficiency Syndrome) in particular (5).

MSF (MSF Médecins Sans Frontières) has been working in this region for nearly 20 years trying to reduce the epidemic’s impact. Thanks to MSF, several thousand people have started on ART despite institutional, structural, human, and technical obstacles. Access to care is still inadequate for all segments of the population. Testing, access to care, and treatment adherence are currently well

below the UNAIDS 90-90-90 objectives (6). The male population is least likely to be tested in testing campaigns; it has poorer treatment adherence and a higher mortality rate.

In Nyanza, where gender relationships and societal functioning have their roots in a specific history and sociology, few studies have examined access to testing and the determinants of treatment adherence for the male population.

In a high-prevalence area, behavior change is often spurred by an individual's awareness of the risk of infection, by testing, and by learning that he is HIV-positive. In particular, such change is reflected in the relationship between the sexes and in the demand for care. The individual then weighs the HIV-related risks against a whole set of health, social, and economic considerations. Hence there may be some process by which the risks and benefits of given behaviors are prioritized.

It appears as though health care interventions need to take these issues into account if they wish to integrate some individuals into a health care effort. Yet few interventions specifically target aspects of male life, such as sexuality and parenthood, for example. Moreover, "masculine" behaviors have recently been used to explain the high HIV transmission rate in this region – hence, men are being blamed (7).

At a time when there seems to be a great deal of pressure on the individual and societies to achieve the global objective of HIV eradication, it would seem important to include and support every individual in the health care effort and process. As we will see, simply setting up a testing or care campaign does not necessarily mean that the entire population will participate; the message has to be tailored to the target population and fine-tuned even within that population.

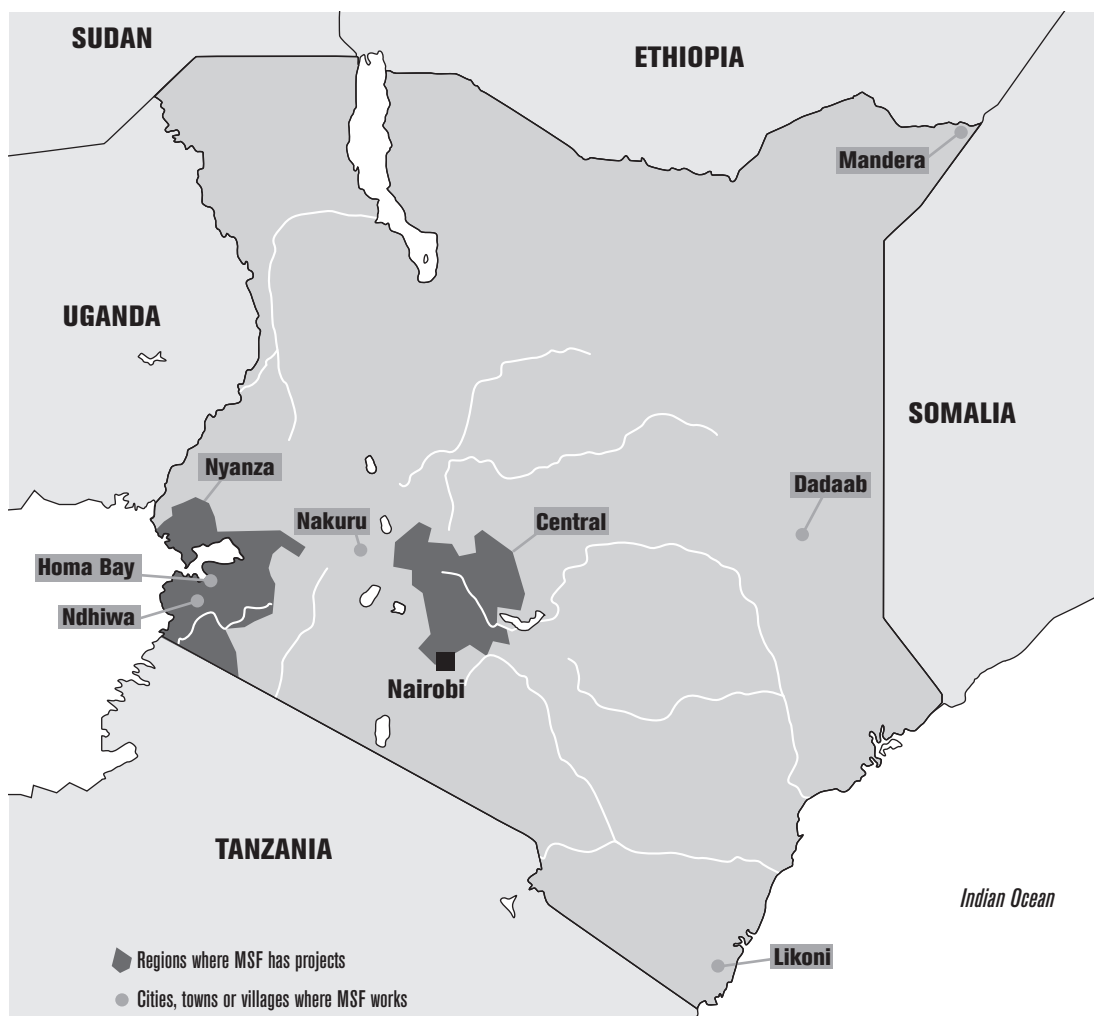
# CHAPTER 1

## FRAMEWORK OF THE STUDY

### I. DEMOGRAPHIC DATA

Nyanza Province, which encompasses Homa Bay County, in particular, is inhabited primarily by the Luo people, the country's fourth largest ethnic group. In total, this ethnic group represents about 3,000,000 people in Kenya, or 10% of the country's population. Though the Luo live mainly in Nyanza Province, they have always been present in the large urban areas as well (39) (55).





Nyanza Province is located in southwestern Kenya, on the shores of Lake Victoria. It is divided into two parts, South and North. Kenya presently has 47 counties, which are themselves divided into districts. The former Nyanza Province includes Homa Bay County, which in turn contains the sub-countie of Mbita, Ndhiwa, Homa Bay Town, Rangwe, Karachuonyo, Kabondo, Kasipul and Suba ; this has been the case since power was decentralized when the new constitution was adopted in 2010 (45).

The population of Homa Bay County was 462,000 males and 501,000 females in 2009, and 542,000 males and 584,000 females in 2016, corresponding to 206,000 households in all (56).

## II. CURRENT PUBLIC HEALTH SITUATION

Here we report the studies done by MSF in the course of caring for patients at the Homa Bay hospital and working in Ndhiwa district. While the results presented are not perfectly representative of Nyanza Province as a whole, they offer a glimpse of the health situation that MSF faces.



## **A. CURRENT EPIDEMIOLOGICAL SITUATION**

### **1) HOMA BAY HOSPITAL**

The overall mortality rate at the Homa Bay Hospital in 2015 was approximately 16%, all pathologies combined. The HIV prevalence among the hospital's inpatients was 49%. The mortality rate for those patients was 16%. Eighty-four percent of HIV-positive patients had been diagnosed prior to admission. Of those HIV-positive patients, 63% were on triple therapy. Seventy-four percent of the patients had been hospitalized at the treatment failure stage. Nearly all of the patients in treatment failure were still on a first-line treatment regimen.

In 2016, the mortality rate was higher for HIV-positive men than for HIV-positive women. The overall mortality rate at the hospital was 14.4%; 37% of those deaths occurred in the first 24 hours. The mortality rate for HIV-positive inpatients was 19%; 26% of those who died did so in the first 24 hours (62). A study on the reasons for admission and mortality at Homa Bay Hospital showed that men came in for care at a more advanced stage of the disease and that the mortality rate was higher for men (19%) than for women (8.8%). Men continued to have a higher mortality rate after discharge (cumulative mortality rate of 40.7%, versus 25.9% for women) (53).

### **2) NDHIWA DISTRICT**

The district has four main working dispensaries, in addition to the Ndhiwa Hospital. In 2015, the district's estimated total population was 242,726, of which 47.6% were male and 52.4% female (62).

Epicentre's Ndhiwa HIV Impact in Population Survey (NHIPS), conducted in collaboration with the Kenyan authorities and MSF in 2012 (6), showed an HIV prevalence for ages 15-59 years of 24.1% and a mean incidence rate of 2.2 new cases per 100 persons per year. In that age group, 13,250 people were diagnosed with HIV.

The estimated number of PLHIV in Ndhiwa District in 2015 was 22,037 (62). Hence, only 60% of HIV-positive patients were being followed. The share of patients on antiretroviral therapy was 50%. In Ndhiwa Hospital, 63,146 people were tested in 2015; 4.69% of them were HIV-positive. In 2015, 2,962 people were diagnosed as HIV-positive. Of those 2,962 people, 82% were integrated into the health care system.

During community-based testing, which began in April 2015, 7,312 people were tested and 3.24% tested positive.

Were there differences between men and women? Men were tested as often as women, except in the health centers where women were tested more often. The positivity rate for tests done in 2015 was 2.39% for males and 4.12% for females.

## **B. CURRENT TESTING CAMPAIGNS**

Testing strategies have changed over the years (53), evolving from voluntary at the start of MSF's intervention to care teams offering testing in dispensaries or hospitals. MSF later organized community-based testing campaigns, and finally home-based testing using a "door-to-door" approach (62). The latter approach, chosen to reach the most isolated rural populations, is part of what is known as COMMOB (community mobile-testing). This activity began in April 2015 and works as follows. A location is chosen. A base camp is set up for assembling the testing equipment and teams. There are nine people on each team. Each team has a leader who coordinates the activities. The rest of the team consists of six counselors, a lab tech responsible for measuring the CD4 count if someone tests positive, and a counselor who specializes in managing HIV-positive patients, to arrange for their subsequent treatment.

Each team is taken to an intervention area. Each counselor, equipped with testing equipment, then goes off to test families who have not yet been tested. Each house tested is marked to prevent another counselor from going there. A local liaison introduces the counselors to the families to make the testing process more acceptable. After the residents are given advice and information on HIV, the testing begins. If the test is positive, the lab tech is called in to take blood, in order to confirm the diagnosis and measure the viral load. The patient is then asked to come to the hospital or a dispensary for treatment. If the test is negative, prevention advice is given. Everyone living in the house is tested. Couples are tested at the same time, and the prevention talk is given simultaneously to both members of the couple, if possible. Children over age 15 years are tested. Confidentiality is not always respected.

MSF has done 10-13% of the home-based testing in Ndiwa District (other organizations also conduct this type of intervention). Once all of the houses are visited and tested (or not), the COMMOB moves on to another locality to carry out the same testing effort. Testing is also done via "moonlight consultation" sessions. These sessions allow men who are unable get away during the day to go to a conventional facility – or be home for door-to-door testing – to get tested. The sessions are held once a week, and vary depending on the possibilities, availabilities, and dissemination of information about them in the population. The moonlight location changes once a certain number of people have been tested. The tent is set up at the end of the day. Several counselors take their places in the partitioned tent to do the screening tests, which go on until midnight.

The final portion of the testing is done in the outlying clinics.

## **C. FOLLOW-UP CARE**

HIV-positive patients are followed at several different facilities (53) (62). Some are followed at Homa

Bay Hospital's Clinic B. Others are followed at "hubs" (the main dispensaries) or at the outlying dispensaries. The choice of follow-up facility is theoretically left to the patient. These dispensaries are run by the MoH with MSF support.

In terms of materials, MSF supplies the third-line antiretrovirals and Kaposi's sarcoma treatment. In terms of human resources, two teams run the dispensaries. Each team consists of an adherence counselor, a Kenyan doctor, a team leader, and a psychologist. These teams go to the main dispensaries each week and to the other dispensaries once a month to collect the data in order to evaluate the dispensary's activity, discuss difficult cases, and make treatment decisions regarding those complicated cases. Sometimes the cases are referred to other teams or to Homa Bay.

If poor adherence is suspected, the treatment is not changed immediately but a visit is scheduled with the adherence counselor. If the viral load is too high after verifying good adherence, second-line treatment is started.

According to Kenya's national recommendations, the viral load should be measured after the first six months of treatment, and then every year. Any viral load >1000 copies/ml is suspicious for treatment failure, and requires a change in the treatment regimen. Currently, viral load testing is done at only one laboratory, in Kisumu, far from Ndhiwa. Once a sample is taken, it takes 1 to 3 months to get the results back. Some results are delayed, or never arrive at all.

Compliant, stable patients on antiretrovirals are seen every six months, though the drugs are dispensed every three months. Patients who show signs of a relapse are seen back sooner, generally in two weeks to a month, then 3 months, and then again 3 months later with a new viral load measurement.



# CHAPTER II

## METHODS

### I. LITERATURE SEARCH AND FORMULATION OF RESEARCH QUESTIONS

Preliminary research was done to gain familiarity with the subject by reading the internal MSF literature on its work in Kenya. The mission reports highlighted the poorer access to testing and care among Homa Bay's male population. According to the observations in Homa Bay, these men were considered a population reluctant to seek preventive or curative HIV care. Lastly, the mortality rate for HIV-positive patients at the Homa Bay Hospital was higher for males, particularly for those diagnosed prior to admission. Therefore, studying access to HIV care for the male population seemed interesting and important.

Based on our literature search, we formulated the following questions:

- 1) *What are the representations of HIV among Homa Bay's male population?*
- 2) *How do those representations impact the demand for care?*
- 3) *How are people informed about and tested for HIV, and how does this impact male representations and practices?*
- 4) *Is the care that is offered tailored appropriately to the men in Homa Bay?*

Our literature search looked for studies focused on a variety of health situations – studies that looked at the factors that determine testing campaign participation (HIV-related campaigns, in particular) in a given population. Those studies also pointed us to previous research on the gender issue, and in particular on gender-related differences in access to HIV care.

The final phase of the preliminary theoretical work was done at the Médecins Sans Frontières headquarters in Paris. We consulted the MSF archives regarding its work in Kenya from the 1980s to the present in order to familiarize ourselves with the workings of the mission – in particular, in the context of HIV projects, testing strategies, changes in practices, and progress made.

The working hypotheses formulated as a result of the literature search were as follows:

- 1) The issues presented by HIV prevention and testing conflict with other issues, and are incorporated with varying degrees of difficulty into men's lives.

2) The moment at which a man becomes aware of HIV may be a pivotal one, at which he adopts certain prevention behaviors and considers being tested. However, prevention and care-seeking behaviors may vary depending on the representations of HIV that new awareness calls forth.

3) Men's lower utilization of care in Homa Bay County may be due to a mismatch between the representations of HIV that prevail among men and the care services offered by governmental and non-governmental organizations.

The resulting study objectives are as follows:

Primary objective of the study:

- To evaluate male representations of HIV and the impact of those representations on care seeking.

Secondary objectives of the study:

- To evaluate the practices of different medical institutions, and how they impact the male population and their representations of HIV.
- To evaluate whether the care services offered in Homa Bay County are in line with male representations and expectations with regard to HIV.

## **II. STUDY POPULATION**

The study involved the male population of Homa Bay County, which is 95% Luo. One portion of the study population was recruited from the male inpatient unit at Homa Bay Hospital, which treats both HIV-positive and non-HIV-positive patients. The HIV-positive patients were not necessarily on antiretrovirals, and may or may not have been hospitalized for an HIV-related illness. At the same time, clinically stable patients being followed by Clinic B or outlying health centers (for prescription refills and clinical follow-up) were interviewed.

After that, we conducted semi-structured interviews with some of the men who had taken part in community-based testing, and thus HIV-negative or of unknown status prior to testing. HIV-negative men over 18 years of age seen during a testing visit were offered the opportunity to participate in the study after their test.

Other men were included independent of testing campaigns, during chance meetings or meetings arranged by intermediaries. The selection criterion for that population was age over 18 years.

