College of Medicine

Perceptions of Heterosexual Men on HIV-Related Stigma in HIV Testing and ART Services in Blantyre District

By

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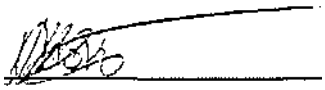
A thesis submitted to health systems and policy, in partial fulfillment for the degree of

Master of Science in Global Health Implementation

December 2020

DECLARATION

I, Thokozani Kazuma, hereby declare that this is my original work except where otherwise acknowledgements are made. The whole work has not been presented for any other awards at the University of Malawi or any other university.

Signature 

Date December 10th, 2020

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ACKNOWLEDGEMENTS

First and foremost, I give thanks and honor to GOD almighty for giving me wisdom, endurance, patience and the privilege of life to complete this study.

To my supervisor Dr Alinane Linda Nyondo Mipando, I am forever grateful for the tireless support and guidance during the proposal development as well as thesis writing. Only God knows how best to reward you.

My dear husband Michael Matululu and our daughter Gabriella you are one of a kind. God richly bless you for the spiritual, financial and social support you gave me during this period. May you find favour in the sight of God.

My gratitude goes to the family members; my mom, my sisters, brothers, in-laws', thank you for your encouragements and support

I offer my heartfelt thanks to, Leticia Kapesa, Joe Nkhonjera, Martin Matululu, Dorothy Palani, Sylvia Kazuma, Besta Kazuma, Juliana Mputeni for moral support and other opportunities you gave me. God bless you.

ABSTRACT

Across the world, the global pandemic of HIV/AIDS has shown its capability of triggering responses of compassion, solidarity and support bringing out the best in people, their families and communities. However, the disease is also associated with stigma. Stigma comprises negative attitudes and beliefs about people living with HIV; it is the prejudice that comes with labelling an individual as part of a group that is believed to be socially unacceptable. Stigma against those infected with HIV profoundly shapes the lives of people living with the disease. It leads to discrediting and discrimination against individuals who are HIV infected. HIV-related stigma remains one of the greatest barriers to the health and well -being of people living with HIV (PLHIV). While literature portrays women as mainly vulnerable to HIV infection, contrary heterosexual men are perceived as active transmitters of HIV but not active agents in prevention. Men are less likely to test for HIV compared with women in sub-Saharan African countries, and ultimately have delayed entry to HIV care. This thesis explores the perceptions of heterosexual men on HIV related stigma in HIV testing and ART services. This was an exploratory qualitative study employing a secondary data analysis which was done from the study titled "Strategies for Early Access to HIV Services by Heterosexual Men in Blantyre, Malawi Version 5.0, dated 8th April 2019." COMREC number P/06/18/2430. The main study aimed at assessing strategies for early access to HIV services among heterosexual men in Blantyre, Malawi. This study established that HIV-related stigma may come in form of name-calling, sidelining, gossiping, and is displayed in the delivery of services. The factors that facilitate the occurrence of stigma include the agent who can be the individual who may self-stigmatize, family members, work colleagues and community members, health care system and the environment. HIV related stigma exists and hinders heterosexual men from accessing HIV testing and ART services which may lead to poor HIV testing and ART services. A complete integration of HIV services into the health systems without designated spaces and days, respect to privacy and no labelling of HIV testing and ART rooms are integral mitigation factors that can minimize HIV-related stigma.

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ABBREVIATIONS AND ACRONYMS

ART	Anti-Retroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
COMREC	College of Medicine Research and Ethics Committee
CCAP	Church of Central Africa Presbyterian
VCT	Voluntary Counselling and Testing
HIV	Human Immunodeficiency Virus
PLWHIV	People Living With Human Immunodeficiency Virus
HCW	Health Care Workers
UNAID	United Nations Program on HIV and AIDS
COM	College of Medicine
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization
HAD	Human Immunodeficiency Virus Diagnostic Assistants
FGD	Focus Group Discussion
KI	Key Informants

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

Across the world, the global pandemic of HIV/AIDS has shown its capability of triggering responses of compassion, solidarity and support bringing out the best in people, their families and communities [1]. However, the disease is also associated with stigma. Stigma comprises negative attitudes and beliefs about people living with HIV; it is the prejudice that comes with labelling an individual as part of a group that is believed to be socially unacceptable [2]. According to UNAIDS, 38.0 million (31.6 million–44.5 million) people globally were living with HIV in 2019 of which 36.2 million (30.2 million-42.5million) were adults [3]. About 1.7 million (1.2 million–2.2 million) people became newly infected with HIV. Of all people living with HIV, 81% (68–95%) knew their status, 67% (54–79%) were accessing treatment and 59% (49–69%) were virally suppressed in 2019 [3]. Most of these infections are heterosexually transmitted, a mode of transmission closely linked with promiscuity, resulting in HIV related stigma [3]. Because stigma continues to be a major barrier to seeking HIV testing, care and treatment services, it is recognized as a priority for both primary and secondary prevention of HIV/AIDS. The complexity of HIV/AIDS-related stigma is often cited as a primary reason for the limited response to this pervasive occurrence [4]. People are devalued shunned and denied because of HIV infection [5].

Stigma against those infected with HIV profoundly shapes the lives of people living with the disease. It leads to discrediting and discrimination against individuals who are HIV infected [5]. HIV-related stigma remains one of the greatest barriers to the health and

well -being of people living with HIV (PLHIV) [4]. Increasing and sustaining engagement in HIV care for people living with HIV, men in particular, are critical to both individual therapeutic benefit and epidemic control [6]. While literature portrays women as mainly vulnerable to HIV infection, contrary heterosexual men are perceived as active transmitters of HIV but not active agents in prevention [7,8]. Men are less likely to test for HIV compared with women in sub-Saharan African countries, and ultimately have delayed entry to HIV care [6]. A study done in Kenya and Uganda found that 86% of men were able to access HIV testing compared to women 92%. Stigma is known to impede such engagement, placing importance on understanding and addressing stigma to improve HIV testing and care outcomes. Stigma is a social determinant of health, which is a major barrier to healthcare access, illness management and completing treatment [9]. Heterosexual men have been a neglected group for HIV/AIDS interventions and research.

The aim of the study therefore was to explore perceptions of heterosexual men on HIV-related stigma in HIV testing and ART services in Blantyre, Malawi.

1.2 Problem Statement

Despite the wide availability and success gained within HIV services, Men have lagged in the uptake of HIV services worldwide [10]. This is in part secondary to HIV-related stigma which affects them the most [11].

Stigma if not addressed in the provision of HIV services among men may lead to delays in HIV testing, poor engagement with ART services, nondisclosure to sexual partners,

lowered adherence to treatment and care regimens. Although the Malawi health services have addressed issues related to stigma there remains disparities between men and women in access and utilization of HIV services [6,7].

Given the relevance of addressing stigma, this study explored perception of heterosexual men on HIV-related stigma in HIV testing and ART services in Blantyre District. This information will help policy makers to reinforce and come up with interventions that will help to eradicate HIV-related stigma thereby returning men to HIV testing and ART services in Malawi.

1.3 Literature Review

1.3.1 Introduction

This section highlights the burden of HIV and AIDS in men, it describes the enablers and the barriers to HIV testing and access to ART services, it looks at the different forms and characteristics of HIV related stigma that are portrayed out there and their effects. Finally, it describes the Holzemah et al. conceptual framework that has guided this study.

1.3.1 Trends of HIV Infection

Global trends in HIV infection demonstrate an overall increase in HIV prevalence and substantial declines in AIDS related deaths largely attributable to the survival benefits of antiretroviral treatment [12].

The trends in HIV and AIDS show that there is a great improvement in HIV management worldwide. There have also been some improvements over a decade in access to

treatment when it comes to HIV and AIDS. From 2009 people who were on treatment accounted to 6.4 million compared to 25.4 million now on treatment from 2019 [3,12].

Sub-Saharan Africa is home to only 12% of the global population, yet accounts for 71% of the global burden of HIV infection [13]. This stipulates how big the burden of HIV related stigma is portraying in Africa hence increasing and sustaining engagement in HIV care for people living with HIV are critical to both individual therapeutic benefit and epidemic control [13].

A study done in Mozambique found that men who anticipated individual HIV stigma were 35% less likely to test for HIV [6]. This significantly meant fewer men (38.3%) than women (47.6%; $p<0.001$) had recently tested for HIV in fear of stigma. The measures of anticipated individual stigma captured how participants felt they would personally react to PLHIV; given the magnitude of the association among men, this suggests that men may avoid HIV testing to avoid similar treatment by others.

1.3.2 Burden of HIV and AIDS among Men

Globally, HIV/AIDS pandemic has caused devastating effects for example, stigma, poverty, and malnutrition [14]. It accounts for 38 million people living with HIV in 2019 out of which 1.7 million were newly infected. About 26 million people were accessing ART in 2019 out of which 73% were female adults and 61% were male adults emphasizing the gender inequalities in HIV services. From the start of the pandemic to the end 2019 around the globe, 32.7 million people have died due to HIV and AIDS [3].

Malawi has one of the highest prevalence in the world despite the impressive progress the country has made in controlling its HIV epidemic in recent years. About 8.8% of women age 15-49 and men age 15-49 in Malawi are infected with HIV; HIV prevalence is higher among women than men (10.8% versus 6.4%) of which the difference in numbers might be due to a lot of factors including stigma.

1.3.3 Uptake of HIV Services among Men

Men's uptake of HIV-testing and counselling services across sub-Saharan Africa is poor compared to universal access targets [14]. HIV testing services (HTS) are a critical entry point to HIV care and treatment. However, in Lesotho uptake of HTS is lower among men than women thus 36% of men were tested compared to 58% of women because cultural and social barriers can prevent or delay men from getting an HIV test [15]. Even amidst the beneficial effects of HIV messaging in Mozambique, individual stigma is negatively associated with recent HIV testing men [6]. Intervention efforts that target the unique challenges and needs of men are essential in promoting men's engagement in the HIV care continuum in sub-Saharan Africa [6].

Another study done in Malawi showed that men who were more educated and at the age of 30 to 39 were more likely to utilize HIV health services unlike the less educated ones [16]. Research has shown a direct correlation between educational attainment and HIV risk: men who are less educated are twice as likely to get HIV infection than those who have attended school [16]. In Botswana, UNAIDS reports that every additional year of school one completes reduces the risk of acquiring HIV by 11.6% [3].

1.3.4 Description of HIV Related Stigma

1.3.4.1 Knowledge of HIV Related Stigma

One of the reported obstacles to the achievement of universal access to HIV prevention, treatment, care and support is stigma. Stigma is a common human reaction to diseases and is described as a social process that involves identifying and using differences between groups of people and legitimatize social hierarchies and inequalities [17].

To assess knowledge on HIV-related stigma, studies were conducted among university students in Nigeria and China. The results showed that more students were knowledgeable about stigma with rates of 90% in Nigeria and in China the findings indicated that participants had several serious misunderstandings about HIV/AIDS and Male students were more knowledgeable than female students however male students were not willing to get tested despite the knowledge [17,18].

1.3.4.2 Perceptions of HIV Related Stigma

Perceptions of HIV-related stigma can be described as actual or potential experiences of diminished social acceptance, opportunity and negative shift in how others perceive the person living with HIV. These perceptions include segregation, prevention from access to something or service resulting in unfair and unjust treatment of an individual based on his or her real or perceived HIV status, limitation of expression, marginalization as well as being judged.

