HIV Stigma Among Men in Tanzania: A Mixed-method Study

by

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Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science in the Duke Global Health Institute
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ABSTRACT

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Abstract

Background: HIV-related stigma is a barrier to the success of programs targeting the prevention and treatment of HIV. In Sub Saharan Africa, where the HIV epidemic is concentrated, men play a critical role in defining and shaping social constructs, including HIV stigma. This study aimed to describe HIV stigmatizing attitudes, to identify factors associated with stigmatizing attitudes, and to explore the broader context of HIV stigmatizing attitudes among men in Tanzania. Methods: This mixed-method study recruited 489 men from antenatal clinics of two public primary health care facilities in Moshi municipality, Tanzania. Participants completed a structured survey using audio computer assisted self-interviewing technology; a subset of 16 men completed in-depth interviews. HIV stigmatizing attitudes were examined using a modified version of the Personal Stigma Scale, and logistic regression models identified associating factors. Qualitative data were analyzed using applied thematic analysis. Results: The majority (72%, n=356) of participants endorsed at least one of the stigmatizing attitudes; the most common attitude endorsed was a perception of HIV is a punishment for bad behavior (37%, n=180). In a multivariable logistic analysis, men with only primary education were twice as likely as those with secondary or high to hold high stigmatizing attitudes (OR=2.05, 95% CI 1.39, 3.04). Qualitative analysis revealed that masculine identity intensified the vulnerability of men towards HIV stigma, while HIV testing experience spurred behavior change to reduce HIV risk behavior.

Conclusions: HIV stigmatizing attitudes are prevalent among men. Comprehensive community-based stigma reduction programs to provide a supportive environment for men are crucial to increase uptake of HIV testing and treatment services.

Dedication

I would like to dedicate this thesis to my beloved parents, Alfred John Kisigo and Eva Eliezer Mwipopo, who have been very supportive in my education. Without them, I would not have made this far. Thank you for the unconditional love.

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1. Introduction

HIV-related stigma is a barrier to the success of programs targeting the prevention and treatment of HIV (Mihan et al., 2016; Turan et al., 2011). Stigma, which is defined as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963), impacts outcomes across the HIV care continuum, from uptake of HIV testing to viral load suppression among people living with HIV (L. Nyblade et al., 2019). Fear of HIV-related stigma leads people to avoid testing for HIV, and individuals who are diagnosed with HIV may refrain or delay to initiate HIV care (Maretha J. Visser et al., 2006). Stigma has a significant impact on HIV disclosure to sexual partners, which increases the risk of forward transmission of HIV (Knettel et al., 2019). At the same time, people living with HIV suffer from the manifestations of stigma, including social judgment and discrimination, which often leads to poor treatment adherence (Treves-Kagan et al., 2017). Collectively, these circumstances drive the persistent spread of the HIV epidemic (Maretha J. Visser et al., 2006). In Tanzania, it is estimated that 1.4 million people aged 15 – 64 years are living with HIV, but only 52.2% of these individuals know their HIV status (Tanzania, 2017). This rate of HIV status self-awareness is far from reaching the UNAIDS target (i.e., 90% of all PLHIV will know their HIV status by 2020) (UNAIDS, 2014). Without addressing HIV stigma in local communities, the elimination of the HIV epidemic will remain an unreachable ambition.

Among individuals who are HIV negative or unaware of their status, HIV-related stigma manifests in two forms: stigmatizing attitudes (i.e., personal negative attitudes towards people living with HIV) and anticipated stigma (i.e., personal perception about community negative attitudes towards people living with HIV) (Green, 1995; Malcolm et al., 1998). These two forms of stigma are mutually dependent, as they are both informed by norms and experiences at the individual and community level. HIV stigma is typically expressed through blame and moral judgment, and through social distancing from people who are known or suspected of living with HIV. Both forms of expressions are rooted in the early metaphors of the HIV epidemic (e.g., HIV is equal to death), individual and community knowledge on HIV transmission (e.g., misconception that HIV can be transmitted via casual contacts), and society belief and religion practices (e.g., believing HIV is the punishment for bad behavior) (Alonzo & Reynolds, 1995; Dab et al., 1989). Individuals and communities with negative attitudes towards people with HIV are more likely to discriminate, reject, abandon, and even physically abuse those who are living with HIV (Baleta, 1999; Maretha J. Visser et al., 2006).

In Sub-Saharan Africa, where the majority of HIV cases are located, men assume leadership roles in the family and community levels, and therefore play a critical role in defining and shaping social constructs (Karim, 1998). This position gives men the power to determine and influence the social, political and economic organization of society,

and to shape norms around identities such as HIV. At the same time as men hold a certain privilege in establishing social norms, those norms also create vulnerability, toxic ideas of masculinity, and risky health behaviors, and give rise to reduced treatment-seeking behavior among men (Harrington et al., 2016; Mburu et al., 2014; Sileo et al., 2018). The context of masculinity, when combined with the manifestations of HIV stigmatizing attitudes, may severely hamper HIV testing, prevention and treatment among men and the general population. There is an urgent need to develop "gender-responsive" interventions that address the unique challenges of men and substantively engage men in HIV programming. This will encourage uptake of HIV testing and treatment, reduce HIV stigma that creates barriers to HIV care, and involve men as advocates who challenge barriers associated with HIV stigma in the community. Male engagement can not only have measurable impacts for men themselves, but can also improve the outcomes for their female partners who often note partner-related barriers to PMTCT care engagement (Kiula et al., 2013; McMahon et al., 2017).

Despite the importance of men in understanding and addressing HIV stigma, there is limited knowledge of how social and personal attributes influence HIV stigmatizing attitudes among men in Sub-Saharan Africa. This study was conducted among men in Tanzania with three aims: to describe HIV stigmatizing attitudes, to identify factors associated with stigmatizing attitudes, and to explore the broader context of HIV stigma attitudes.

2. Methods

2.1 Overview

This mixed-method study involved 489 men who were enrolled in a pilot randomized control trial of *Maisha,* a stigma-based counseling intervention among women and their partners presenting for antenatal care (ANC) in Moshi, Tanzania (Watt et al., 2019). The study analyzed data from baseline surveys completed by men enrolled in the trial, and purposively selected a subset of 16 men to complete in-depth interviews. Surveys were completed between April and September 2019, while in-depth interviews were conducted between June and August 2019.