The interviews used to meet the secondary objectives were conducted mainly during testing campaigns. In some cases, MSF helped us connect with the government or community representa-

tives responsible for organizing testing missions. We met with other individuals without MSF's help, via meetings in the field or connections made outside of the study context. Once the person agreed to participate, we applied no other selection criteria beyond age over than 18 years.

### **III. SEMI-STRUCTURED INTERVIEWS**

The men encountered during door-to-door testing were interviewed at their homes; the rest of the family was asked to leave. Those interviews were done after the HIV test, in order to tie into what had just been said. That also allowed us to observe how the testing sequences took place, the medical information that was given, and the similarities and differences in testing practices by the various members of the medical corps. By studying these testing practices we were able to discern the messages aimed at the men and the ones that appeared frequently or more rarely. And that helped elicit more precisely the experience of their test visits.

An experienced bilingual English-Luo interpreter translated the questions and answers for the interviews conducted in Luo. The interpreter was present throughout the study, and for all of the interviews. The interpreter was accustomed to doing translation work for interview-based studies. A male interpreter was preferred, to make the men more comfortable when talking about personal subjects.

The interviews were recorded by Dictaphone. They lasted one hour, on average. Various subjects were broached; interviewees were not forced to answer a set series of questions, but allowed to express themselves as freely as possible and then to go back to or emphasize subjects that they considered more relevant or important. The questions were open-ended. The interview might be more structured, depending on the person being questioned and the expansiveness of his responses, and in those cases the questions might be more detailed. At the end of the interview, the subjects were offered an opportunity to go through the interview again to go back to subjects they deemed important or inadequately explored. The point of offering to repeat the interviews was to make them more like a dialog than an interview, by creating a "relationship" between the researcher and the subject and enable access to other information, which would be truer to personal experience.

### **IV. PARTICIPANT OBSERVATION**

In parallel with the interviews, we observed the workings of the MSF mission. Participant observation is an expression used by some anthropologists and is applicable in sociology, as well (65). Participant observation is an integral part of the field survey.

This active observation can result in the creation of recorded "corpus data," which are included in

the study results or become part of what Olivier de Sardan calls “impregnation” (65), which while not part of the listed, recognizable data in the final written work, enables the researcher to better understand the setting in which it evolved. I observed formal education and therapeutic education sequences, days dedicated to monitoring HIV-positive adolescents, and advising or monitoring sequences for adult HIV patients.

Most of the results of this study meet the primary objective and come from interviews with the male population. Yet the results and discussion in this study are not solely the fruit of formal interviews. An entire portion of the discussion came from various meetings, informal interviews, and observation of different situations and therapeutic and medical sequences. Unexpected reflections raised new questions that then had to be confirmed or refuted by interview.

The knowledge obtained from the survey was supplemented by consulting local writings, Luo literature, in particular – admittedly sparse, but rich in information on Luo culture and practices, as described several decades ago. Luo writings were studied and discussed with the translator and with others after that, in particular with regard to the current persistence of certain practices or representations.

That part of the work, done on in the field, was useful in several ways; first, it enhanced the semi-structured interviews aimed at meeting the study’s primary objective. That then allowed us to compare several sources of data and reflection in an attempt to meet the secondary objective, that is, to know how well the care being offered met the expectations of the male population.



# CHAPTER III

## RESULTS

### I. STUDY POPULATION

The mean age of the men questioned was 40 years and their median age was 37 years, i.e., their median year of birth was 1970.

In terms of marital status, 58.7% of the men questioned were married and monogamous, and 15.2% were polygamous with two wives. Another 17.4% were bachelors, widowers, or divorced. Finally, 8.7% were part of an unmarried couple.

In terms of fatherhood, 21.7% had no children, 23.9% had one or two children, and 37% had three to five children. Another 15.2% had more than 5 children. Finally, the parental status of 2.2% was not known.

In terms of HIV status, 53% were HIV-positive and 47% HIV-negative.

In terms of occupation, 23.87% were farmers; 13.02% were still in school or university; 13.02% were fishermen; 8.68% had mechanics-related jobs; 6.51% drove Boda-Bodas (motorcycle taxis); 6.51% were teachers; 6.51% were engineers (active or retired); 4.34% were shopkeepers, some of them also fishermen or farmers; 4.34% did casual work as masons, depending on manpower needs; 4.34% had management or administrative jobs; 4.34% were unemployed; 2.17% did religion-related work, and 2.17% were security guards.

As for the geographic distribution of the study population, 60.8% lived in rural areas and 39.2% in urban areas.

Forty-one percent of the study population described themselves Christian, 41% as traditional, and 8.7% as members of the Legio Maria movement, a combination of Christian and traditional practices.

The characteristics of the primary study population are as follows:

Interview	Birth year	Domicile	Marital status	Occupation
E1	1975	Rural	Polygamous	Farmer
E2	1971	Urban	Monogamous	Engineer
E3	1963	Rural	Monogamous	Farmer
E4	1983	Rural	Monogamous	Shopkeeper
E5	2000	Rural	Single	Student
E6	1993	Rural	Single	None
E7	1966	Urban	Monogamous	School teacher
E8	1974	Rural	Monogamous	None
E9	1964	Rural	Monogamous	Farmer
E10	1980	Urban	Monogamous	Painter
E11	1958	Urban	Monogamous	School teacher
E12	1997	Urban	Single	Student
E13	1977	Urban	Monogamous	Fisherman
E14	2001	Urban	Single	Student
E15	1992	Rural	Monogamous	Vehicle driver
E16	1957	Rural	Polygamous	Shopkeeper
E17	1953	Rural	Polygamous	Farmer
E18	1946	Rural	Polygamous	Plantation supervisor
E19	1981	Urban	Divorced	Vehicle driver
E20	1998	Urban	In a couple	Student
E21	1994	Rural	Monogamous	Farmer
E22	1987	Urban	In a couple	Boda-Boda driver
E23	1955	Urban	Monogamous	Legio-Maria cardinal
E24	1982	Rural	Monogamous	Boda-Boda
E25	1982	Urban	Monogamous	Fisherman
E26	2000	Urban	In a couple	School
E27	1985	Rural	Monogamous	Fisherman
E28	1993	Rural	In a couple	Farmer
E29	1943	Rural	Monogamous	Guard
E30	1965	Rural	Monogamous	Engineer
E31	1999	Urban	Single	School
E32	1985	Rural	Monogamous	Mason
E33	1973	Rural	Monogamous	Farmer
E34	1980	Rural	Monogamous	Fisherman
E35	1978	Urban	Monogamous	Farmer
E36	1998	Rural	Divorced	Welder
E37	1993	Urban	Monogamous	Fisherman
E38	1969	Rural	Monogamous	Farmer
E39	1982	Rural	Monogamous	Engineer
E40	1991	Rural	Polygamous	Boda-Boda driver
E41	1971	Urban	Monogamous	Fisherman
E42	1974	Rural	Monogamous	Farmer
E43	1955	Rural	Widower	Farmer
E44	1971	Urban	Monogamous	Administrator
E45	1947	Rural	Polygamous	School teacher
E46	1984	Rural	Polygamous	Mason

Study population characteristics (year of birth, type of area in which they live, marital and occupational status)

Interview	Religion	HIV status	Parental status
E1	Traditional	Positive	Unknown
E2	Legio Maria	Positive	2 children
E3	Legio Maria	Negative	7 children
E4	Traditional	Positive	1 child
E5	Christian	Positive	0 children
E6	Traditional	Negative	0 children
E7	Christian	Positive	5 children
E8	Traditional/Christian	Positive	4 children
E9	Christian	Positive	5 children
E10	Traditional	Positive	1 child
E11	Christian	Negative	4 children
E12	Christian	Positive	0 children
E13	Traditional	Negative	3 children
E14	Christian	Positive	0 children
E15	Christian	Negative	2 children
E16	Traditional	Positive	13 children
E17	Traditional	Positive	6 children
E18	Traditional/Christian	Negative	4 children
E19	Traditional	Positive	2 children
E20	Christian	Positive	0 children
E21	Christian	Negative	1 child
E22	Traditional	Negative	0 children
E23	Legio Maria	Negative	6 children
E24	Traditional	Negative	4 children
E25	Traditional	Positive	3 children
E26	Christian	Negative	0 children
E27	Christian	Positive	2 children
E28	Christian	Negative	0 children
E29	Christian	Negative	3 children
E30	Christian	Negative	5 children
E31	Christian	Positive	0 children
E32	Traditional	Positive	3 children
E33	Traditional/Christian	Negative	1 child, deceased
E34	Traditional	Positive	3 children
E35	Legio Maria	Negative	7 children
E36	Traditional	Positive	0 children
E37	Christian	Negative	3 children
E38	Christian	Positive	5 children
E39	Traditional/Christian	Negative	5 children
E40	Traditional	Negative	4 children
E41	Christian	Negative	4 children
E42	Traditional	Positive	2 children
E43	Traditional	Positive	2 children
E44	Christian	Unknown	2 children
E45	Traditional	Negative	7 children
E46	Traditional	Positive	7 children

Study population characteristics (religion, HIV status, and parental status)

## II. RELATIONSHIP TO EDUCATION AND WORK

### A. UPBRINGING AND FORMAL EDUCATION

Fathers are supposed to instill certain values in their sons, in particular regarding their family responsibilities and the need to start a family in order to carry on the family name and to become the head of family should the father die.

*“Much of my time, like often in our culture, boys are given the education by the father, how to take the family responsibilities, to be concerned when they grow up”. E11*

Some Luo feel that such teaching has changed, and that parents and grandparents are less interested in bringing up the younger generation, and at the same time that children and adolescents have lost interest in what their parents have to teach them:

*“You see the grand father is teaching mostly how they should behave in the society. The grand mother is supposed to give the same message to the girls, “you should take care of yourself, you should not do this, you should not do this...” Things have changed, these old people don’t take interest in that house, not like before.” E30*

Though masculinity had, in the past, been defined based on physical attributes, parental upbringing seems to have gradually placed more value on intellectual pursuits, or at least those requiring more education. Thanks to access to education, views on what used to be considered a sign of masculinity and the clear distinction between female and male roles appear to have changed:

*“But when we look at how things change, as this people don’t go to work physically, so there is not much about men being a warrior, they defend the family, they are believed to be the strongest. So there is a little change, because of the education.” E11*

Among the youngest patients we questioned, formal education is now a source of social recognition. They associate sexuality with marriage, which is itself associated with having children, and such a life plan is possible only for men whose financial status and employment situation are sound. Hence education allows access to parenthood, and as we will see, to a form of social recognition:

*“I would like to, after finishing my school, maybe apply for a good work, then I marry, then I have children that is my plan (...) it is better to get married after education, when you have get a good job for you to get money to protect the family, the children” E31*

In an economically difficult context, some young people become concerned with finding a source of income that will at least allow for their family’s survival, even if that means sacrificing formal education – in particular, when parental support for the family declines or evaporates completely. Indeed, the loss of parental support forces some young men to shoulder the family’s financial burdens:

*“We lived in peace in a good way, my father died. Now, I am the remaining leader of this family (...) The money was not enough it was less than one hundred schilling. That stopped me from doing my class exam. I continued struggling to support my mother by going fishing.” E27*

Thus the situation is more complicated for young men forced to become the head of household early, who must sacrifice formal education, which is increasingly important socially and offers access to gainful employment, which is rare in this region. As a result, they must resort to lower status, lower-paying physical labor.

In the population surveyed, participants who studied for longer and then got a job related to their studies reported having had a religious upbringing or being exposed to strongly Christian messages. In contrast, the men doing physical labor – farmers, for example – tended to report a traditional family upbringing. The religious talk dealt, in particular, with intentionally limiting the number of children. This gave some of them access to higher income, which could allow them or their children to pursue more formal education. For many, adhering to Luo traditions made it impossible to educate their children – regarding formal education, in particular:

*“That is the Christianity, so when people perceive this and live the Christian way, many men at these days said ‘I can see that polygamy decreasing’ (...) maybe the Luo men they tend to be polygamous, it is like they are feeling that it was also a sign of wealth before (...) you are even more wealthier so people used to compete for having many women and many children. And now it is a problem because you can see the flour is two hundred, one cage of sugar is two hundred, now what to think if you have 40 children, it is stress, it is more hassle.” E44*

## **B. RELATIONSHIP TO WORK**

According to the men we met, there is limited work to be found in Nyanza Province. Most of the jobs are in agriculture, fishing, and trade. Jobs requiring more years of study – such as engineering or teaching – are limited. There are few employment opportunities, and so access to university or a lengthy training program in no way guarantees a job in the region.

Despite the changes in young men’s upbringing and access to work and the importance of formal education to social status, one thing seems not to have changed: the quasi-constant feeling among the men we met of being responsible for their family’s survival and wellbeing.

Difficulty finding work can lead men to defer plans like marriage, which is in turn associated with having children. Indeed, marriage and children require sufficient income:

*“I was planning for mechanics but I can’t go because of the financial problems. So I am still waiting and I can’t marry right now. Because for marriage I have to spend more money, provide for her, build a house...” E28*

### C. SEX EDUCATION

At adolescence, girls are taught the value, primarily moral, of their virginity, as it is a source of family pride. Aside from its moral value, virginity also ensures a higher dowry. Transmission of such values has tended to change, and virginity is not protected as strongly as in the past. Yet several men report having commended it to their children:

*“You know the values of African cultures, the values that are still much respected like, when a girl is married with her virginity, it is pride to the parents and the community, though today you find a break of those values. But we still teach them about the importance of those values.” E7*

Young men’s virginity is protected for different reasons – above all, to ensure that they can continue their formal education, which would be threatened by beginning their sex life early:

*“They believed too that having premarital relationship would ruin your future in term of concentration in your studies, you are diverted, so that is the reason they wanted us to focus on one thing, so if it was school, just school and they advised that it is not bad to have a relationship but after you achieved your education.” E7*

Boys currently seem to enjoy relative lenience when it comes to monitoring their sexual behavior, which is better known and accepted. When the subject of young people’s sexuality did come up, it was often in terms of early female sexuality and the socioeconomic explanations for it.

In the past and still, to a lesser degree, today, children were taught via prohibitions voiced by their parents – by fathers to their sons, in particular. Children were told they would bring a curse on the family should they violate the rules of behavior. Some of those rules applied to sexual behaviors, others governed everyday family relationships. Traditional prohibitions and recommendations seemed, according to those surveyed, to apply particularly to males. Hence a parent-child conflict could bring a curse upon the family home; among the dangers was the threat of a curse on any future homes set up by a family member on the family land. That curse has a name – *Chira* – and is believed to affect individuals who fail to follow the rules of behavior imposed by Luo society. *Chira* manifests primarily by weight loss, and ultimately leads to death. The threat of *Chira* seems to serve as a means of moral control over sexuality by dictating the behaviors – sexual, in particular – that young people may or may not engage in:

*“Chira is when one do a taboo, which is not accepted in the society, or it was something which was not supposed to be done according to our traditions (...) Even the prostitution, one is not supposed to have sex intercourse with somebody who is not his wife. They could tell you “he has Chira”, so it was a form of teaching.” E11*

When the subject came up, subjects cited male behaviors to explain the occurrence of the *Chira* curse.

