

# **“We Play Football Till They Are Gone”: Navigating Masculinity-Related Challenges To Viral Load (VL) Testing Appointments By Adolescent Boys On Anti-Retro-Viral Therapy (Art) In Public Health Facilities In Siaya County, Western Kenya.**

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## **Abstract**

*Between 33.1 million and 45.7 million people were living with HIV in 2022, out of whom 1.7 million were adolescents aged 10–19 years. In addition, recent statistics show a decline of HIV-related deaths by 51%, except for adolescent boys’ HIV-related deaths. Viral Load testing is recommended to monitor ART failure and reduce HIV-related mortalities. Whereas men are socialised to be strong, resilient, and disease-free, whether this has also formed a challenge to VL testing appointments to adolescent boys in public health facilities has remained underexplored. This insight is critical in highlighting social factors causing differentials in HIV-related deaths in contexts such as Siaya County of Western Kenya where mortalities among boys on ART are higher than their female counterparts. This paper investigated masculinity-related challenges to Viral Load (VL) testing appointments by adolescent boys on Anti-Retro-Viral Therapy (ART) in Public health facilities in Siaya County, Western Kenya. This was a cross-sectional study used questionnaire to collect data from 263 adolescent boys on ART. Two focus group discussions were held with the boys, while three key informant interviews were conducted with healthcare practitioners and government officers. Masculinity issues are found to be a challenging factor in public health facilities in the area, hampering VL testing uptake. The study also reveals that adolescent boys honouring VL testing appointments would rather play football within the facility’s compound or engage in menial jobs to earn income than join long queues of patients comprised of women and children where they would be seen as weak help-seekers. It is concluded that enactment of masculinity by the boys is a barrier to VL testing in the health facilities, and tailored interventions should be directed at public health facilities.*

**Keywords:** *Adolescent boys on ART; Masculinity-related challenges; Public Health Facilities; Siaya County; VL Testing Appointments*

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## **I. Introduction**

Substantial evidence has been showed across the globe that enactment of particular gender norms is associated with a series of negative health outcomes related to human immunodeficiency virus (HIV) and acquired immuno-deficiency virus (AIDS) treatment uptake among men (Leddy et al, 2021; Mukumbang, 2021; Newmann et al, 2023). This presents a discouraging reality towards the achievement of the Sustainable Development Goal (SDG 3) that focuses on ensuring healthy lives and promoting well-being for all at every stage of life, including ending AIDS epidemic by 2030 (Mushy et al, 2024). Indeed recent statistics indicate that globally, approximately between 33.1 million and 45.7 million people were living with HIV in 2022, out of whom 1.7 million were adolescents aged 10–19 years (UNICEF, 2023; United Nations Programme on HIV and AIDS [UNAIDS], 2023). In addition, while recent statistics show tremendous decline in HIV-related deaths by 51%, down from between 970 000 and 1.8 million in 2010 to approximately 630 000 in 2022 (UNAIDS, 2023), more adolescent boys have

succumbed to HIV –related deaths than their female counterparts in the same period (Stannah et al, 2023). Described by the World Health Organisation (WHO, 2017) as persons aged between 15 and 19 years, adolescents particularly in the Sub Saharan Africa (SSA) constitute three in every four new HIV infections, with females making up six in every seven new infections among this cohort (UNAIDS, 2022). The higher rates of HIV-related deaths recorded among adolescent boys could therefore suggest there is comparatively low viral load (VL) suppression among this population.

In the HIV and AIDS treatment continuum, viral load suppression is a crucial marker of therapy efficacy amongst patients on anti-retro-viral therapy (ART) (WHO, 2016). According to Waju, Dube, Ahmed and Assefa (2021), viral load (VL) suppression among patients on ART is noted on improved prognosis evident in reduced rate of disease occurrence and decreasing VL counts, progression and mortality. The fundamental goal of HIV infection treatment is to suppress HIV, which will ultimately increase survival and reduce HIV-related deaths, improve quality of life, and reduce HIV transmission (Nanyeenya et al, 2023; Mushy et al, 2024). In this regard, follow-up or monitoring of the VL status among patients on ART is crucial for identification of treatment progress including drug failure as well as patients needing adherence counselling for purposes of preventing the occurrence of drug resistance (Nicholas et al, 2019; Thinn et al, 2019). To cement this effort, the UNAIDS launched the 95–95–95 targets in 2014, with the “Third 95” target aiming at increasing viral load suppression to 95% of all HIV-infected individuals on ART by 2030 (Frescura et al, 2022; Global AIDS Monitoring, 2022). The importance of VL testing is pegged on the fact that within a span of six months of ART administration, a patient’s HIV and AIDS should be significantly suppressed (UNAIDS, 2019). A recent study, however, has highlighted sex differences in VL testing and suppression between men and women, with the latter performing far better than the former (Fernandez et al, 2023). While various scholars (Pham et al, 2017; Ehrenkranz et al, 2019; Cleary et al, 2023) have associated sub-optimal VL testing to resource-constraints, the reason why men have more poor uptake in this endeavor remains underexplored. Similarly, whereas some studies (see for example Olanrewaju et al, 2019; Pulerwitz et al, 2019) have specifically linked masculinity among men to poor health behavior, less consideration has been given to adolescent boys who have already been initiated into ART.