2.2 Setting

The study was conducted in ANC clinics in two public primary health care facilities in Moshi municipality, Tanzania. The two study sites together served approximately 2500 pregnant women per year. Both clinics had policies in place to incentivize pregnant women to bring their male partners during the first ANC visit for pregnancy education and HIV couple testing and counseling. For example, women who presented with a partner they were given preferential services. As a result, approximately 70% of pregnant women in our study clinics attended their first ANC appointment with their partner.

2.3 Participants

Men who escorted their pregnant partners to a first ANC appointment were invited to participate in the study if their partner (i.e., pregnant woman) agreed to enroll in the trial. The eligibility criteria included a minimum age of 18 years, fluency in Swahili, and the ability to provide consent. The study was introduced to the couples by the nurse at the ANC before HIV counseling and testing. If a couple were interested in participating in the study, they were referred to the study team. In the study office, the research assistant provided detailed information about the study and screened couples for eligibility.

2.4 Procedures

Participants completed a structured survey using audio computer-assisted self-interview (ACASI) technology on tablets running Questionnaire Development System (QDS) software. This technology allowed participants to simultaneously read and listen to questions and response options, and then select their preferred response. The ACASI modality was used to protect the privacy of participants and minimize the risk of social desirability (van de Wijgert et al., 2000).

2.4.1 In-depth interviews

We purposively intended to interview men with different socio-demographic characteristics, and who could provide insights on community-level stigma. Thus, to identify suitable men for the in-depth interview, we developed a selection criteria guide

to ensure equal representation of age, religion, level of stigmatizing attitudes (i.e., low or high), and trial treatment status (i.e., intervention or control). In addition, we consulted research assistants who had interacted with participants in the previous study visit to identify potential candidates who they thought would be willing and able to talk on this topic.

For the 16 men who were invited for in-depth interviews, they all came between two to four weeks after completing their baseline survey. The interviews were conducted in Swahili by a trained Tanzanian researcher who had prior experience with qualitative research. Interviews took approximately one hour and were audio-recorded with the participant's consent. Following the completion of the interview, the audio files were transcribed and translated into English by a translator who is fluent in English and Swahili. An incentive of 5000 Tanzanian Shillings (approximately $3) was given to each participant following the in-depth interview.

2.5 Measures

2.5.1 Structured survey

2.5.1.1 HIV stigma attitudes

To measure stigmatizing attitude, we used a modified version of Personal Stigma Scale, referred to as the HIV Stigma Attitudes Scale (HSAS) in this study. The original scale includes two subscales: blame/judgment and interpersonal distancing (Maretha J. Visser et al., 2008), which are considered as core component of HIV stigma in an African

context (Maman et al., 2009; L. C. Nyblade, 2006). Fourteen of the 17 items from the original scale (Maretha J. Visser et al., 2008) were included, three items were adapted to for the local context, and one item was identified from formative research (Watt et al., 2019). The final HSAS included 18 items. Responses were answered on a 4-point Likert scale that ranged from 0 (strongly disagree) to 3 (strongly agree), with a possible total score range of 0-54 (see Table 4). For analysis, we used the sample mean score of 14 as a cut-off to identify men with high stigma attitudes. The Cronbach alpha reliability coefficient for the HSAS in our sample was 0.922.

2.5.1.3 Perceived social support

To measure social support that participants perceived as available from their social networks, we used the perceived availability of social support scale (PASS) (O'Brien et al., 1993). The PASS includes 8 items that probe different sorts of support (e.g., Is there someone who would help take care of you if you had to stay in bed for several weeks?). Each item was answered on a 4-point Likert, from 0 (not at all) to 3 (yes, very likely). The items were summed and used as a continuous measure with a range of 0 to 24. The Cronbach alpha reliability coefficient for the PASS was 0.883.

2.5.1.4 Contact with people living with HIV

To assess the level of contact with people living with HIV (PLWH), participants were asked to answer six yes/no questions. These questions explored contact with PLWH from a close relationship (e.g., "Have you ever had a family member who was HIV positive?") and to the community at large (e.g., "Have you ever known anyone else

who was HIV positive?"). Men were categorized into two groups; first, "no contact" if they answered no to all questions, and "some level of contact" if they answered yes to any question.

2.5.1.5 Demographics and HIV information

The survey included questions about age, highest level of education attained, marital status, religion, area of residence, and source of monthly income. Questions were also asked about prior experience of HIV testing, awareness of individual and sexual partner HIV status, and willingness to test for HIV in the future.

2.5.2 Qualitative interview guide

The development of the semi-structured interview guide was informed by a literature review and formative data collected from stakeholders' meetings. The guide included open-ended questions and probes related to HIV testing and counseling experiences, stigma practices at an individual and community level, and thoughts about the unique experiences of being a man with HIV (see Table 1 for additional detail). Each section of the guide began with an opening question, followed by potential probes to be used to explore the topic in greater depth.

Table 1. The contents of the in-depth interview guide

HIV Testing experience
Feelings about getting the HIV test
Feelings after getting HIV test results
Possible reactions if tested positive for HIV
Plan for HIV testing in the future
Personal and community attitudes towards people living with HIV

Attitudes (self and community) toward people living with HIV
How men perceive and talk about people living with HIV

Discussion about a hypothetical neighbor who has HIV
Discussion about a hypothetical situation in which participant is diagnosed with HIV
HIV status disclosure
Gender and stigmatizing attitudes

2.6 Analysis

2.6.1 Quantitative analysis

Data were processed in the central warehouse of QDS and transferred to a secured cloud-based Box file for storage. After completing enrollment, data were imported into StataSE 15 for statistical analysis. The analysis was performed in multiple stages to address each of the study aims. The first stage was to establish the prevalence and distribution of stigmatizing attitudes across sub-groups. We started by classifying men into two groups based on their HSAS total score using 14 as a cut-off (i.e., an overall score of below 14 = low stigma; a total score of 14 and above = high stigma). Descriptive statistics were examined, and results were presented in a 2x2 contingency table. The second stage was to assess the pattern of stigmatizing attitudes across the HSAS. Each item was dichotomized by combining strongly agree and agree into first-level response (i.e., agreement with the statement) in order to describe the proportion of the sample who express agreement with each item. The last stage was to identify factors that were associated with high stigmatizing attitudes. Each factor we hypothesized to have an association with high stigmatizing attitudes was considered as a univariate

predictor of high stigmatizing attitudes. Then, factors were entered into backward stepwise logistic regression models to determine factors that were associated with high stigmatizing attitudes. We used mean square error (MSE) and a change of parameter estimates (i.e., odds ratios and confidence intervals) to ascertain the importance of each factor and its association with stigmatizing attitudes.

