IOSR Journal of Humanities and Social Science (IOSR-JHSS)
Volume 31, Issue 9, Series 5 (September, 2026) 34-42
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Masculinity factors and implications on uptake of Home-based HIV Testing and Counseling Services Among Men in Rarieda, Siaya County

Gilham Ann Katieno[1] Charles Omondi Olang'o [2] and Dr Michae Owiso[3]
[1]*School of Development and Strategic Studies, Maseno University, Kenya*
[2]*Department of Sociology and Anthropology Maseno University, Kenya*
Corresponding Author: Gilham Ann Katieno

ABSTRACT
Among the global HIV/AIDS targets is 95% of all people living with HIV to know their HIV status by 2025. Kenya adopted a Home-based HIV Testing and Counseling (HBHTC) policy to accelerate HIV testing among men who are typically hard-to-reach. Despite this effort, men are showing significantly lower uptake of HBHTC services compared to women. In Siaya the HIV prevalence is 21% compared to the national average of 4.8% among adults. However, reports show low uptake of HBHTC, and it remains unclear whether masculinity issues influence men's participation in these. The study examined masculinity factors and their implications on HBHTC uptake among men in Rarieda Siaya County. The Study adopted cross-sectional design, combining both qualitative and quantitative data collection methods. Using Cochran's formula, a sample size of 384 men was determined, and selected from 72,569 men, with stratified sampling used to choose the participants. Quantitative data were collected using semi-structured questionnaire administered to men, while qualitative data was obtained through key informant interviews with healthcare workers, religious leaders, and five focus group discussions targeting men not tested for HIV. Secondary data were obtained from journals and official government documents. Qualitative data were thematically analyzed and corroborated with verbatim quotes while quantitative data were analyzed using logistic regression and presented as tables of frequency and percentages. Findings reveal that cultural expectations of male strength, fear of stigma, and perceptions of vulnerability shape men's willingness to engage with HBHTC. Being the heads of families, men feared loss of respect, discrimination and likelihood of separation. The paper argues that addressing masculinity-related barriers is critical in improving male participation in HIV testing and advancing public health outcomes.

Key words: *Home-based HIV testing and counseling services, masculinity, uptake.*

Date of Submission: 15-09-2026 Date of Acceptance: 27-09-2026

I. INTRODUCTION

HIV is a significant public health problem worldwide (Swinkels et, al., 2026). Globally, 40.8 million people were living with HIV in 2024, while 1.3 million people became newly infected with the virus in 2024 (UNAIDS, 2025). According to WHO (2025), by 2025, 95% of people living with HIV ought to have known their HIV status first, 95% of people with HIV should be put into care and treatment, and 95% of people on treatment should have their viral loads suppressed. This means that an additional 3.2 million people living with HIV need to be tested to be aware of their HIV status (WHO, 2025). Home-based HIV testing and counseling (HBHTC) is one of the approaches to HIV testing services, and it has been demonstrated to be acceptable, feasible, and to improve access to HIV testing and counseling (WHO, 2012). However, the uptake of HBHTC among men is generally lower compared to women (Adepoju et al., 2024).

Masculinity factors have been identified to affect men's uptake of HIV testing services despite its acceptance. Stoebenau et al., (2023), state that men face expectations to work to provide for their partners and families, giving them authority to make decisions as family head. In this situation, men may make a decision about participating in HBHTC with an aim of maintaining good health so as to continue providing for the family. On the other, since masculinity demands that men ought to be strong and not show vulnerability, their participation in HIV testing services may be compromised as this may reveal signs of weakness, which they are rarely permitted to show. Additionally, masculinity allow men to have multiple sexual partners, and in other circumstances, they may also engage in violence to demonstrate their masculinity (Blakstone et, a., 2017). In their study, Camlin et

al., (2016) argue that male gender norms act against men's participation in HBHTC. Culturally, men are expected to provide for the family, and women are supposed to take care of the children being sick. This often causes men to be absent, focusing on how families can survive, thus missing from Population-based HIV testing services. Additionally, the study highlights questions about masculinity norms related to sexual behaviors in men, particularly the belief that men should have multiple sexual partners. This reflects the moral insecurities expressed by both male and female participants which deter men from participating in HIV testing out of fear of being blamed for bringing the disease into the family if they test positive due to their unfaithfulness. Similarly, Mweembe et, al., (2018) also found that men often refuse couple testing, viewing a positive HIV test as a sign of infidelity that threatens their masculinity. However, the study by Camlin et. al., (2016), although conducted, cannot be generalized to all populations in Sub-Saharan Africa, as the findings were from selected communities in Western Kenya and Uganda, and therefore, it is not known whether these masculinity factors affect men's participation in HBHTC in Rarieda, where culture and work practices performed by men may not be the same.

