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Non-Testing For HIV among Men Aged 35 To 49: Between Fear and Voluntary Ignorance.

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Abstract
Resistance to HIV testing among men is perceived as a refusal for social, medical, psychological or other reasons. The aim of the study is to understand non-testing among men aged 35 to 49 through an analysis of the link between this behavior, fear and voluntary ignorance. The research used qualitative data from 45 individual interviews and three (3) Focus Groups.
Screening is very important, as it provides information on serology. However, 75% of informants categorically refused screening. Fear of finding out one's HIV status and suffering the consequences is the main reason why men aged 35 to 45 refuse to undergo screening. This fear is fuelled by structural, personal and social mechanisms. Thus, deliberately ignoring screening is an alternative way of clearing oneself of a certain health conscience in order to live better.
Key words: *Non-testing, men, HIV/AIDS, fear, voluntary ignorance*

Résumé
La résistance au dépistage VIH chez les hommes est perçue comme un refus pour des raisons d'ordre social, médical, psychologique, etc. L'objectif de l'étude est de comprendre le non-dépistage chez des hommes âgés de 35 à 49 ans à travers une analyse du lien entre ce comportement, la peur et l'ignorance volontaire. La recherche a utilisé des données qualitatives à partir de 45 entretiens individuels et trois (3) Focus Groups.
Le dépistage est très important, il permet de connaître la sérologie. Cependant, 75% des informateurs refusaient catégoriquement le dépistage. La peur de se découvrir séropositif et d'en subir les impacts est la principale cause du refus de se faire dépister chez des hommes âgés de 35 à 45 ans. Cette peur est entretenue par des mécanismes d'ordre structurel, personnel et social. Ainsi, ignorer volontairement le dépistage est une alternative pour se dédouaner d'une certaine conscience sanitaire afin de mieux vivre.

Mots-clés : *Non-dépistage, hommes, VIH/sida, peur, ignorance volontaire*

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I. Introduction

Voluntary HIV testing is a dreaded act for a significant number of men in sub-Saharan Africa. A January 2022 UNAIDS report indicates that 82% of men aged 15 and over worldwide are living with HIV without knowing it. In Côte d'Ivoire, only 24.2% of HIV-positive men know their HIV status (CIPHIA, 2017-2018). This implies that the majority of HIV-positive people are unaware of their HIV status. A situation that increases the risk of contamination and negatively impacts efforts to combat the pandemic.

However, HIV screening, at the crossroads of prevention and care, is not widely discussed as a specificity for men. Yet it opens up new avenues for research into care and prevention. (S. Le Vu, F. Lot, C. Semaille, 2004). Screening is a generally dreaded practice, particularly among men, which explains its low prevalence in this social category. (J. YessonguilanaYéo-Ténéna, A. Koua, B. Traoré et al, 2014; O. Ouédraogo, F. Garanet, S. Sawadogo, et al, 2015). Resistance to screening in men is most often analyzed and perceived as a refusal for socio-cultural, medical, psychological, etc. reasons.

Research into HIV/AIDS is abundant and falls into two categories: prevention and care. Given the spread of the disease despite the fight against it, the emphasis is on both prevention and care. Thus, research on men has also focused on prevention, specifically among vulnerable men such as homosexuals, prisoners, truck drivers and so on. Here, prevention is often analyzed by assessing knowledge, attitudes and risk behaviors with a view to reducing risk-taking among vulnerable men. (O. O. Ouédraogo, F. Garanet, S. Sawadogo et al. 2015; G. Girard, 2014; M. Bochow, 2016; I. T. A Yaya, K. Sitsopé, M. N'Dri et al. 2015).

In analyzing care among men, research has addressed issues relating to stigma reduction, consideration of patients' needs and expectations, care compliance, care difficulties and improving medical practice with a

view to improving their living conditions. (G. Bouzillé, C. Brunet, P. Fialaire, et al, 2012 ; J. Le Talec, et F. Linard, 2015; J. Belche, T. Kang, Ketterer, F., et al, 2015, CCP, 2013). Our work focuses on never-screened men aged 35 to 49 who are not systematically opposed to screening but, they don't dare cross it.