2.6.2 Qualitative analysis

Data were analyzed using applied thematic analysis (Guest et al., 2012) with an emphasis on qualitative memo writing (Birks et al., 2008). The applied thematic approach is a rigorous set of inductive procedures designed to identify and examine themes from textual data in a way that is transparent and credible. After multiple readings of the transcripts, document memos were written for each individual interview. Memos followed an established template of a priori domains, informed by the interview guide, to extract and synthesize the core meaning from text related to the research questions and to pull out representative quotes. The memo writing process identified emerging themes and informed the development of a structured codebook focused on understanding the intersection of masculinity and HIV stigma . The codebook included six components: the code, a brief definition, a full definition, guidelines for when to use the code, guidelines for when not to use the code, and examples. The 16 document memos were uploaded to NVivo software and coded using the final codebook. After coding, code-level queries were run, and analytic memos were

written to synthesize the content, make comparisons across participant characteristics, and draw deeper meaning on each theme.

2.7 Ethics

The informed written consent was obtained from all study participants. While completing a survey, participants were given snacks and drinks, and after completing study procedures, they were given 2000 Tanzanian shillings (approximately $1) for lunch. All study procedures were approved by the ethical review boards at Duke University, Kilimanjaro Christian Medical College University, and the National Medical Research Institute in Tanzania.

3. Results

3.1 Survey findings

3.1.1 Description of sample

Of the 492 men who completed the survey, the mean age was 32 ± 7 years. Most participants were married (69%, n=343) and had no steady source of income (70%, n=347). A majority (67%, n=334) said they had tested for HIV at least once in the past, and almost all (90%, n=436) reported that they were likely to test for HIV in the coming year. About half (48%, n=232) met the criteria for high stigmatizing attitudes towards PLWHA. Further demographic characteristics of the study participants are presented in Table 2.

Table 2. Demographics, HIV related experiences, and psychosocial measures by the level of HIV stigma (N=492)

	Total N=492	Low stigma n=249 (51.8%)	High stigma n=232 (48.2%)
Socio-demographics			
Age			
18-25	139 (28.3%)	62 (45.6%)	74 (54.4%)
26 +	353 (71.7%)	187 (54.2%)	158 (45.8%)
Education			
Primary or less	259 (52.6%)	108 (42.5%)	146 (57.5%)
Secondary or higher	233 (47.4%)	141 (62.1%)	86 (37.9%)
Marital status			
Married	343 (69.9%)	174 (51.8%)	162 (48.2%)
Unmarried	148 (30.1%)	74 (51.4%)	70 (48.6%)
Religion			
Christian	240 (48.8%)	134 (57.5%)	99 (42.5%)
Muslim	252 (51.2%)	115 (46.4%)	133 (53.6%)

Steady source of income			
No	347 (70.5%)	174 (51.6%)	163 (48.4%)
Yes	145 (29.5%)	75 (52.1%)	69 (47.9%)
HIV related experience			
Tested for HIV			
No	158 (32.1%)	76 (48.4%)	81 (51.6%)
Yes	334 (67.9%)	173 (53.4%)	151 (46.6%)
Partner tested for HIV			
No or Don't know	188 (38.2%)	85 (46.4%)	95 (53.6%)
Yes	304 (61.8%)	164 (55.0%)	134 (45.0%)
Likeliness to test HIV next year			
Not likely	47 (9.7%)	21 (44.7%)	26 (55.3%)
Likely	436 (90.3%)	227 (52.4%)	206 (47.6%)
Contact with PLWHA			
No contact	204 (41.5%)	84 (42.4%)	114 (57.6%)
Some level of contact	288 (58.5%)	165 (58.3%)	118 (41.7%)
Psycho-social measure			
PSA*	15.9 (5.52)	16.9 (5.44)	15.0 (5.41)

* Perceived availability of social support, mean (standard deviation)

3.1.2 HIV stigmatizing attitudes

Table 3 summarizes how participants endorsed the 18 items for HIV stigmatizing attitudes. The majority (72%, n=356) of participants upheld at least one of the stigmatizing attitudes. The most commonly endorsed items in the blame and judgement domain were: HIV is a punishment for bad behavior (37%, n=180) and people with HIV must have done something wrong to get it (27%, n=135). The most commonly endorsed items in the interpersonal distance attitudes domain were: men not wanting someone

with HIV to look after their child (28%, n=138) and men not wanting their child to play with a child who has HIV or whose parents have HIV (28%, n=137).

Table 3. Agreement with items in the HIV stigmatizing attitudes scale (N = 492)

	n	%
Blame and judgement		
Getting HIV is a punishment for bad behavior	180	37.3%
People with HIV must have done something wrong to get it	135	27.8%
People with HIV have only themselves to blame for getting HIV	116	23.9%
I would be ashamed if someone in my family has HIV	115	23.8%
People with HIV should feel ashamed about having HIV	88	18.1%
I would think less of someone if I found out the person has HIV	79	16.3%
Interpersonal distancing		
I would not want someone with HIV to look after my child	138	28.6%
I would not want my child to play with a child who has HIV or whose parents have HIV	137	28.4%
I would not want to buy food from someone I know has HIV	119	24.6%
I do not want to get too close to someone with HIV because I am afraid I might get infected with HIV	116	24.1%
If a relative of mine became ill with HIV, I would not want to care for that person in my home	108	22.4%
I would not eat together with someone I knew had HIV	104	21.6%
I would not employ someone with HIV	104	21.5%
I feel uncomfortable around someone with HIV	90	18.7%
I would not like to be friends with someone with HIV	87	18.0%
I would be upset if someone with HIV moved in next door to me	87	17.9%
If a teacher has HIV but is not sick, she should not be allowed to continue teaching in the school	89	17.8%
If I was in public or private transport, I would not like to sit next to someone with HIV	78	16.2%

3.1.3 Predictors of HIV stigmatizing attitudes

Table 4 reports the estimates of the univariate and multivariate logistic regression analyses of social and behavioral predictors of HIV stigmatizing attitudes. In

a final multivariate model, younger men (18-25 years) had 1.54 times (95% CI 1.01, 2.37) odds of having high stigmatizing attitudes than older men (26 years and above); men with only a primary education were twice as likely as those with secondary or high to hold high stigmatizing attitudes (OR=2.05, 95% CI 1.39, 3.04); men with no prior contact with PLWHA had 1.52 times (95% CI 1.03, 2.23) odds of having high stigmatizing attitudes than those with prior contact with PLWHA; and Muslims had 1.49 times (95% CI 1.03, 2.15) odds of exhibiting stigmatizing compared with Christians. On the other hand, an increase in perceived availability of social support was associated with less likelihood of having stigmatizing attitudes (OR=.95, 95% CI 0.92, 0.99).