HIV in Sudan is portrayed as a ‘moral disease’ as such many people who are living with HIV are often thought to suffer social stigma, community discrimination and are considered to be living in information, education and communication isolation[19]. About 83.3% of people in Sudan thought that people were afraid of getting infected with HIV from them, and that the reason for stigma and discrimination due to HIV infection is associated with behaviors such as homosexuality, drug addiction and prostitution. The remaining 26.7% thought that HIV infection is often thought to be result of personal irresponsibility [19].

Same sentiments are shared in a study done by Roura et al. where most community members interviewed attributed infection to personal decisions over sex life and alcohol consumption. Such behaviors were perceived as degrading and avoidable and PLWH were consequently accused of being negligent and irresponsible [20]. According to Derlega et al. perceived HIV-related stigma was associated with the endorsement of various reasons against disclosing to a friend and parent including concerns about self-blame, fear of rejection, communication difficulties and a desire to protect the other person [21].

A study done by Li et al. highlighted that in health care settings HIV-related stigma appear in practice rather than in registration and policies [21]. This implies that there is a link between discrimination and work environment that triggers HIV-related stigma against people seeking care in the health facilities. Lack of adequate supplies of

protective equipment in the hospitals like gloves and googles can cause reluctance to care for HIV-infected patients.

Treves –Kagan et al. reported that in north of South Africa participants complained that simply being seen at a health clinic meant risking exposure of ones' status. And this was reported to be a major barrier to accessing health facilities for testing or treatment and a reason for delaying access to care until extremely sick [22]. The study also found that men had a delayed entry to care because of masculinity beliefs [22]. Men are viewed as weak whenever they are seen at clinics seeking for care.

1.3.4.3 How HIV Related Stigma is Displayed

HIV-related stigma is displayed in several ways such as being pinpointed as sinners, being blamed for being HIV-infected and it extends to people affected by HIV.

People living with HIV (PLWHIV) are stigmatized and looked upon negatively by people at large [23]. In low income countries especially south Asia and sub-Saharan Africa, HIV related stigma extends its reach to people associated or affected with HIV-infected people [23]. These people include health care providers as well as family members and friends [23]. 'Sins that they committed are punishing them' is a general term used to people LWHIV in Bangladesh [23]. A study done in India found that most people viewed sex workers as the ones responsible for the spread of HIV [23].

A study done in Zambia and South Africa by UNAIDS found that women and men are not dealt with the same way when infected or believed to be infected by HIV. A woman is more blamed than a man even when the source of infection is her husband and infected women are not easily accepted by their families as well as the community [23].

According to Sengupta et al., some individuals living with HIV experience isolation, differential treatment, violence, and concerns regarding disclosure of sero-status that could be potential barriers to participation in clinical trials concerning HIV/AIDS[13]. Block also reported that individuals felt rejected and blamed for their sero-status, and felt shame, loneliness, and anger in response to poor treatment by others [19].

1.3.5 Factors Influencing HIV Related Stigma

The factors that influence HIV-related stigma can be categorized as individual factors, health service-related factors, cultural and environmental factors.

1.3.5.1 Individual Factors

In China, a study found that PLWHA can develop negative beliefs about HIV and stigmatize themselves because of being found positive [18]. Another participant in Canada felt shame so profoundly that filling prescriptions for medications at a pharmacy became a great difficulty for that participant [4].

A study done in South Africa found that the predominant enabling factor for HIV testing were deteriorating physical health and death of sexual partner [4]. As these brought fear to people to find out more and how they would be helped in the end.

On the contrary the barriers that led most men not to go for HIV testing were perceived low risk of HIV infection, perceived health workers' inability to maintain confidentiality and fear of HIV related stigma [4].

1.3.5.2 Health Service -Related Factors

Stigma in the health services is displayed either by health care providers and the organization of health services. Amongst health care workers, PLWH have reported that they experienced stigma such as blame and stereotypes, fear of contagion, disclosure, and social contracts when with healthcare providers [13]. These factors are believed to come about because of lack of trust by the health care workers. People complain how health care workers judge people because of HIV infection and how they disclose their status without their consent.

Participants reported avoiding obtaining medical care for fear of disclosure of their sero-status, and some reported receiving inferior medical care due to living with HIV, such as when obtaining emergency care [13]. On the contrary, healthcare providers displayed an abnormal level of fear of infection with some participant. For example, one participant described a healthcare provider putting on a mask and double gloves to take a blood pressure reading. Participants described feeling as if they were "contaminated" [19]. In a

qualitative study, Yannessa et al. found that health care providers and their clients experienced multiple forms of stigma [12]. A lack of acceptance of clients living with HIV and with substance abuse issues, and stigma due to assumptions made about these clients. The reluctance of primary care physicians to provide care for people living with HIV and substance abuse [12].

Conduct of health care workers in rural areas also exhibited stigmatizing behavior toward clients living with HIV. Infectious disease specialists sometimes refused to care for these clients, made stigmatizing remarks to these clients, and some claimed that a lack of knowledge of HIV precluded them for caring for these clients [12].

1.3.5.3 Cultural and Environmental Factors

A study on HIV-related stigma in China, found that individuals living in an environment in which they felt there was a high degree of risk-taking behavior were more likely to hold stigmatizing attitudes, suggesting that perception of high risk leads to fear of infection [18]. Another study in the USA found that Black individuals living with HIV were more concerned with discrimination and being judged in terms of their morals, whereas white individuals living with HIV were more concerned with rejection [12].

Experiences of external stigma for individuals in rural areas with low HIV/AIDS rates were examined by Zukoski and Thorburn. In this qualitative study, the authors suggest that stigma may be worse in rural areas due to less acceptance of individuals who contrast with the outcome of the results [24]. Social rejection, thus being asked to adhere to

specific directives due to living with HIV and common responses to being stigmatized were shame and conflict over whether to disclose sero-status to others [24].

1.3.6 Characteristics or Forms of Stigma

HIV-related stigma is characterized as self-stigma, enacted or external stigma, governmental stigma and health care stigma.

1.3.6. Self -Stigma /Internalized Stigma

Internalized stigma occurs when a person living with HIV endorses negative attitudes associated with HIV and accepts them as applicable to oneself [3]. It is characterized by a feeling of shame and guilt and worthlessness [3].

A study done in New York found that internalized stigma associates significantly with indicators of affective i.e. helplessness regarding the acceptance of and perceived benefits of HIV and behavior (days in medical care gaps and ARV non-adherence) health and well-being [25].

1.3.6.2 Enacted Stigma (External Stigma)

It refers to unfair treatment by others characterized by social rejection or devalued identity that discredits a person in society [3]. Despite treatment advances that have transformed HIV/AIDS into less deadly, more manageable chronic disease, it remains highly stigmatizing and contributes to the social marginalization of those infected, thus undermining their mental and physical well-being.

In Florida, PLWH were stereotyped, excluded, or discriminated against due to one's HIV status and was associated with individual depression [26]. In India spouses widowed by the disease have been forced to return to their towns or villages in which they were born [27]. In one instance an entire village became a target of HIV-related stigma after one of its bus drivers tested positive for HIV, resulting in villagers being unable to find employment, being dismissed from a nearby college and having difficulty arranging marriages [27].

In China participants complained of acts of discrimination from the society which included individuals being rejected because of HIV infection in access to social resources like jobs, education and social welfare and their family being rejected because of the participant's HIV infection [18].

1.3.6.3 Governmental Stigma

A country's discriminatory laws, rules and policies regarding HIV can alienate and exclude people living with HIV reinforcing the stigma surrounding HIV and AIDS. About 64% of countries reporting to UNIADS, had some form of legislation in place to protect people living with HIV from discrimination [3].

A study done in Kenya found that more women were educated on HIV-related stigma than men representing 74% to 26% respectively because usually women get information from antenatal, under-five clinics compared to men [28]. This meant that out of the funds

that were given by the government for sensitizing people on HIV-related stigma, more men were left out and much focus was given to women [28].

1.3.6.4 Health Care Related-Stigma

HIV-related stigma remains an issue and is particularly present in some countries including Malawi. It can take many forms including mandatory HIV testing without consent or appropriate counseling [29]. Health providers may minimize contact with or care of patients living with HIV delay or deny treatment demand additional payment for services and isolate people living with HIV from other patients [29].

Health care workers may violate a patients' privacy and confidentiality including disclosure of a person's HIV status to a family member or hospital employees without authorization [29]. This can lead to HIV-related stigma from family members as well as hospital employees [29].

HIV infected patients expressed concerns that health care workers have judgmental attitudes like they were immoral and believe that the disease was self-inflicted. It was also noted that moral judgements, socially conservative beliefs and level of education may be important foundations for discriminatory attitudes toward PLWH in health care settings [29].

A study done in China have demonstrated that knowledge about HIV is low even among service providers and medical students [30]. This implies that people can be exposed to

HIV-related stigma by these service providers because they have little knowledge on how to handle people who are HIV infected.

1.3.7 Mitigation Strategies for HIV-Related Stigma

A study done in the Netherlands found that PLWH employed various coping mechanisms which included problem-focused and emotion-focused strategies to mitigate the negative consequences of stigma [22]. Problem-focused strategies included selective disclosure, disengagement, affiliating with similar others, seeking social support and to lesser extent activism. These worked by putting much emphasis on things that would prevent one from internalized stigma. Instead, people who would know their status were those that were giving social support and encouragement. Emotional-focused strategies included positive reappraisal, distraction, religious coping, misidentifications and acceptance [22]. These worked by giving themselves distracters that help them focus on positive thinking and not negative thinking.

Brown et al. conducted the first global review of interventions to reduce HIV- related stigma in 2003, the review was an attempt to increase the general public tolerance or healthcare provider's willingness to treat PLWH by changing individual level fears, attitudes or behaviors [31]. The interventions were information impartation interventions, skills building for example coping anxiety skills to reduce HIV/AIDS anxiety and improve attitudes towards PLWAHA, counselling skills.

Home-based HIV counselling and support for PLWH were employed in Zambia as some of the mitigation strategies to be used in primary and secondary schools [32]. There were some great improvements as students showed different attitudes to their fellow students who were LWHA. Similarly, counselling and support and information-based strategies were employed in Uganda. These interventions were typically included to reduce HIV-related stigma which in turn proved to be effective in most areas that were being implemented. A study done by Senguptal et al. found that information, skills-building and counselling were associated with less stigmatizing attitudes among participants [13].

1.3.8 Effects of HIV Related Stigma

HIV-related stigma has devastating effects that impact on PLWHA and even those affected by the disease. The effects of HIV-related stigma include delayed uptake to testing, fear of disclosure, shame and isolation.

HIV-related stigma contributes to delayed uptake of testing and intermittent post-diagnosis care engagement, supporting findings from other recent single-country [33]. A study done in Tanzania, Kenya Malawi just to mention a few found that HIV-related stigma persists every day which further leads to delayed uptake of HIV testing [33]. In Botswana, early provision of ART therapy did not encourage widespread testing as HIV-related stigma persists [34]. The study interviewed 112 patients receiving ART. Ninety-four percent of the patients reported keeping their HIV status secret from their community, while 69% withheld this information even from their family. Twenty-seven percent of patients said that they feared loss of employment as a result of their HIV

status. Forty percent of patients reported that they delayed getting tested for HIV; of these, 51% cited fear of a positive test result as the primary reason for delay in seeking treatment, and all of these results were due to HIV-related stigma [34].