In Kenya, recent studies such as Turan, Kwena, Owuor, Helova, Hatcher, Braun, Owengah, et al., (2026) showed that CHTC uptake was higher in the home visit groups and HIV self-test group, with 56.2% compared to clinic-based testing. However, this study relied on couples selected from antenatal and postnatal services, who could have been motivated due to the expected baby. Other studies had shown that even with with different programs including antenatal home-based couple interventions being implemented to target men (Kwena et al.,2021), they still test less through home-based than women (Ware et al., 2023). These mixed results still point to the need for further research to verify how masculinity factors that could be behind the low uptake have not been fully addressed particularly in the Luo community in which according to Anudo et al., (2016), the Luo culture is build on patriarchy, and from the onset, males have been socialized in such a way that they are seen to be superior, strong, powerful, domineering, and respectable members of the society than women.

In Siaya, Rarieda sub-county, Dalal et al., (2013), in examining home-based HIV testing and counseling in rural Lwak and Urban Kibera highlighted reasons for refusal to take part in HBHTC which included fear of knowing one's HIV status, previously known HIV status, preferring to test away from home and wanting to test later. However, this study was too general and lacked relevant data concerning how other factors affect the uptake of home-based HIV testing and counseling among men. For example, gender-based violence towards men, the notion that men should have multiple sexual partners that affect male adults' uptake of HBHTC are not clear in the literature. Additionally, solutions to these problems have not been fully addressed, which limits HIV program interventions. The choice for Rarieda was because HBHTC done in the region only achieved 82% testing rate as compared to 87% testing rates in other regions like for example Yala and Bondo sub- counties (Muttai et al., 2021).

II. METHODS

Research Design

The study adopted cross- sectional study design combining both qualitative and quantitative research methods to explore the relationship between masculinity and the uptake of HBHTC.

Study Area

The study was conducted in Rarieda sub-county in Siaya County. It is one of the five sub-counties (including Bondo, Alego Usonga, Gem and Ugenya) making Siaya County. According to Centre for Health Solutions (CHS) end of project report 2021, in terms of HIV care and treatment, only 22 facilities in Rarieda get support compared to other sub-counties like Gem, Alego-Usonga, Bondo and Ugunja with 29, 26, 24, 21 facilities being supported respectively. This makes Rarieda to be amongst the least supported region in terms of HIV care and treatment after Ugunja sub-county. Further the region has a large area lying along the lake shores of Victoria, with highly mobile fishing communities, who form part of them hard to reach (Muttai et al., 2021).

Study population

This study was conducted in Rarieda, Siaya County targeting men. According to Kenya National Population Housing Census (2019), approximately 72,569 adult men were in Rarieda included both men tested and those who have not been tested for HIV. This group was of interest because they are the ones with first-hand information on factors that affect men's uptake in HBHTC. They also have a poor tendency to seek health care services (Brown et al.,2022), and are the ones that suffer most due to HIV AIDS-related deaths (Institute for Health Metrico and Evaluation Report, 2019). Another group of people who may have information on factors affecting the uptake of HBHTC among men are healthcare workers because they are the ones who normally offer HBHTC and religious leaders because some religious teachings can encourage or discourage HIV testing.

Additionally, they always spread health information during sermons or during counseling thus their opinion on HBHTC can shape their congregant' attitude towards.

Sample and Sampling procedures

Cochran's formula was used to determine sample size of 384 men who were selected from 72,569 target population using stratified sampling. In this study, there were five different strata formed to select the men from five wards in Rarieda. Simple random sampling was then used to randomly select men in each stratum that had a proportionate representation depending on its sample population.