Masculinity is the set of local beliefs and practices that reflect what it means in a particular context to be a man (Cornell, McIntyre & Myer, 2011; Colvin, 2019). According to Mukumbang (2021), masculinity is described in three versions: responsibility, respectability, and reputational. In this regard, responsibility requires that a man should take care of his family and economic productivity therein. For respectability, a man should be strong, resilient, and disease-free, while for reputational, one should be highly sexual, be and act in control, and have the know-how (Colvin, 2019). These views constructed of a man as being strong and healthy becomes a big challenge when men are faced with HIV-positive status. According to Russell (2019), treatment requirements for HIV is an ambush to masculinity and consequently ‘men are frequently less able to admit there is a problem, seek support or remain engaged with treatment’ (pp. 1199). Loss of their authority, weakened provider role and reliance on others lead to a “dented” masculinity that men are not prepared to accept in patriarchal societies (Siu, Seeley, and Wight, 2013; Mukumbang, 2021). Whereas adolescent boys in contexts such as the Luo community in Kenya have been socialized to enact particular gender norms, paucity of information exist linking the same with viral load testing appointments especially in public facilities.

According to Ocholla-Ayayo (1976), Luo male children are often encouraged to become *Thuon*, a title given to a brave fighter whose battle field exploits are often exemplary, so that such instincts and courage are inculcated in them. *Thoun* or *Nyathi-majachir* is male child who is brave, does not fear darkness, and is able to confront hostile situations (Ocholla-Ayayo, 1976). In Siaya County, the area of the current study, Ombere, Nyambedha and Bukachi (2018) revealed that young men have the habit of performing hurried sexual intercourse on the grass and without protection along numerous beach landings in Bondo, referred to them as green lodges. In another study in the same area, Blommaert (2014) documents that *disco matanga* (Disco music at funerals) forms an arena where adolescent boys showcase their prowess in seducing different girls and having sexual intercourse with them on the grass. In these social events, drugs and illicit brews flow in plenty and boys who can consume and smoke profusely are viewed as the strongest and powerful of all. Kwena et al (2012) reports that *jaboya* system, where women fishmongers in the various beaches in the study areas form relationships involving exchange of fish for sex which is hurriedly done without protection on the grass, is a common practice among young men. While these studies provide evidence that social behaviour of adolescent boys in this study area has the potential of escalating HIV and AIDS pandemic, understanding how enactment of such socially constructed practices affect VL testing appointments by this population in public health facilities in Kenya has not been exhaustively discussed in past studies.

Kenya is one of the countries with extraordinarily high HIV epidemic in the world with 1.6 million people living with HIV in 2016 and ranking fourth globally alongside Mozambique and Uganda (UNAIDS, 2017; Avert.org, 2019). Despite challenges faced in constrained resources, Kenya unveiled VL testing program in 2012 initially prioritizing on patients with suspected virologic failure and expanding to routine testing 6 months and 12 months after ART initiation and annually thereafter, for patients with undetectable viral loads (Mwau et al, 2018).

For HIV patients, VL testing across the country has however presented various challenges including cost of testing, choice of facility to test and weak social support systems (Okal et al, 2020). In the context of the current study, Adino (2016) revealed that poverty, stigma, cultural and religious beliefs, lack of social support especially from healthcare workers, and transport cost to the facility are some of the barriers to HIV treatment uptake in the area. While social and public facility-related factors are identified by the aforementioned literature as significant barriers in VL testing among others, how these are skewed to the disadvantage of the adolescent boys on ART needs critical scrutiny.

Public health facilities in Kenya are categorised in six levels of hierarchy: community services level; dispensaries and clinics; health centres and maternity and nursing homes; sub-county hospitals and medium-sized private hospitals; county referral hospitals and large private hospitals; and national referral hospitals and large private teaching hospitals (Primary health care systems [PRIMASYS, 2017]). PRIMASYS (2017) further notes that public healthcare services are primarily provided at levels 1 to 3- community services level; dispensaries and clinics; health centres and maternity and nursing homes. The Kenyan National AIDS Control Program (NASCOP, 2022), in one of their recent statistics, estimates that more adolescent boys (150) as compared to females of their age group (100) succumbed to AIDS related fatalities over the years despite such adolescents being on ART in Siaya County. Thus, whereas masculinities have been associated with poor health outcomes among adult men in existing literature (Mboggo et al, 2024), little effort has been made to explore whether adolescent boys in areas such as Siaya County of Kenya have endorsed masculinity and the extent to which such endorsement has influenced VL testing appointments among them. This being the case, this paper therefore sought to investigate how enactment of masculinity identities has had effect on viral load testing appointments among adolescent boys on ART in Siaya County of Kenya.