Use of traditional healers or private doctors was another way people avoided going to the hospital in South Africa [22]. People in the communities take various steps in an attempt of shielding themselves from being identified as HIV- infected, including avoiding healthcare facilities entirely and seeking help to places where are not certified to provide HIV testing and ART services.

The availability of effective treatment transformed HIV into a manageable condition which contributed to reduction of HIV related stigma in Tanzania [20]. People on ART realized that the HIV drugs restored normalcy in PLWH and that made those on ART to encourage others to get tested and seek treatment once found positive [20]. To the people of rural Tanzania HIV and AIDS were just like any other disease like Malaria [20].

There is voidance or fear for HIV testing due to HIV-related stigma. In the United States of America, heterosexuals who already experienced the negative effects of race/ethnicity and low social-economic status, the association with HIV and other stigmatized social categories may threaten to add further to their social vulnerability which in turn, may be closely linked to fear for HIV testing knowing the damage HIV-related stigma is overrated [13].

ART was found to increase stigma among PLWHA and compromised adherence to ART. Consequently, PLWHA who had recently been enrolled in ART (less than a year) perceived more stigma than those who had been on ART for over 6 years [19,34]. Arreola et al. in 2015 also found that exposure to stigma is associated with a lower HIV-related knowledge, a lower HIV-testing rate, reduced access to HIV prevention services and treatment, as well as to riskier sexual behaviors [35].

1.3.9 Conceptual Framework

The study was guided by Holzemer et al. Model namely ‘’Model of the dynamics of HIV/AIDS stigma” [36]. According to this model, stigma in the past years focused on how others view the stigmatized person forgetting the social process that can only be understood in relation to broader notions of power and dominion [36].

The framework suggests that HIV stigma impacts people’s decision to get HIV-tested, decisions to disclose their HIV status, adherence to HIV medications and their day-to-day quality of life. “HIV stigma also impacts the quality of work-life for health care professionals, as they are perceived by some to be contagious, since they work with HIV-positive patients [36].

1.3.9.1 The Framework

The framework identified two components which are contextual factors and the stigma process. The stigma process includes four dimensions: triggers of stigma, stigmatizing

behaviors, types of stigma and the outcomes of stigma. The contextual factors include the environment, healthcare system and agent [36].

1.3.9.2 Contextual Factors

1.3.9.2.1 The Environment

Environmental factors include cultural, economic, political, legal and policy environment. Politics in the sense of power may play a role in the approach taken towards PLWHA in the cultural, economic, legal and policy environments [36]. There may be a secondary gain for those involved in stigmatizing PLWHA and this might lead to them using their power to stigmatize thereby also increasing their perceived power. In the model, the legal and policy environments are usually secondary to the culture, politics and economics influencing the response to an illness [36].

1.3.9.2.2 The Health Care System

The health care system includes settings such as hospitals, clinics, and home-based care settings such as physicians, nurses and others. Health service delivery settings are noted as a context for stigma, since they are primary settings in which stigma can be triggered and also where stigma manifest. In the model, the health care system was given an independent status because of its importance in health care and as a potential site for anti-stigma interventions [36].

1.3.9.2.3 Agent

Agent of stigma includes the individual who may self-stigmatize, family members, work colleagues and community members [36].

1.3.9.3 Stigma Process

The stigma process takes place within the contextual factors [36].

1.3.9.3.1 Triggers of Stigma

The stigma process can be triggered or activated by a variety of factors such as HIV diagnosis or disclosure of HIV status. A trigger is any action that allows people to label themselves or others as HIV infected. PLWH and those affected by HIV/AIDS indicate that the suspicion of being positive is enough to trigger stigma such suspicion can be created by a persons' behavior like attending a particular clinic or a symptom such as losing weight.

1.3.9.3.2 Stigmatizing Behaviors

Triggers lead to stigmatizing behaviors that harm, isolate, exclude or negatively identify the person.

1.3.9.3.3 Types of Stigma

The model identified 3 types of stigma: received stigma, internal stigma and associated stigma. Received stigma refers to all types of stigmatizing behavior towards a person

living with HIV/AIDS as experienced or described by themselves, which may include fearing, labelling, avoiding, rejecting and gossiping [36].

Internal stigma is thoughts and behaviors stemming from the person's negative perceptions about themselves basing on their HIV status. These may include social withdrawal, fear of disclosure and self-exclusion [36].

Associated stigma involves examples of the stigma that result from a person's association with someone living with, working with or otherwise associated with PLWHA. For example, having a family member who is HIV positive or working with people who are HIV positive [36].

1.3.9.3.4 Outcomes of Stigma

These are consequences of stigma and are grouped into general health, violence, poor quality of life and reduced access to care [36].

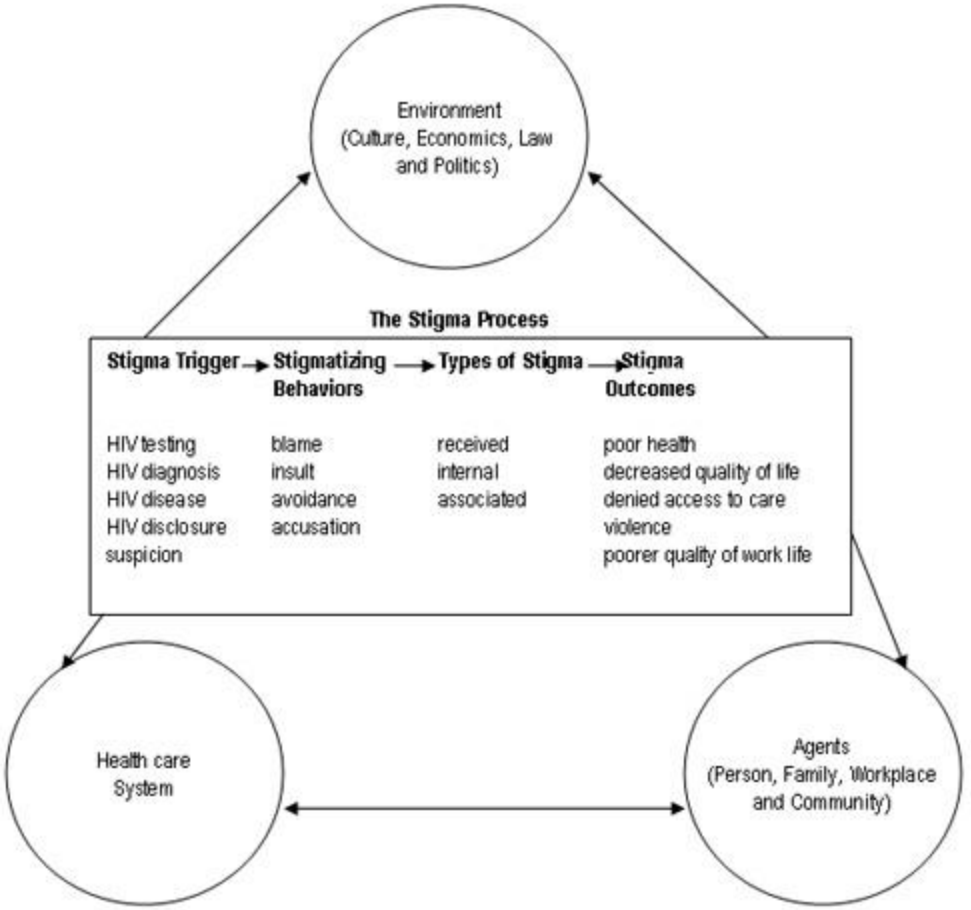

Figure 1: Model of the dynamics of HIV/AIDS stigma framework [36]

1.3.10 Previous Use of Model of Dynamics of HIV-Related Stigma

Several studies have used the Model of dynamics to identify HIV-related stigma aimed at improving access to HIV-testing and ART services. The model has helped to identify contextual factors which influence the stigma process and also identify potential areas for stigma reduction interventions.

The model has been used in Malawi, Tanzania, South Africa, Lesotho and Kingdom of Eswatin to identify and organize the concepts or variables that affect stigma [36].

It has been used by Chaudoir et. al. to come up with a revised framework to show that HIV-infected individual develops knowledge about his or her socially devalued status through the process of enacted stigma, anticipated stigma and internalized stigma, perpetrated by the HIV-infected patient [25].

1.3.11 Application of Model of the Dynamics of HIV/AIDS Stigma

The tenets of this model were used in deducing the codes from the data.

This model helped in understanding the nature of stigma heterosexual men face in Malawi. It looked at how heterosexual men who were HIV positive and negative viewed themselves as individuals in their geographical setting, with family, workmates and the community. If just being in that particular setting told a different story or did not affect them in any way about HIV/AIDS related stigma. It also looked at how the health care system had contributed to HIV/AIDS related stigma in heterosexual men, be it in HIV testing, disclosure as well as ART adherence. It helped to look at how the environmental factors like, social, cultural, political and economic aspects contributed to HIV/AIDS related stigma. Finally, the model helped to identify areas appropriate for the design and testing of stigma reduction interventions that have a goal of reducing the burden of HIV/AIDS-related stigma.

1.4 Justification of the Study

This study will give a greater understanding of how stigma is perceived in HIV testing and ART services which will be used to inform policies to mitigate stigma for optimal uptake. HIV-related stigma, HIV testing, and poor engagement with HIV services and

nondisclosure to sexual partners in heterosexual men will be appropriately addressed through this study and its findings.

CHAPTER 2: STUDY OBJECTIVES

2.1 Broad Objective

To explore perceptions of heterosexual men on HIV related stigma in HIV testing and ART services in Blantyre district.

2.2 Specific Objectives

1. To assess views and attitudes of heterosexual men towards HIV testing and ART services in Blantyre district
2. To explore consequences of HIV related stigma on uptake of HIV testing and ART services in Blantyre district
3. To identify ways of mitigating HIV related stigma in HIV testing and ART services in Blantyre district

CHAPTER 3 METHODS

3.1 Type of Study

This is a secondary data analysis on a dataset from a qualitative exploratory study in the phenomenological tradition. This study "perception of heterosexual men on HIV related stigma in HIV testing and ART services" version 2 dated 31st August 2020 was approved by COMREC with number P.05/20/3066. The main study was "Strategies for Early Access to HIV Services by Heterosexual Men in Blantyre, Malawi Version 5.0, dated 8th April 2019." COMREC number P/06/18/2430. The aim of the study was to determine the strategies that heterosexual men prefer for scaling up early uptake of HIV Testing and Antiretroviral initiation.

3.2 Study Place

This was a qualitative study conducted in 7 public and 10 private health facilities and 10 in Blantyre, Malawi from January to July 2017 and March to September 2018 respectively. From the public facilities, it included 2 health centers from urban Blantyre (Ndirande and Chilomoni), 2 health centers from semi-urban (Mpemba and South Lunzu), 2 health centers in rural Blantyre (Madziabango and Lirangwe) and a tertiary hospital (Queen Elizabeth Central Hospital).

In private settings, it included 2 clinics from rural Blantyre, 4 clinics from semi-urban and 4 clinics from urban Blantyre, Malawi. The HIV services are done by Nurses, doctors, lab assistants, pharmacist and are usually open for 24 hours depending on the time they close the hospital for the day.

3.3 Study Population

The study targeted heterosexual men and healthcare workers in urban, semi-urban and rural health centers in public facilities and private hospitals of Blantyre district.