Table3.1Sample distribution via proportionate stratified sampling

Wards (Stratum)	Population census (2019)	Sample per ward
East Asembo	17883 ÷ 72569× 384	94
North Uyoma	11185÷ 72569× 384	59
South Uyoma	9875÷ 72569× 384	52
West Asembo	18395÷ 72569× 384	97
West Uyoma	15231÷ 72569× 384	81
Total		**384**

Source: Kenya National Population and Housing Census (2019).

Sample size for each stratum=population of stratum ÷ Total male population× 384.

384 questionnaires were administered to participants without regard to their prior participation in HIV testing. However, 326 were completed. Among these, 111 reported having participated in HIV testing while 215 had not. From the 215 who reported not tested for HIV, 60 were purposively selected to participate in FGDs, alongside ten healthcare workers from five wards, and two religious leaders purposively chosen for key informant interviews. These groups together formed the sample population of the study.

Data Collections Methods and tools

Quantitative data was obtained from quantitative part of semi-structured questionnaires administered to men tested and not tested for HIV while qualitative methods were obtained from qualitative part if semi- structured questionnaires, in-depth interviews which allowed religious leaders and health care workers to share their opinions freely, and 5 FDG of 10 respondents not tested for HIV was conducted by a well-trained research assistant to help in taking notes and the researcher to moderate discussions, and address masculinity factors that affect the uptake of HBHTC among men. Likewise, observation checklist was also designed to watch and record participants the behaviours.

Data analysis

Qualitative data was primarily analyzed majorly using coding and afterward, data was categorized into themes to provide answers to the research questions. Coding of major themes was performed by identifying patterns that describes the masculinity factors affecting the uptake of HBHTC among men. Findings from the qualitative data were also presented where appropriate as verbatim quotes.

Quantitative data was analyzed using descriptive statistics and presented in frequency distribution tables and association of variables in the study population and answers to questions that could be counted or expressed numerically. In addition, a multivariate binary regression model was applied to determine the association between the independent and dependent variables with respect to the uptake of HBHTC in men. The results were then presented using odds ratio calculated as a percentage different from reference category using the formula (AOR - 1)×100, 95% confidence interval and p_ values with statistical significance assessed at 5% level.

2.8 Ethical considerations

Ethical approval was obtained from the school of graduate studies (SGS). Research permit was obtained from National Council of Science Technology and Innovation (NACOSTI), while ethical clearance was sought from Maseno University Ethics and Review Committee. Informed consent written was obtained by researcher using English. Kiswahili and dholuo for those not conversant with English.

III. RESULTS

Results from the respondents revealed that in the Luo community, having multiple sexual partners is allowed and is considered a traditional masculinty norm signaling manliness. The findings are as reported below:

Table 1: Descriptive statistics on how masculinity affect the uptake of HBHTC

		Frequency	Percent	Tested	Not tested
Fear of discrimination	Seleceted	61	18.7	21	40
	Not Selected	265	81.3	114	151
	Total	**326**	**100.0**		
Sex discussion taboo	Not selected	189	42.0	69	120
	Selected	137	58.0	85	52
	Total	**326**	**100**		
Fear Nothing	Not Selected	285	87.4	129	157
	Selected	41	12.6	25	15
	Total	**326**	**100.0**		
Fear separation	Not selected	267	81.9	114	153
	Seleted	59	18.1	40	19
	Total	**326**	**100**		
Loss of respect	Not selected	139	57.4	80	59
	Selected	**187**	**42.6**	**74**	**113**
	Total	**326**	**100.0**		
Being considered weak	Not Selected	199	61.0	109	90
	Selected	127	39.0	45	82
	Total	326	100.0		
Fear being found with HIV with	Not Selected	224	68.7	105	119
	Selected	102	31.3	49	53
	Total	**326**	**100.0**		

In reference to the table 1 above, 61(18.7%) men selected fear of discrimination would make them not to participate in HBHTC. Amongst them, only 21(34.4%) had participated in HBHTC and 40(65.5%) did not participated in HBHTC. 137 (58.0%) of men selected existence of taboo hindering them from discussing sex related topics with their partners and out of them, 85(62%) took part in HBHTC while 52 (37.9%) did not take part in HBHTC. 41 (12.6%) of men said that nothing could make them not to participate in HBHTC. While 25(60.9%)of them had participated in HBHTC ,15(36.5%) had not participated in HBHTC.