Table 4. Factors associated with high HIV stigmatizing attitudes among men

	Crude odds ratio (95% CI)	Adjusted odds ratio (95% CI)
Socio-demographics		
Age		
18-25	1.41 (0.95, 2.11)	1.54 (1.01, 2.37) *
[ref: 26+]	1	1
Education		
Primary or less	2.22 (1.54, 3.20) ***	2.05 (1.39, 3.04) ***
[ref: Secondary or higher]	1	1
Religion		
Muslim	1.57 (1.09, 2.25) *	1.49 (1.03, 2.15) *
[ref: Christian]	1	1
HIV-related experiences		
Contact with PLWHA		
No contact	1.90 (1.32, 2.75) ***	1.52 (1.03, 2.23) *
[ref: Some level of contact]	1	1
Psycho-social measure		

Perceived social support	0.94 (0.91, 0.97) ***	0.95 (0.92, 0.99) **

*p-value <0.05, **p-value <0.01 ***p-value < 0.001

3.2 Qualitative findings

3.2.1 Description of the sample

In comparison to the large sample, the 16 participants who participated in an in-depth interview were more likely to have had previous testing experience (75%), to have a secondary education (58%), to have prior contact with PLWHA (56%), and to report being a Christian (75%). Additional, individual-level details of the 16 study participants are presented in Table 5.

Table 5. Description of the sample of men completed an in-depth interview (n=16)

ID	Age	Relationship status	Highest Education	Occupation	Prior HIV testing	Contact with PLWHA	HIV stigma level
01	34	Unmarried	Secondary	Self-employed	No	Some level	No or low
02	35	Married	Primary	Self-employed	Yes	Some level	High
03	24	Unmarried	Secondary	Self-employed	Yes	No	High
04	24	Unmarried	Secondary	Employed	Yes	No	High
05	45	Cohabiting	Primary	Peasant farmer	Yes	No	High
06	38	Married	Primary	Self-employed	No	No	No or low
07	31	Married	Secondary	Peasant farmer	Yes	No	No or low
08	27	Cohabiting	Primary	Self-employed	Yes	No	No or low
09	37	Married	Primary	Employed	Yes	Some level	No or low
10	26	Cohabiting	Primary	Employed	No	Some level	No or low
11	29	Married	Secondary	Peasant farmer	Yes	Some level	No or low
12	45	Married	Primary	Self-employed	Yes	Some level	No or low
13	25	Married	Secondary	Self-employed	Yes	No	High

14	33	Married	College	Self-employed	Yes	No	High
15	22	Married	Secondary	Self-employed	Yes	Some level	High
16	24	Cohabiting	Secondary	Employed	No	No	High

3.2.2 Emergent themes

Three broad themes emerged in the data. The first theme, named "living with HIV as a devastating new reality," represents the hypothetical experiences of men living with HIV. The second theme, named "PLWH as a threat," represents the view of men towards people living with HIV. The final theme, named "HIV testing as a step toward behavior change," represents the experiences of men with HIV testing and how receiving a negative HIV test result can influence positive behavior change.

3.2.2.1 Living with HIV represents a devastating new reality

3.2.2.1.1 HIV is a threat to masculine identity

When asked about the hypothetical scenario of getting a positive HIV test result, men spoke about how their lives and their position in society would be inevitably reordered. Among the salient reactions was the anticipation of becoming less of a "real man". This notion was supported with speculation that HIV will limit their physical strength, will take away their respect in the society, and will create a new identity (i.e., otherness).

> "Therefore this [HIV positive status] would have caused me to look for another job to do because this [current job] would have been too hard for me in my new state of health" (PID 08; No or low stigma)

"Some of them will disrespect him [a person living with HIV]. And even if you have a family meeting, if this person [living with HIV] begins to speak and he says something that is a big point, still the others will regard the point as meaningless." (PID 02; High stigma)

"[Living with HIV] is as if you are a different person, a photocopy of you. You know, when you make a photocopy of a paper the copy is not like the original; so it's something like that. I mean you become a somewhat different person and they will stigmatize you in many ways." (PID 07; No or low stigma)

3.2.2.1.2 HIV is a man's misfortune

Although participants acknowledged that HIV can be effectively managed with antiretroviral therapy (ART), the thought of living with HIV provoked a sense that dreams would be squashed and life would be over. HIV was perceived to be a barrier towards prosperity via multiple pathways, including an inability to concentrate on work, a lack of motivation, and disconnection from income-generating peer networks.

"I mean [if I had HIV] I would have lost my life's direction and I would have been thinking a lot saying, 'I am already infected!' " (PID 13; High stigma)

"To be frank, that was my main fear; thinking that this [HIV] would have affected my activities and when I looked at myself being a young man, having a problem like this would have meant that my dreams would be smashed because I wouldn't have been able to perform my work properly because this would have affected my mind." (PID 08; No or low stigma)

"Men are more stigmatized because even at the place of work cooperation is weak. Because once they discover that he has HIV, the community around him in the street or at the place of work will avoid him in many areas saying, 'we should avoid this man because he's got *the drum* [metaphor for HIV]'. " (PID 10; No or low stigma)

3.2.2.2 View of PLWH as a threat to the broader community

3.2.2.2.1 PLHW are incompatible with reproduction

Men asserted that they would end the intimate relationship or marriage if a female partner were to learn she had HIV. This decision was driven by a fear of forward transmission of HIV. Most men reported to want more children, which they saw as incompatible with protecting themselves from HIV.

> "You might want a second child. How are you going to do it? You would have a constant fear that if you do it [condomless sex] you will get it [HIV] …this fear will be in your soul." (PID 01; No or low stigma)

3.2.2.2.2 PLWH are untrustworthy

Some men reported that PLWH are perceived to be harmful in society. This perception appeared to be driven by anecdotes of PLWH who intentionally sought to spread HIV to others in the community. As a result, men expressed attempts to distance their loved ones from PLWH who were perceived to be emotionally unstable and willing to purposively spread HIV if triggered.