3.4 Study Period

The main study was conducted from January 2017 to March 2018. And the secondary data analysis was conducted from May 2020 to August 2020.

3.5 Sample Size

Eighteen (18 IDIs) and sixteen (16) KIIs were done at private facilities and a total of twenty (20) IDS and seventeen (17) KIIs interviews were conducted at public facilities and fourteen (14) FGD were conducted at public facilities as well. All audio recorded interviews were done at the health facility at a private place. The FGDs groups were divided according to age and interpreted into one FGD with younger men with an age bracket of eighteen to twenty-four (18–24) years and the other with older men with an age bracket of 25 years and above at each site. This was done in order to promote participation which could have been limited if we had mixed younger and older men in one group.

To expand the possibility of multiple sources of information in the study, men of different individualities such as age, residency, education level, marital status, religion, occupation, HIV status were encompassed in the participants, to achieve thorough variation.

3.6 Data Collection

De-identified data on 'Perceptions of Heterosexual Men on HIV Related Stigma in HIV Testing and ART Services in Blantyre District' was extracted from the study 'Strategies for Early Access to HIV Services by Heterosexual Men in Blantyre, Malawi.' This was taken from the principal investigator of the study Dr Alinane Linda Nyondo Mipando. (Appendix 5) Semi-structured open-ended IDIs, FGDs and KIIs guides were used to collect data from the eligible study clients and health workers respectively. Data collection tools were designed in both English and Chichewa (see appendices 2 to 3). Data collection tools had two parts, part A which contained demographic data whilst part B contained guiding qualitative questions to elicit answering the intended question of 'Strategies for Early Access to HIV Services by Heterosexual Men in Blantyre, Malawi.' The same guides were used to facilitate secondary data analysis in 'Perceptions of Heterosexual Men on HIV Related Stigma in HIV Testing and ART Services in Blantyre District'. Permission to access the data was obtained from the principal investigator and is attached (Appendix 1). Before conducting the study, the interview guides were pre-tested and modifications were made based on the lessons learned from the pre-testing exercise and all data collectors that were recruited for the study were oriented to ensure data quality. The orientation included instruction on interviewing techniques, a detailed review of interview guide content and mock interviews between enumerators.

3.7 Data Management

Data were managed manually and not shared with any other individual outside the designed individuals. Data were used only for analysis that respected privacy and confidentiality of all concerned parties including respondents. Data was used to answer

the research questions and was at no point changed or tampered with. The location of the data was carefully tracked, stored where only the confidential data request application designed principal and secondary investigator accessed the data and data files remained secure throughout data storage. There data were transferred manually and kept in a locker. Credibility of data was ensured through use of both key informant interviews and focus group discussions and use of different data sources from both private and public facilities.

3.8 Study Eligibility

The inclusion and exclusion criteria are adopted from the main study "Strategies for Early Access to HIV Services by Heterosexual Men in Blantyre, Malawi."

Inclusion Criteria

- a man who is 18 years and above
- willingness to participate in the study
- ability to read and write in either Chichewa or English

Exclusion criteria

- below 18 years of age
- inability to read and write in English or Chichewa
- unwillingness to participate

Table 1 shows key informants and the reason why they were picked for interviews. This table was copied from the main protocol.

Table 1: Characteristics of key informants in private and public hospitals

Key Informant	Location	Number	Rationale
HIV Coordinator	Blantyre DHO	10	This person coordinates the HIV services in the district and had knowledge and was interested generated information.
ART Clinic workers	Blantyre Health Centers and QECH, 1 at each facility	7	These were the health care workers that provide HIV services and interacted with men at different levels of the HIV care continuum. They provided a deeper understanding of strategies for scaling up access to HIV services for men
	Health Care workers in Privately owned facilities	16	

Clients	All health centers in the study and the privately owned health facilities	38	These were the customers for the targeted services and were at varying stages along the HIV Services cascade

3.9 Data Analysis

Thematic data analysis using step by step guide was used in this study [37]. The researcher familiarized with the data by reading and re-reading transcripts at least 3 times, this helped the researcher to understand the depth and breadth of the content and also get the meaningful segments and the essence of the data. The objectives and model-

assisted in the deductive coding of the data. During the process, notes and markings were made within the transcripts for coding. Once the list of codes was made, the researcher reread the transcripts to identify similar codes that were organized and used into a theme. A set of similar codes that formed a coherent pattern formed a theme. The transcript was then reread to identify additional themes that initially were missed Themes were reviewed to assess if indeed they were relevant to the themes or sub-themes. When all the themes and subthemes were organized, the researcher then defined and named each theme accordingly ready for analysis. Finally, thematic content analysis was done and the report was written providing sufficient evidence of the themes.

3.10 Ethical Considerations

Prior to using the secondary data, permission was obtained from the principal investigator of the study and all the data was fully available and granted without restriction for academic use. The agreement form has been added as Appendix 3.

Consent forms and interview guides were translated into Chichewa, the local language, to eliminate language barriers and preserve consistency across users. All focus group discussions were conducted in Chichewa. In-depth interviews with health care workers were in both Chichewa and English depending on a health care worker preference and with clients in Chichewa. The consent document was either read or given to the participant to read. An illiterate participant was asked to thumbprint the consent form after it has been read to him or her in the presence of a literate witness. The purpose of the study was discussed, the outline and the risks and benefits of participation, the

duration of the study, procedures in the consent forms. Finally, the participants were given a copy of the consent form to take home. People data collection, a letter of approval was granted by COMREC number P/06/18/2430.

CHAPTER 4: RESULTS

4.1 Introduction

The results have been analyzed following the model of dynamics and have been presented according to this framework whilst respecting study objectives.

4.2 Characteristics of the Participants

Table 2: Characteristics of men in private and public hospitals

	Private hospitals	**Public hospitals**
	Number (N= 51)	**Number (N=133)**
Age	27 (IQR 21-35)	27 (IQR 21-35)
Marital Status • Married	38	65
Literacy • Able to read	49	120
Education Level • Primary	49	71
Employment • Not Employed	7	52
HIV Testing		
HIV Testing • Had an HIV Test • HIV Infected • HIV Uninfected • Never tested	32 11 21 19	101 40 61
Uptake of ARVS • On ARVs	11	32

4.3 Characteristics of Health Care Workers

A total of 17 health care workers were interviewed from the public facilities. These were the key informants working either in the HIV and ART department to have more concrete data on what was happening on the ground. A total of 16 health care workers were also interviewed from the private hospitals to also have rich data from what was really happening on the ground. These included nurses, clinicians, pharmacist, laboratory assistants, HIV diagnostic assistants and medical assistants.

4.4 Description of HIV Related Stigma

In the discussion, participants described stigma in terms of what is involved and what the whole concept entails. For example, they described how people insult other people because of being HIV-infected.

> *A lot of men are always anxious and we always doubt that we can be moving freely in this area more especially if we are found to be HIV positive and people can know about our HIV status. (Ndirande H/C, FGD 25 years above)*

> *Because they do not want to be insulted by people because some people may say look at that AIDS patient thereby sidelining and discriminating them in the process ... by not wanting to sit or to be next to them for fear of contracting the virus from them (Ndirande H/C FGD 18-24years)*

They think that we will start to stigmatized them in the process sometimes people feel shy more especially when they are known by other people in that room, so he wouldn't want to be seen by other people, people start to point and say things about you if you have been seen at the VCT area and start telling others that you have decided to go to the hospital to do the HIV testing because you are not feeling well and you are already on ARV's and the most common reason is feeling shy to be seen by people. (IDI Ndirande H/C)

Some participants associated HIV-related stigma with discrimination. They would differentiate how a person who is HIV-infected would look like compared to a person who is not HIV-infected giving the unjust treatment because of their status. The following excerpt indicate this finding

The issue of discrimination is there in our community and it does not take long for them to know that you are HIV positive but sometimes it happens like that because of the places where the ART is placed within the hospital since people can see you going there and getting the drugs and if people can see you daily in that ART clinic they can discover that you are actually HIV positive and then you go back to your community , you end up being discriminated against and even the girls women or even your fellow men discriminates you and they think that if you have AIDS then it means that you are done with your life.(Ndirande H/C FGD 18-24 years)

4.4.1 Expectations of HIV related stigma

Men described HIV-related stigma as an expectation meaning to say HIV-related stigma was something that they think would happen if they happen to test positive or initiate on ART.

> *I think that a lot of men are shy as my friend has already said this before and they think that if they are to be found positive then they will not be feeling good and people will view them as something else (Ndirande FGD 25 years above)*
>
> *Fearing the test because of this experience even myself I have gone through that…. because once I found to be positive my health will deteriorate and I do not want that and I do not want to be disappointed and let me live the way I am living (KII BT DHO)*

4.4.2 Sidelined and Discriminated

Some participants from the public facilities share the same sentiments and fears of being sidelined and discriminated against. They think that once people find out that they are HIV positive they will no longer view them as the same people they hang out with comfortably and may not be involved in different activities in the society like church meetings and community gatherings so they would prefer not to know their status.

> *Because they do not want to be insulted by people because some people may say look at that AIDS patient thereby sidelining and discriminating*

them in the process... by not wanting to sit or to be next to them for fear of contracting the virus from them. (Ndirande H/C FGD 18-24 years)

4.4.3 Community Discrimination

The fear of negative reactions from the community is one-way men described HIV-related stigma. Participants from public facilities stated that people usually like to talk about ones' status to the whole community, disclosing the status without one's permission.

If you can reveal the secret to one of your best friends then that person ends up revealing it too to his/ her friend, as a result, everyone ends up knowing about your HIV status in the process and end up being discriminated against-+ in the community and as such you do not feel comfortable to live in that community because of that issue (Ndirande H/C FGD 18-24 years)

The same thoughts are shared by participants from the private facilities on community discrimination. Despite liking the privacy of the private clinics they go to for assistance, their worries are in the communities where they stay.

Most of the times, it is good to be given the drugs in a room like this one to avoid meeting familiar faces out there and you don't know how those people will be sharing your story out there. Some people think that it is an issue now maybe the person who has seen you taking the drugs is your

neighbor hence spreading the issue around very unfortunate community. So people are free to know about it but you don't know how some people will take it or react to it. (IDI clinic 6)

4.4.4 Name-Calling/Labelling

Some participants described HIV-related stigma in form of name-calling or labelling. People tend to look down on others because they have tested positive. The virus itself is associated with promiscuity and the participants reported the same as not being morally upright. There is an image that has been associated with HIV-infected people healthy wise as well. This was portrayed in both respondents from private and public facilities.

Some people who do not speak good about their friend's status after they have gone for HIV testing or after they have known their HIV status. for example, when they are chatting some men will be saying you are on ARV's instead of chatting in a good way which is not good at all. (Ndirande H/C FGD young men 18-24)

They think that if a person is HIV positive then it means that he/she has a bad behavior and It is you and me who knows that it's a lie (KII PVT clinic 8))

Sometimes it is because of the community perception towards people who are on ARV's because they observe them the way they look and their

appearance sometimes changes which makes other people not to be able to go to the hospital to access HIV testing because they would not want to be like those people who are n ARV's, they would not want to look like them because some people look so thin which makes others to think twice to go to the hospital to access HIV testing (South Lunzu H/C FGD 25 years above)

They want to hide, some are promiscuous, sleep with 4 or 5 women and are scared someone will see them testing or taking treatment. They know that women will reject them if they know their status (IDI PVT clinic 7)

Most people start to laugh at you when they see you and they start to say that you have the virus in you and that is the main reason why men find it very difficult to access HIV testing but women are found everywhere (IDI, PVT clinic 3)

4.5 Factors Influencing HIV Related Stigma (Barriers and Enablers)

4.5.1 Agent

According to the model of dynamics by Holzelma et al., he relates barriers and enabler factors to an agent. An agent can be a person, family, community as well as a work place that influences men from accessing HIV testing and ART services. According to the model, the surroundings (this can be a person, community, family) plays an integral part

in ones' decision to get tested or initiate on ART. Below are the quotes in parts by men concerning the agent as a model of dynamics stipulates.