Such beliefs tend to disappear gradually from one generation to the next. Nowadays there is some doubt about the danger of Chira when certain rules are broken; for some, it has been replaced by another threat – HIV:

*“Before you could cheat somebody that “you have Chira”, but he had AIDS. HIV and Chira are two different things. HIV is AIDS and Chira is a traditional family disease.” E27*

Christian values and medical messaging on HIV have tended to supplant, or even condemn, traditional Luo beliefs, which were perhaps a way to control behavior. Traditional education and prevention messages are being replaced by several other sources of knowledge – school, religion, and medicine – conveying different ideas:

*“They are unsaved. Those who are not saved talk about Chira, but with the saved we have not talked about it, we don’t build our faith on it (...) **When has it changed?** After the teaching. By the Community Health Worker, in the community, and the health educator.” E38*

Schools seem to deliver a relatively ambiguous message. Abstinence until marriage is strongly recommended, but condoms should be used if sex is “necessary”. Not only is there ambiguity about what determines whether sex is necessary; the men reporting these messages failed to figure out younger men’s motivations for having sex, assuming that peer pressure was primarily responsible for that type of behavior:

*“I told them about the need to hmm... to be... to avoid sex... Avoid it completely. We call it abstinence. Because they are still pupils. So they should not think about sex at their age... we teach them ways of protecting themselves from STI (sexually transmissible infection), one of them is abstinence, another one is the use of condoms, if it (sex) is necessary.” E7*

Teaching girls about condoms was seen as inconsistent with teaching them value of virginity. These messages coexist more easily for boys, confirming that girls’ sexuality tends to be limited and that of boys more accepted.

The message about condoms is sometimes hidden, and often reserved for boys:

*“I teach boys how to use condoms. **And girls?** Yes but it is mostly the boys who use the condoms, in fact we demonstrate them openly how it is supposed to be use and the rest. To the boys.” E30*

Hence boys have sole responsibility for condom use:

*“Only the man we propose. Every woman I have met I didn’t see them propose I don’t know why (...) According to me I always have to propose. It is the responsibility of men.” E37*

Some men were having difficulty, and reported having to negotiate condom use and being met with refusal or misunderstanding by their female partners, as in this case:

*“She didn’t want to use condom and she hate the condom, I could not even find them in the house (...) Where I put them in the box in the house, I could not find them. Even the box I could not get (...) I asked*

her 'why you don't want to use condom' then she spoke a word: 'those ones are for dogs!' Maybe this is just to stop me, to ask no more questions." E19

#### **D. IMPACT OF EDUCATION ON BEHAVIOR**

There seem to be two schools of thought regarding education's impact on behavior. The older men, who received sex education – whether traditional or Christian – before the HIV epidemic, seem to have been more sexually active prior to marriage than the youngest, and were possibly at higher risk. For the youngest men, it seems to depend on the type of prevention message received. The message based on abstinence and condoms seems to be more efficient. Among the youngest subjects, condoms are an option for those who will not consider abstinence. Fewer of them seem to respond to the abstinence-only message, whether it comes from religious or educational institutions or from the family. And the medical message seems to carry the greatest weight.

### **III. RELATIONSHIP TO WOMEN AND FATHERHOOD**

#### **A. VIEWS ON PREMARITAL SEX**

Despite individual differences, at each "stage" of male life the importance of reputation forms a backdrop that often seems to condition specific behaviors. Education and access to high social status are of the utmost importance; this was a major concern and a central topic of discussion.

Being sexually active and having numerous partners is particularly valued by young boys, as is the ability to have these types of relationships. There is peer pressure on young men to be sexually active as early as possible. This is associated with reputation, because some link it closely to masculinity itself. Thus being a "man" is associated with early sexuality, sometimes leading to sexual competition among adolescents. Among the men we questioned, this pressure was not confined to a particular social class and seemed to happen both in and outside of school, and in certain work settings.

*"In the past we used to talk about girls (...) competitions about how many girls we can have again, if we can seduce, if you can seduce girls and things like that (...) when you abstain, somehow young fellows see you as somebody who is a coward (...) So that's where you are sure that you are men, capable of that."*  
E37

Some rejected such behavior once they became aware of HIV. Some gave up or changed their social relationships in order to avoid that pressure and that type of behavior:

*"I could have such character if I would have interacted like them. You can be involved under pressure, if you are close to them, you listen to their conversation and you will be lured to get into these acts (...) That is why I am not close to women (...) I don't like it that is why I don't have friends."* E15



Rejecting sex as the only means of social recognition, others found a way around the reputation problem without altering their social relationships, placing value on other behaviors and avoiding situations that might involve them in sex too early:

*“I was respected at school because I am a celebrity at school (...) Some have sex just because of the pressure (...) But sometimes it is fashion to be virgin (...) what I’ve come to realize, they wait for boys to come to ask. But no, when she comes and sometimes we meet, I come up differently she cannot even think of it.” E20*

## B. MARRIAGE

While the discussions and concerns of younger men leaned more toward sexual competition, there came an age where recognition by others, a sense of personal accomplishment, and even masculinity required being married, which was in turn associated with having children. According to many, that pressure generally started not when they reached manhood, but between ages 20 and 25; some adolescents planned to get married around that age. Young men who had had multiple partners in the past felt pressured by their friends to get married and change their sexual and relationship behavior. The feeling that they were unable to get married, however, prompted them to put it off, to avoid the problem:

*“You know a lot of my friends, they use to tell me, “why don’t you marry?” (...) Them they are married (...) They only want me to get married. You know when you are a boy from age twenty to twenty-five you need to be married (...) According to them, it is important. But to me, you can’t get married if there is no mean to provide for her. To be a man you have to get married in the community. No even it is not a shame, but you are someone neglected, that you are not a man, such thing like you are mad...” E28*

Some men rejected that pressure, but their rejection was often partial, or temporary, and the men found other ways to satisfy their community and their own desires by showing that they were involved in a single relationship, as a way of shielding themselves from other people’s judgments.

*“So they tell me “are you afraid?” “no I am not afraid, I have a girlfriend you know” (...) I already told her, I didn’t propose but I just tell her “now I am not ready to marriage but if you can wait for me two or three years to come...” E28*

Despite a positive rejection of marriage, some individuals found the pressure too strong, due in particular to the personal importance placed on descent and perpetuation of the family name. That value was also transmitted, indirectly, by their upbringing, whether traditional or religious. One man, for example, separated from his first wife, initially refused to remarry. But coming from a traditional background, he felt indirect pressure from the community to have a child. Because he had recently converted to Christianity there were also religious principles at play, pushing him to make fatherhood a part of the marriage he had rejected initially:

*“The perception which I have, sincerely, if it were that women are not to be married to give birth and give the family to continue, it is better for one to stay alone, to be unmarried (...) When I see my friends*

*around, they had family, but I did not have family so that notion forced me to get another wife to live with, to have continuity in my family I should also have children, to have someone to be...to live behind me.” E8*

The men who reported pressure to marry from their friends, family, or community usually came from a rural, traditional background. They seemed to have less lucrative, less secure, and more agriculture-related jobs, in particular, or jobs requiring less education. Men from other backgrounds with a religious upbringing tended to give more personal – i.e., financial, health-related, or spiritual – reasons for marrying. The men with the most advanced education did not mention this pressure, or the importance of passing on the family name, or that they needed to marry so that their younger brothers could marry in their turn (as seniority dictated). Moreover, pressure from family and friends did not seem related to age. Both the youngest and oldest men described that pressure.

### C. MARRIED LIFE

The men we interviewed said that their concerns changed when they got married. Discussions changed and they became less interested in relationships with women. They became more oriented toward being able to ensure the family's wellbeing, and particularly that of their children, by finding a stable, adequate source of income. As mentioned above, ostensibly “male” family responsibilities were instilled from early childhood. Many of the men described their role as the economic mainstay of the family:

*“Of course there are differences. One even that I have a family now I have more responsibilities that I have to do (...) I have a role to play with my family. I take care of my family that is the role. I see how they can feed how I can get some money to take children to school” E2*

Traditionally, women who failed to fulfil the role assigned by society or behave as their husbands wished may have been cast out of the home, but “combined” with another woman, the couple entering a polygamous relationship.

*“But today, population has grown, you don't have that vast land to keep the cattle so it is not really valued today but depending on individual circumstance, you can be forced to be polygamous, maybe if you don't have peace in your family, with your first wife, or maybe she ran away.” E7*

In addition, it was often said that polygamy was considered a sign of wealth, because it showed that the man could bear the financial burden of numerous marital relationships.

*“I don't know how our traditions, if you have many women you are wealthier, if you have many children, you are even more wealthier (...) You will be considered in African culture then, traditionally if you have many women and children, to be somebody...” E44*

This practice is being challenged by current economic problems and moral condemnation by religious, governmental, and humanitarian institutions, particularly in the context of HIV:

*“I can say things have changed, because we realized previously, men used to have 4-5-6 wives, but of late and because of the economic situation, getting some boys with two (wives) is a problem. And you see the problem of having many wives, they are more at risk than one wife, maybe things have been a problem.” E30*

#### **D. REPUTATION AND COMMUNITY TIES**

Respectability and responsibility go hand-in-hand. As mentioned above, there is social pressure on young men to have sexual relationships, and then there is societal and self-imposed pressure to marry. The pressure there comes from how the man is seen by others, and respect from his peers depends on his ability to fulfil his duty to his family, single-handedly:

*“In my family, my community, people, not like those who are rich, when you are poor they enjoy, because now you cannot have earning and living and you depend on others, but when you provide for yourself, they respect you.” E34*

Men who are unable to meet their family’s needs risk losing their reputation, especially if they ask for help from their family or community. Men are considered responsible for supporting their family financially. This idea seems to be shared by both men and women alike.

#### **E. FATHERHOOD**

The connection between respect and fatherhood is still quite strong. In this population, becoming a father is a major event in a man’s life – a source not just of personal happiness, but of peer recognition and membership in society as well. In contrast, couples that cannot conceive and men who are still single beyond a certain age are to some degree excluded:

*“In the area I don’t now have shame that I did not have children. Shame not to have children? You are not respected when you are not married and you have no children but your age mates have family and children. So you will not have respect. To be a man you need a family. The other responsibility or resource that you are a man: if you have a woman and then has not given birth to a child then you make her pregnant then she has a baby.” E40*

For some, fatherhood was a part of marriage, never outside it. Not being married was equivalent to not having children. Fatherhood was, however, jeopardized by their economic and, as will see later, health situation. Fatherhood, a source of personal accomplishment and community respect, is now being reconsidered in terms not of its foundation, but its configuration. The Luo agree that having a large number of children from several different wives in a household was traditionally considered a sign of wealth and masculinity. But this view is changing, and some of the practices that define masculinity in this society are being rejected:

*“And now it is a problem because you can see the flour is two hundred, on cage of sugar is two hundred, now what to think if you have 40 children, it is stress, it is more hassle” E44*

Economic difficulties led to different behaviors as people attempted to adapt. Rather than wanting to have lots of children, formerly seen as labor power or a long-term economic investment, some now want to limit the number of births to reduce child-related expenses. This is another rejection of traditional masculinity – or the typical practices, at least – in favor of an image of men having control over their own sexual, family, and economic lives, being independent of the community, and meeting the economic, educational and health needs of their children:

*“I wanted to have three. But now my income has not reached the level I expected (...) I want to have children but my income cannot allow me (...) One of the challenges is to have food for the family, the woman has to be dressed well, the child also has to be dressed well (...) It is not a threat to my life and it does not affect my reputation in the community because I know what I do.” E21*

## **F. RELATIONSHIPS TO WOMEN AND MONEY**

Whatever the man’s relationship to women, there was a connection to money. Relationships ranged from prostitution to marriage, including casual encounters and stable non-marital relationships. This connection was mentioned especially by the youngest men, for whom money is a necessity regardless of the woman or relationship type. There is a hierarchy in the responsibilities that men think they must fulfill, depending on the woman and what they expect from the relationship. Prostitution, which is by definition connected to money, does not require as much financial investment as marriage, for example. Then there are casual encounters that are automatically a financial burden for these young men, as they have to buy gifts, for example, for the purpose of seduction:

*“You can also give a girlfriend a gift, it is not easy to give money when I don’t know how the money is going to be used, but the money I have, after time, I can spend them on.” E22*

Before a man can get married, he must be able to shoulder the financial responsibility; this principle is instilled from a very young age. He must apprise his current or future wife, or her family, of his financial background. After paying his in-laws the dowry, money earned is invested in the marital relationship, strictly speaking, but there is still this notion of male responsibility:

*“There was a change when I worked before I married; my girlfriend was the lady I used to be close to, so I gave her money, she used to give to her parents. Since we are married the money we have, we spend in our house, to upkeep us” E15*

Apparently, this connection to money has not always existed. This man reported that current society is different than what he experienced in the same place in his youth. Relationships with women have apparently changed, and are more connected to money these days than they were before. Some

of the older men tended to view the present connection to money as no different than prostitution, regardless of relationship type.

*“During that time there was no use of money as it is right now that women I give them money. Right now they give money to women. You might have a lady and you talk with and after short time she observes how much you have in your pocket and then she goes with you and that is why people have to go testing so much because you don’t know the lady that you have contact with is well or not (...) I have been a watchman up to the bar and I have experienced how prostitutes behave.” E29*

Yet in the interviews, these connections seemed to be multifaceted, between sex and money, love relationships and money, and marriage and money. Some subjects felt that young women used prostitution as a way to get the necessities, or to continue their formal education:

*“For example, there is a problem even in university right now where they pay a lot of money, girls cannot raise because education at the university is payful and also what they need. So you may find a girl may have a boyfriend or what you can call a “sugar daddy”, so they may lure the young girls because they have a lot of money, or a lot of thing, and definitely this is prostitution. You know girls are more vulnerable, and also very weak when they are not properly cared for.” E11*

In their opinion, by delaying marriage for any reason men risk losing the relationship, which would be threatened by other men more comfortable or more inclined to provide for the woman financially:

*“Because for marriage I have to spend more money, provide for her, build a house ... No, maybe this credits... “send me credits”... to go out. Well, girls always say yes but she has another plan... Yes, she could meet other men, you know... women love money” E28*

Associating the idea of prostitution with relationships based on money, whatever the arrangement –with all that implies in terms of moral judgment – was more common in the older men. As mentioned above, they emphasized how different things were in their time, and in their past relationships with women. With the younger men, the monetary relationship seemed different and worked in different ways, although prostitution was not unknown to them. Many of the relationships, which took a variety of forms, had a monetary connection but that connection seemed as much self-imposed as demanded by the women. Note that the men who mentioned this monetary connection in their relationship – premarital relationships, in particular – came from more modest, and often traditional, backgrounds.

## **IV. ACCESS TO INITIAL INFORMATION AND HIV AWARENESS**

### **A. ACCESS TO HIV-RELATED INFORMATION**

#### **1) THE MEDIA**

The men questioned got their information on HIV in a variety of ways. Many men got information via the media. This included reading newspapers and books about HIV, or more commonly, listening to the radio. Radio seemed to be an important source for first learning about HIV or getting further HIV-related information. The men who said they discovered HIV in this way were no different in terms of their urban or rural origins, their age (although most were born in or around the 1970s), or their religious affiliation.

Those who described getting their information from scientific articles, the radio, or books seem to have had a higher level of education. The oldest men more commonly described getting information from the media in general. Those from a rural background were more likely to get information from books about HIV, for example, but not from the radio.

#### **2) LEARNING ABOUT HIV AT SCHOOL**

School was another source of HIV-related information, but it was not a major source of information for the men questioned. Those who described getting information at school were among the youngest, born in or around the 1980s. Indeed, the youngest men got a lot of sex-related information at school. Was it, however, the first contact with HIV for most of them? That does not appear to be the case.

#### **3) LEARNING ABOUT HIV FROM COMMUNITY-BASED PUBLIC HEALTH CAMPAIGNS**

Another group of subjects said they first learned of HIV via interventions by medical or governmental institutions. This subset was small. Others first learned of HIV from discussions with their entourage – their family, in particular – or with community members; some even said that they had “heard talk” of HIV around them. The last route was among the most common, and was fairly specific to men from a rural background with no Christian influence, who claimed to adhere to Luo traditions.