## II. Methodology

### Research Design

This study used adopted cross-sectional design utilizing mixed methods approach of collecting and analyzing both quantitative and qualitative data as recommended by Poth and Munce (2020). This design enabled the researchers to use quantitative approach to measure some aspects of the phenomenon under study and qualitative methods for others (Dawadi, Shrestha & Giri, 2021). The advantage of this design is that it provides for complementarity in data collection, analysis and interpretation (Shorten & Smith, 2017).

### Study Setting

This study was carried out in Siaya County in western Kenya. The county is predominantly occupied by the Luos who follow male-line or superiority of the boy child and practice patriarchal kinship system (Ocholla-Ayayo, 1976). Siaya has the second longest landing beaches of fishing line, the shores of Lake Victoria, after Homa Bay County (Akobi, Oyore & Otieno, 2022). The fishing community has been associated with HIV/AIDS (Ombere et al, 2018). Sex in exchange of fish is rampant among these beaches (Ombere et al, 2015). The study was done across purposively selected six sub counties comprising Gem, Bondo, Alego-Usonga, Ugunja, Rarieda and Ugenya. The choice of the study area was based on the high HIV prevalence. Between 2015 and 2019, Siaya County recorded the highest HIV prevalence in Kenya, standing at 15.3% by end of 2020, 4 times higher than the national prevalence rate of 4%, and with Sub Counties such as Bondo having as high as 21% rate (NASCOP, 2023).

### Study population and sampling strategy

The study targeted 795 adolescent boys with high viral load aged 14 – 19 years as contained in National AIDS and STI Control Programme (NASCOP, 2023) records as at December 2022, alongside six comprehensive care-in charge (CCC) responsible for providing HIV care to patients in each sub county, the County AIDS/HIV and STI Coordinator (CASCO), 6 Sub County AIDS Coordinators (SCACOs), and fourteen Public Benefit Organizations (PBO) officials.

This study adopted Yamane’s (1967) formula to calculate the sample size of adolescent boys with high viral load on ART as shown below:

$$n = \frac{N}{1+N(e)^2}$$

Where:

$n$  = the sample size,

$N$  = the population size, and

$e$  is the level of precision (0.05).

The calculated sample size for adolescent boys with high viral load on ART was 265. Using stratified proportional technique, the adolescent boys were distributed in each of the six sub-counties based on each administrative unit’s population (of the adolescent boys under ART) as illustrated in Table 1. Similarly, the study

purposively selected healthcare practitioners and government officials for interviews and Focus Group Discussions until saturation was attained.

**Table 1: Distribution of Sample Size**

| Sub County    | Population | Sample Size | Percent |
|---------------|------------|-------------|---------|
| Alego -Usonga | 118        | 40          | 15      |
| Bondo         | 188        | 63          | 23.8    |
| Gem           | 92         | 31          | 11.7    |
| Rarieda       | 227        | 76          | 28.7    |
| Ugenya        | 92         | 31          | 11.7    |
| Ugunja        | 78         | 27          | 10.1    |
| Total         | 795        | 265         | 100     |

**Instrumentation, Validity and Reliability**

The study used semi-structured questionnaires consisting of closed ended questions to collect data from the sampled adolescent boys alongside in-depth interviews and Focused Group Discussions (FGDs) guide. Interviews and FGDs were also done with care givers as well as government officials in charge of HIV and AIDS treatment in the County to collect qualitative data.

**Data Analysis and Presentation**

Data obtained using questionnaire was analysed via descriptive and inferential statistics with the aid of SPSS version 23. Descriptive statistics enabled generation of frequencies and percentages as well as mean and standard deviation which was essential for interpretation of quantitative results. The following key was adopted to interpret the mean ratings based on the Likert Scale values:

- 1.00 – 1.44: Strongly Disagree
- 1.45 – 2.44: Disagree
- 2.45 – 3.44: Neutral
- 3.45 – 4.44: Agree
- 4.45 – 5.00: Strongly Agree

**Ethical Considerations**

The researchers obtained clearance to conduct the field study from Maseno University Scientific and Ethics Review Committee (MUSERC) and the National Commission for Science, Technology and Innovation (NACOSTI). An assent form was designed and signed by the adolescent boys who were under 18 years old in the presence of their parent/guardian. For purposes of confidentiality, participants were asked not to include their identities from the research instruments.