4.5.2 Individual/Host

Most men put themselves in an ''if'' situation before thinking of going for HIV testing and initiating on ART. Looking at the responses most men consider what the future will hold what would become of them when they go for VCT. Below are some of the responses they have to give.

> *What if I am going to be found with HIV in my body, it means that my wife is going to think that I have been going around with different women out there (KII, PVT clinic 3).*

> *They think that if they can go for such HIV testing and the results on the positive side they might be deprived of whatever the motives that they may have behind as men always would like to go for more than one partner so they would rather stay without being tested and in addition to that it's just fear of unknown. (KII, PVT clinic 3)*

Some men went further to differentiate public and private hospitals as contributing factors to their reasons for not being able to gather the courage to go for HIV tests and initiate ART. Most men don't like going to public hospitals because they are most congested and lack privacy.

Men want to do things at their own time and free will but the conditions they meet for them to get tested personally were not meeting their innermost peace. Here are some of the responses they had to give.

> *Some men don't like to be in the queue or take time and that maybe can hinder them not to get tested (KII, PVT clinic 3)*

> *There is always congestion in the public facilities so there are some people who most of the times are shy to go to the public facilities to get the drugs hence coming here to the private clinics to get the drugs. (KII PVT clinic 7)*

4.5.3 Family

Family can be a significant source of stress for men when found with HIV. Also families experience HIV- related stigma because of their association with infected family members. The stigma comes from the risk behaviors that bring the disease such as commercial sex. Participants from both private and public clinics shared equal sentiments on the family as a contributing factor to one's experience of HIV-related stigma. here is what they had to say:

> *And again there are some people instead of discussing their things in their homes they end up discussing your HIV status by telling the family*

members that you are on ARV's. People will be talking behind their back by saying that 'that family are on ARV's' (IDI, Chilomoni H/C)

4.5.4 Community

The communities that men live in are not very accommodative when it comes to issues on HIV. Participants from both private and public facilities expressed worry about how the community treats an individual who is HIV positive. The closeness of the facilities to their homes does not make things easier for the men either. Once people find out why one usually visits the hospital it becomes an issue.

Maybe because this hospital is within this community and that can hinder some men... because of the closeness with the community and the relationship that they have with health workers since they know each other (Madzi abango H/C, FG,older men 25 above)

People start to laugh at you when they see you and they start to say that you have the virus in you and that is the main reason why men find it very difficult to access HIV testing but women are found everywhere (Mpemba H/C FGD younger men 18-24)

In the community they are scared that others will know and will discriminate against them so they would rather not start treatment. In some communities, when you are on treatment you are a victim and they

don't treat you like part of them. You are like the black one. (IDI PVT clinic 6)

4.5.5 Workplace

In the workplace men living with HIV may suffer stigma from their co-workers and employers. Most people feel they are going to be denied work opportunities because of linking the status of positivity to ill health. It may be at the back of one's mind if I get a job, "should I tell my employer about my HIV status?" There is a fear of how they are going to react to it. It may cost you your job yet you would want to explain why you are absent from work

It becomes very difficult for some men to come here and do the HIV testing because they feel like they are going to meet the nurse who is one of their friends and for them to be tested by her they feel like it is not right for them to do so because they are friends and they do not want their status to be known by her as such they feel shy to come here and do the testing. (KII Chilomoni H/C)

Maybe other people are HIV positive at the company and then if there is a clinic at that company most of the times it becomes so hard to keep secret of those who are HIV positive and that is what I have observed so far and that's my thinking anyway (PVT clinic 5)

Sometimes it is because of being shy to take the drugs since you are advised to take the drugs at 6pm but then you knock off at 7pm and it becomes very hard for you to take the drugs with you when going to the work place for fear of being seen by people there. (Ndirande FGD young men 18-24)

4.5.6 Stigma Influenced By the Health Care System

Our health care system does not give much security of the fears most men have when they want to access HIV services. Unintended disclosure of their status just by the setting where these services are provided are one of the major setbacks men do not attempt to seek for these services. Lack of privacy was one of the major concerns many men raised during the interviews. They described Public facilities to be of inferior quality when it comes to privacy and confidentiality as most of the public facilities lacked privacy and confidentiality. People are always everywhere where everyone can see and have a sense of the reason for visiting the hospital. Both health workers and the facility itself poised an impediment to accessing HIV and ART services by men in Blantyre district.

These days were established that Tuesday and Thursday people are supposed to collect drugs for example, I happen to pass by here and I have a girlfriend who take medication but didn't tell me, you will know that oh she is also amongst the group, and this one too and this one too and the other thing they have identification. They are given peg cards. (Mpemba H/C young men 18-24)

The act of providing HIV-related services may also promote stigma to men. Some participants complained about how, where and what the service providers do when conducting HIV testing and providing ART services especially in public facilities. Some participants also recommended private facilities on how they deliver their services. Most of the men preferred private hospitals to public hospitals. Here is what they had to say:

> *There is always privacy on that issue and you will know that the client is here for HIV testing because they always maintain the privacy issue here. When I say privacy it's the way we are treated and their hospitality, they welcome us with warm hands and that's how I can put it. (IDI PVT clinic 3)*

The fundamental facilities to where the HIV testing and ART services were provided were not conducive for most men to come and access the services. Most of the facilities were close to the road where a lot of people pass, close to another room which is not meant for HIV services and also most of them were near markets.

> *The other thing is that our infrastructure is not conducive for men. A lot of our HTC's are designed in a way that they are next to the OPD… It's like they are all at one place offering different services as such some men do not like such a design… we could have separate rooms that would make people not to be seen but just going straight in the room without being seen by people (BT DHO,KII)*

Our VCT room is next to the OPD where people usually come for the diagnosis so may be that could be the reason because they wouldn't want to be seen queuing on the line because that brings shyness on their part, so the OPD is just near the VCT room and I believe that it can be one of the main reason why men shun HIV testing at this hospital (Mpemba H/C FGD young men 18-24)

4.5.7 Human Resource HIV-Related Stigma

The people that are supposed to be regarded as the best in the job are also a threat to most men when they try to access HIV testing and ART. Most men complained that health workers responsible for HIV testing and ART services were not to be trusted that they can disclose their status to other people. To avert that type of stigma hence men patronize private facilities.

I went to Zingwangwa and I met my neighbor who is doing the testing there would it be okay? Because if I automatically go there and meet my neighbor that I am positive, the story will go out and that is what I am trying to say here so people shun those situations. (IDI, PVT clinic 1)

Another reason can be that of familiar faces who offer such services because some people happen to be in a very good relationship with those that are 0ffering such services or they are friends as such it becomes very hard for that client to come and access the HIV testing because they would

not want to be recognized by that health worker providing such a service. (KII, PVT clinic 5)

And also as I said, sometimes service providers of this hospital Mpemba when they go around in the villages, they talk don't just see that guy he was found with the virus (Mpemba H/C FGD, young men 18-24)

People are shy to come here because maybe they are known by some doctors here. for example, surrounding the hospital, most of them are shy saying we are known to the doctors and if we are to be found with the virus maybe they can expose us. (Madzi abango H/C FGD older men 25 above)

4.6 Consequences of HIV Related Stigma and Uptake of HIV Services

HIV-related stigma among men living with HIV and AIDS has been associated with many negative consequences. The impact of HIV treatment is further aggravated by other factors such as worry about employment, sexuality, the prospect of relationships and the social reactions of community members as well as family.

4.6.1 Isolation

Concerns of not being able to associate with others were also raised as a way of avoiding being stigmatized. Participants preferred to stay than get tested for fear of being isolated. Some went further to associate it with self-stigma because others make the stigma on their own when in actual fact it is not there.

A lot of men are always anxious and we always doubt that we can be moving freely in this area more especially if we are found to be HIV positive and people can know about our HIV status. (IDI Ndirande H/C)

In general, in public hospitals they lack privacy so they fear and lack of time. Men are always on the move. And again you have to include self-stigma as well which comes about because of your own making (KII, PVT clinic 3)

4.6.2 Shame

A painful feeling of humiliation because of HIV status if it turns out to be positive was raised among the participants. Where guilt is primarily associated with a belief that one has *acted* in a transgressive manner, violating a law or social norm, shame, it is often proposed, operates on one's being: it is less about what one does and more about who one is, and how this might stand in relation to a person's awareness of how others perceive them. The act of attending a clinic for a test can be shaming in itself, in that the person perceives their attendance at the clinic for testing serves as a confirmation or admittance that they warrant the suspicion that they might be infected even looking at what HIV is perceived out there in the communities. Men are usually shy to be seen in public especially with issues that are private and confidential like HIV-related issues. They have this feeling that once they are discovered then everyone will know about their status and will be the talk of the town.

He does not want to be seen by people that he is on ARV's for fear of being publicized and it will be a very shameful thing for him because these people will start to talk and spread the news to the public (Chilomoni H/C IDI)

I think that most men are shy because they feel like if they are going to meet their friends at the hospital they are going to be seen by them, as such they will be embarrassed and people will be anxious to know about their results after been seen at the VCT department hence anxiety develops in them. (chilomoni H/C IDI)

Some men went further to describe the kind of shame men faces depending on the environment they come from and also the facility environment, they gave their example

Sometimes it can be as a result of the place when that man lives, for example, will talk more of myself, I stay at my wife's place so for me to be found to be HIV positive whilst staying at that place, it will be very difficult and this will bring shyness in the process because people will be saying a lot of things behind my back by saying that have you seen that Mary father? He has HIV and I will become shy in the process because of the status and this comes in because of the place which one lives or stays at that particular time or maybe if the man is staying at a certain plot or he is renting at a certain place, people will be talking a lot of things behind his back by pointing at him and that is the reason why we men just

stay without accessing the HIV testing. (South Lunzu H/C FGD 25years above)

Some places do not have a conducive environment and even if they do it inside the rooms from outside everyone can see everything that happens in that room and they can notice that the person entering into that room is going there for this reason even at a place where we offer the ART clinic is easily noticeable by people (Ndirande H/C KII)

There is however a different notion on what participants from public hospitals said to what participants from private hospitals said. Most men expressed satisfaction with the kind of treatment they get from the private facilities they go to. They expressed loyalty, respect and privacy from their service providers and they did not see any reason why they would be ashamed to come to the hospital to get tested and even start on ART when they are found HIV positive. Here are some of the comments they had to make

There is always congestion in the public facilities so there are some people who are most times shy to go to the public facilities to get the drugs hence coming here to the private clinics to get the drugs. Privacy is always there here at this clinic and once the person has been tested positive we always make sure that we are keeping the secret for him/her. Again when somebody has come here for the ARVs, you hardly notice that he is here for the drugs because once he has been tested positive, he is

asked to pass through those wards as you can see and you cannot notice where the person is going, you may think that he/she is either going to the wards or upstairs in the offices or maybe going out not knowing that he is actually here to get the ARV's. so privacy is always here and we never heard someone complaining about it. (IDI PVT Clinic 3)

Health workers always make sure that they do provide privacy to the clients in such a way that no one can know that this client has come here because of this particular service, again the client has the right to choose the time suitable for him/her to get the drugs here. So privacy means that there is nobody who can know what the client has come for except the doctor who is assisting that particular patient. (KII PVT Clinic 2)

I should say I have been handled professionally or ethically including privacy and the like and nobody knows what I am so far that I give them credit. You can get several people with different illnesses out there but you are taken into a private room like this one and you and the clinician himself discuss the matters arising and when going back say for example you have been given the drugs and if you have something like a good container he tries to find one so that as you are leaving this room nobody should be able to know what has been discussed inside the room or what has taken place. (KII PVT Clinic 4)

4.6.3 Fear

Some participants expressed an unpleasant emotional feeling they may have once they find out that they are HIV positive. Lack of knowledge about HIV can lead to fear which can increase stigma whether in community or families. Some men conveyed apprehension that a positive HIV test would undermine their ability to support a family as they may not stay healthy which they felt was necessary to be successful in all other areas of their lives. They questioned the impact of HIV and their ability to find female partners and be heads of their households at all.