#### **4) LEARNING ABOUT HIV FROM DIRECT CONTACT WITH THE DISEASE**

A significant subset of men reported having lived through the start of the HIV epidemic and witnessing its rapid spread and the severity of the symptoms once the infection broke out, and its high mortality rate. They had closer or more remote contact with the disease: seeing loved ones infected, seeing other individuals infected with HIV, or seeing the bodies of patients who had died from AIDS. For nearly all of those men, seeing such horrors seems to have given them a more acute awareness

of the HIV problem than the rest of the men questioned. They were more likely to date their awareness of HIV, their initial questioning of their practices, behaviors, and/or test-seeking behaviors to the moment of their first contact with the disease:

*“In 1989 when I saw HIV positive patients with the rashes on the body, thin person (...) During that time when you see somebody like that who is HIV and AIDS when you go to the hospital, the way he looked, and then to know that is how every patient look like it is terrible...it was terrible to me (...) I was afraid to have any other sexual intercourse and partners and that is why in my life even now I don't have any other partner. So I don't get HIV.” E3*

## **B. HIV AWARENESS**

### **1) AWARENESS PROCESS**

While the experiences that raised subjects' HIV awareness were as varied as the routes by which they received HIV-related information, those experiences were distributed far less evenly in the population questioned.

#### **a) Gradual HIV awareness**

Most of the interviews suggested that the awareness process was gradual, with the first contact acting like simple HIV information with no major psychological impact. A second, different contact via another source of information then confirmed the veracity of the initial information, which was often doubted at first.

Those who had never seen HIV's effect on human beings and those who had prejudices about the origin of the virus or the populations suffering from the disease had been able to deny the existence of HIV or their own vulnerability to it:

*“I had just the belief that it was for other people. I did not imagine it could come to me because I had my wife and that woman. So I think I was just cheated (...) that it is not around here, it is far away. Yet I was right living in the infection (...) Yes I was aware it was there (...) Prostitutes in the bar, I thought, but it was for everybody.” E7*

For them, the awareness process seems to have required more time and greater exposure to signs proving that there was indeed an epidemic going on around them, via successive contacts with different sources: school, the media, community-based interventions, and newspapers. Some men, after having questioned the very existence of the disease described on the radio or by outsiders, were forced to acknowledge its reality after learning that people close to them were HIV-positive:

*“I used to hear in the announcement before I saw anyone infected in the village. I heard one of the man or the ladies was infected. So this one, it was the proof that it exists.” E1*

### ***b) Sudden awareness***

Discovering HIV through school, family discussions, or community-based HIV activities (especially at a time when the younger generation is challenging the legitimacy of those institutions), did not seem to have an immediate impact on future behavior, but served merely as a first contact with the disease. In contrast, experiencing it up close had a greater impact and made men more determined to deal with it. A significant percentage of the men questioned said they first truly became aware of HIV (as a disease that actually existed in those around them, or by a recognition of their own vulnerability) when they saw its effects on the human body.

This mode of contact with the disease was reported by men of all socioeconomic backgrounds and religious preferences. The older men reported this more frequently.

### ***c) Awareness upon diagnosis***

A significant number of men had their HIV awareness raised by their own diagnosis. Patients who described this “late” awareness had gotten their information primarily through family or community discussions. Some had tended to consider the epidemic as remote, and did not necessarily connect the sick people they saw with HIV:

*“In the 1990s (...) Some who went to work in town died and when the bodies was brought home, they were wrapped in polythene so we were told that the disease killed them, that we could not touch them (...) So you did not fear HIV? Because it had not been affected in my family (...) It was not a rural problem (...) I did not have faith that I could be infected (...) I thought it was just a simple thing, a disease which was not common in the rural area.” E38*

## **2) IMPACT OF AWARENESS ON BEHAVIOR**

HIV awareness had an impact on several levels. Some men got tested, stopped having sex or had it less often, or changed how they had sex, in particular by using a barrier method of protection. Those attitudes were modulated by a number of factors.

### ***a) Gradual or sudden nature of awareness***

Sudden awareness occurred when HIV's effects on infected patients were not previously unknown. In such cases, subsequent behavior tended, at first, toward a radical change in sexuality.

When awareness was more gradual, men adopted a wider range of prevention behaviors. Most had themselves tested, in combination with another prevention measure. Many adjusted their sexual behavior, but in a less restrictive way than the first group – that is, by using protection, rather than by having no, or less, sex.

The repetition of prevention messages appeared to have a more lasting effect on behavior. It seemed to attest to the reality of the HIV epidemic and the veracity of its effects. As a result, new awareness



was accompanied by better knowledge about how to avoid getting the disease. An analysis of the impact of information dispensed by schools and via loved ones or community-based interventions, when awareness occurred at that moment, showed similar results: most of the men used barrier protection, without giving up sex or modifying their sexual habits. However, further interviews showed that the use of such protection varied over time, in conflict with the desire to have children, itself associated with marriage. Some men saw marriage as protective, and used it as their sole defense against HIV, without other safeguards like a screening test:

*“Most of the things I continue to learn them at school (...) Like myself, to have a child is on my mind, so that is why I cannot use condoms always. The first lady I did not use condoms.” E33*

#### ***b) Religion***

The use of barrier protection was most common among those who were more religious and/or more educated. It was less likely to be used by Christians, however, who believe in the protective value of God and marriage and have issues with condom use itself.

#### ***c) Proximity to the disease***

Seeing a loved one suffering from the disease had a different impact than seeing “strangers” suffering. Men who saw a loved one with the disease were more likely to have less sex than those who saw it affect people with whom they had no emotional ties. Men who were not very close to any HIV patients were more likely to resort to testing alone.

#### ***d) Age***

Older men and men who were already married when they became aware of HIV saw getting married and being faithful to their wives as a means of future prevention. The older men tended to start by being tested to ensure that they were HIV-negative, after which they relied on their faith in the protective value of marriage, and on giving up any extramarital sex, for prevention.

Most of the young men started by changing their sexual behavior, and then got tested afterward. With them, however, it all depended on marital status. Among the younger men who had not yet started having sex, awareness prevented some of them from having premarital sex, which was protection for them. Among those who had already begun having sex, the behavior change was more gradual, and often less restrictive. They tended change their sexual habits – a more or less satisfactory adaptation in terms of risk – but did not stop having sex completely:

*“No I didn’t stop immediately even though I had the message but I still went on but this time round I was really, really careful. I used protections, at times I was at least bit by bit abstaining (...) you see, as we were competing. As teenagers we were competing (...) but now (...) maybe if I could only have one at a time. So I had to at least abstain or have one partner.” E37*

Formal education, which had an influence on the youngest men, emphasized abstinence and condom use, either as a first choice or if abstinence was impossible. Some considered the abstinence recommendations unrealistic and rejected them. Here is one explanation by a young man:

*“As teenagers we were seeing all the older people that they want to tell us the things which are not good but they used to do it (...) we believed they used to do it so it’s like there are telling us what to do, it is hypocritical so we never heard of them actually.” E37*

### 3) NEGATIVE IMPACT OF AWARENESS

With some men, learning that HIV infection could be fatal was a shock, but led to inappropriate reactions, with fear causing inertia when it came to prevention strategies:

*“There was at time in radio “HIV is dangerous for your life”. It was advertisement through the radio. When I hear, I feel sorry because I pressed the God the world is over (...) When I go to the Bible (...) getting when the world will end so many diseases will come. I think “time has come”. Time was coming slowly, slowly we are now with thing dangerous from America that were coming here in Kenya.” E24*

This type of reaction was seen with most of the modes of receiving information. It was more common for men who had had no prior information on HIV, prevention, or testing, and or whose initial contact with the disease involved a death.

## V. REPRESENTATIONS AND PERCEPTIONS OF THE HIV RISK

### A. CATEGORIZING RISK

When the men first received information on HIV, depending on how they received it, there was a tendency to blame the epidemic on different segments of the population.

For many, Christianity was not compatible with the persistence of traditional practices, as the latter would be fundamentally at odds with religious principles. Yet many of the men questioned did not choose between tradition and Christianity; while claiming to be Christian, they continued some of the practices condemned by Christianity. There was a distinction between “good” and “bad” Christians, depending on their adherence to traditional practices. Some felt that those who failed to reject such practices were false Christians who affiliated themselves with a religious group out of necessity, because they feared the potential impact on their social status of “rejecting” of Christianity.

*“When you come from that family who are persistently not leaving the past, they want to follow the fathers request, they may not let you go so much easily. As much as they are Christians they may be Christians on Sunday or Saturday but the rest of the week they are not Christians (...) if you die the first question will be, “where do you want to be buried ?” (...) so everybody want to belong to a church.” E44*

The “false Christians” who continued to adhere to traditions were considered a danger to the populace, due to the HIV risk associated with traditional practices:

*“And also what they fear is the public image, the public relation. Right now the level of Christianity that*

has led people to know that wife inheritance [The expression “wife inheritor” refers to the practice of levirate marriage, that is, a man’s obligation to marry his brother’s widow] socially it is becoming a vice. And when we are in charge the way the messages have been spread, it is like a vice. When you see it, we call him these days a terrorist. If you are called a terrorist, you are a quite vile wife inheritor so they fear those names (...) They must feel very guilty, they are called terrorist...” E44

Hence Christianity was seen to have protective value of against HIV, and the risk of HIV used as a way to convince men of the benefits of respecting Christian principles and converting:

*“I preach about HIV and AIDS. We must take care of ourselves so that you may protect yourself because in the church we are not all saved there is some who come only to listen to the word of God but they are not saved so we have to tell them there is a serious disease called HIV AIDS.” E29*

When talking about young men and older men, that is, men between the ages of 16 and 80 years, there seemed to be a contrast between the sexuality of the young men and that of the old men; that contrast was quite striking in the interviews. For most of the men, sexuality and its representations changed throughout life, from a more competitive sexuality in the young to a more fatherhood-oriented sexuality as they got older. Accusations were mutual; to those in one age group, the other age group’s sexuality seemed less controlled and more morally reprehensible. According to the older men, economic insecurity, recourse to mostly female, but also male prostituting themselves, or Western cultural influence explained the young men’s high-risk sexual behavior.

*“If they have little activities to engage them, their last resort is maybe have sex, just sleep. To get some resources, something to keep them busy, even apart from. You know when you get that money, maybe that money can also make you to start some enterprise, so if you can start some income activities, some business, that can build up in the process and will sustain you very well.” E7*

The younger men, on the other hand, sometimes saw HIV as linked to traditional practices or to an earlier time when the epidemic seemed more serious. Hence the younger men associated HIV with older people:

*“We knew it but we took it as just a normal thing we knew it was the disease of older people so young people don’t realize, we knew that but as we grew we learn that it is real.” E37*

It is undeniable that the men interviewed tended to connect high-risk behaviors to membership in various social categories based on age, occupation, beliefs, or sexual practices, and that that connection was narrowly and firmly established. Some blamed the illiterate, single people, or fishermen; others blamed the Boda-Boda drivers.

## **B. PERCEPTION OF RISK**

Some of the men (those subject to Christian influences, in particular) felt that the more traditional population engages in higher-risk sexual practices. That prejudice is based on their assumption that

the more traditional population engages in sexual practices like polygamy, levirate marriage, and sexual purification rites and more widespread prostitution. In their view, belonging to that segment of the population equates to a higher risk of being infected. The idea that traditional families engage in more unrestrained sexuality leads the latter to fear, consistent with that prejudice, that their own practices are more risky:

*“So when I also hear that HIV was common I didn’t know in which way it can come in my life. Already I was polygamist, you don’t know how one has protection. **Did you think that you could be infected by sex?** I was in a polygamist relationship.” E1*

*“Yes I fear HIV... You know from that time when I hear... I hear that people got it through sexual I got that sexual I’m just living like my father...” E39*

That more traditional segment of the population would be more inclined to feel vulnerable when entering marriage. Their desire for children or difficulty using condoms in their marriage then makes protection more complicated. Marriage – which may not have the same spiritual value for them – may be more frequently associated with a sense of risk. Hence traditionalists would not necessarily consider marriage protective – quite the opposite, in some cases:

*“A woman has secret sin in her heart she will not tell you everything she has in her mind and she will not tell you she made love with someone (...) You know when you have not married you know what is all about you, you are sure of the movements, but when you are in a group you cannot be assured of yourself.” E1*

Yet the Christians did not report significantly fewer affairs or less premarital sex; their conversion sometimes happened after having been sexually competitive in their youth. In some cases, their sense of vulnerability with regard to premarital sex seemed hidden, if not completely, at least in what was said.

### C. SENSE OF BEING PROTECTED FROM HIV

Most of the men that did not feel threatened by HIV had a strong Christian influence. Getting married was a form of protection that would continue into the future. Some who had not been taught this early and/or had not practiced total abstinence before marriage believed they could get married specifically for its protective value, as we said before:

*“I thought when I married that I could not get infected because it would also stopping from having other issues out of marriage. I will depend on my wife.” E3*

Some saw marriage as a form of protection because (in their view) having sex with only one partner was less risky, and also because its spiritual association made it protective:

*“I didn’t stop walking here and there not because of HIV but because Christ came into my mind, in my life and changed my life... That has helped me. And saved me.” E29*

*“It was hard but you know, if the heart has no God in it, there is no protection.” E38*

Some thought that faith protected them, though their knowledge prompted some to get tested before engaging in marital sex:

*“When I was at school I knew that HIV is contracted through sexual intercourse, it was my wish that God takes care of me that I get a wife who is not infected.” E35*

To this man, his wife’s faithfulness was proven (among other things) by their not contracting an HIV infection over time. Condom use, recommended by doctors, made no sense because condoms were justified only in case of confirmed HIV infection:

*“if my wife was not faithful to me we could get HIV and AIDS... so when I use my own wife without condom I don’t see any problems (...) If you are walking here and there we could have got it and we could have been using condoms by now.” E29*

Some associated condoms with infidelity and risk:

*“My wife, I don’t use condoms... Because she will think you don’t love her (...) If you use condoms, she may think you have other sex partners.” E15*

Sometimes, prevention involved observing their partners; this was primarily about symptoms, and about how much they trusted each other. Their judgment regarding the absence of risk – or lower risk – was based on that.

*“I had to discuss about it before we go into act we discuss about it. Even testing was not there by then so we discuss and if we trust...” E2*

The Christian-influenced sub-population was more likely to see risk as connected to prostitution, unmarried women, and certain socioprofessional categories, and to consider their own practices protective. The more traditional men who did not feel themselves at risk tended to have little knowledge about HIV in general, and to have become aware of it late – at diagnosis, in particular.

## **VI. REPRESENTATIONS OF TESTING AND TESTING PRACTICES**

### **A. REPRESENTATIONS OF TESTING**

#### **1) TESTING, MARRIAGE, AND FATHERHOOD**

Awareness of HIV brought with it a change in viewpoint regarding marriage and fatherhood. For many, marriage was often a form of protection by itself. Yet some rejected it due to HIV – on one hand, because marriage could be a source of transmission, and on the other, because marriage would force them to have a test that they were not ready to accept.