According to a study conducted by CCP in 2017, they are aware of HIV testing and believe that everyone is exposed to HIV and should be tested. Yet they are afraid to do so. (K. D.Ekouevi, P A .Coffie, M. Salou et al. 2013). The aim of our study is to understand the phenomenon of non-testing among sexually and economically active men aged 35 to 49. This, in three Ivorian localities, Abidjan, Bouaké and Abengourou through an analysis of the link between this behavior, fear and voluntary ignorance.

The results address (i) social representations of HIV testing among men aged 35 to 49, (ii) socio-psychological factors in non-use of HIV testing among men, and (iii) misconceptions, attitudes and behaviours induced by fear of testing among men. The discussion deals with (i) fear of refusal: a structural and tangible cause of resistance to HIV testing, and (ii) remain ignorant and live better: an alternative to testing phobia. The conclusion opens with the prospect of the impact of support on the use of screening and adherence to care.

1.study methodology

The research used qualitative data from interviews conducted using an interview guide. Three localities were used as sites for data collection: Abidjan in the south, Bouaké in the center and Abengourou in the east.

In Abidjan, interviews took place in the commune of Cocody, at the university hospital (CHU). Some interviews were conducted at the Université Felix HouphouëtBoigny and on the premises of the Catholic Church of Saint Albert le grand. In Bouaké, surveys were mainly conducted in a room reserved for this purpose. Some interviews took place at participants' homes. In Abengourou, participants were mainly interviewed in the vicinity of the PMI, where a space had been specially reserved for the interviews. A few interviews were carried out at respondents' homes at their request. The survey sample comprised 45 participants, with 15 participants per locality in the 35-49 age bracket. A focus group of 8 people per locality was conducted. Resource persons (doctors, community workers and nurses) were also interviewed.

Participants came from various socio-economic backgrounds and business sectors (formal and informal). Respondents were selected by recommendation and by snowballing. The choice of participants in the three localities was facilitated by a focal point (health agent). Saturation was reached after the fifteenth individual interview and a focus group. Thus, taking into account saturation and triangulation, 45 individual interviews and 3 focus groups were carried out.

The participants in the survey came from a variety of sectors, including machinists, dressmakers, refuse collectors, police officers, drivers, lawyers and doctors. Respondents included married men, cohabiting men with or without children, single men with or without children, illiterate people (but able to express themselves in French), others with primary, secondary or university education. Their consent was obtained orally.

Data storage and transcription began in the field and continued as the survey progressed. All interviews were recorded and processed anonymously and confidentially, taking ethical standards into account. The interviewers transcribed them in French as they were conducted. Three types of coding were used. These were open coding, axial coding and selective coding. Open coding enabled immersion in the material and discovery of the characteristics (properties) of non-screening among men. Axial coding was used to articulate these properties. Selective coding refined and systematized the statements.

The encoded interview corpus was then used for thematic content analysis. The discourses of the various key informants were interpreted and analyzed separately according to social categories, and then paralleled to identify similarities and divergences expressed on non-screening among men aged 35 to 49. The socio-demographic characteristics of the authors of the speeches were examined in order to identify factors of intelligibility of the representations of HIV, in connection with the logics which support the non-recourse to screening in the surveys.

II. Results

2.1. Social representations of HIV testing among men aged 35 to 49.

Examination of the empirical data revealed a close correlation between representations of the disease and those of the screening test. Screening is perceived as the medical process by which a person's serological status is known. It is the only way of knowing whether or not the disease virus is present in the human body. According to a key informant in Abidjan: *"It also means going to hospital to have your blood tested. If it's positive, it means you've got HIV; if it's negative, it means the virus isn't in your blood"*[1].

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[1]Excerpt from the words of a 40-year-old single informant with two children, during a focus group held in Yopougon, one of the sites visited during our study.

On the other hand, some respondents state that the screening test is the gateway to the disease, in the sense that its purpose is to reveal seropositivity for those infected. According to one key informant, *"the test is where the pathology really begins"*[2]. So, according to their perception, HIV/AIDS and the screening test are two sides of the same coin. This is why the meanings, values and representations they have of the disease are identical to those of the screening test. The misinformation and preconceived ideas they receive from their social networks are their main sources of information and knowledge on the subject. Based on this information, they shape their attitudes and behavior towards the screening test. All these attitudes and behaviors will be analyzed later in this work.

Field data also showed that all informants were aware of the importance of testing. They affirmed that it is essential for every sexually active man to know his serological status. In this way, having a screening test helps to protect against the disease. It is also a family protection measure; in that it breaks the chain of contamination within the family. A health worker in charge of care in Abengourou had this to say about the role of screening in prevention.