A total of 59 (18.1%) of men selected fear of separation as a masculine factor that would hinder them from participating in HBHTC. Interestingly among them, 40(67.7%) had taken part in HBHTC and on the other hand, 19(32.2%) had not taken part in HBHTC. With regards to loss of respect as a masculinity factor affecting the uptake of HBHTC, 187(42.6%) of men said they feared loss of respect and out of them, only 74(39.5%) had participated in HBHTC . Meanwhile, while 113(60.4%) had not. 127(39%) confirmed they would fear being considered weak as a masculine factor that can affect their participation in HBHTC and among them, only 45(35.4%) had been tested through HBHTC while 82(64.5%) had not taken part in HBHTC. On the other hand, 102(31.3%) said they would not participate in HBHTC for fear being found with HIV. Among them, 49(48%) had tested in HBHTC while 53(51.9%) did not.

This study further conducted a multivariate binary regression on how masculinity affect the uptake of HBHTC among men and results is as follows:

Table 2: Binary regression on how masculinity affect the uptake of HBHTC

		B	Sig.	Exp(B)	95% C.I.for EXP(B)	
					Lower	Upper
	Fear of dicrimmination	-1.514	.001	.220	.111	.436
	Loss of respect	-.972	.001	.378	.220	.651
	Considered weak	-1.017	.001	.362	.212	.618

	Fear nothing	1.291	.001	3.636	1.657	7.976
	Fear searation/ end of relationship	-1.247	.001	.287	.144	.575
	Sex_discussin	-1.234	.001	.291	.171	.495
	masc_fear_found_with_hiv	-.167	.548	.846	.490	1.461
	Constant	3.260	.000	26.039		

Theme one: Masculinity related to men having multiple sexual partners

The sub-themes under this include fears related to end of relationship.

According to the table above, those men who feared that their relationship would end had 71.3 % significantly lower odds of participating in HBHTC(AOR =0.287, P=0.001, 95% CI: 0.144-0.575) indicating that fear of separation could deter men from participating in HBHTC. This was mirrored in qualitative findings in which one respondent noted that:

> It is not good for my partner to know the problem I have (being HIV positive) when she knows that, she may leave. Secondly, she may not even agree to have sex with me and she might also not be free with me and this might affect me emotionally (FDG participant, June, 2025)

On the contrary, 32.2% revealed that fear of separation would actually lead men to accept HBHTC as one of the respondents noted that:

> If I don't test because I am unfaithful to my partner, she will start suspecting me of being unfaithful and leave me (FDG participant, June, 2025).

The respondent suggests that refusing to test could raise doubts about fidelity. In a context where trust is fragile, avoiding the test might be seen as evidence of infidelity, potentially leading to separation. This shows that men's decision-making around HIV testing is not only about personal health but also about social and relational consequences. Fear of stigma or abandonment can be a powerful motivator.

Theme two: Masculinity related to fear of becoming HIV positive

Table 2 also indicated that those who feared becoming HIV positive were 15.4% less likely to participate in HBHTC (AOR=0.846, P=0.548, 95% CI: 0.490- 1.461). However, this finding was not statistically significant. However, qualitative findings was not consistent with the above quantitative findings. In the except below, see the response from one respondent when asked whether fear of becoming HIV positive would make him not to participate in HBHTC expressed that:

> Fear of becoming HIV positive would make me not to participate in HBHTC because of the shock that I can get.

In an observation, one participant when asked whether he could not participate in HBHTC for fear of becoming HIV positive just smiled and nodded his head to indicate he feared then as if shy to explain what he felt said that:

> Ehh... that fear is there, I can't imagine being found with HIV. (Observation checklist, May, 2025).

The fear of turning HIV positive in this case, is related to men losing their dignity and social status in the family and in the community as a whole.

Theme three: Masculinity related to fear of nothing implying men's expectation of being strong.

Table 2 also reveals that men who said that they fear nothing showed 264% increased significant chances of participating in HBHTC (AOR=3.636, p=0.001, 95% CI: 1.657-7.976).This implies that increased uptake of HBHTC among men is dependent on men not motivated by any fear. Likewise, This was evidenced by narratives of other participants from FGD discussions who explained that even though they have multiple sexual contacts, nothing would make them fear to participate in HBHTC. A boda-boda man echoed that*:*

> I can't fear participating in HBHTC even though I have multiple sexual contacts because I know how I protect myself. Besides I don't fear HIV anymore. The only disease I fear is cancer. HIV is nowadays a normal disease (FDG participant, June 2025)

This statement reveals a shifting perception of HIV among men, showing how normalization of the disease influences attitudes toward Home-Based HIV Testing and Counseling (HBHTC). The phrase *"HIV is nowadays a normal disease"* reflects how advances in treatment (like ART making HIV manageable) have changed the way people view the infection. HIV is no longer seen as a death sentence but as a chronic condition.