> "I think that it is the evil that is in the human heart. … People like that when they know that they are infected with HIV they might deceive your child and sleep with her or him just to infect your child just because he did something that made him angry." (PID 05; High stigma)

3.2.2.2.3 PLWH got what they deserve

Participants described how the mode of HIV transmission and behavior of a person determines how society reacts toward an individual living with HIV. For those individuals who are perceived to be promiscuous, participants felt it is morally acceptable to withhold empathy towards them after getting HIV. Participants extended

this same opinion to themselves, asserting that they would not feel sorry for themselves if they were to get HIV through sexual risky behavior.

> "For example, if you used to sleep around with different people.. If you contract HIV all the people will disrespect you. They will say you got what you deserved." (PID 03; High stigma)

> "You would have felt badly if you didn't do things that would've caused this (your HIV status). But if you were sleeping around, then it would be right to receive what comes your way." (PID 02; High stigma)

3.2.2.3 HIV testing as a step toward behavior change

3.2.2.3.1 Fear of HIV testing.

The majority of men reported experiencing heightened anxiety of testing for HIV for the first time. This fear was mainly driven by their own perceived risks for HIV based on their sexual behaviors, including multiple sexual partners and unprotected sex. Some of the men noted that they avoided testing with their partners to prevent shame if they were to be found with HIV.

> "At first, it was a problem. And as you well know, we young people have passed many places [multiple sex partners] and did many things [including unprotected sex]. Now you ask yourself, 'how many places have I been to, and what are the consequences?' If I take the test and the results turn out to be positive, that I am infected, I will have a very hard time." (PID 01; No or Low stigma)

3.2.2.3.2 HIV Negative results as a motivation for positive health behavior change.

After receiving HIV negative test results, most of the men aspired to change their risk behavior for the sake of their health and that of a partner. This motivation of change

was facilitated by critical moments of reflection during the HIV testing experience and a recommitment to their role as a family leader.

> "[After the results came out negative] I decided to stop drinking and stand as the head of the family." (PID 12; No or Low stigma)

All men reported that after testing for HIV for the first test, they were willing to test more frequently. Among men who had a subsequent HIV test, they described it as a good experience associated with confidence and peace. Thus, each HIV test with a seronegative result was a motivation for testing in the future.

> "[During follow-up test] … I was feeling good. … And when I was in [town name] I used to test often because there the health testing is done free of charge." (PID 07; No or Low stigma)

4. Discussion

This study sought to describe HIV stigmatizing attitudes, to identify factors associated with stigmatizing attitudes, and to explore the broader context of HIV stigmatizing attitudes among men in the Kilimanjaro region in Tanzania. We found that personal attitudes that promote judgement and distancing toward PLWH were common among men. Men were more likely to endorse stigmatizing attitudes if they were younger, less educated, Muslim, or had less social support. These findings highlight the persistence of HIV stigmatizing attitudes among men in the community, despite several decades of campaigns to reduce stigma toward PLWH.

Men's narratives from in-depth interviews revealed an intersection of HIV stigmatizing attitudes and masculine identity. Most men in this study perceived themselves at risk for HIV due to their sexual behaviors. Although having multiple sexual partners was considered as part of being a "real man," most participants embodied an idea that contracting HIV was a product of moral misconduct. Given that participants possessed an attribute that is perceived to be associated with HIV, and identified themselves at risk of HIV, it is remarkable to note their keen sense of blame toward PLWH.

Men in our sample expressed a fear of PLWH, whom they saw as being full of emotions and having "ammunition" (i.e., HIV) that they can use to harm others. This view of people with HIV might have been constructed by the experience of interacting

with a minority of PLWH, who do not represent a general population of PLWH. Similarly, our survey results demonstrated that men who have no contact with people living with HIV are more likely to hold high stigmatizing attitudes compared to those with some level of contact. Exposure to PLWH has the potential to produce positive attitudes towards individuals with HIV, suggesting the need for role models of individuals living openly and confidently with HIV (Dageid et al., 2012; Mfecane, 2012). At the same time, it is imperative to support PLWH to disclose their status to trusted individuals. Previous studies (Dessie et al., 2019; Knettel et al., 2019; Whembolua et al., 2019) have shown that often PLWH typically receive social and treatment support following disclosure. As more PLWH disclose their status, the proportion of community members who know someone living with HIV will increase, which has the potential to impact stigmatizing attitudes (M.J. Visser et al., 2009). It should be noted, however, that context, frequency, and type of exposure to people with HIV might have a differential influence on stigma attitudes (Treves-Kagan et al., 2017). This concern is essential for men who, because of gender roles, are frequently less involved in taking care of PLWH when they are sick (Campbell et al., 2008; Schatz & Ogunmefun, 2007).

Narratives from the in-depth interviews displayed a heightened vulnerability of men towards HIV stigma, which was induced by prevailing notions of masculinity. Even though men knew that ARTs were universally available and can contribute to a long and healthy life, living with HIV was perceived to be a serious disability that

hampers productivity and longevity. The prospects of living with HIV threatened masculine identities that promote respect, strength, independence and emotional control (Connell, 2005; Courtenay, 2000). In the process of protecting their masculine identity, men are predisposed to avoid HIV testing and delay care initiation if are found to be seropositive. It can, therefore, be assumed that men will be motivated to engage with HIV testing and treatment services if they are designed to stimulate positive masculine identities such as success, power, and competition (Mburu et al., 2014; Nyamhanga et al., 2013). This idea could be achieved by promoting HIV testing and treatment as a way of preserving good health that can enable a man to take care of the family.

It is interesting to note that men who had high levels of social support in this study were less likely to have hold HIV stigmatizing attitudes. It can thus be suggested that a sense of feeling supported and belonging in your social network may evoke more empathy for others. Further research is required to establish the mechanism by which perceived support influences HIV stigma attitudes. This knowledge could be used to enhance programs that leverage social networks to promote HIV prevention and treatment among men.