"Screening is very important for the individuals themselves. When they know their serological status, they adopt healthy behaviors for those who are most aware. It also protects the whole family from the risk of contamination. If the individual is positive, he or she takes more precautions to avoid contaminating other family members. The chain of contamination can be broken at this level by knowing one's serological status. But it's not easy to do the test"[3].

However, they are all reluctant to be tested, and see it as taking a risk. Nevertheless, certain situations are likely to compel them to undergo HIV testing.

These include the onset of certain illnesses such as shingles, long bouts of diarrhea, weight loss without cause or recurrent bouts of malaria. Some also believe that those who should be tested are men who have engaged in deviant behavior, such as having unprotected sex with someone other than their wife. Others said they could take the test to find out their serostatus, especially after engaging in risky sexual behavior. This was to protect themselves and their families. Still others could be tested as part of a marriage project. These are just some of the reasons why men who have never been tested for HIV might decide to take the test.

An analysis of these discourses leads us to conclude that voluntary recourse to HIV/AIDS testing seems to be a challenge for these men who have never been tested. For this informant we met in Bouaké, *"I can never come and take the test myself, never. I'd rather die without knowing. It's an illness that can send me here for an HIV test"*[4].

Why do men refuse to take HIV tests systematically and without coercion?

2.2. Socio-psychological factors in men's non-use of HIV testing

Social resistance to HIV testing among men is due to a phobia of rejection by the social environment. A combination of social, psychological, personal and collective factors have contributed to this fear. In fact, in the collective consciousness, HIV is associated with unprotected sexual intercourse, with sexual behavior that is not recommended for the infected person. The HIV-positive person is indexed as someone who has not led a healthy life. A life of debauchery and shame is associated with the image of the HIV-positive person. The bad reputation (frivolity, prostitution, etc.) of HIV-infected people feeds men's fear of visiting voluntary testing centers (VCT). This pejorative image of the disease leads HIV-positive people to live with chronic guilt, caused by a multitude of unanswered questions about the circumstances of their infection. The fear of living with the certainty of death is reinforced by the fact that HIV is a chronic, incurable disease. Indeed, the fear of living with an incurable disease and of taking lifelong medication makes screening useless. All these negative considerations have shaped a sense of fear and a reluctance to be tested among men. Speaking of the fear of living with the spectre of an incurable disease, one respondent in Abidjan said: *"What's the point of going for screening for a disease that can't be cured, and being condemned to take medication for life? As far as I'm concerned, there's really no point. It's better to live without knowing your status than to torture yourself '*'[5].

The study also showed that society has always been judgmental and accusatory towards infected people (stigmatization). As a result, in local languages, pseudonyms are attributed to HIV and to carriers of this disease. These pseudonyms carry pejorative connotations. For example, HIV is called "*Djandécloclo*" in *Baoulé*, the name of a large animal that can't stand up, can't stand on its feet, is weak and stays down. People

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[2] In-depth individual interview with a nurse in charge of caring for PLWHA in Abengourou

[3] These words come from an in-depth personal interview with a health worker involved in the care of people living with HIV in Abengourou.

[4] Based on a personal interview with a 37-year-old cell phone employee, married with three children in Bouaké.

[5] Excerpt from an interview with a 42-year-old polygamous craftsman with 6 children in Abidjan.

living with HIV (PLHIV) are likened to this animal, and men are afraid of these insinuations, which tarnish their image and their masculinity, stripped of all virility. As a result, they refuse to be tested for HIV.

Another source of fear identified by informants is the spread of status in the seropositive person's social environment (neighborhood, company, etc.). Fear of spread is linked to social exclusion, rejection and abandonment. In some cases, the infected person may lose his or her job. Mr. A. Y, an interviewee, expressed this fearful state of mind in these terms: *"AIDS has never killed, it's fear that kills. When you don't know your status, others don't either. Right now, we're living better. The day we find out we're HIV-positive, the disease will start at the same time. We're afraid that our status will be revealed to others (...) I'd rather die in ignorance than die of AIDS''*[6].

Also, taking medication regularly over time is a source of fear of arousing suspicion of HIV-positive status by the immediate social environment (relatives, neighbors, friends, etc.). As HIV is a shameful disease, men are afraid of being suspected of contracting it through any act or behaviour that might expose them to suspicion. As one community worker put it: *"As soon as people notice someone taking a drug for a long time, they immediately suspect him of being HIV-positive. Taking medication regularly is a subtle way of revealing HIV status''*[7].