Theme four: Masculinity in terms of fear of being discriminated as head of family

Men who feared taking part in HBHTC for fear of being discriminated as the head of the family were are 78% not likely to participate in HBHTC as compared to those who did not (AOR=0.220, p=0.001, 95% CI: 0.111-0.436). This implies that stigma and discrimination negatively affect the uptake of HBHTC among men. Considering the role a man plays as the head of the family, one healthcare worker commented that:

> Despite the fact that men head families, they play important role in terms of decision making with regards to the uptake of HBHTC I have been in scenarios where a man totally refuses to take part in HBHTC with the whole of his family but if you inquire deeper, the reason is because the man fears being discriminated with his entire family should he be found with HIV particularly in circumstances where the man is aware that the wife knows about his infidelity. The bad treatment he can get from the family may make him feel worthless and lose his role as the head of a family (Interview, June, 2025).

This healthcare worker's comment underscores how male authority within families intersects with fear, stigma, and infidelity to shape HIV testing behavior. The statement shows men equate their role as family heads with dignity and authority. Thus, being treated badly or losing respect due to HIV status could make them feel worthless, undermining their identity as providers and leaders.

Theme five: Masculinity related to fear of losing respect as head of family

This study also found that men who feared losing respect as the head of family were 62.% less likely to participate in HBHTC compared to those who do not fear losing respect as family heads (AOR=0.378, P=0.001, 95% CI: 0.220-0.651). This result was confirmed by qualitative findings in which one participant who stated that:

> I will definitely lose respect as the head of the family if tested and found with HIV. I might not even have a voice in that house.

The respondent fears that testing positive would undermine his authority and respect within the household. In patriarchal family structures, being the "head" is tied to dignity, decision-making power, and voice.

Theme six: Masculinity related to fear of being considered weak

masculinity in terms of being considered weak made men to have a significant 63.8% decreased chances of participating in HBHTC as compared to those who do not (AOR=0.362, P=0.001, 95% CI: 0.212-0.618). When asked about his opinion about a masculine factor as head of family that may hinder uptake of HBHTC, one respondent reported in this manner:

> I may fear testing as the head of family because should I turn positive my partner would turn violent and start beatings. She can overpower you, you cannot even report such issues anywhere because it is shameful. Community and friends may even laugh at you and wonder how weak you are that even a woman can beat you.

An interview with one healthcare worker confirms this:

> If a man doesn't want to test, he may start becoming violent without no course. There is this lady who came and was tested but became HIV positive. However previously the husband had warned her, if you go test and became HIV positive I will kill you first before I kill myself, you see such cases, so we wanted to do a physical follow up for the woman, we created time and went there, we found the woman alone and started talking with her, but upon hearing the footsteps of the man she ran away and left us alone in the house. I informed my colleague to stand so that we may leave. If the woman of the house was the first to run, what do u think the man was capable of

doing to us.(Interview, June, 2025)

Other findings from observation revealed that men who feared taking part in HBHTC due to masculinity reasons seemed reluctant to really express their feelings on the same. They would look at their neighbours with curiosity to check at the answers that they had joted down to confirm if their neighbours had the same opinion as theirs.

Theme seven: Masculinity related to gendered communication

Results from table 4.14 above indicated that men who viewed sex discussions as taboo were 70.9% significantly less likely to participate in HBHTC than those who have contrary opinion. An interview with one male healthcare worker on how gender affects the uptake of HBHTC among men admitted that:

> Culturally we have been brought up not to discuss sex not only at household level but when growing up, so the the fact that it is not always discussed mean minimal information. This means that you can't share any information that might be important in changing our attitude towards seeking health services. Like in our setting especially in our facility its only women who come to the hospital and its during this time that we give them information (about HIV) and we expect them to go back to their spouses to disseminate the information to their partners so if culture prohibits that, the information will not reach them and our objective might not be met
>
> (Interview, June, 2025).