*“At times I feared to get married (...) I was afraid by then and did not have courage (...) I had to take the girl to VCT first so that we may know our status before we get married (...) That also put you power to make money to your drugs (...) You had to at least look for money to treat the sick so by the time the person dies and you, you are left poor for that fear made me at least not to get married.” E37*

As they saw it, the combination of marriage and HIV infection would be too heavy a financial and health care burden. These men claimed that if they turned out to be HIV-positive, they would be unable to both provide for their own care and that of their loved ones and fulfill their familial responsibilities:

*“And I really feared to be HIV positive because it will prevent me from having children and getting married (...) if you are affected by HIV it is just a new lifestyle or if you don’t adhere to the rules on the recommendation of the new lifestyle. That is why I am saying the one who win the competitions is either poor or dead.” E37*

So the first step was to be tested themselves so that they could get married, and then take preventive measures after that. The condition for getting married was that their future wife would agree to be tested. This man also expressed a fear of having his partner refuse to be tested and of difficulties discussing HIV as a couple before marriage, which might lead to a refusal to get married:

*“To find a girl very courageous enough to let us go to VCT, to HIV testing and counselling it was very, very much hard.” E37*

Some felt it was easier for married people to get tested because being positive would have fewer consequences for the couple once they were married. Knowing that their spouses would have to be tested when hospitalized for maternity care would make it easier for the men to agree to be tested:

*“The unmarried ones those who are not married they fear testing but those who are married they don’t refuse. Because nowadays if a woman goes to the hospital she is supposed to be tested positive or negative so they know (...) They think also that if you have a virus you’re not supposed to marry so that is why they fear.” E41*

Some felt that getting tested beforehand might lead the woman to refuse to get married:

*“With the ladies if you say that before you get married “let us go and get tested” she might run away.” E41*

If their wife or child was HIV-positive, some automatically assumed they were also positive. After that, they did not see any need to get tested:

*“I could also accept myself to be sick because if the child was born sick, so all of us are sick. That is why I did not ask for a test.” E27*

With regard to fatherhood, HIV often represented a threat, insofar as an HIV diagnosis would make it morally impossible for these men to have children, due to the risk of infecting their wife and progeny:

*“Yes, they delay testing because it will prevent them from having children. They are being told by misconceptions that “I am going to pregnant the woman, the woman is going to give birth to a child so it is better I stay alone with my HIV. I was born a man, I’ll die a man” E41*

Others seemed to set aside this risk, and the importance of fatherhood seemed to outweigh the threat represented by HIV.

*“What I know is my child is sick, even right now the child is under drugs, our life is still...hmmm... every human being wish to have a child.” E27*

There seem to be two types of testing-related behaviors guiding the view of marriage and fatherhood.

Some men prioritized marriage and fatherhood over testing:

- Either because they felt they had previously taken risks and testing – if positive – might rule out marriage and fatherhood. There would indeed be a risk of transmission, or an inability to meet the inherent responsibilities of being the mainstay of the family. So testing does not happen.
- Or because marriage represented protection at a given time – despite some feeling that they had previously taken risks. Some stopped considering risk once they were married, and freely experienced fatherhood.

Others felt that marriage and fatherhood depended on the HIV risk. Due to the need to protect their future spouse and children, marriage might be impossible without being tested beforehand. Some of those men avoided, or at least delayed, marriage. Others, who seemed better informed about HIV, did marry and begin having marital sex, provided both members of the couple knew their HIV status.

## 2) FACTORS THAT LIMITED TESTING

Some men did not view testing as a way to protect themselves from HIV, or consider it a way to get access to treatment. Getting tested was not a way to improve their quality of life, but a source of additional constraints.

Treatment led to greater acceptance of testing, since diagnosis led to treatment that helped stabilize the disease. Thus testing took on new meaning, and diagnosis meant hope of longer survival.

Not everyone knew about treatment, however, and some still associated testing with impending death:

*“Because people were saying “I’d better die without knowing my status than knowing that I am HIV and*

*living with it, I will die faster". This is a belief. They believe that after knowing that you got it, you have chance to die very fast but you don't know you can stay with it." E30*

Those men felt it was better to live without knowing they were HIV-positive than to agree to a test that was synonymous with near-term death. This denial was not necessarily accompanied by a feeling of vulnerability or fear of the stigmatization that might result from disclosure of their HIV-positive status. Nevertheless, such motives seem to be an important cause of test refusal. It also seemed that test refusal was often due to the assumed impact of being HIV-positive and of treatment on their self-image, their bodies, their capacities, and their future plans.

*"No I said it is a better that remain a secret to me (...) From today I changed, that is why I accepted the test today, because she told me if we find the virus by now when I am still strong, no one will realize that I have the virus so I will just continue with my activities, working, doing everything and I will be the one to decide where I will be taking the drugs. Just from there I decided to change my mind." E28*

The fact that the drugs only keep the disease in check and must be taken for life also seemed to be limiting factors in terms of testing:

*"The people refuse, they know there is drugs to nurse it but not to treat it. We have been told that these ARVs they are boosting immune system they are not treating." E41*

### 3) TESTING AND REPUTATION

*"There is a day they came where we worked (...) everybody had a test, it is only me who remained, so I feel embarrassed, if I refuse, I will be the only one who refused for the test. So let me just test myself. From a group of people doing something and then you refuse, of course the members will say there is something... They will maybe suspect that I am infected so I just accepted and maybe I found myself forced" E28*

For this man, accepting the test was a multi-stage process. First, there was social pressure from his family circle and his village. Refusing to be tested in the presence of others in a public place, for example, might indeed make it look like he wanted to hide his HIV status or high-risk behavior. Under those conditions he agreed to be tested, though reluctantly. After that, he took the step of voluntarily going to a health care facility to ask for a test, something that same circle might associate with risk-taking, and thus be highly suspicious that he was HIV positive, causing inevitable stigmatization:

*"Not afraid of having symptoms (...) now I would know I have it... but not going to the hospital and somewhere to be tested, or coming here for test me. I don't want people to say "he has HIV AIDS, he has been affected" E28*

Indeed, being HIV-positive can jeopardize a man's social status and status as the mainstay of the family, and his ability to fulfil his responsibilities and personal plans – due not to the disease itself, but to the image of the treatment, which leaves the man open to the judgment of those around him.



Moreover, treatment comes with a lot of constraints. This rejection, combined with denial about a potentially positive result, led some men to wait until they had symptoms to begin care:

*“No even the community, because when you are using the drugs, they will just find the truth (...) From there I’ll be sick, then I’ll decide what to do (...) I was afraid of taking medicine every day. I did not think of taking the drugs, I thought if I find myself with drugs, I will kill myself.” E28*

Test refusal or acceptance was based neither on the sense of risk, strong or weak, nor on the direct consequences of potential disease, but on the social (and, to a lesser extent, professional) consequences of being HIV-positive and taking the drugs. For interviewee E28, it took the assurance that he would be fully able to meet his responsibilities (since starting treatment early would prevent any symptoms) and the possibility of getting anonymous follow-up care far from where he lived, to persuade him to have the test.

There was already prejudice stigmatizing certain occupations. For some men, that stigma created misgivings about being tested, or strategies for getting tested without risk by finding a place to get tested far from home or work, since their income depended on their reputation:

*“They say that motorbikers are at risk to get infected by HIV (...) Some are afraid, some go for testing at night or very far away from here (...) Because when you are a motorbike rider, a lot of people know you and they meet a lot of people. That is why they don’t want to be tested.” E22*

#### 4) TRIVIALIZATION OF HIV

HIV is sometimes seen as a commonplace disease, like other STIs or other diseases in the region, like malaria. Some even saw it as secondary:

*“But now community don’t perceive it as a killer because there is some drugs that you may swallow. So it is something taken under control, so this time we normally talk of other killers like cancer or malaria (...) People don’t fear it more or so because stigmatization is down.” E2*

In some cases, the fact that there was a treatment for a condition that people knew to be silent – but did not know was deadly – made testing easier:

*“I did not know my life was at risk... I did not know that my life was at risk, but I wanted to know my conditions, to see if I can start drug...” E9*

#### 5) QUESTIONING THE RISK AND TESTING

Sometimes, the medical community’s prevention message was misinterpreted or transmitted incorrectly. That message was used to minimize the men’s feeling of vulnerability. First, a lack of symptoms was interpreted as an absence of infection – a feeling reinforced by the medically-confirmed existence of serodiscordant couples. Second, an absence of genital lesions was thought to make HIV transmission impossible. So care was delayed significantly – until symptoms appeared and enough external pressure was applied.

This man denied needing testing, despite the fact that his partner was HIV positive. As a priest for his church, his reputation would be jeopardized by a positive test; he seemed to be going through a process of self-negotiation and weighing the risk:

*“There is a teaching that you can find that one partner is positive and the other partner is negative. So I thought I was negative and she was positive... Yes, and even sometimes they say there was false results, that there is machine that could not detect the virus. That is why I did not have a test, because I did not have any symptoms, and I feared the test (...) We have been educated that you can have sex but if there is no wounds on your private part no cut so there is no entry point for HIV/AIDS so that is a possibility to come off it” E38*

#### 6) TESTING AS A PERSONAL ACTION. FEMALE INFLUENCE.

What women said had varying degrees of influence on whether the men were tested. In general, women played a significant role in their loved ones being tested. Their approach was either direct or indirect. There was either a confrontation with direct urging to get tested, or more indirect strategies aimed at avoiding confrontation:

*“She is the one who, silently, suspected that I was infected. Later, my sister was in Nairobi and my sister advised me, well she invited me to visit her at Nairobi so I was going to visit my sister but it is like, some arrangement had been made for me to see a counsellor so she did this by my knowledge” E7*

For the men who experienced it, that urging came mostly from female family members like sisters or mothers. Yet female influence regarding HIV was rare. Indeed, some men refused to be tested despite the possibility of openly discussing the risk with their partners and pressure from close family members.

To this man, disease, and thus risk, was associated with symptoms. He did not care what his family thought of his levirate marriage and the attendant risk. Although he had respected the opinion of the village elders his entire life (for his marital choices in particular), he felt that HIV was a personal matter:

*“My wife was no satisfied, she said after I’ve gone there, the people come to her and told her “you know this thing, from what that person died” (...) You know this AIDS, they have taken it as essential (...) It is not a community affair, because you are not for me, I am not for you” E18*

The younger men were more likely to consider testing a personal undertaking. Some got tested even without symptoms. Their first test – not requested but offered during government or NGO interventions – usually fell into this category. Pressure from loved ones was a far less important factor.

Among the older men, choosing to be tested was less of an individual decision; it was due to pressure from mainly female loved ones and to the death of loved ones. In addition, those men tended to draw a connection between the onset of symptoms and the possibility of HIV infection, while the

younger men often attributed their symptoms to other conditions, such as malaria – a more common, more disabling, and equally deadly disease, especially in the short term.

## B. TRIGGER FOR THE FIRST TEST

### 1) EXPOSURE TO THE DISEASE

Though sudden awareness of HIV due to contact with the epidemic's effects came as a shock to some men, it did nothing to give them practical information about HIV and or raise some men's awareness of testing. The possibility of testing positive was terrifying, and they refused to be tested. This was different, however, from denial or a lack of awareness of the risk that HIV represented. In the same sense, it did not mean that they did not take preventive measures:

*“You could not go for test even to go to VCT or a lab you could not approach that place because HIV was a terrible disease (...) it is God who helped me around that time until I went for the testing (...) I was afraid to have any other sexual intercourse and partners and that is why in my life even now I don't have any other partner. So I don't get HIV.” E3*

### 2) ONSET OF SYMPTOMS

Few men said they drew a connection between what they already knew about the signs of the disease and their symptoms. Once obvious, the symptoms gave some men the idea that they might be HIV-positive and motivated them to get tested. More often, they connected their symptoms not to the possibility of being HIV-positive, but to other diseases like malaria, for example. Sometimes putting it off for months or years, they were eventually motivated to get tested (in the course of routine care) by the frequent reappearance of relatively banal but bothersome symptoms. The possibility of HIV infection had not occurred to them before their hospital visit or test; all of these men were traditionalists:

*“Bodies had been brought from Mombasa, who died from HIV AIDS (...) I didn't know because when the dead body came, they were wrapped, so we were told this is a disease that killed the man (...) I thought it was like any disease, like malaria, headache, like any other disease (...) One of my friend go to those white men and said to me “they treat the disease”. That is how I came to them.” E43*

Many people associated the symptoms and treatment behavior with beliefs from systems other than modern medicine, for example:

- Traditional beliefs associated with Chira, a curse on individuals who fail to respect the rules of Luo society. This caused people to blame their symptoms on current or past behaviors that they sometimes deemed morally reprehensible. This also explains why they sought folk remedies, which further delayed the use of hospital services. The failure of traditional measures prompted

some to get an HIV test, often due to pressure from their loved ones, thanks to the visibility of testing campaigns:

*“During that time before I was tested, I thought it was the cause of my sickness, it could be Chira but after I was tested I knew the problem, I know that one is now useless, it is not the cause of the problem, but HIV AIDS. Even if he works on the piece of land, I don’t care. **Did you know that HIV existed when you fell sick? Yes. Did you think it could be HIV?** My mind did not think of that, because my mind was set on cultural beliefs.” E8*

- Christian beliefs, which prompted some patients (one example being the members of certain religious movements like Legio Maria) to rely exclusively on prayer for treatment.

*“I pray before I go to the hospital then when it is becoming difficult for me, I go to the hospital. So I pray trying to get healed and if it fails I go to the hospital.” E35*

## C. IMPACT OF THE FIRST TEST ON PRACTICES

### 1) NEW SENSE OF RISK

Testing was the moment at which some men first sensed they were at risk. Not because they were engaging in what they considered risky behaviors, but because of the ubiquity of the HIV epidemic, transmitted easily by routes other than sex. Those men tended to question some of the old values – for example, the view among some Christians that marriage was protective. Indeed, couples were urged to get tested together, and barrier protection was recommended for sex within marriage:

*“I think she could infect me. You know those who are teaching us about HIV thus people teach us that you can get HIV not only through sexual but sharp object: razor blade, knife...” E39*

### 2) IMPACT ON MARITAL AND EXTRAMARITAL SEX

Testing is an opportunity for medical institutions to deliver a message to HIV-negative patients on modifying their sexual practices. Married men were advised to stop having extramarital relationships and to use barrier protection with their wives:

*“They told me that my status was very good and that I had not to have sexual intercourse with other lady (...) They told me to take care of myself to use protection because we were negative.” E35*

Doctors advised some unmarried men to stop having sex before marriage. In other cases, medical professionals recommended condom use and circumcision when men were tested:

*“So there was those who visit door to door and they were teaching that men must go to circumcision to reduce the rate of infection. I know it is a disease, and it kills (...) we use condoms. Men must also be circumcised to reduce the infection.” E21*

The recommendations on sex dispensed to single, HIV-negative men during testing often had little, or only partial, effect – either because they were inappropriate, as mentioned previously, or more often because they were already being followed prior to testing, after the men had become aware of HIV.

The recommendations that did seem to have an effect were primarily those regarding barrier protection within marriage. Yet the extent to which this recommendation was followed varied depending, in particular, on the perceived risk, the existing sense of protection in the marriage, and religious convictions. It seemed to be the most religious men that most questioned condom use after these recommendations. The others weighed condom use against their desire for children and their ability to negotiate condoms with their partners. We also saw the importance of marriage, in particular through its association with having children. Yet the medical community urged the married men we questioned to use barrier protection with their own wives, even when both members of the couple were HIV-negative:

*“They told me that my wife and myself were two different persons maybe one may have other relationship and then the other one do not know. So I should use condoms (...) I was surprised first, then later I realized it was a good thing that could help me. So that I may continue living (...) They told me that any of us maybe is not faithful to the other and that if we don’t use condom it may have real effects on us.” E3*

This is where one sees the bind these men found themselves in, feeling obliged to follow medical recommendations on condom use. Since having children was sometimes their first priority, condom use was only partial:

*“When I enjoyed sex as a leisure I use condoms, but if it is for procreation, I have to use it free (...) When she has attended her monthly period, and then the monthly period end, I should use free flesh without condom to make her pregnant. (...) From that time we did not have another child. We still have faith God to give us a child.” E33*

### 3) REPEAT TESTING

The men were advised to get re-tested every three months, regardless of the social or professional context, their view of the risk, or their practices. Many tended to follow that recommendation, even when they saw no risk. The medical community justifies that approach by the fact that there are other transmission routes, aside from individual practices deemed to be high risk. Hence there was always a feeling that infection was possible, despite behavior changes and a negative HIV test.