For all these reasons, screening is seen as a difficult ordeal, dreaded by some men. On the other hand, those who refuse to take the test say they have to be morally prepared to do so. In order to withstand the reaction, rejection and stigmatization, of other members of society should the test prove positive.

In other words, for some men, the possibility of a positive test is a foregone conclusion; it's the end of a normal, fulfilling life. In the sense that testing positive means being put on lifelong treatment which, moreover, does not really guarantee life. They believe that screening means signing a death warrant. They are therefore reluctant to undergo screening. Some of the men targeted in this research feel that they would be very distressed if they were to test positive. For them, the possibility of a positive test would mean death, despair, the end of all life and all immediate and future projects. An informant in Bouaké testified to this abandonment with the following example: *"My brother contracted the disease in town. As soon as he found out he had the disease, he resigned from his job. He gave up everything, job, wife and children in town. He returned to his village to await his death. His wife stayed in town alone to look after the children"*[8]. Informants said that this was the feeling of most people declared HIV-positive.

Once tested positive, the mind is also affected. Those concerned think they could find themselves in a situation with no favorable outcome. In their minds, HIV is a downfall, and social death gradually sets in. A phenomenon characterized by abandonment, isolation and the breakdown of social ties. Faced with such a situation, they would ask themselves a multitude of questions, such as: who gave them this disease? When did they contract it? What will others say? What will become of them? What will become of their children? What would their families think? Etc. That's why many of them felt it would be preferable, under the circumstances, *"to kill myself"*. So, to be positive would mean: *"I'll be down, I'll be upset, I can't even imagine it. I don't think it's possible, dying is better"*[9].

According to the medical staff interviewed, the obstacles to screening also lie in a misperception of how condoms are used. It is used circumstantially with the same partners. After a period of sexual relations lasting one or two months, men generally conclude that their partners are no longer at risk. As a result, they don't consider it worthwhile getting tested. This is because they believe that they have recourse to a prevention method that protects them from contamination.

Finally, some health workers cited a lack of trust in healthcare staff as an obstacle to screening. This lack of trust is explained by the fact that some healthcare workers do not respect the confidentiality promised to patients.

Taken together, these fears forged the misconceptions or preconceptions about HIV held by the men interviewed in this research. What are these HIV-related misconceptions?

2.3 misconceptions, attitudes and behaviours induced by men's fear of screening

A significant proportion of those interviewed categorically refused to undergo screening for a number of reasons. For these men, there is no reason why they should go for HIV screening. The first reason cited was denial of the disease. Indeed, for this category of men, HIV is perceived as a pure invention made by Westerners to control the demographics of poor countries, especially in Africa. In the sense that it's a way of preventing unions and therefore reducing births. As one informant put it: *"AIDS doesn't exist, it's white people*

[6]Interview with a 37-year-old man in Abengourou.

[7] Focus group report from Abidjan

[8] Comments from a focus group in Abengourou

[9] Interview with a 45-year-old man in Abidjan

who invented it to stop blacks having children"[10]. In addition to reducing demographics, HIV is also a profit-making invention. Indeed, according to the perception of some respondents, through hospitals, they contaminate African patients in order to capture financial resources through the ARV and condom production industries. As a result, the more people are tested, the more likely they are to be contaminated and declared HIV-positive. As a result, the demand for ARVs and condoms increases, boosting the sales figures of the pharmaceutical and rubber industries. Mr. A.D., an informant, declared: *"Hospitals are white people' accomplices. You catch HIV at the screening center. That way we can buy the HIV medication. It's a fake, it doesn't exist. I can't go to a screening center to be killed''*[11].

The second reason stems from the aforementioned crisis of trust between patients and medical staff. The medical profession is accused of not respecting professional secrecy and ethical standards. Some men accuse the medical profession of divulging the status of PLWHA within health facilities. This confidential information is then passed on to the general public, leading to the stigmatization of PLWHA. In turn, this unprofessional attitude of which health workers are accused dissuades the population from adhering to screening for fear of seeing their serological status (seropositive) disseminated in the social body at high speed and thus exposing the seropositive to stigmatization, social rejection and ostracism. A situation dreaded by the general public.