Results from observations indicated that some men seem not to be aware of the existence of a taboo prohibiting men from discussing sex issues with their partners. A 19 years old man when was asked about that during questionnaire administration nodded his head in surprise and said that:

> Does such a thing exist? I have never heard of that taboo since.

However, men aged 30 years and above seem to be aware of that culture and gave out their opinions without showing any difficulties and to some nothing would make them not to discuss sex issues with their partners.

IV. DISCUSSIONS

Findings from this study demonstrate how masculinity norms remain a central determinants of men's uptake of HBHTC in the study area. Despite increased awareness of HIV as a manageable condition, cultural expectations around male authority, strength, and sexual freedom continue to shape attitudes and behaviors in ways that hinder uptake as discussed below:

Masculinity and fear

Men's fears of discrimination, being perceived as weak, losing respect, and contracting HIV were the most influential barriers. These fears are not simply individual anxieties but are embedded in broader cultural constructions of masculinity. In patriarchal family structures, men equate their role as heads of households with authority and dignity (Stoebenau, 2023). A positive HIV test threatens this identity, leading to avoidance of HBHTC. Specifically, the proportion of men who were aware of these masculinity norms who had not been tested through HBHTC was lower compared to those who had undergone testing.

Most participants avoided HBHTC for fear of discrimination, related to men's masculinity role to serve as family head. This fear significantly affects their willingness to undergo HBHTC as supported by previous studies by Siloe et, al., (2018), showing stigma limits men's ability to meet masculine norms and prevents them from accepting HIV testing services. Mahajan et al., (2008), similarly found in their study that as the head of families, men would not accept HIV testing services on the basis of being discriminated thus being incapable of providing for the family thus for increased HBHTC among men, combating these is necessary. These findings are in line with socioecological theory which highlights how various factors starting at the individual level and extends to interpersonal and community level interconnectedly impact behavior.

Fear of Separation and Infidelity

The data also reveal contradictions. While 81.9% of men reported that they do not fear separation from their partners, this reflects a cultural acceptance of multiple sexual partners. Yet HBHTC uptake was much lower (42.6%), showing that fear of separation still indirectly discourages testing. Men may avoid HBHTC to prevent exposing infidelity, which could destabilize family relationships and undermine their authority. This indicates that fear of separation influence uptake of HBHTC among men negatively. Fears related to discrimination, being considered weak, lose of respect, and contracting HIV were the most influential masculinity factors in hindering

men from participating in HBHTC. Specifically, the proportion of men who were aware of these masculinity norms who had not been tested through HBHTC was lower compared to those who had undergone testing. Majority (81.9%) of men stated that they don't fear separating with their partners a factor that explains the existence of culture around masculinity norms that supports men to have multiple sex partners although, in terms of HBHTC uptake, the number tested was much lower (42.6%) than the number of men who had not been tested through home-based. This indicates that fear of separation influence uptake of HBHTC among men negatively.

Regression analysis showed a significant associations between fear of separation and the uptake of HBHTC among men, influenced by perception of masculinity related to having multiple sexual partners. Men worried about fear of being left or abandonment were more likely to participate in HBHTC, emphasizing the need to address and educate couples on how to manage discordant relationships. Previous studies such as Siu et, al., (2014 as cited in Sileo et, al., 2018) support this findings indicating that men declined HIV testing for fear of losing their masculine role as husband. This contradicts socio-ecological theory which suggests that interpersonal support from peers and families influence behaviour and that lack of support, such as fear of separation my motivate men to participate in HBHTC. The results suggest that some men see testing as a way to reduce mistrust in relationships. Interestingly, some men find HBHTC to be convenient option that encourages their participation (Hlongwa et, al., 2019). However the study did not examine role of familial support in influencing men's decision to get tested for HIV.

Masculinity centered on male strength

In this study, only 12.6% of men indicated that they are not motivated by any form of fear to participate in HBHTC. This somehow reveals the existence of a masculinity factor associating men to be strong, with many believing that using protection with sexual partners reduced HIV concerns, and helps avoid tension that might occur between the couples as a result of having multiple sexual partners. Higher uptake was significantly observed among these men. Conversely, other studies show that some men avoid testing despite high-risk exposure, believing they are safe based on partner's negative HIV status Okal et, al., (2020), highlighting the need for ongoing education about other transmission routes. This findings align partially with socioecological theory, emphasizing knowledge as a key factor, but also reveals gaps in awareness of other influences like stigma, which contradicts the theory's view of the complex interindependence of behavioral determinants.