*“No, I did not feel at risk but later I understood that it can really get to anybody even if you don’t have sexual intercourse (...) They told us there is HIV and AIDS and the ways people can contract it”. E29*

As pointed out earlier, these men had to go through a process of reflection and of analyzing their risk, their past practices, their sense of vulnerability, and the potential consequences of the test before agreeing to be tested. Even learning that they were HIV-negative had consequences, in terms

of taking preventive measures, needing to repeat the test, or developing a sense of risk, leading to changes in their social relationships, for example:

*“After testing, if I found I am ok, I have to take care of myself. I need not to have many ladies, (...) After playing I went to my room booked for me only to sleep. When we have to come back, I come back. I have only one lady. When she is not there I cannot meet any lady even if I have to stay there for 5 to 6 month, I can just stay.” E13*

## **VII. IMPACT OF TESTING POSITIVE**

### **A. BEING INFORMED OF THE DIAGNOSIS - IMMEDIATE REACTION**

#### **1) SENSE OF IMMINENT DEATH**

For some of the men, learning that they were HIV-positive was a shock, as the diagnosis was synonymous to them with imminent death. As indicated with regard to representations of the test, this was due to the idea that once diagnosed, HIV was almost immediately fatal:

*“I almost lost hope in life, I was just counting my days. I knew my days was numbered, I was waiting for that time (...) at that time, we knew that once you are found with the virus, the final to handle will be death. So that thing really stressed me” E7*

The feeling of imminent death was experienced by men of all ages and socioprofessional backgrounds, all of whom were diagnosed after antiretroviral drugs became available in the area. In some cases, the feeling was observed even in men who were more knowledgeable about HIV and its treatment. For many, the anxiety was due to personal experiences or beliefs, and to the fear of dying or being stigmatized. However, it also seemed related to a sense of responsibility to their family, which could face great difficulty after their death:

*“We think we may die and leave our children without anyone to care for.” E34*

#### **2) UNEXPECTED DIAGNOSIS**

Some men were shocked when informed of their diagnosis. They had assumed they were protected against HIV, hence their surprise at being diagnosed HIV-positive when nothing in the past would have suggested it – they had not taken any risks or had any symptoms that could be attributed to HIV. For the men questioned, the shock seemed to be significantly mitigated by the fact that there was a treatment, and by medical community messaging:

*“When I was at the hospital, the first day I got little worried and then they put me on the drugs but still I kept on going but as I went on taking my drugs, I now got a lot of courage.” E16*

For others, the diagnosis was unexpected but not necessarily surprising. While their practices did

not lead them to suspect HIV infection, their proximity to and knowledge about the disease helped them accept it more easily. Those men, who did not expect their diagnosis, were relatively young and often married at the time of diagnosis:

*“I did not feel really sick. I was just normal because I was counselled and I am also a counsellor; I know how to handle these matters, I was just relaxed, I am not the only person who is supposed to be ill, many people are positive so the life continues” E25*

### 3) SEEING TESTING AND DIAGNOSIS AS MEANS OF RECOVERY

Some of the men thought that they were about to die just before testing positive. Because their symptoms had been very obvious and unresponsive to the treatments tried to that point, the HIV test – often fortuitous – made a recovery they no longer expected possible.

*“I was to die (...) I did not feel bad, because I had been sick for a long time, so I was told that is the way to get my life back, because it is the way to make things getting better” E8*

These men, who were traditional at the time of diagnosis and had unsuccessfully tried traditional treatments, turned to the modern medicine offered by community-based interventions:

*“I was sick for a long time in Ndhiwa, and one day a group of people went to Ndhiwa to propose test so I voluntary came for a test. First I was given counselling, I was first counselled and asked: “if you are found positive, what will you feel?” I told them that what I want is life, and if there is a drug, I will take it.” E8*

### 4) NORMALIZING THE DIAGNOSIS

Some of the men tended to normalize their HIV diagnosis. In some cases the medical advice they received at the visit served as a way to normalize the disease. That advice, combined with other (notably spiritual) resources, helped them accept the diagnosis:

*“I did not overreact because the teaching we have about HIV I had learn a lot (...) When I discovered that I was sick I was worried and surprised. I decided I studied the bible and I was taught that you cannot run away from sickness (...) You may think you have ran away from it but you cannot defeat it and that is not the end of the life.” E27*

Others accepted the diagnosis with a certain degree of indifference; they had had frequent contact with the disease and did not see its potential severity – like this man, who seemed matter-of-fact about his disease:

*“I was not surprised. Because I saw so many people HIV positive, some friends. So I reacted well.” E10*

Some even greeted it relatively joyfully, preferring to be diagnosed with a disease for which they could get free effective treatment, rather than some incurable, recurrent disease that was impossible to avert or would ultimately have a greater impact on their daily lives. These were some of the youngest men, and they were generally diagnosed later than others:

*“I felt happy and even I wanted my wife to be together with me so that we go for treatment (...) Before I used to be sick and I thought I was suffering from malaria on/off but now I was diagnosed and now my medical HIV status has been revealed to me then I become happier because now I know I am HIV positive and I will continue living if I go for the treatment.” E4*

## **B. SEROPOSITIVITY – DELAYED IMPACT**

### **1) IMPACT ON WORK**

We have stressed the social importance of work and how necessary it is to meet not just individual, but also family needs – needs that increase with the number of children and the number of wives. Social recognition of education pushes men to fight to give their children more schooling.

In that context, being diagnosed with a chronic disease was a source of worry and financial difficulties. All of the men reported financial difficulties that started, or were exacerbated, when they were diagnosed. Free HIV drugs were not enough to make their care, as a whole, affordable. Indeed, this chronic disease meant additional expenses for lab tests, hospitalization during intercurrent events, and transportation to often remote health care facilities in this underserved rural area. In addition, the medical recommendations require a treatment-appropriate diet:

*“When I have been discovered positive I must find means to live, to care for myself and to provide for myself and to get food (...) as you know someone who is on HIV treatment need money even for feedings and care. It needs proper care. That is food. You have to feed well so that you can be healthy. You should also have money for that (...) you may not have worries in your mind. It does not need you to have a lot of stress.” E1*

Having symptoms at the time of diagnosis made looking for manual work complicated. Diagnosis and subsequent treatment made it easier to work by reducing the severity of the symptoms:

*“From the time I was put on treatment, on Septrin, I have not been able to feel sick, even weakness on the knee, I don't feel. From that time, I don't feel weak. I feel normal like I was before the infection.” E4*

Yet some of the men said they discontinued their income-generating activities in accordance with medical recommendations, for fear of seeing their symptoms return. Those men had a lot of difficulty meeting their financial needs.

*“When I started taking the drugs, my power of earnings has gone down (...) when I come to the hospital, the doctors advised him not to go again to the lake to fish because I could easily develop a pneumonia (...) When I don't go fishing, I farm but because it was a drought, there was no rain, so the crops failed.” E34*

In some cases, the doctors told the men they needed a better diet, and refused to put them on antiretroviral drugs unless they changed their diet at the same time:



*“I am supposed to be eating fruits, but when I have money, I only buy milk for the child and fruits I can find in the house. I have got a problem, the problem is money, because the little bit we have is used for travel or to provide.” E4*

So they were told to eat better on an ongoing basis, while at the same time being advised to take a leave from the job that allowed them to afford that food.

How was strict adherence possible under such conditions? How could they support their families in relative comfort? We observed, in particular, wives getting involved in income-generating activities; hitherto that was considered only for men. In some cases there was a reconfiguration in the male-female relationship, greater female involvement in activities that men had felt to be entirely their remit. Though it was not easy for these men, in some cases the woman's situation, and the couple's relationship, changed:

*“The wife was working also at the lake, as a fisherwoman (...) Because the income is low, the wife also joined me to the lake (...) Yes, when I was put on treatment, I was advised by doctors not to go fishing to avoid further complications so it affected my incomes (...) because I was not working and I was suffering, I was left to children (...) So I decided to go back to the lake, to fish, with my brother and the wife also” E34*

For some men, however, work was an escape, a way to avoid being stigmatized by a disease that was hard to hide from their loved ones:

*“Ah no I am not excluded because I am always busy at work so there is no time you will get so called sitting with people. It is like that you can see that you are excluded (...) We just meet it shortly, a short while, like four hours, then that time you came back to talk with people.” E25*

Lastly, social relationships were often scaled back, or even eliminated, after diagnosis:

*“Maybe we are in a pub and they are taking alcohol, even the soda I don't take or I have to take water so I am not stable here for a long time because I am not really feeling I am enjoying their company. As they enjoy their drink, be very happy, they shout, they do the things, they expressed their joy and I am very normal” E7*

## **2) IMPACT ON SEXUALITY**

There seemed to be a very significant link between changes in sexual behavior – or even questioning sex entirely – and the medical advice given during diagnosis and follow-up. The recommendations seem to have varied depending on the patient's marital status and age and on the person conducting the consultation. Restrictions on sexual activity were always recommended, however. Medical advice was not the sole reason for altering sexual behavior; there were often multiple factors. Some men seemed to have started questioning their sexual behavior prior to diagnosis, when they first became aware of HIV. Then, based on the medical recommendations, they took restrictive measures, which they saw as protection against worsening disease:

*“I know there is no cure for it. If you protect yourself you can live longer. I’m faithful (...) When I have been put on drugs there is a time when we did not have interest for sex.” E1*

The counselors advised married men to be faithful to their wives and stop engaging in extramarital relationships. All men, without distinction, were asked to stop any extramarital relationships. The main justification for that was to prevent HIV transmission to other partners. It was also motivated by the risk of being infected with another form of the virus having a different antiretroviral resistance profile:

*“My edge for sex went down when I knew I was HIV positive. I have less interest (...) To avoid to spread the disease, I was advised by my doctors, I should not have sex outside the marriage because I may join with somebody who has not known her status and could give me viral load, and change my viral load.” E4*

The medical recommendations made some men feel guilty, with medical professionals making a value judgment regarding their patients’ past behaviors and issuing a kind of warning. Those guilt feelings, instilled by the medical community, were reinforced by restrictive medical recommendations:

*“The counsellor made an advice: “V. from now you got a little bit fool man from here” and they warn you what you ought to do. And I just said “I don’t have any feeling for any woman and I think I will be faithful to my wife (...) I have had a tremendous change in my sexual life (...) because I really felt sorry for having... I am the person actually who have infected my wife to which I am truly sorry (...) and since having known my status, I want to live by what I was taught” E7*

After diagnosis, the men who had the most difficulty with the disease and diagnosis seemed to give up relationships with the opposite sex. This was not the adjustment in sexual behavior seen in most cases, but a complete break-off in sexual and emotional relationships.

In our study, the men who rejected women were the ones who associated their diagnosis with imminent death, or who were diagnosed at a later stage when the symptoms were obvious. This seemed to have caused a more significant reconfiguration and a more dramatic change in their priorities. However, social pressure ultimately forced these patients to marry, as without doing that they could not have children:

*“I hated women, I didn’t want them (...) I knew I was going to die soon and that is why I left women (...) From that time I didn’t want any women when I had known my status (...) I married because my fellow young group had women and children but I didn’t have. I had pressure from my friends and relatives. They told me to marry.” E36*

When followed to the letter, the medical recommendations caused significant suffering. Some men were torn between following advice strongly tied to survival, on the one hand, and the need to be in a marital relationship where disclosing their HIV status would be complicated:

*“I was told by the doctors that there was an exchange of virus so the doctors told me to leave alone women*

*and then I stopped, from that teaching (...) I feel lonely because even right now I am alone in the house so it is a suffering (...) It is not easy to talk about HIV with somebody (...) unless you are a teacher, who is teaching someone, so they will understand you.” E19*

Some men adapted to the medical recommendations and used condoms with their wives. Others refused to use condoms because they did not see a need for it, either because marriage was protection against their disease getting worse, or because having children was a matter of course for them. Some followed the recommendation, but had less sex as a result. This was the best way for them to avoid getting infection with another type of virus, and thus “survive”:

*“When we use condom, we don’t have a lot of needs for sex, you could also practice it once because you don’t have a lot of interest, because condom is a foreign body and is not the same to free sex. I was told to stop having sexual intercourses out of marriage. “For you to live longer, have adherence”.” E16*

Some men reported that their sex life improved after diagnosis. Nevertheless, the diagnosis did have a negative effect on their sex lives. In the following case (E43), using a condom made his sexual partners suspect that he might be HIV-positive. This changed his sex life and relationships with women:

*“Now I was put on ARV I could now erect (...) There was a change because they knew I was HIV positive. Because I cannot keep quiet about myself. When you want to have sex intercourse and you put a condom the woman may also be suspicious and ask you “what is this thing you put in your...?” When you tell one, she will refuse to have sex, so they refuse.” E43*

### **3) IMPACT ON MARRIAGE AND FATHERHOOD**

Some of the men avoided confrontation with their partner(s) regarding the source of their infection. The fact that the medical community has recognized multiple routes of infection thus shield couples from accusations of adultery:

*“They asked because I was diagnosed positive and them negative. And I answered I didn’t know. And the discussion ended like that (...) They started asking, who is the cause, and I told them not to be worried, because even me I didn’t know but I remember there was a time when I helped my sister in law who was sick and I used to take care of without using gloves.” E16*

Some were told at diagnosis that it was possible to procreate and have HIV-negative children. Condom use was lower among the younger men who were married and still wanted children. When the topic had not been discussed at the consultation, the men were distressed over having to choose between the risk of transmitting HIV to their partners and the risk of revealing their HIV status, which might ultimately make it impossible to have children.

Managing marriage and fatherhood was more complex for the younger, unmarried, HIV-positive men. Most of them understood the need to disclose their status to future partners and were informed

that it was possible to have children safely. The problem for them was disclosing their status to their partners and managing sex before marriage. Those who planned to disclose their status beforehand often planned to do so after proposing marriage. They would not be proposing to partners who had accepted their HIV status, with whom they already had a trusting relationship with regard to that status. They would do the opposite. The idea of proposing before disclosing their status seemed to make them feel more secure about the relationship:

*“The person who I will marry is the one I would disclose my status to (...) And I think that is the main reason why I haven’t share with her because I have to see if she can be trusted (...) If I will propose to her “would you marry me?” and she says yes. Then from that time I will tell her about my status. After my proposal. If she accepts (...) If the love is so strong she will not leave you.” E20*

This is an attempt to take as little risk as possible in the hopes of preserving their reputation before marriage. Hence sex would not become impossible, as it would have had they disclosed their status. This creates a relationship seen as “different” before marriage, making it possible to not talk about sex.