The third reason is organizational. In their view, the arrangements put in place for screening and for the acquisition of care slow down the commitment and retention of men in the continuum. In fact, in hospitals, the offices of the healthcare staff responsible for HIV and the premises reserved for this purpose are known and seen by all. The presence, and above all the regularity, of a patient in the queue to access these premises are indicators that may give rise to suspicions about a patient's serological status. As a result, confidentiality is compromised when dealing with patients in these areas. What's more, the *"inappropriate"* comments and gestures of health and community workers sometimes expose the status and identity of PLWHA. In some cases, after a positive test, the necessary steps are not taken to conceal the emotion of those declared positive after a test. For example, when the patient emerges in tears from the nurse's office into the waiting room, his or her status is already known, and the news spreads like wildfire. As one participant in Abidjan put it: *"When you go into the screening room and come out with tears in your eyes, the patients in the room can tell from your facial expression what your result is, and it spreads like wildfire''*[12].

III. Discussion

3.1. From fear to refusal: the structural and tangible cause of resistance to HIV testing.

Fear is the first enemy of screening. In all three sites visited, fear was cited as the main reason why men refused to undergo screening. This fear is fuelled by a number of structural, personal and social mechanisms. One of these mechanisms is a lack of confidence in the organization of the mechanisms put in place to support men in their recourse to screening. As a result, men are afraid to undergo screening, and some authors see screening for men as a simple refusal. (YessonguilanaYéo-Ténéna, J., Koua, A., Traoré, B et al, 2014).

This great fear of screening is linked to the harmful consequences of the disease. They are perceived at all levels of life in society. Men who refuse screening therefore claim fear of the disease (death) and fear of the risks associated with the consequences of the disease. Social rejection, loss of employment, blocking of action or social paralysis, erosion of parental authority, the accusatory social gaze of those around them, stigmatization, etc. are all phenomena feared by men. All of these factors make the decision to undergo screening contingent on a bond of trust between the test candidate and the members of his or her family. This fear of taking an HIV test often leads men to test by proxy. Proxy testing involves deducing their status from the test results of their pregnant wives during prenatal visits.

Fear also feeds on the shame and embarrassment of knowing you're HIV-positive once you've been tested. As HIV/AIDS is an STI transmitted mainly through sex, it is one of the "shameful diseases". So, as soon as a person is declared HIV-positive, the immediate inference is that he or she has led or is leading a life of sexual debauchery (prostitution, multi-partnership, infidelity, etc.). This is why, in the collective consciousness of the participants, it is sex workers who are likely to contract the disease. This conception of the link between HIV and a hectic sex life leads men with high-risk sexual practices (infidelity, several sexual partners, occasional sex without wearing a condom, not systematically using a condom) to refuse screening. Health workers report that men refuse to be tested at the risk of discovering they are HIV-positive, as they have a history of risky sexual practices. HIV/AIDS is thus perceived as a disease of shame, leading to disgust and social death. As such, going for screening means facing death. Making the commitment to get tested means

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[10]Extract from a personal interview with a 39-year-old father of two, security guard in Bouaké.
[11] Extract from a focus group in Bouaké
[12]Interview with a 49-year-old Bouaké man, father of 7, motorcycle cab driver.

hastening one's own death. As one participant put it: *"HIV is a disease of shame. If I test positive, I'm no longer a man, I'm a corpse"*[13].

Fear of screening has also been fuelled by the rumor epidemic that accompanied the disease during the first awareness campaigns. The alarming rumors about HIV/AIDS and the image that the media have long attributed to sufferers are an obstacle to men's commitment to screening. These rumors and the media's portrayal of the disease have not only helped to generate and fuel fears but have also influenced ethnic groups' representations of the disease. In Malinké, for example, HIV/AIDS is called *"siidan",* meaning *"incurable disease","end of life*". Pezeril. C, (2011) for his part has shown the disgust and rot that transpires through awareness campaigns. Anything that supports the fear of disease and any act related to disease. Knowing one's status means *"signing one's death warrant"*. This perception of the incurability of the disease is an obstacle to screening. In other words, the knowledge that there is no total cure for HIV slows down the impetus for screening.