Masculinity and gendered communication

As family heads, the study highlights that most men consider sex discussions a taboo hindering women to disemminate health information about HIV testing to their partners, a factor that significantly affect the uptake of HBHTC in this analysis. The research aligns with studies in Cameroon, Zambia and Uganda which found that men's position of power in the household meant that women cannot approach their husbands about testing and were unable to influence men to test (Dicarlo et al., 2014). The socioecological theory suggests that gendered communication norms influence individual behaviour regarding HBHTC. Aronica et, al., (n.d) state that Interventions using community based strategies , social change communication, and media can help shift harmful masculinity norms at interpersonal level where social change and behavioral can be used. Overall, although sex discussions remain a taboo, for many men, evolving perceptions among some suggest progress in overcoming these barriers. Thats is why in this study some participant's mentioned the importance of sex discussions while some were not aware of its existence thus the need to do away with harmful masculinity norms that reduce men's uptake in HBHTC.

V. CONCLUSION

This study aimed at assessing masculinity factors affecting the uptake of HBHTC among men. Masculinity factors interms of men allowed to have multiple sexual partners, men as family heads and gendered communication affect the uptake of HBHTC. To ensure increased HBHTC uptake in men, there is need to do way with harmful masculinity norms.

References

[1]. Adepoju, V. A., Udah, D.C., Adnani, Q.E., Ahmed,M.M., & Okesanya, O.J. (2024). Uptake and acceptability of HIV self- testing among pregnant and postpartum women and their male partners in Sub-Saharan Africa. Benefits and Challenges and Delivery Strategies. HIV/AIDS- Research and Palliative care 16, 467-476.

[2]. Anudo, N., C & Awuor E.Q. (2016). The portrayal of masculinity in Dholuo ohangla music. *Journal of language, Technology and entrepreneurship in* Africa 7(2) 12-22. Aronica,Crawford, Licherdell & Onoh (n.d) Core Principle of Ecological Model. Retrieved Courses.lumenlearning.com.Retrived.July26,2024 from https: //courses.lumenlearning.com/suny-biffalo-environmentalhealth/chapter/core-principle-of-the-ecological-model.

[3]. Aronica, K., Crawford, E., Licherdell, E., & Onoh (n.d) Core Principle of Ecological Model. Retrieved Courses.lumenlearning.com.Retrived from https: //courses.lumenlearning.com/suny-biffalo-environmentalhealth/chapter/core-principle-of-the-ecological-model.

[4]. Blackstone , S.R., Nwaozuru, U., & Lwelmurnor, J. (2017). Antenatal HIV testing in Sub-Saharan Africa during the implementation of millennium development goals: a systematic review using the PEN -3 cultural model. In*ternational Quarterly of Community Health Education,* 38(2), 115–128.

[5]. Brown, J.S., Sagar-Ouriaghli, L & Sullivan, L. (2019). Help-seeking among men for mental health problems. In J. A Burry R. Kingerlee, M, Seamer & Sullivan (Eds). *The Palgrave Handbook of Male Psychology and Mental Health* (pp 397-415). Springer International Publishing.

[6]. Camlin, S. Ssemondo, E., Charmie, G., Ayadi, A., Kwarisiima, D., Sang, N. (…) Havlir, D. (2016). Men 'missing from the population HIV testing: Insights from qualitative research. *AIDS CARE*, 28:67-73.

[7]. Centre for Health Solutions End of Project report (December, 2021). Implementation, expansion of high quality sustainable and comprehensive HIV Care, Prevention and Treatment Services in the Western Region of the Republic of Kenya SHINDA Project.

[8]. DiCarlo, A. L., Mantell, J. E., Remien, R. H., Zerbe, A., Morris, D., Pitt, B., Abrams, E. J., & El-Sadr, W. M. (2014). "Men usually say that HIV testing is for women": gender dynamics and perceptions of HIV testing in Lesotho. *Culture, Health & Sexuality, 16(*6), 667–682.