Contrary to the expectations, this study found that younger age was associated with higher stigmatizing attitudes. This finding is contrary to previous study (M.J. Visser et al., 2009), which has suggested that younger individuals have more positive towards PLWH, perhaps because they have more access to HIV education and are more

socially liberal and open (Herek et al., 2002; L. C. Nyblade, 2006). This surprising finding highlights the need to target a younger generation. Since primary education is nearly universal in Sub Saharan Africa (Bennell, 2002), an introduction of HIV stigma reduction in the curriculum may help to reduce HIV stigma in young men (Gill & Beazley, 1993).

Another important finding was that men avoided HIV testing because of their own perceived risk of HIV. However, an HIV negative test brought an incredible sense of relief and spurred behavior change to reduce HIV risk behaviors. Based on this observation, it can be inferred that HIV testing experience has a potential to create learning moments that could be leveraged to change negative attitudes about PLWHA (Knight et al., 2016). As men reflect on the possibility of being HIV positive during an HIV test, there is an opportunity to introduce empathy and reduce stigmatizing attitudes towards PLWH.

Although our study survey did not examine a participant's level of exposure to the religious doctrine, we found that men who identified themselves as Muslims were more likely to have high stigmatizing attitudes compared to Christians. The difference detected between the two dominant religious groups could have been caused by social stratification. Those who identify themselves as Muslims might have been prone to reside in settings with lower access to education and limited health care services – including HIV testing and counseling (Dzah et al., 2019). These structural factors, instead of religious doctrine, might have influenced their negative attitudes towards

PLWH (Mihan et al., 2016). Future studies on the process of how religious identification influences HIV stigma attitudes are recommended to inform the development of stigma reduction intervention focusing on religion.

4.1 Implication for research

The findings from this study make several contributions to the current literature. First, although we have made significant progress in improving treatment and caring for PLWH, contemporary HIV stigmatizing attitudes among men remains prevalent, with a similar pattern as the early years of the HIV epidemic (Green, 1995; Malcolm et al., 1998). This finding highlights the need to develop comprehensive stigma reduction interventions that focus on normalizing HIV and building resilience in PLWH to endure stigma. Second, HIV stigmatizing attitudes is associated with several socio-demographic and behavioral factors among men. Some of these factors warrant further research to provide more in-depth insight on how they influence HIV stigmatizing attitudes, while others can be leveraged in designing interventions to address stigma. For example, (Payne-Foster et al., 2018) developed a stigma reduction intervention, which was informed by Christian faith nuances and tailored to reduce HIV-related stigma among members of African American churches in rural Alabama. This innovative idea can be replicated and implemented in Sub-Saharan Africa, where religion has a significant influence on personal attitudes toward others. Lastly, in order to connect with men and exert sustainable behavioral change, the design of future interventions should

incorporate elements that support the male role in Sub Saharan African. Therefore, the inclusion of income-generating activities and community development projects in these interventions might persuade men to remain engaged (Maman et al., 2016; Mburu et al., 2014).

4.2 Implication for practice and policy

The findings of this study have several important implications for future practice. Men in this study overtly expressed concerns about the risk of HIV transmission among discordant couples. This genuine issue could be addressed by introducing the Undetectable is equal to Untransmittable (U=U) campaign in public, and integrating this message in the HIV testing and counseling package. The U=U campaign is supported by scientific evidence, which indicates that if a person with HIV is on antiretroviral therapy with a consistently undetectable HIV viral load, the virus cannot be transmitted to a sex partner (Rodger et al., 2016). Since most settings in SSA, including Tanzania, have introduced HIV viral load testing as a standard procedure of monitoring treatment adherence, the U=U campaign is feasible and likely to be successful in reducing fear of HIV transmission among couples. However, it is essential to note the low uptake of the U=U campaign in Sub Saharan Africa, unlike high-income settings in North America and Europe (Cohen et al., 2019; The Lancet HIV, 2017). The World Health Organization and national governments have not shown enthusiasm in

the U=U campaign, perhaps due to concerns about the limited capacity to monitor viral load.

Overall, the study findings have raised an important question about the equal inclusion of men in HIV prevention and treatment programs. Policy and social factors place men at a disadvantaged position when it comes to access to HIV testing services. In our sample, one out of three men reported never tested for HIV, while Tanzania is almost achieving universal testing in women mainly through the PMTCT program (Tanzania, 2017). This observation highlights the importance of dedicating resources to provide HIV testing services in settings that are male-friendly.

4.3 Study Limitations

This study has two limitations. First, we used a convenient sampling strategy, and all men were recruited from the antenatal clinics, where only men with pregnant partners attend to take HIV couple testing and counseling. Men in our sample may not represent the attitudes of the general population of men, because all of our participants were presenting for an HIV test at the time of the survey. As noted in our results, HIV testing experience influences behavior change. Also, our findings are based on cross-sectional data. Therefore, associations that have been identified should not be interpreted as a causal relationship. Second, men's responses to the survey and opinions reported during interviews are likely to be affected by social desirability bias since stigma is a sensitive topic. Although the use of ACASI technology has shown to

minimize the effect of social desirability significantly (Estes et al., 2010), men may have felt uncomfortable being honest about their attitudes toward PLWH.

5. Conclusion

HIV stigmatizing attitudes is prevalent among men in Tanzania, and masculine identity heightens vulnerability of men towards HIV stigmatizing attitudes. Given the evidence that HIV testing experience in itself can spur behavior change, comprehensive community-based stigma reduction programs to provide a supportive environment for men are crucial to increase uptake of HIV testing and treatment services. These programs might have a larger impact if they are incorporated into the primary school curriculum and designed to target men in their social networks.

Appendix A

MAISHA SURVEY

QUESTIONS TO BE COMPLETED BY RESEARCH ASSISTANT

SUBJECT	Subject ID	
CLINIC	Clinic	1. Majengo 2. Pasua
DATE	Today's Date	*Automatic variable*

PRACTICE QUESTIONS TO BE COMPLETED TOGETHER WITH PARTICIPANT

In this survey, you will sometimes be given statements and asked how much you disagree or agree with the statement. These questions do not have a right or wrong answer. We would like to know your opinion. I will go through a few examples of these questions so that you understand how to use the answer choices.