3.2. Staying ignorant and living better: an alternative to screening phobia

For most participants, voluntary testing is a source of voluntary isolation and anxiety. In a study of homosexual men, Perez asserted that screening was not compulsory because, in the absence of effective treatment, the announcement of seropositivity is a source of anxiety and isolation for individuals (Hirsch, 1991), quoted by (Perz, 2020). Also, Dodier had argued that in the second half of the 1980s, associations, medical specialists and health authorities agreed to refuse compulsory screening (Dodier, 2003). In our study, to avoid these anxieties, the men voluntarily ignored the screening test, a way for them to live better. As proof, the 2012 census in Côte d'Ivoire showed that 75% of men had never been tested for HIV/AIDS.

For this reason, ignoring one's status allows one to lead a peaceful life and maintain one's place in the social network. With HIV, living in ignorance is the best way to lead a stress-free, calm and balanced life. After all, when you're diagnosed as HIV-positive, everything around you collapse. Health care providers have confirmed that one of the main reasons why men refuse to be tested is that they prefer to remain in deliberate and maintained ignorance, in order to be guaranteed social, economic and family stability. When you don't know your HIV status, you live better. It's no use trying to find out if you've got a disease you can't treat.

In a kind of repression, they socially construct refuges to justify and support their voluntary ignorance of HIV/AIDS testing. As a result, HIV is likened to a conspiracy theory. In the sense that, according to Peter Knight, conspiracy theories stipulate that *"it is a small group of powerful people who coordinate in secret to plan and undertake an illegal and harmful action affecting the course of events"*, in order to obtain or retain some form of power (political, economic or religious) (Knight, 2003).

Indeed, HIV/AIDS is seen as the result of a Western plot. The disease is an imaginary invention of the West for economic, demographic or other purposes. So why get tested for a disease that doesn't exist? Because the disease was invented to curb demographic growth in Africa. So, the pandemic is a ready-made alternative to prevent pregnancies and limit births among populations of child-bearing age. What's more, HIV was invented to help the rubber industry prosper. On this subject, a CNEWS publication in 2020 stated that: *"According to the IFOP study, 32% of French people are convinced that the virus was "tested on the African population before spreading throughout the world" and more than half of French people (55%) believe that "the Ministry of Health is in cahoots with the pharmaceutical industry to hide the reality of the harmfulness of vaccines from the general public"* (CNEWS, 2020).

This conspiracy theory also supported the idea of a possible transmission of the virus to men. Some informants believe that the lubricant in the condom contains the virus that is transmitted to the man when the condom is worn before intercourse. In other words, the condom is rigged to encourage the spread of HIV in order to keep the ARV drug industry working. Other participants don't believe in the reliability of the screening test. They even believe, under the guise of conspiracy theory, that the virus can be deliberately transmitted during the screening test.

IV. Conclusion

Men in general are test-phobic and stay away from voluntary HIV testing centers (VCT) in sub-Saharan Africa. However, HIV testing is an important factor in the fight against the disease. Our work focuses specifically on never-tested people aged 35-49, who are not systematically opposed to screening, but who do not dare to go through with it.

[13] Excerpt from a personal interview with a 44-year-old father of 5, a law enforcement and security officer.

The aim of our study is to understand the phenomenon of non-screening among men, by analyzing the link between this behavior and fear and ignorance, through a qualitative study. The dialectical method of content analysis enabled us to grasp the meaning these men give to HIV, and to understand their attitudes and behaviour towards screening.

Screening is perceived by the men as a necessity for every sexually active man to know his serostatus. However, because of their perception of the disease, they equate it with risk-taking. There are three reasons for this attitude. Firstly, HIV is perceived as a purely pathological invention made by Westerners to control demographics. Secondly, there is a crisis of confidence between patients and healthcare personnel. The medical profession is criticized for not respecting professional secrecy and ethical standards. Finally, the third reason is organizational. It stems from the fact that the screening arrangements put in place are not conducive to VCT attendance.

All these social constructions of the disease are evoked by the men. They are underpinned by the fear of finding out they are HIV-positive and having to live with the consequences. The fear of arousing suspicion about their serological status in their immediate social environment, and the misconceptions widely shared by men, are also obstacles to screening. So, faced with this phobia of screening, men prefer to ignore it voluntarily in order to live better. In a word, it's the fear of testing that justifies this wilful ignorance, in order to escape all the consequences suffered by PLWHA.

Given the importance of screening in care and prevention, strategies and mechanisms need to be promoted to encourage people to visit VCT centers. From this perspective, what is the impact of support on screening and retention in the HIV care continuum for men?

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