*“Because she’s used to my different stories it is very hard to accept the first time (...) Sometimes it is a lie. For example that one of my legs was disused that at times I walked with three legs. That is stories that can keep her mind out of thinking about (sex)... that is stories that could sometimes bring tears, some emotional stories.” E20*

#### 4) IMPACT ON SOCIAL RELATIONSHIPS

We have already discussed how the medical recommendations create challenges in terms of friendships and activities. Those recommendations concerned diet and alcohol consumption, for example, or focusing on work to avoid stigmatization. We found cases of more virulent stigmatization in the most traditional settings, especially within the family. There seems to be a balance of power within such families where respect is based on one’s ability to meet one’s responsibilities and project an image of confidence and vitality. HIV disrupts that image and reputation. For the men who lost that reputation, social ties with family members – a source of help and support – were weakened:

*“In my community, people feel happy when you suffer or when you become sick (...) our income has gone low, so they know that when we are very poor, so there is no need to give us respect (...) The relatives, the family, the uncles were happy, when I was sick because they knew that will make my life on end. And a moment ago, one uncle went from Migori, he got me in the ward with my wife and ask me about the day of the discharge but he didn’t even help me, he went away.” E34*

Such families usually associated HIV with imminent death, and so seeing a family member with the disease led to exclusionary behaviors. That was the case for this man, whose family members took his possessions after the diagnosis:

*“And others that remains my clan’s men took and they divided among them because they knew I was to die (...) When they were discussing my time to die, my mind was still very clear, I was in my house. It was*

*a small house, I did not build a good one, it was a house which was so poor, it was raining and wet inside”*  
E8

These behaviors then pushed the men to deny the importance of family and to try to gain respect by asserting their independence from the family.

Reputation was also important in non-traditional settings:

*“You know I am a priest, and I have members in my church, and some of my members, are also on the programs so when I come as a pastor I also line up with the members... it is a problem because these ones they see me as a sinner, so I even requested the counsellors so that they treat me separately so that stigma is not in me. But they have not helped me”* E38

Though preserving his reputation among members of his church less important than antiretroviral therapy, it was more important to this man than the likely consequences of transferring to a more remote, expensive medical center beyond his means:

*“I’ve asked them even to transfer me to Homa Bay to take my drugs because Homa Bay is far, people that I serve in the church will not know me and I will not get that embarrassment (...) if it is that way, I can struggle, I can struggle to go, because even when I come from Homa Bay I use 200 schilling, I can still struggle to get my money.”* E38

For some, preserving social relationships was an obstacle to adherence. In their desire to conceal their HIV status in order to maintain their social status, they deliberately stopped taking their drugs:

*“I sleep here and my neighbor sleep here (...) But the time after work, we have to work with students so I was fighting with time so that I can take my drugs at the proper time it was a challenge. Living with people is difficult to take the treatment (...) It was hard sometimes I could skip because I wanted to keep myself...I wanted that around I was respected at school (...) so you had to fight sometimes I got courage I wake up earlier than other people.”* E20

In contrast, others build their reputation by demonstrating an ability to manage their disease and fulfil their male role – or even question it – despite the disease. Some are open about their disease, and serve as an example for the rest of the population:

*“I tell people about HIV even one of my friends I convinced him to go to hospital to testing. And before I convinced him I went with him to my house to show him my drugs that I am on drugs so he accepted and now his life is better.”* E46

For some of the men, seeing an epidemic that spared no one, that hit all social and professional classes, seemed to help with adherence:

*“The people that I see in the queue, very respected and very important people in the public life and that also gives me courage, because it is not only a disease for the poor like me, the rich are also suffering like myself, so that is an encouragement to me to keep on taking my treatment.”* E8

## 5) REJECTING TRADITION – CONVERTING TO CHRISTIANITY

Often, when men became aware of HIV – or more especially, were diagnosed as HIV-positive – they rejected traditional medicine. Discovering modern medicine was a shock to some:

*“I did not use any traditional when I was sick but my sister used to buy for me panadol (...) So my sister was a Christian and then she did not bring traditional healer but instead a group of church member to pray for me (...) Since I started drugs, my sister also taught me about the word of God, I became a true Christian, and I forgave these people. Now I don’t feel stigma, I only rely on my treatment and my God (...) what they told me, two of my friends, is only to have hope in God and that I should not look for an traditional treatment.” E8*

Once diagnosed, some men began to have doubts about the existence of Chira and its treatment by traditional medicine, which had failed to diagnose their HIV. Some simultaneously rejected Luo tradition as a whole, along with its care practices, and converted to Christianity. This was associated with the conflict between tradition and the Christian religion, a conflict affirmed by medical and governmental actors. In addition, the medical contraindication to using traditional (often plant-based) at the same time as antiretroviral drugs further marginalized Luo medicine:

*“The traditional herbs does not treat HIV, and the drugs for HIV does not treat Chira. At this time people do not believe in Chira because some have become Christians. It is not there anymore. For anybody I cannot tell but for me since I was put on this drugs, I don’t use traditional medicine” E43*

Thus, some strongly rejected Luo traditions. Those patients, after dealing directly with the medical community (which often conveyed a religious message), associated their seropositivity with Luo practices, which they blamed for their infection or even for the high HIV prevalence in the region.

*“We are telling the dangers of inheriting wives, the dangers of having many wives, polygamy (...) When you see it, we call him these days a terrorist. If you are called a terrorist, you are a quite vile wife inheritor so they fear those names.” E44*

# CHAPTER IV

## DISCUSSION

### I. LIMITATIONS OF THE STUDY

In order to allow the men to express themselves as freely as possible, rather than using closed-ended questions, we conducted the interviews in a conversational manner; this gave us more detailed knowledge about the population. Repeating the interviews to the point of saturation served the same purpose.

Subjects were recruited as opportunities presented themselves; meetings with informants led, when possible, to harder-to-reach segments of the population. In some cases the informants were people involved with MSF, resulting in selection bias, in that such people might have had an interest in presenting a positive view of themselves or MSF, and thus an inaccurate or partial view of reality. To minimize such bias we forged a number of ties to the population, and the meetings happened in different ways – through MSF, through the translator who was with us throughout the study, and directly, through various day-to-day encounters. Those personal encounters likewise introduced bias, in that they depended on the interviewers' areas of interest and on their own representations, values, affinities, and ability to create connections. The interviews were done mainly during MSF-organized testing campaigns. Since the testing was done randomly in the villages and during scheduled testing sessions, the men we encountered varied in age, socioprofessional background, religious affiliation, and HIV status. One of the shortcomings of our approach was that the our population was not representative of the population as a whole, and that by recruiting people who had already been tested or who were being tested for the first time, we omitted an entire segment of the population that refused to be tested, and so were unable to study their representations regarding testing. I would address that issue by saying that the interview guide was constructed to retrace the subject's history regarding testing before it was done and to elicit their reactions when they were offered testing and when they first became aware of HIV. By retracing their life histories, we learned about their past behaviors and practices, about the reasons for test refusal among men of different age groups, about acceptance of and doubts about the testing, and about the adoption of certain behaviors – preventive, in particular. In that way we were able to study a wide variety of representations regarding testing.

However, using anecdotal information about things that happened years ago may have introduced bias, since the veracity of subjects' reports about past events may be questionable. To try to minimize

the effects of this bias, we recruited men who differed according to how long it had been since their first test or diagnosis. Those who had been tested in the late 1990s or early 2000s gave us information about the representations of populations who had lived through the emergence of HIV and testing. That data was compared to the data from men tested more recently. To check the veracity of what they said about past events, the comparison looked for correlations and similarities in the representations, or category effects. This enabled us to see whether and how representations and practices had changed over time, in parallel with care and testing practices and with changes in the society as a whole.

The formal and informal interviews with organizational, governmental, medical, and religious stakeholders gave us information about the representations of the different actors involved in disseminating messages to the population. This also helped confirm or refute the information gathered during interviews with HIV-positive or negative men, and to back up — or question — specific statements. One potential source of bias was my position as a researcher and, at the same time, a doctor (at least I was considered as such in most cases) — and an MSF doctor at that — and it sometimes felt as though I was being equated with the practitioners. That may have led to a situation where the interviewee wanted to “satisfy” the interviewer and give the “right” response. Seeing a researcher in a position of authority might cause the informant (in some cases a patient) to relate little from their individual perspective, and to talk about norms rather than his own personal practices or experience. To avoid that situation, we clearly stated that I would have no role in their care; I explained the aim of the study and how it would unfold, and emphasized the anonymity of the information collected. In addition, there was the question of whether my presence might alter the “normal” behavior of the patients questioned, or that of the doctors or counselors during the testing and treatment sequences I observed. As Howard Becker (64), and later Jean-Pierre Olivier (65), showed, an observer’s presence has only a minor influence on these operations, since the researcher has only a limited impact on the individuals, whose problems go far beyond the framework of the interview or the sequence the researcher is exploring.

Another question concerns my own subjectivity and involvement with the men with whom I had established a relationship. That is, whether creating that relationship changed my relationship to the study subject or my involvement with my interlocutors. The issue is knowing at what point emotional involvement, whether significant or modest, negatively impacts interpretation of the results. As the investigator, I vacillated between wishing to be included in order to obtain certain knowledge and wishing to remain objective.

One final source of bias, which is inherent to all qualitative research, has to do with the representativeness of the results detailed in our study. This relates mainly to questions about the population studied. Are the results applicable to the entire male Luo population? To what extent are they applicable to other male populations? Since this was not a statistical study, it cannot be used to study the distribution of identified behaviors and practices.



## II. DISCUSSION OF THE MAIN STUDY RESULTS

Despite the fact that MSF has succeeded in placing several thousand individuals on antiretrovirals, no one has yet been able to reduce the very high incidence of HIV in Homa Bay to the national average. Yet reducing that incidence is necessary to achieving the UNAIDS goal of ending the epidemic by 2030.

In Homa Bay, the desire to achieve that goal has led to the targeting of so-called “vulnerable” populations with regard to HIV – i.e., women and children – on the one hand, and the apparent vectors of the disease – i.e., men – on the other. The effort to bring men into the health care system, however, seems to have been difficult, only partially successful, and the subject of debate on how best to raise their awareness and get them to take responsibility in the fight against HIV.

Few studies have looked at the specific characteristics of the male population or their personal experience with the epidemic in the region where this study was done.

We will therefore start by discussing the key distinct attributes of the male population facing HIV, and its reactions to institutional messages on prevention and care-seeking. Then, by comparing those distinct attributes to the data we obtained from observing the care being offered, we will attempt to assess how well the health care system has lived up to the male population’s expectations.

HIV, which is extremely severe in the region, has caused significant societal transformations. Recognition of the disease came late there, and the initial absence of a health care system capable of diagnosing or treating AIDS-related pathologies allowed the disease to become a plague; no solution seemed to emerge. Hence it was the oldest subjects that were most likely to equate an HIV diagnosis with almost immediate death. At the same time, the association between HIV risk and certain practices deemed morally reprehensible made it a stigmatizing disease. Those prejudices were due, in part, to the messages coming from institutions in high-income countries, as well as to messages from the HIV organizations working in sub-Saharan Africa. Though the HIV epidemic began in the early 1980s, political awareness of it in Kenya came later, and it was initially associated with certain high-risk practices, themselves attributed to a stigmatized segment of the population. This occurred in other countries – and in the global North, in particular, where HIV was first blamed on homosexuals alone, and then on the 4Hs: homosexuals, Haitians, hemophiliacs and heroin addicts (66). It gradually became apparent that the infection spared no one, yet the prejudices persisted. In Homa Bay especially, where the majority of residents are Luo, the severity of the epidemic was quickly blamed on traditional practices such as polygamy and levirate marriage. That belief was reinforced by the medical institutions. They considered such practices an “obvious” contributing factor, which they associated with what they believed was more – and thus higher risk – sex. At the same time, Western authorities legitimized the notion of a specific “African sexuality”, which they used early

in the epidemic to explain the higher prevalence on the African continent. Here is anthropologist Jean-Pierre Dozon's analysis of that ideology (67):

*“[translation] Whether or not Africa was its cradle, it gave AIDS many springboards for its expansion, thanks to the excessively free and unbridled character of sexual mores (...). In that regard, any excuse can be used to support that assertion; some invoke traditions, attributing to them the anachronistic but performative expression, “sexual promiscuity” (which they seem to confuse with inherently instinctual polygamy); some scrutinize African modernity, finding only permissiveness and frivolity”*

No studies have proven that such practices are responsible for the high HIV prevalence in this region, however. Several authors dispute the idea that sexuality differs between developing and developed countries, or that there is a difference that would explain HIV's more rapid spread in some areas (68). Based on HIV studies done in Africa, some have pointed out the difficulty of proving that sexual behavior alone is responsible for the severity of the epidemic on that continent. They mention the possibility that higher HIV incidence is due to other transmission routes, and in particular medical procedures such as injections and transfusions (69) (70).

Though testing in Kenya began in the 1990s, the testing campaigns appeared ineffective because testing – without the possibility of subsequent treatment – unquestionably led to harsh social exclusion. Access to free antiretroviral drugs in the early 2000s offered some hope. HIV gradually evolved from a disease that was fatal in the relatively short term into a disease that could conceivably be survived, provided one took the drugs. That was a pivotal period – not just for the populations targeted by treatment programs, but for the programs' sponsors as well.

With the arrival of antiretrovirals, populations and caregivers were faced with the problem of managing a chronic disease. How to provide information, prevention, diagnosis, and follow-up care to an entire population, especially in a rural area where the health system was less sophisticated than in Western countries, and where the HIV prevalence was far higher?

Once free drugs became available, poor treatment adherence became less acceptable. Then came the attempts to explain. It was at that point that assumptions blaming Luo culture for the lack of adherence to treatment campaigns first appeared (29). For example, campaign sponsors and doctors thought the population was using traditional medicine, rather than HIV testing and antiretrovirals. Yet it was shown that poor participation in HIV testing was primarily an institutional problem, and that testing was not being offered to enough of the patients consulting at hospitals. At the same time, the preconceived notion that the Luo population was at higher risk due to their continued engagement in traditional practices persisted, and was used to explain the higher HIV prevalence in the region.

Recently, the lower demand for testing and poor treatment adherence among men was being blamed on male “arrogance”, which supposedly led them to deny their vulnerability to HIV. In addition, the

high HIV incidence in the region was being attributed to their “irresponsible” sexual behavior. And according to some members of the medical community, men’s “more unbridled and aggressive” male sexuality explained why they were less likely to be tested, out of fear of revealing high risk sexual behaviors (7).

## A. PREVENTION MESSAGES AND BEHAVIORS

Several institutions are involved in disseminating prevention messages; they convey a variety of values and recommendations.

First, the communities with traditional values seem to have lost, at least in part, their role in educating the young about sex. Some have pointed out that the role of grandmothers in giving sex-related advice has disappeared. In addition, the value placed on formal education and abandonment of tradition in favor of a Christian education have led to the questioning of Chira, a belief that dictated rules of behavior considered by some a means of controlling sexuality.

The sex education dispensed by educational or religious institutions strongly advocates abstinence before marriage, and often treats condom use as secondary. We know that teachers have trouble tackling or adapting sex education; we know that adolescents reject the messages transmitted by educational institutions. One APHRC (African Population and Health Research Center) study on adolescents (71), published in a journal as we were doing our study, showed that they consider such messages moralistic and unrealistic. And as our interviews revealed, some adolescents found such messages hypocritical. There was a major incongruity between young men’s competitive sexuality (a source of social recognition) and the rigidity of the prevention messages, which failed to consider their motivations for engaging in sex.

When condom-related messages were conveyed, they generally emphasized men’s exclusive responsibility for condom use. Often, in fact, only boys are instructed on condom use. As anthropologist Laurent Vidal showed (72), in an effort to promote virginity, girls were given no instruction on their future sexuality, and that lack of instruction rendered them incapable of negotiating condom use. Other studies have revealed that there is very little teaching on the existence and use of condoms (45) (73). One might wonder about shared male-female responsibility for the lack of condom use. Indeed, women are often unable to negotiate this prevention method due to an unequal power relationship between men and women. In addition, women seem to be ignorant or make erroneous assumptions about condoms. Men themselves describe having trouble negotiating the use of these prevention methods with their partners or spouses.