		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
PRAC1	Moshi is a safe place to live.	0	1	2	3
PRAC2	The tourists who come to Moshi don't have respect.	0	1	2	3
PRAC3	If I run out of maize flour, I have neighbors who can lend	0	1	2	3

	me some flour.				
PRAC4	Please listen carefully to the following options, then select "strongly disagree"	0	1	2	3

QUESTIONS TO BE COMPLETED BY PARTICIPANT

1. Basic Demographics		
DEM2	How old are you?	_____ years
DEM3	Do you live in Moshi town?	0. No 1. Yes
DEM4	What is your religion?	1. Christian 2. Muslim 3. No religion 4. Other religion

DEM5	What is the highest level of school that you completed?	0. No formal education 1. Standard 1 2. Standard 2 3. Standard 3 4. Standard 4 5. Standard 5 6. Standard 6 7. Standard 7 8. Secondary education 9. Higher education
DEM6_M	What best describes your current relationship with the woman you accompanied to the clinic?	1. Married 2. No longer in a relationship or divorced 3. In a relationship but not married, not living together 4. In a relationship but not married, currently living together 5. Just a friend or relative
2. Socio-Economic status		
SES1	Are you currently working in a sector where you receive a regular salary?	0. No 1. Yes

SES2	**If not employed:** If you are not formally employed, what do you do to earn an income?	0. No income earning activities 2. Big farmer 3. Peasant farmer 4. Business 5. Petty trader 6. Other
4. HIV history		
HIV1	Before today, have you ever tested for HIV?	0. No (SKIP to HIV4) 1. Yes
HIV2	**If YES:** What is your HIV status?	0. HIV negative 1. HIV positive 2. Don't know
HIV3_M	**If HIV positive:** When did you learn that you were HIV positive?	1. Within the last six months 2. Six months – 1 year ago 3. 1-2 years ago 4. 2-5 years ago 5. Over five years ago
HIV4_M	Has the woman you accompanied to the clinic been tested for HIV before today?	0. No 1. Yes 2. I Don't know

HIV5_M	**<u>If tested:</u>** What was the result of her most recent HIV test?	0. HIV negative 1. HIV positive 2. Don't know
5. Willingness to test for HIV **SKIP IF HIV-POSITIVE**		
TEST1	After testing today, in the next year, how likely are you to test (again) for HIV?	0. Not at all 1. Not very likely 2. Somewhat likely 3. Very likely

6. Attitudes Toward People Living With HIV (HIV Stigma Attitudes Scale)

SKIP THIS SECTION IF HIV-POSITIVE

Description: The next statements will describe your beliefs about people who have HIV. For each statement, please indicate whether you strongly disagree, disagree, agree, or strongly agree.

		Strongly Disagree	Disagree	Agree	Strongly Agree
HSAS 1	Getting HIV is a punishment for bad behavior.	0	1	2	3
HSAS 2	I would think less of someone if I found out the person has HIV.	0	1	2	3
HSAS 3	I would be upset if someone with HIV moved in next door to me.	0	1	2	3
HSAS	I feel uncomfortable around	0	1	2	3

4	someone with HIV.				
HSAS 5	People with HIV have only themselves to blame for getting HIV.	0	1	2	3
HSAS 6	People with HIV must have done something wrong to get it.	0	1	2	3
HSAS 7	People with HIV should feel ashamed about having HIV.	0	1	2	3
HSAS 8	I would be ashamed if someone in my family has HIV.	0	1	2	3
HSAS 9	If I was in public or private transport, I would not like to sit next to someone with HIV.	0	1	2	3
HSAS 10	I would not like to be friends with someone with HIV.	0	1	2	3
HSAS 11	I would not employ someone with HIV.	0	1	2	3
HSAS 12	I would not eat together with someone I knew had HIV.	0	1	2	3
HSAS 13	If a relative of mine became ill with HIV, I would not want to care for that person in my home.	0	1	2	3
HSAS 14	I would not want to buy food from someone I know has HIV.	0	1	2	3
HSAS 15	If a teacher has HIV but is not sick, she should not be allowed to continue teaching in the	0	1	2	3

	school.				
HSAS 16	I would not want someone with HIV to look after my child.	0	1	2	3
HSAS 17	I do not want to get too close to someone with HIV because I am afraid I might get infected with HIV.	0	1	2	3
HSAS 18	I would not want my child to play with a child who has HIV or whose parents have HIV.	0	1	2	3
QC1	Please listen carefully to the following options, then select "strongly agree"	0	1	2	3

7. Anticipated HIV/AIDS Stigma (AHAS)

ASK THIS SET OF QUESTIONS FOR THOSE WITHOUT KNOWN HIV DIAGNOSIS

Today, you'll be receiving an HIV test during this ANC appointment. The following questions will ask about how you might feel if you tested positive for HIV today. For each statement, think about what might happen to you if you were to test positive for HIV and others found out about your HIV status. Then indicate whether you strongly disagree, disagree, agree, or strongly agree with the statement.

		Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
AHAS1_N	If I had HIV, I would be treated badly by	0	1	2	3

	health workers.					
AHAS2_N	If I had HIV, I would lose my job, customers, or livelihood.	0	1	2	3	
AHAS3_N	If I had HIV, my family would not take care of me when I am sick.	0	1	2	3	
AHAS4_N	If I had HIV, my family would reject or abandon me.	0	1	2	3	
AHAS5_N	If I had HIV, I would be treated badly in my community.	0	1	2	3	
AHAS6_N	If I had HIV, I would be physically abused by my partner.	0	1	2	3	I don't have a partner (9)
AHAS7_N	If I had HIV, my relationship would end.	0	1	2	3	I don't have a partner (9)
AHAS8_N	If I had HIV, I	0	1	2	3	

	would be shunned at social gatherings.				
AHAS9_N	If I had HIV, I would lose friends.	0	1	2	3
AHAS10_N	If I had HIV, I would not be allowed to participate fully in the church or mosque.	0	1	2	3
AHAS11_N	If I had HIV, I would lose respect/standing within my family or community.	0	1	2	3
AHAS12_N	If I had HIV, people would gossip about me.	0	1	2	3
AHAS13_N	If I had HIV, I would tell my partner.	0	1	2	3
AHAS14_N	If I had HIV, I would tell a family member.	0	1	2	3
AHAS15_N	If I had HIV, I	0	1	2	3

	would tell a friend.				
AHAS16_N	If I had HIV, I would tell a neighbor.	0	1	2	3

10. Contact with People Living with HIV

Description: The following questions ask about people you may know who are HIV positive.