> *Those married men fear to go out there and do the testing because they feel like their marriages will end in the process after being found to be HIV positive (IDI PVT Clinic 3)*

> *People are shy to come here because maybe they are known by some doctors here. for example, surrounding the hospital, most of them are shy saying we are known to the doctors and if we are to be found with the virus maybe they can expose us. (IDI Mpemba H/C)*

CHAPTER 5: DISCUSSION

5.1 Introduction

The main findings of this study which aimed at exploring perceptions of HIV-related stigma from heterosexual men in HIV testing and ART services show that HIV-related stigma manifest in different ways like in an individual himself, family, community, health care system as well as workplace. These factors have also consequences like fear, shame and isolation. It is influenced by the agent, individual, family and community [36].

5.2 Description of What HIV-Related Sigma is involved

The findings from the study show that participants noticed that PLWHA were sidelined, shy and being pinpointed as someone with HIV infection. The finding is consistent with findings reported by UNAIDS IN 2005 and Block in 2009 where they highlighted that participants were being rejected and blamed for their sero-status and felt shame and loneliness in response to poor treatment by others[3,19]. A study done in China further described HIV-related stigma on a scale of four; personalized stigma which measured the consequences of others knowing about ones' status which included rejection loss of friends, rejection and avoidance of others [38]. The second scale was disclosure concerns which measured issues related to whether or not individuals tell others about their diagnosis. The third one was negative self-image which measured ones' feelings towards oneself such as shame, guilty and self-worth. The fourth and the last one was concerns with public attitudes which measured participant's perception of the public 's attitudes towards PLWHA [38]. These are the characteristics and description the participants gave

in their responses. They would look at how friends, their own feelings and even the public would look a them after knowing their HIV status.

This implies that how people describe HIV-related stigma can be categorized according to how one thinks about one self when they have tasted HIV positive, what others think about someone when they have disclosed their status and what consequences there is after disclosing [39]. Involving policy makers and private stakeholders to incorporate mental activities to people who are newly diagnosed before initiating them on ART can help to reduce HIV-related stigma in that individually, they will not stigmatize themselves because they have made peace with their status and also they will not worry about what others think about them [38].

5.3 Expectations of HIV-Related Stigma

Our analysis showed that participants anticipate poor health once diagnosed with HIV infection. This finding is consistent with the findings reported by Kimera et al. where participants looked at their future as unfeasible due to their status and the associated stigma around it in their surroundings [40]. A study done by Turan et al. in 2017 also highlighted that perceived HIV-related stigma in the community may cause PLWH to internalize stigma and anticipate stigmatizing experiences, resulting in adverse health and psychosocial outcomes [39]. This implies that for one to have poor health outcomes have to pass through different stages. What we feel for ourselves and what we think how others view us makes one to be in denial and ashamed [40]. As a result, one would not

want to be seen at the hospital for checkup or medication refill leading to non-adherence hence poor health.

There is therefore need for policy makers and Ministry of Health to reinforce incorporating mental health services in the implementation of HIV/AIDS services[40]. More training on mental health relating to HIV/AIDS needs to HIV service providers including volunteers. PLWH who anticipate stigma may withdraw from social relationships in an attempt to minimize potential discrimination, which would lead to social isolation and reduce opportunities for social support [39]. This implies that perceived stigma and internalized stigma can make one not to feel comfortable with company of friends or family. Therefore, reinforcement of community awareness campaigns on mental health related to HIV through religious leaders, local leaders as well as political leaders need to be emphasized so that no one is left out in the communities hence providing comprehensive care to PLWHA as well as those affected with HIV/AIDS [40].

5.4 Sidelined and Discriminated

The findings on sidelined and discriminated from both private and public facilities show how PLWHA are being viewed in their communities. People in the communities would not want to sit close to them at a gathering for fear of contracting the virus and being refused participation in church and community gatherings. These findings are different from the results reported by Treves-Kagan et al.. where they highlighted that community members reported declining discrimination with most narratives describing improvement, but not resolution, in how individuals with HIV infection were treated [22]. This implies

that there has been improvement in the communities with how PLWHA are treated compared into past decade. Community leaders who are able to influence norms and values should closely collaborate with people living with HIV/AIDS (PLWH) in community sensitization activities promoting HIV testing uptake and ART uptake.

5.5 Community Discrimination

The findings from both private and public facilities show that people in the community talk about one's status once they discover their HIV status. The findings are consistent with findings reported by Egbe et al. where they highlighted that during disputes or disagreement, a person's status could be used as a weaker point to win over and argument [41]. A study done in Karonga Malawi found that there were signs of social acceptance of HIV over historical time within communities. People no longer gossip and talk about one's status like in the past [29].

HIV was acknowledged as widespread, even normal and no longer viewed as death sentence in the age of ART. A study done by Jacobi et al. highlighted that to insist that PLWHA attend clinics to obtain treatment is to fail to acknowledge the importance of stigma in everyday time and the consequence would be PLWHA wait until they are desperate or die before they get help [42]. This implies that there is need to find solutions to where ART could be dispersed apart from the clinics to combat HIV-related stigma. Incorporating ART services in community health campaigns and home-based settings would be much better for men to access ART without fear of being discriminated [42].

The use of peer leaders to model and disseminate positive social messages has proven to be successful at raising awareness and reducing stigma in rural communities [39]. However, emphasizing on the Ubuntu to alleviate HIV/AIDS stigmatization can be more successful. It can be interpreted as a rule of conduct or social ethic in a community [22]. The political, religious and local leaders should be empowered to make this Ubuntu spirit as a by-law that everyone understands and obey [22].

5.6 Name Calling/Labelling

The finding show that people give inappropriate names to individuals who are HIV infected because the virus itself is associated with bad behaviors like promiscuity, heavy drinking as well as smoking. This finding is consistent with findings reported by Mupenda et al. that fear of HIV/AIDS made people avoid or stigmatize PLWH, even in their presence. These labels were subjective distortions of HIV/AIDS, with which people seemed to be making light of and soften the naming of the illness because it was about private and sensitive issues not usually named publicly and these labels could be subtle, because some appeared neutral and non-stigmatizing on the surface. This implies that intensifying on education reinforcement like is already been done in the country will help people to have a better understanding on how and who can acquire HIV infection.

Our finding also show that men are afraid of being labelled weak because of seeking care in hospitals which are usually occupied by women, elderly and children. The finding is consistent with findings reported in South Africa where it was highlighted that men who recently initiated ART felt that seeking care put them at risk of being labeled as HIV-

infected and that men vie public facilities as women spaces [43]. Traditional ideas of masculinity further intensify the relationship between stigma, engagement to care and gender norms. Reinforcing gender and masculinity as part of awareness campaigns of HIV-related stigma will help men to feel comfortable to seek health care services without raising suspicions that they may be HIV infected [43].

5.7 Factors Influencing HIV-Related Stigma

The study shows that participants were more concerned with issues of privacy. HIV testing and ART initiation would have been easily followed if privacy was respected in our facilities. The finding was consistent with an earlier study from in 2013 where they highlighted that Health care workers gossip about a client HIV tests result because the person tested positive [44]. Similarly, a study done in Ethiopia reported incidence of gossiping and showed that health care workers stigmatization is decreased by increased knowledge, education and training on HIV and AIDS [45]. This implies that privacy is paramount and lacks in our hospital setting. Human rights activist need to partner with ministry of health to combat such issues. Educational activities should highlight teaching on ethics and healthcare law with a clear understanding of patient's rights [45].

We found that family members experience HIV-related stigma because of their significant other. This was also earlier reported in a study that highlighted that family members were being discriminated because of ones' HIV status and because of that many participants preferred not to disclose their status to anyone in an attempt of protecting them from HIV-related stigma [21]. Our findings further cements the results form a

study conducted much earlier that family members felt shunned by their neighbors which may be particularly difficult because the visible signs of disrespect prevented them from saving face [39]. A much more recent study, in 2020, has shown that family with HIV infected member is still ashamed of having such a family member [46]. This underscore the continued existence of stigma irrespective of the progress made in HIV treatment and survival.

Notably, a study done in Malawi, Zimbabwe and Zambia reported that when there has been disclosure of an HIV status, family members offer support to PLWHA [16]. This implies that in Malawi as a country, there is a positive feedback on how families support each other when one is found with HIV infection and has to be encouraged even to the young ones which can be leveraged as a platform for mitigating stigma.

Our finding show that participants worried of the distance there is between their houses and the health facilities in the community. Once people notice how frequent one goes to the hospital then they conclude that the person is HIV infected. The findings are consistent with findings found by Mhone and Nyamhanga whose results showed that people on ART felt compelled to go to different district or even region far away from their homes just to conceal their HIV status to neighbors to avoid HIV-related stigma [37].

One of the interventions that are already in place is mobile HIV testing but ART is not provided on the spot. Incorporating ART administration at first contact so that the men

that are usually found and tested at these joints are not missed. Home based ART dispersion and during community health campaigns can help to reduce HIV-related stigma since the men will be found right at the comfort of their homes [37].

Our finding show that employees are usually afraid to disclose their HIV status because of the reaction they may get from their bosses. They complained that people lose their jobs and are denied opportunities even trainings because of being HIV infected. These findings are consistent with the findings reported by Mbokazi et al. in 2020 where they highlighted that there was a greater fear of losing their jobs, with men facing the difficult task on how to balance the competing interest of their health needs against their economic needs [47].

There is however need for employee empowerment in human rights as well as strengthening work HIV work policy programs. The International labor organization emphasized that no employer is to deny employee opportunities or fire any employer in his line of duty because he is found with HIV infection unless when the employee is failing to deliver services [47]. Therefore, incorporating Human rights activists in making these policies known to everyone through community sensitization would help to reduce HIV-related stigma in work places [37].

The health care system also has a way of influencing HIV-related stigma. As previously reported by Chambers et al. where they highlighted confidentiality violations as one way of inciting HIV-related stigma, was also highlighted in our study when participants

complained of privacy and confidentiality especially in the public hospital and are usually afraid of being exposed by the health care workers [48]. They further highlighted how institutional practices such as labeling client records was potentially a form inciting HIV-related stigma from other healthcare providers to the individual as a client has to carry the charts from laboratory to doctors all those people would give a judgmental eye to the individual [48].