Information from the medical community does have an impact on perceived risk and prevention. Men seem to have the most respect for information and prevention advice from the medical commu-

nity. But that medical advice is sometimes misunderstood, misused, or expressed poorly, causing some men to ignore their sense of vulnerability. Reasoning based on false or inadequate medical advice on prevention allows those men to ignore the advice. One study (74) analyzed the perception of risk prior to seroconversion. It found four types of risk perception or risk rationalization; one of them was called “protective reasoning”, in which someone constructs a more or less valid argument to justify ignoring their sense of vulnerability.

We have shown that access to HIV information dispensed by medical, educational, religious, and community-based organizations did not necessarily translate into awareness of the HIV risk – which we defined as either a change in behavior for the purpose of self-protection, or as an awareness of the proximity of HIV and a potential threat. While exposure to HIV-related mortality or morbidity was an important source of initial information for the men we met, it was above all the primary means of HIV awareness. In some cases, seeing the effects of the disease led to a complete rejection of sex, in particular among men who had no access to detailed information about prevention methods and whose awareness of the disease came abruptly. Some men modified their sexual behavior by having fewer partners, but did not necessarily use a condom. Lastly, some began using barrier protection, which they weighed against other concerns, such as their desire to have children or the potential difficulty posed by the negative image of condom use in couples.

HIV protection was not contemplated in isolation; it was fitted into life plans with varying degrees of ease, depending on the pressures the men faced. Their ability to adapt to the risk depended on how well they combined protective measures with personal desires and prevention with social pressure. For example, social pressure pushed the younger men toward early sexuality, which was associated – especially by those responsible for educating them – with a higher risk of HIV. Those responsible for transmitting educational messages prioritized abstinence-based messages over messages about condom use. Condom use turned out to be complicated for the younger men, because their partners sometimes feared it indicated risk-taking or even known, but undisclosed, seropositivity.

Many of the men we met believed that marriage – which confers another type of social recognition – offered adequate protection from HIV. But since marriage is only possible with enough income (which is difficult in the current context), access to that form of “protection” is limited. Indeed, men can only marry if they can meet their responsibilities by obtaining gainful employment. If that is not possible, they do not consider, or they delay, marriage. Financial difficulties caused the younger men to prefer non-marital relationships.

In some rare cases, they adopted alternative behaviors, attempting to keep their reputations intact while avoiding HIV infection. That involved resisting social pressure and rejecting the behaviors it encouraged – regarding sex, in particular. They based their reputation on alternative behaviors like valuing virginity, to take one example. The solution for men who found those alternatives impossible

was social withdrawal, so that they could avoid the pressures around them and protect themselves from HIV.

## **B. FROM AWARENESS TO TESTING**

The second objective of treatment campaigns was to promote testing, in order to get more people on antiretrovirals and reduce the incidence of HIV. Those campaigns encountered certain obstacles; as we have seen, launching a testing campaign was no guarantee that the population would participate. Several factors seemed to condition testing campaign participation in the male population, which was being targeted by actions like door-to-door and night-time testing when this study was being done in 2017. The testing strategy seemed to be conditioned, in part, on a view of masculinity based on reputation and resilience, on the importance of providing economically for the family, and on the social importance of marriage and fatherhood.

First, we have seen that when men first got information on HIV, depending on how they got it, they tended to blame the epidemic on different segments of the population. That categorization of risk seems to have influenced their perception of personal risk. Indeed, some individuals felt that belonging to a certain category protected them or made them vulnerable. The Christians provided the most striking example; they felt protected by their religion or its practices. They often contrasted themselves with traditionalists, who themselves began to feel that their practices – sexual practices, in particular – put them at higher risk for HIV.

Other characteristics like age, marital status, and occupation were used to divide up the population according to HIV risk. For example, Boda-Boda drivers are an occupational category thought to spread the disease, based on the fact that they have cash and/or can pressure their customers.

These contrasting attitudes with regard to HIV risk make prevention measures less effective. Those who feel protected from HIV (like the most religious, for example) slow the testing process, while those in the “opposite” categories are more concerned with such prevention measures, and will adopt them more or less efficaciously.

Second, marriage is considered for a number of reasons, but especially for social recognition – in particular, via fatherhood – or for its economic benefits. We did, however, observe some questioning of marriage due to HIV, either because marriage would mean having to be tested, which some were afraid of, or because the burden of being HIV positive, combined with the burden of marriage, would be financially or physically insupportable (30). Some of the men felt incapable of fulfilling their assigned role as the mainstay of the family (some, who were very young, because their father had died) if they were HIV-positive. Some refused, or postponed, testing. For men who were already married, testing depended on the perceived risk, with some considering their marriage a risk. Some,

swayed by institutional messages, considered their polygamous unions high risk and willingly went to get tested. Those who considered their marriage protective were less likely to consider a test necessary. Finally, some preferred to be tested after marriage because being tested prior to marriage might make marriage impossible.

The relationship between fatherhood and HIV follows the same logic. People who are HIV-positive often think having children is impossible, due to the risk of transmission and the economic burden having children represents. While they may temporarily question marriage due to the need to be tested beforehand, this is less true with having children. Our interlocutors said having children was the most important source of social recognition; there is a lot of pressure to do so, causing some men who had firmly rejected marriage to reconsider, so that they could become fathers. Some men believed that finding out that they were HIV-positive would prevent them, physically and psychologically, from having children, since they equated being HIV-positive to having AIDS (fatal in the short term) and it would be too much of a financial or psychological burden.

Third, the fear of stigmatization – due to the importance of reputation – led to test refusal. Indeed, some men felt that their loved ones would see their going to a testing facility as evidence of sexual risk-taking and possible infection (63). In other cases, though rare here, men felt obliged to get tested to preserve their reputation, and because their loved ones might associate refusal with seropositivity. It is easy to understand how the desire to preserve family ties – often intimately related to reputation, particularly in traditional families – might cause test refusal. All the more so when a man has yet to develop symptoms and is afraid to disclose his status to loved ones. Indeed, disclosure sometimes leads to fierce rejection. Some of the men who were HIV-positive and dependent on loved ones saw those ties broken after disclosing their status.

Lastly, some men – even though aware of HIV – considered it like other diseases such as malaria, for example, and did not think it worth getting tested until symptoms appeared. Others failed to attribute the symptoms to possible HIV infection, and put off being tested. The difference between disease and seropositivity was unclear to some. As we saw, since a positive test was often equated with the disease and the disease was equated with symptoms and death, they felt they might as well wait for the symptoms to get tested and be treated as late as possible. Studies on similar contexts found this to be true as well (15) (23). Yet there is a huge difference between being diagnosed HIV-positive at the AIDS stage and at an earlier stage, particularly in terms of treatment efficacy, reducing opportunistic infections, and lowering the transmission risk. It is understandable that someone without a clear understanding of these differences and the benefits of early treatment, given that the treatment is not curative, would find it difficult to ask for a test that might on one hand endanger their reputation or marriage (75), and on the other, if positive, force them take prevention and treatment measures that might be an additional economic burden (76). The institutions that offer testing operate under a logic that is at odds with the representations and logic guiding the behavior of populations (15). For the former, testing – if positive – makes it possible to

establish a treatment regimen to avoid the onset of the illness. For the latter, being tested amounts to being HIV-positive, or in any case considering oneself as such, and being HIV-positive amounts to having the disease, and thus the symptoms, with all their physical and social consequences.

In contrast, although the older generations associate HIV with high mortality, the younger generations more readily normalize HIV and testing. Indeed, seeing HIV-positive patients remain stable on treatment, and the widespread prevalence of the infection and information about the epidemic seems to foster that normalization. Normalization and the existence of a treatment can in some cases favor testing, because the younger generations do not associate testing with early death. (28) (77).

### **C. FROM TESTING TO ENTRY INTO THE HEALTH CARE SYSTEM**

Whether a man tests negative or positive, he is asked to enter the health care system. Men who are HIV-negative are asked to get tested every three months, due to the ubiquitous nature of HIV. Those who are HIV-positive are asked to come in for treatment monitoring and follow-up visits. Both categories are asked to follow the medical advice given at the visit. Whether the person normalized HIV or associated it with rapid, certain death, the message delivered at the testing visit seems to have had a strong impact.

Most of the medical recommendations concern the sexual behavior of both HIV-negative and HIV-positive individuals. Due to the universal nature of HIV – which can be spread via blood, sex, or medical procedures – men often begin to question their own practices and those of their loved ones after being tested. All sex becomes potentially risky, even for HIV-negative couples, who are asked to stop having extra-marital – or even marital – sex, or to have it less often and use protection, despite their desire to have children. While the recommendations vary from one doctor to another, all are restrictive. As our study showed, it was rarely possible to follow them.

For some men, the medical recommendations were hard to reconcile with work, which was necessary to their survival, their family's well-being, and their social status. Free antiretroviral drugs, first made available by MSF, did not prevent care as a whole from being hard for these men to afford. Now that treatments are available, HIV has become a chronic disease with a new set of problems requiring adaptation. First, according to the medical community, patients should not be on the drugs unless they are sure they can take them with food. Next, patients have to find a way to enrich their diet, in order to improve their health. Those recommendations were hard for most patients to follow, resulting in some degree of noncompliance. They would have had to increase their income-generating activities in order to obey the hygiene and diet rules. But instead, to complicate things, they were told to limit their physical activity, which was for most the only way to earn income, something that is up to the men in many families. According to the medical recommendations, an enriched diet, together with the medications, helps patients work better. That would increase their income,

helping them afford a richer diet. And so on. The question is, where to start? For most of the men, following these recommendations to the letter left them very little leeway, since it was difficult for them to afford a better diet, and even more difficult to increase their income. That's where the biggest economic difficulties came in, resulting, in particular, in the aforementioned change in male-female relationships. In addition, despite health care facilities being distributed throughout the country during the decentralization, the cost of transportation may render them inaccessible. Several men assured us that they wanted to stay away from the health care facilities closest to them to avoid stigmatization.

Once they became aware of HIV, both HIV-negative and HIV-positive men tended to change their behavior in response to the medical recommendations. This was seen frequently, whether the medical opinions took the form of a simple piece of medical advice or guilt-inducing recommendations implying a value judgement on past practices. Other studies have shown the negative impact of moral judgments (31). Moreover, the medical recommendations often seemed similar from one visit to the other, and so not very personalized, and were aimed especially at avoiding HIV transmission, even if that meant giving up other aspects of life – something they rarely seemed to consider.

In addition, there seemed to be some reappraisal of social ties. This often happened at the time of diagnosis, due in particular to exclusionary behaviors toward HIV-positive men. It may have been a question of self-exclusion, because the medical recommendations were incompatible with continuing the old way of life (drinking alcohol, for example). It may have been a question of being excluded from the family circle, because seropositivity is associated with imminent death or reputation loss. Some men developed strategies for incorporating the disease into their social relationships, while others found affirmation in their ability to face the disease alone. Still others did not have the resources to redefine their social relationships or their masculinity, and suffered as a result.

### **III. GENERAL CONSIDERATIONS**

There are not enough teams working in the field during community-based actions; those that are there lack recognition (84) and are ill-equipped to deal with the expectations and the problems posed by seropositivity and serodiscordance (85) (86). Indeed, our observation of the testing sequence, in parallel with the interviews, showed that there was some difficulty tailoring the information given at each visit to each individual. Some of the HIV-related information was delivered in the exact same way from one visit to the next; there seemed to be no attempt to evaluate the individual's characteristics or history, though these have an impact on risk-taking and on the patient's familiarity with testing and treatment. In contrast, other information was delivered at the speaker's discretion, and it was then that their own representations of the men and their health – and certain overly-simplistic assumptions – became evident. Male communication problems were often advanced to explain noncompliance by men, despite the latter's reported desire to share, under certain conditions, their



experiences and difficulties with HIV. One study (87) showed a connection between the quality of the testing and adherence to subsequent treatment. Noncompliance appeared to be related to weakness in the caregiver-patient relationship, difficulty accessing health care facilities, the fear of being stigmatized for going to those facilities, the inefficiency of the existing health care system, and the lack of help for patients. We observed that the messages delivered by some institutions – governmental institutions, in particular – were viewed with suspicion because those institutions were associated with corruption, most notably as a result of years of political instability and the marginalization of Luo society (88).

The limited use of care by the male population seems, at least in part, to be the result of a mismatch between the care offered and dispensed by people with certain representations (of what a man is and does) and the transformations occurring in the society and population in question (90). As we have seen, the medical recommendations – for those who wished to follow them – do not always fit into the lives of the men, who have other concerns pre-dating, or resulting from, their HIV infection.

They are asked to cut back on their sexuality (a measure that in our study appeared most frequently respected by the men who were considered highly sexual), their desire to have children, and their work. Studies have shown that some patients ignore or deny these recommendations in order to normalize their sex lives, for example (77). Moreover, in our study it appeared that some men, wanting to follow the recommendations, sometimes found themselves struggling to negotiate between medical advice and the need to remain anchored in their reality and their problems – economic problems, in particular. Although some could successfully adopt both systems simultaneously, for others they seemed irreconcilable. These men associated both systems with survival: survival through access to economic resources, which were also essential for getting their drugs and honoring their follow-up visits; social survival through work, sex, and fatherhood, and the respect that comes from those things; and finally, survival through adhering to their treatment regimen and medical recommendations that were supposed to protect them from a deadly infection.

More general studies have questioned the ethics of some HIV treatment interventions, particularly in sub-Saharan Africa (94). The increase in people being tested does not mean unconditional acceptance of the test – as the smaller number of people entering the health system after diagnosis attests. The acceptability of testing campaigns is questionable, because the procedures for obtaining consent and informing patients are sometimes weak. At home visits in Homa Bay, confidentiality is not respected and men are under a lot of pressure to agree to be tested in front of their family and, ultimately, disclose their HIV status. This would seem to make it hard for these men to refuse to be tested – especially since the population has a positive image of MSF, which might lead more people to agree to the test. Spousal testing has undeniable advantages in terms of subsequent care for members of the couple, women in particular, as it makes disclosure to their male partners less risky. Joint intervention has been shown to improve treatment adherence by both members of the couple

(34) (95) (96) (97). New testing and care strategies such as decentralization and home-based testing obviously represent progress in epidemiological terms. In some contexts, there are new initiatives that are partially improving the testing rate among men – community-based actions, in particular – thus demonstrating an ability to work in unexpected domains (98). However, as in other contexts (99), this does not yet seem sufficient for reaching equal numbers of men and women in Kenya.

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## List of abbreviations

<i>ART</i>	Antiretroviral therapy
<i>HIV</i>	Human Immunodeficiency Virus
<i>PLHIV</i>	Person living with HIV
<i>UNAIDS</i>	Joint United Nations Programme on HIV/AIDS
<i>AIDS</i>	Acquired Immunodeficiency Syndrome
<i>MSF</i>	Médecins Sans Frontières
<i>STI</i>	Sexually transmitted infection
<i>HBM</i>	Health-Belief Model
<i>KANU</i>	Kenya African National Union
<i>KNBS</i>	Kenya National Bureau of Statistics
<i>MoH</i>	Ministry of Health
<i>CD4</i>	Cluster of differentiation 4
<i>PMTCT</i>	Prevention of mother-to-child transmission
<i>NARESA</i>	Network of AIDS Researchers in East and Southern Africa
<i>APHIA</i>	AIDS, Population and Health Integrated Assistance
<i>NGO</i>	Non-governmental organization
<i>VCT</i>	Voluntary counselling and testing
<i>HPV</i>	Human papilloma virus
<i>ANC</i>	Antenatal care
<i>NHIPS</i>	Ndhiwa HIV Impact in Population Survey
<i>COMMOB</i>	Community mobile testing
<i>ICPD</i>	International Conference on Population and Development
<i>ARV</i>	Antiretroviral drug
<i>APHRC</i>	African Population Health Research Center
<i>EARC</i>	East Africa Resource Center