CON1	Have you ever lived in the same home as someone who was HIV positive?	0. No 1. Yes 2. Don't know
CON2	Have you ever had a family member was HIV positive?	0. No 1. Yes 2. Don't know
CON3	Have you ever had a close friend who was HIV positive?	0. No 1. Yes 2. Don't know
CON4	Have you ever had a partner or spouse who was HIV positive?	0. No 1. Yes 2. Don't know

CON5	Have you ever known a neighbor, co-worker, classmate, or other acquaintance who was HIV positive?	0. No 1. Yes 2. Don't know
CON6	Have you ever known anyone else who was HIV positive?	0. No 1. Yes 2. Don't know

13. Perceived Availability of Social Support (PAS)

Description: The following questions have to do with the support you get from people in your life. You will hear a series of questions about the different types of help people might give you. Please respond whether someone would be available to provide that kind of help or support if you needed it. Remember that we are not asking whether or not you need this kind of help at this time, but whether someone could help you if you needed it.

		Not at all	**Not very likely**	**Somewhat likely**	**Yes very likely**
PAS1	Would someone be available to talk to you if you were upset, nervous, or depressed?	0	1	2	3
PAS2	Is there someone you could contact if you wanted to talk about an important personal problem you were having?	0	1	2	3

PAS3	Is there someone who would help take care of you if you had to stay in bed for several weeks?	0	1	2	3
PAS4	Is there someone you could turn to if you needed to borrow 2,000 TSh, needed to get a ride to the doctor or clinic, or needed some other small immediate help?	0	1	2	3
PAS5	Is there someone you could turn to if you needed to borrow some money to help pay your rent for one month?	0	1	2	3
PAS6	Would the people in your personal life give you information, suggestions, or guidance if you needed it?	0	1	2	3
PAS7	Is there someone you could turn to if you needed advice to help make a decision?	0	1	2	3
PAS8	Is there someone who could take care of your children if you got sick?	0	1	2	3

QC5	Please listen carefully to the following options, then select “Not at all”.	0	1	2	3

Appendix B

IN-DEPTH INTERVIEW GUIDE

STUDY ID: _____

BACKGROUND INFORMATION

Age:

Relationships Status:

Condition: Intervention / Control

READ ALOUD:

Thank you for agreeing to spend some time talking with me today. Our conversation will take about an hour, and the tape recorder will be used to make sure that nothing will be missed during our interview. What you say to me today will be confidential, and I will not share any information with your health care providers OR your partner. The purpose of this interview is to talk to you about HIV in your community. In particular, I'm interested in understanding how men perceive people with HIV. I hope you will feel comfortable to speak freely and honestly with me. Do you have any questions or concerns before we begin?

I. Introduction

I know that you've had a chance to talk to other members of our research team (like [INTERVENTIONIST NAME]) sometimes in the past. I'd like to start by getting to know you better. Can you tell me a little about yourself?

Be sure to probe about:

- *Relationship status*
- *Occupation*
- *Education*
- *Time in Moshi*

[NOTE: Give him the opportunity to talk briefly about himself. Let him know that you'll come back to some of these issues later in the interview.]

II. HIV Testing Experience

As you know, men who escort their pregnant partner to first ANC visit receive routine HIV testing and counseling. I'd like you to think back to the day you escorted your partner to her first ANC visit.

Tell me why you decided to go to the clinic with your partner for her first ANC appointment.

How were you feeling about getting the HIV test?

***Probes*:**

- Fears, concerns, expectations
- Thoughts about the future
- Previous HIV testing experiences

How did you feel when you got your HIV test results?

***Probes*:**

- Confirm his test result (and partner's results)
- Reactions, feelings when he got his result
- Discussion with nurse about results

Now imagine you had tested positive for HIV. How do you think you would have reacted if you had tested positive?

***Probes*:**

- Feelings
- Greatest fears
- Questions you would have/things you would want to know
- Who you would tell, if anyone
    - Anticipated reactions

How would you have felt if your partner tested positive for HIV (but you were negative)?

***Probes*:**

- Reaction
- Thoughts/feelings
- Impact on the relationship

Do you plan to get tested for HIV in the future? Why/why not? If yes, when?

III. Enacted and Anticipated Stigma

As I mentioned, we're interested in how men in the community think about people with HIV.

- In your community, how do men talk about HIV? (Get examples of what they say)
- How do men in your community feel about <u>people</u> living with HIV? (Get examples of what they say/discuss; any specific examples of individuals they know with HIV) *Be sure to understand how the <u>participant</u> feels, which may be same/different from men in his community
- WHY do you think men feel this way about people living with HIV?

HIV stigma can take many forms. What are some ways that you have seen HIV stigma exist in your neighborhood, family, or broader community? (Get very specific examples and keep probing for more. Ask WHY.)

- What types of people with HIV experience the most stigma (get at intersecting stigmas)
- How might women and men (with HIV) experience stigma differently

Say you found out your neighbor tested positive for HIV. Let's talk about how you might feel about this.

Probes:

- Who would you feel about your neighbor?
- How would you treat your neighbor differently?
- How do you think others in the community might react?
- What if your neighbor were a female.
- What if your neighbor were a male. (and why any gender differences)

Do you think PLWHIV are comfortable or safe to disclose their status in the community? Why or why not?

Comparing men and women, who do you think has more stigma toward people living with HIV? Why? (Be sure to probe for what is unique about men's stigmatizing attitudes)

Is there anything else you want to tell about why you think HIV stigma exists in your community.

IV. Intervention ideas

What do you think can be done to change men's attitudes toward PLWHA? (Get details of intervention ideas – explore ideas for both clinic, community, other settings)

For yourself, what do you want to learn about HIV and stigma?

For men who have HIV, what are your thoughts about how we can support men to start and stay in care after being diagnosed to have HIV infection?

V. FOR INTERVENTION GROUP ONLY

Now I want to get some feedback on the education session you did with [NAME] at this clinic. (Confirm they remember)

What did you think about the video?

- What was the most important thing you took away from the video?
- Was the video realistic? Why or why not?
- Would it be useful for all men to see this video? Why or why not?

How was the discussion you had after the video with the counselor?

- What was the most important thing you took away from the discussion?
- How did the discussion help to prepare you for HIV testing?
- How did the discussion change the way you feel about people with HIV?
- What things would you want to change in the way the discussion was conducted?

VI. Conclusion

How did it feel for you to speak to me today?

- Anything helpful about the conversation?

Do you have anything else you want to add before we end?

Thank you for taking the time to talk with me. Your views and experiences will help us to provide support for men in this community.

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