Geter et al. found that health care providers with training in HIV-related stigma in the past 12 months had lower rates of stigmatizing attitudes than those who never attended the training [49]. There is a need therefore to reinforce the policy that look at confidentiality of clients in HIV and AIDS. This can be done through refresher trainings for the health care workers on how HIV is transmitted and how to conceal patients or client's status in the health care setting. Offering clients, the opportunity to provide feedback not only helps patients feel heard and supported but also provide health care providers and administrators with quality improvement data that can constructively inform processes and strengthen HIV related care.

Our finding also shows that the delivery of services triggered stigma from others. In private hospitals no one would notice the reason why one has visited the hospital as everyone is treated equally. This finding is consistent with the finding reported by A study done by Geter et al. in 2018 found that hospitals where policies regarding HIV-related stigma are enforced reported lower levels of HIV-related stigmatizing attitudes compared to hospital which do not enforce policies that deal with HIV-related stigma

[49]. Therefore, stakeholders and the Ministry of Health should make an initiative to reinforce the policies that are already there so that they are implemented and effective.

Our finding show that hospital infrastructures where HTC and ART services are provided are close to the market or the road. This incited HIV-related stigma because people who are passing by can easily relate on what is going on. This finding is consistent with the finding reported by Geter et al. in 2018 where they highlighted that men feared that members of their communities would see them in health care facilities and assume that they were HIV infected [49].

Similarly, Treves-Kagan et al. reported that infrastructure played a role in keeping PLWHA from accessing care due to fears of disclosure [22]. Informants reported and study staff observed, extremely full facilities with long wait times and physical infrastructure not designed to serve such a high patient load [22]. Not labelling the or giving files of different color to those who are HIV infected can help to reduce HIV-related stigma and improve men involvement in health seeking behaviors.

A study done in Malawi by Dovel K et al. found that testing services were often located near antenatal or under-five clinics [29]. These mainly are taken to be traditionally female-oriented spaces where men do not find it comfortable to be. This implies that men can be stigmatized by the women and that alone precipitate HIV-related stigma from the lookers.

Looking at the facilities, Dovel et al. found that general health education which was to give men an open point of entry to HIV testing and ART services were not done [29]. Therefore, taking into account the policies that govern men participation in public institution is very vital because more people will be knowledgeable to accommodate men when they see them accessing the services. In this way more men would be more comfortable hence reducing HIV-related stigma.

In our study, participants preferred private facilities to public facilities because of unconsented disclosure. This finding is similar to findings reported by Perlo et al. in 2019 where they highlighted participants chose to receive care from private facilities than public facilities because of concerns over sero-status disclosure and added that care provided at public hospitals was inferior to care at private facilities [50]. Similarly, Treves-Kagan also reported that participants spent money to receive treatment in a more confidential setting instead of utilizing the fee care at the public health facilities [22]. This implies that Reinforcing confidentiality policy and human rights sensitization in these hospitals will help to reduce HIV-related stigma and return more men to care.

5.8 Consequences of HIV-Related Stigma

As reported by UNICEF 2020 that PLWHA and those that are affected by HIV/AIDS face internalized stigma and isolation as a result of judgement and rejection, our findings cement the same as we found that isolation was more related to internalized stigma [51]. Similarly, Cao et al. reported that PLWA were deliberately avoided and ignored by other member of the village including family members because of being HIV infected [52]. As much as there has been mitigation over stigma, there still remains parts of the

communities that practices HIV-related stigma. Reinforcement of the use of Human Immunodeficiency Virus Diagnostic Assistants to give life experience examples on how they live a positive life despite being HIV infected or affected.

In our study, shame stems from guilty which is primarily associated with fear. Guilty is primarily associated with a belief that one has acted in a transgressive manner, violating a law or social norm this in turn led to decreased uptake to HIV testing and ART services. Similarly, Walker et al. in 2019 highlighted that HIV/AIDS infection was a form of punishment for engaging in behaviors that were seen as improper or sinful [53].

Furthermore, a study done by Bennett, Sullivan, and Lewis in 2015 found that shame-prone individuals may avoid keeping a clinic appointment because doing so can of their HIV status and precipitate shame [54]. centrally to our findings, another study done by Fergus et al. found that guilt-prone individuals may be highly motivated to keep appointments to maintain their health [55]. This was also asserted by Roura et al. in 2008 who stated that ART visibly restored normalcy in clients' productive lives, this source of stigma appeared to decrease as did PLWHA own feelings of shame. Many felt comforted that the disease had become just like malaria as there were drugs they take to improve their health [40].

This implies that efforts that are being done to mitigate HI-related stigma are becoming effective. Though there is positive change in HIV-related stigma, more emphasis on how HIV is transmitted is very crucial to avoid raising a generation that may grow up with the

same notion of being HIV-infected is a punishment [53]. The education policy already incorporated HIV/AIDS it the curriculum but needs to be evaluated on how the knowledge is transferred in schools.

Men in our study feared deterioration of their health once found with HIV infection which will deter from their primary responsibility of heading their families or finding life partners. The findings resonate with findings reported by Cao et al. where they highlighted that participants believed that death from HIV infection was immediate and were afraid of the physical of PLWHA [52]. In addition to that they were afraid of not being able to be heading their families and find life partners at all. The findings are consistent with findings reported by Cao et al. where they highlighted that participants believed that death from HIV infection was immediate and were afraid of the physical of PLWHA.

Treves-Kagan et al. in 2016 however, found that HIV-related stigma and fear of deaths were less common than in the past [22]. This implies that interventions that are reinforces in the communities are taking shape thereby improving HIV-related stigma. People know the advantages of taking drugs correctly and follow instructions given to them by health care providers. There is need to incorporate human rights enforcement in the community awareness campaigns to empower PLWHA to stand on their rights whenever they are being inflicted.

5.9 Strengths and Limitations of the Study

The study used the Model of the dynamics of HIV/AIDS stigma which helped the study to capture the views of people from the providers as wells the recipients of HIV testing and ART services.

The study has presented the opinions and perceptions of heterosexual men and health care workers which means it provides the true opinions on how heterosexual men perceive HIV-related stigma, however the study used secondary data which means that the intended data set was not meant for this research nevertheless it highlights important insights in issues of HIV-related stigma. The sampling technique and the study design employed does not allow for generalization. Further research should use primary data to have reach information on HIV-related stigma.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

HIV related stigma exists and hinders heterosexual men from accessing HIV testing and ART services. This has led to poor access to HIV testing and ART services because of the impact of isolation, shame and fear it brings among men seeking these services. HIV-related stigma can be propagated by individual factors, family members, community members, workmates even health care workers. Our health care system needs to be amended in order to accommodate men to improve HIV testing capacity and access to ART services. There have been good reports however, on how private hospitals provide these services country wide. Men preferred private hospitals to public facilities because of their ability to maintain respect to privacy and confidentiality to their client's. Imitating these policies into the public hospitals can help to improve the perception of HIV-related stigma in Heterosexual men. A complete integration of HIV services into the health systems without designated spaces and days, respect to privacy and no labelling of HIV testing and ART rooms are integral mitigation factors that can minimize HIV-related stigma.

6.2 Recommendations

1. Policy makers should consider making policies that would strengthen facilitated mutual access to HIV testing for both men and women and not just put much emphasis on women and girls alone.
2. Health providers may also consider checking their system on how best they can accommodate men in their setting for them to be comfortable and not feel out of place whenever they have gone for HIV testing and ART services. Be it

infrastructure wise and how, when and where they provide HIV testing and ART services.

3. Men should be given a chance to voice out their concerns when to access of ART services and not giving the designated dates to collect the ARV's.
4. Further research studies are needed to establish the right ways and long term outcomes on how to help men overcome the challenges they face when accessing HIV testing and ART services.

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APPENDICES

Appendix 1: Interview guide for focus group discussion

HSHM Study

Topic guide for focus group discussion

1. Can you explain in detail the factors that make it difficult for a man to access HIV testing?

2. Can you explain in detail the factors that make it difficult for a man to initiate antiretrovirals?

For question 1 and 2

- Probe the factors related to:
- Health systems, clinic flow, avenues for IV services, operation times and days, human resources, health worker attitudes and skills, human resource gender, policies in place, waiting time, geographical distances, individual factors, community factors

3. Can you explain in detail the avenues or methods that can be used to increase HIV testing among men?
4. Can you explain in detail the avenues or methods that can be used to increase early antiretroviral initiation among men?

Probe on clinic based strategies, community based strategies, mobile strategies, urban areas strategies, rural area

5. Amongst the suggested strategies or avenues, which one is most preferred for HIV Testing?
6. Amongst the suggested strategies or avenues, which one is most preferred for early initiation of ARVs

Appendix 2: interview guide for in-depth interview

Introduction

I would like to thank you all for coming today. My name is _____ and my assistant is _____. I am a member of staff on the HSHM study at the College of Medicine in Blantyre.

Our research team will be conducting interviews with men and health care workers within this area as part of a project on HIV services for Heterosexual Men. By HIV Services we are referring to HIV testing and initiation of Antiretrovirals when HIV infected. We feel the services may be improved if we incorporate views of men and health care workers. Your opinions are very valuable to us

Informed Consent Section

Before we start the discussions, we would like to ask for written informed consent following the Informed consent form that describes the study in detail.

Note: Informed consent will be obtained following the ICF

Collect Socio demographic details as per socio demographic Questionnaire.

Discussion

Before we start the discussions please introduce yourself by telling us whether you are currently working or not and the nature of your work .

In your communities, what are the commonest illnesses people suffer from?

For Health care workers only: How long have you been at this facility? Which sections have you worked in?

HSHM Study

Topic guide for In depth interviews

1. **In your opinion, what is the role of privately owned health facilities in the provision of HIV and AIDS services in Malawi?**
    a. **Probe on HIV testing: what they do and what they should do**
    b. **Probe on ART initiation and administration: what they do and what they should do**
    c. **Probe on perceived differences between Privately and Public owned health Facilities.**
2. Can you explain in detail the factors that make it difficult for a man to access HIV testing at this facility and other areas?

    Can you explain in detail the factors that make it difficult for a man to initiate antiretrovirals at this facility and other areas

    For question 1 and 2

1. Probe the factors related to:
2. Health systems, clinic flow, avenues for HIV services, operation times and days, human resources, health worker attitudes and skills, human resource gender, policies in place, waiting time, geographical distances, individual factors, community factors
3. On Privately owned Health facilities: inquire on barriers specific to the settings

3. Can you explain in detail the avenues or methods that can be used to increase HIV testing among men at this facility and other areas?
    a. Probe on Privately owned specific avenues

b. probe on differences between Public and Privately owned health facilities

4. Can you explain in detail the avenues or methods that can be used to increase early antiretroviral initiation among men at this facility and other areas?