[9]. Health Metrico Evaluation Report (2019, October). healthdata.org/Kenya-Siaya. Retrieved from healthdata.org: www.htpps://www.healthdata.org/Kenya Siaya

[10]. Hlongwa, M., Mashamba-Thompson, T., Makhunga, S. Hlongwa, K.(2019). Mapping evidence of intervention strategies to improving men's uptake to HIV testing services in sub-Saharan Africa: A systematic scoping review. *BMC Infect Dis 19,* 496.

[11]. Kenya National Bureau of Statistics. (2019). 2019 Kenya Population and Housing Census: Volume I: Population by County and Sub-County. KNBS.

[12]. Kwena, Z., Kimbo, L., Darbes, L. A., Hatcher, A. M., Helova, A., Owino, G., Thirumurthy, H., Bukusi, E. A., Braun, T., Kilgore, M., Pisu, M., Tamhane, A., Nghiem, V. T., Agot, K., Neilands, T. B., & Turan, J. M. (2021). Testing strategies for couple engagement in prevention of mother-to-child transmission of HIV and family health in Kenya: Study protocol for a randomized controlled trial. *Trials*, 22(1), 19.

[13]. Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Sze-keres G, et al. (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS Behav* ;22(Suppl 2):S67.

[14]. Mweemba, O., Dixey, R., Bond, V., & White, A. (2018). The influence of social constructs of hegemonic masculinity and sexual behaviour on acceptability of vaginal microbicides in Zambia. *Global Public Health, 13*(7), 931–943.

[15]. Muttai, H., Guya, B., Achia, T., Musingila, P., Nakhumwa, J., Oyoo, R., (…) Zielinski-Gutierrez, E. (2021). Mapping geographic clusters of new HIV diagnoses to inform granular-level interventions for HIV epidemic controlling western Kenya. *BMC Public Health*, 12889-11890-7.

[16]. Okal, J., Lango, D, Matheka, J., Obare, F., Ngunu- Gituahi, C., Mugambi, M., & Sarna, A. (2020). It is always better for a man to know his HIV status. A qualitative study exploring the context, barriers and facilitators of HIV testing among men, in Nairobi, Kenya. *PLOS ONE, 15*(4), Article e0231645.

[17]. Sileo, K., Fielding-Miller, R., Dworkin, S., Flemming, P. (2018). What role do masculine Norms pay in men's HIV testing in Sub-Saharan Africa? a scoping review. *AIDS Behav*, 2468-2479.

[18]. Stoebenau, K., Bingenheimer, J.B., Kyegombe, N. Datar, R., Ddumba-Nyanzi, I. (2023). Development of Gender Roles and Male Provision Expectations Scale*Arch Sex Behav* 52, 2403–2419

[19]. Swinkels, H. M., Nguyen, A. D., Samandari, T., & Gulick, P. G. (2026). HIV and AIDS. In StatPearls. StatPearls Publishing.

[20]. Turan, J. M., Kwena, Z. A., Owuor, K., Helova, A., Hatcher, A. M., Braun, T. M., Owengah, E., Okombo, M., Nghiem, V. T., Thirumurthy, H., Bukusi, E. A., & Darbes, L. A. (2026). Effectiveness of interventions to promote couples-based HIV testing and family health during pregnancy and postpartum in Kenya: A multicentre, couples-based, randomised controlled trial. The Lancet HIV, 13(9).

[21]. UNAIDS. (2025). *Global HIV/AIDS Statistics Fact Sheet*. Retrieved from Unaids.org: https://www.unaids.org/en/resourse/fact_sheet

[22]. Ware, N. C., Wyatt, M. A., Pisarski, E. E., Kamusiime, B., Kasiita, V., Nalukwago, G., Nalumansi, A., Twesigye, C., Boyer, J., Nakyanzi, A., Naddunga, F., Mujugira, A., & Celum, C. L. (2023). How pregnant women living with HIV and their male partners manage men's HIV self-testing: qualitative analysis of an HIVST secondary distribution process in Kampala, Uganda. Journal of the International AIDS Society, 26(1), e26050.

[23]. WHO (2025). HIV statistics globally: Retrived from https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/who-ias-hiv-statistics_2025-new.pdf

[24]. WHO (2012). Service delivery approach to HIV testing and Counseling (HTC): strategic HTC Program Framework. World Health Organization.