   Probe on clinic based strategies, community based strategies, mobile strategies, urban, rural and semi urban areas strategies

   a. Probe on Privately owned specific avenues

   b. probe on differences between Public and Privately owned health facilities

5. Amongst the suggested strategies or avenues you have mentioned, which one would be most preferred by men for HIV testing and why?

   a. Probe on why men prefer privately owned facilities and why he prefers privately owned facilities

6. Amongst the suggested strategies or avenues you have mentioned, which one would be most preferred by men for early initiation of ARVs and why?

   a. Probe on why men prefer privately owned facilities and why he prefers privately owned facilities

For HIV infected men alone:

7. What was your experience with HIV testing at the centre you tested?

   Probe on the setting, the avenues any facilitating and hindering factors

For men on ARVs

8. What was your experience with initiation of ARVs, in terms of avenues?

   Probe on the setting, where, and any facilitating and hindering factors

Thank you very much; you are free to ask me any questions if any. I appreciate for sparing your time to share your views with us.

Appendix 3: in-depth interview guide for key informant interview

Introduction

I would like to thank you all for coming today. My name is _____ and my assistant is _____. I am a member of staff on the HSHM study at the College of Medicine in Blantyre.

Our research team will be conducting interviews with men and health care workers within this area as part of a project on HIV services for Heterosexual Men. By HIV Services we are referring to HIV testing and initiation of Antiretrovirals when HIV infected. We feel the services may be improved if we incorporate views of men and health care workers. Your opinions are very valuable to us

Informed Consent Section

Before we start the discussions, we would like to ask for written informed consent following the Informed consent form that describes the study in detail.

Note: Informed consent will be obtained following the ICF

Collect Socio demographic details as per socio demographic Questionnaire.

Discussion

Before we start the discussions please introduce yourself by telling us whether you are currently working and the nature of work or not or are a business man.

In your communities, what are the commonest illnesses people suffer from?

For Health care workers only: How long have you been at this facility? Which sections have you worked in?

HSHM Study

Topic guide for In depth interviews

1. Can you explain in detail the factors that make it difficult for a man to access HIV testing at this facility and other areas?

2. Can you explain in detail the factors that make it difficult for a man to initiate antiretrovirals at this facility and other areas

   For question 1 and 2

   - Probe the factors related to:
   - Health systems, clinic flow, avenues for HIV services, operation times and days, human resources, health worker attitudes and skills, human resource gender, policies in place, waiting time, geographical distances, individual factors, community factors

7. Can you explain in detail the avenues or methods that can be used to increase HIV testing among men at this facility and other areas?
8. Can you explain in detail the avenues or methods that can be used to increase early antiretroviral initiation among men at this facility and other areas?

   Probe on clinic based strategies, community based strategies, mobile strategies, urban, rural and semi urban areas strategies

9. Amongst the suggested strategies or avenues you have mentioned, which one would be most preferred by men for HIV testing and why?
10. Amongst the suggested strategies or avenues you have mentioned, which one would be most preferred by men for early initiation of ARVs and why?

For HIV infected men alone:

11. What was your experience with HIV testing at the centre you tested?
    Probe on the setting, the avenues any facilitating and hindering factors

For men on ARVs

12. What was your experience with initiation of ARVs, in terms of avenues?
13. *Probe on the setting, where, and any facilitating and hindering factors*
14. **Thank you very much; you are free to ask me any questions if any. I appreciate for sparing your time to share your views with us.**

Appendix 4: Agreement Form

COLLEGE OF MEDICINE

Principal
M. H. C. Mipando MSc PhD

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 871911
01 874107
Fax: 01 874 700

Our Ref:

Your Ref:

DEPARTMENT OF HEALTH SYSTEMS AND POLICY

I Thokozani Kazunga as a secondary investigator agree to receive confidential data from Dr Alinane Linda Nyondo Mipando from College of Department of Health Systems and Policy for academic purposes and to observe the following security provision transferring, storing, Analyzing and reporting of the data.

This data will be used to complete a dissertation in a Masters' Programme in Global Health Implementation. The title of the dissertation is : **Perceptions of**

2. **Policy for data usage**

   a. Data may be accessed only by the confidential data request application designed principal and secondary investigation
   b. Data may not be shared with any other individual outside the designed
   c. Data may be used only for analysis that respect privacy and confidentiality of all concerned parties including respondents
   d. Data may only be used for the purpose of answering the research questions
   e. Data will at no point be changed or tampered with

Agreement Page

Section to be completed by Student:

Name of Student Thokozani Kazuma

Program: Global Health Implementation

Signature: _____

Date: 20th March 2020

Section to be completed by Principal Investigator (owner of Database)

Name of Principal Investigator: Alinane Linda Nyonde-Mipand

Name of Study: Strategies for early access to HIV services by Heterosexual men in Blantyre, Malawi. Version 5.0, 08 April 2019

CoMREC Number: P/06/18/2430

Signature of PI: _____

Date: 20th March 2020

Section to be filled by Global Health Tutor or Coordinator

Name: Dr Vincent Jumbe

Signature: _____

Date: 01.04.2020

Appendix 5: Certificate Of Approval

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.05/20/3066 - Perceptions of Heterosexual Men on Stigma in HIV Services in Blantyre District' by Thokozani Kazuma

On 31-Aug-20

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC some of which are indicated on the next page for your study

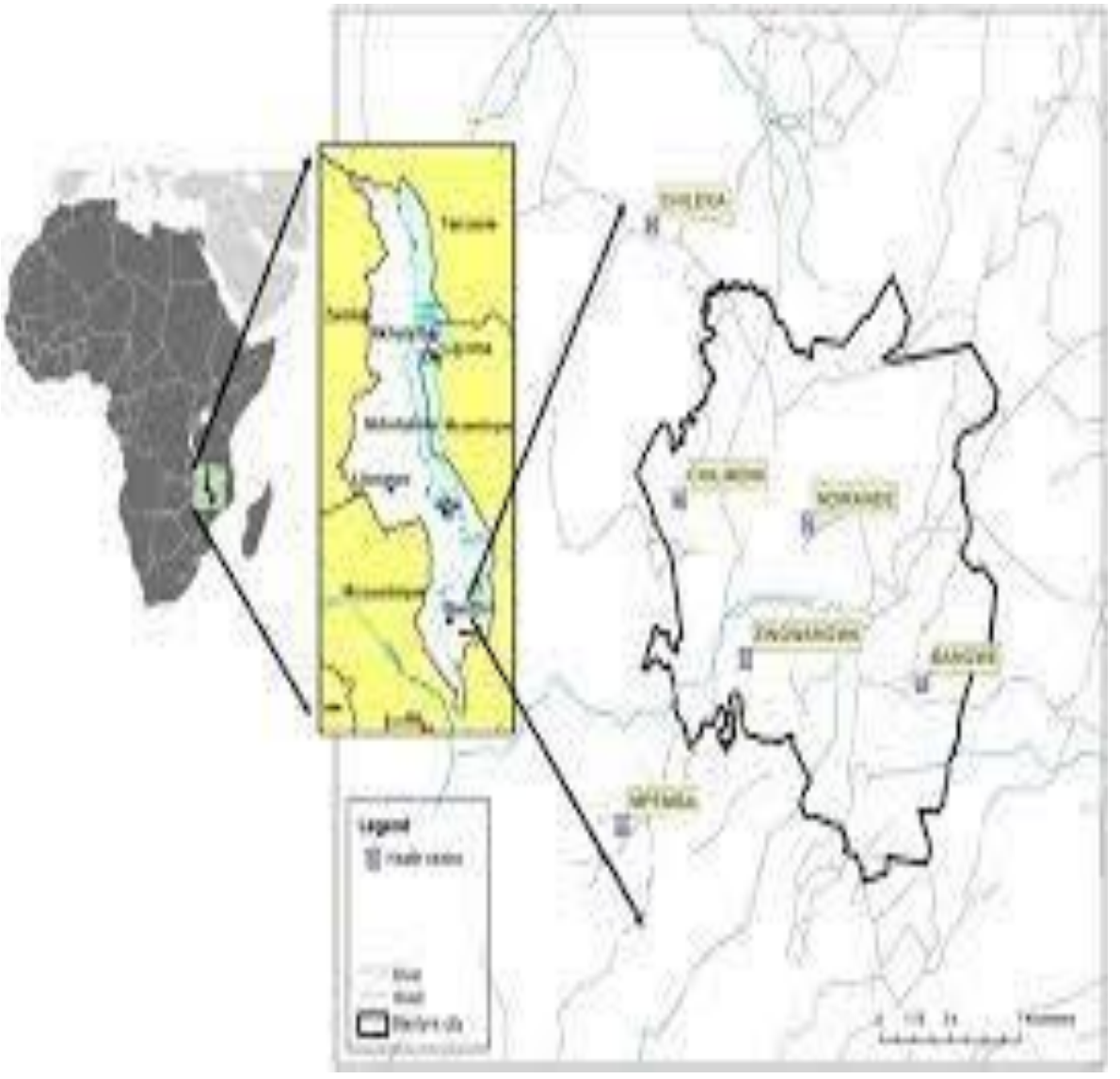
31-Aug-20

Prof. E. Umar -Chairperson (COMREC)

Date

Approved by College of Medicine 31-Aug-2020 (COMREC) Research and Ethics Committee

Appendix 6: Map of Blantyre



Appendix 7: Manuscript

Original Research Article

Journal of the International Association of Providers of AIDS Care
Volume 20: 1-10
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DOI: 10.1177/23259582211059921
journals.sagepub.com/home/jia
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"Men Are Scared That Others Will Know and Will Discriminate Against Them So They Would Rather Not Start Treatment." Perceptions of Heterosexual Men on HIV-Related Stigma in HIV Services in Blantyre, Malawi

Thokozani Kazuma-Matululu[1,2] and Alinane Linda Nyondo-Mipando[1]

Abstract

Background: Although the concept of treatment as prevention has generated optimism that an AIDS-free generation is within reach, the success of this approach centers upon early diagnosis and linkages to care for people living with HIV. Unfortunately, people continue to present for HIV care at late stages of disease and HIV-related stigma has been recognized as the major impediment to HIV prevention and treatment efforts. Given the relevance of addressing stigma to improve access and utilization of HIV services among men, this secondary analysis assessed perceptions of heterosexual men in HIV-related stigma on HIV testing and ART services in Blantyre District.

Methods: Purposive sampling was done with maximum variation which included men with unknown statuses, newly diagnosed with HIV infection and not yet on ARVs and those with HIV infection on ART. These participants were varied according to age and area of residency and included men from urban, semi urban and rural areas. Health care workers were included depending in the participation in the provision of HIV services. Eighteen (18 IDIs) and sixteen (16) KIIs were done at private facilities and a total of twenty (20) IDS and seventeen (17) KIIs interviews were conducted at public facilities and fourteen (14) FGD were conducted at public facilities as well. The data were collected from January to July 2017 and March to September 2018.

Results: Men perceived that there are barriers and enablers that influence men from accessing HIV testing and ART services. These factors include individuals, family, community and workplace. The surroundings can be a person, community and a family and it plays an integral part in ones' decision to get tested or initiate on ART. At all these levels, men would navigate the options of accessing the services while risking stigma and discrimination.

Conclusion: HIV-related stigma exists and impedes access to HIV testing and ART services in men. Men preferred private hospitals to public facilities because of their ability to maintain respect to privacy and confidentiality to their client's. Imitating these policies into the public hospitals can help to improve the perception of HIV-related stigma in heterosexual men.

Keywords
heterosexual men, HIV-related stigma, HIV testing, ART services

Date received: 25 August 2021; accepted: 27 October 2021.

Background

The HIV and AIDS epidemic is associated with stigma and discrimination.[1] Stigma comprises negative attitudes and beliefs about people living with HIV and it is the prejudice that comes with labelling an individual as part of a group that is

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