**III.Results**

Out of 265 semi-structured questionnaires which were administered, 263 were accepted as validly filled up by the researchers. Six In-Depth Interviews (IDIs) were done with the adolescent boys and 12 Key Informant Interviews (KIIs) done with government officials.

**Socio-demographic characteristics of the study population**

The results showed that 23.2% of the sampled boys were 14 years old, while 19% were 15 and 18.6% being 16 years of age. This suggests that majority (60.8%) of the boys under the current study were 16 years old and below. Similarly, part of the results showed that majority of the adolescent boys (53.6%) had lost at least one parent or were total orphans and were living with grandparents as well as other relatives including aunts, uncles and sisters/brothers among others.

**Masculinity-related challenges to Viral Load (VL) testing appointments**

This study investigated the masculinity-related challenges to VL testing in public facilities in the by the sampled adolescent boys. The responses regarding the possible masculinity related challenges among men are presented in Table 2.

**Table 2: Masculinity-related challenges to Viral Load (VL) testing appointments**

| Endorsement of Masculine Identity  | Yes  | No   | Neutral | Mean | STD  |
|--|------|------|---------|------|------|
|  | %    | %    | %       |      |      |
| Queuing at the facility often make me skip Drug/VL test appointments   | 72.6 | 16.8 | 10.6    | 3.93 | 1.41 |
| Queuing with women and small children at the facility for healthcare services often make me skip Drug/VL test appointments | 76.5 | 16.8 | 6.8     | 3.85 | 1.12 |

|  |      |      |      |      |      |
|--|------|------|------|------|------|
| Queuing with younger boys at the facility for healthcare services often make me skip Drug/VL test appointments                                       | 52.5 | 41.4 | 6.1  | 2.95 | 1.58 |
| Queuing at the facility with older men for healthcare services often make me skip Drug/VL test appointments  | 51.7 | 36.9 | 11.4 | 3.13 | 1.4  |
| The discomfort I get from being served by female nurses at the facility sometimes make me skip Drug/VL test appointments                             | 52.9 | 33.4 | 13.7 | 3.20 | 1.23 |
| The discomfort I get from being seen by village mates picking drugs from facility closer to my home sometimes make me skip Drug/VL test appointments | 84.4 | 7.3  | 8.3  | 4.19 | .957 |
| Overall Mean   |      |      |      | 3.54 | 1.28 |

**Interpretation Key:** 1.00 – 1.44: Strongly Disagree; 1.45 – 2.44: Disagree; 2.45 – 3.44: Neutral; 3.45 – 4.44: Agree; 4.45 – 5.00: Strongly Agree

Based on the interpretation key of the study, a mean of 3.54 denotes that the sampled respondents “agreed” that a number of statements depicting masculinity-related issues presented to them in Table 2 are some of numerous challenges that they face at the facility in regards to access to drug or viral load test services. The respondents indicated that the discomfort they get from being seen by village mates picking drugs from the facility closer to their home sometimes make them skip Drug/VL test appointments (M=4.19; SD=.957; n=84.4%). They also indicated that queuing with women and small children at the facility for healthcare services often make them skip Drug/VL test appointments (M=3.85; SD=1.12; n=76.5%). The respondents further agreed that queuing at the facility for healthcare services often make them skip Drug/VL test appointments (M=3.95; SD=1.41; n=72.6). Perhaps by queuing with children and women who are seen as ‘weaker’ people in the society, the adolescent fear that they will be seen to be losing the respectability trait of ‘being a man’, who should be strong, resilient and disease-free.

Findings in the qualitative data also supported results in Table 2 with regards to queuing at the facility for health services. The issue of shunning of queues at the facility emanating from masculinity conceptions of not wanting to be seen queuing together with females as well as children, emerged during the FGDs with some of the adolescent boys. It emerged that the boys have designed approaches of maneuvering around the whole issue by playing football around the facility till the queue is drastically reduced, as articulated by one 16 year-old adolescent:

*An okanyal pango lain bwana, mano oloyo atug atuga opera e facility kanyo nyaka lain dog piny ekorka ane daktari* – me I can never queue alongside women and children my friend, instead, I would rather play football within the facility until the queue reduces: that is when I will see the doctor.

The statement attributed to the 16 year-old adolescent boy is a testimony to the fact that long queues at the facility coupled with the fear of being associated with being “weak” as the women and children on the queue is a challenge to accessing HIV treatment services. The maneuvering adopted by playing football could result into delayed VL testing or drug uptake, although the facility management seem to be prepared and aware of the predicaments of the boys based on a statement gathered during KII interviews with one Sub County AIDS Coordinators who also indicated that:

In a number of healthcare facilities in the sub county, there are a number of playing fields for playing football, basketball or volley ball where boys (mostly) pass their time while awaiting their time to see the doctor for check-up, drug uptake or VL testing. These playing facilities have been put intentionally by the facility management with the assistance of partners since without them, a number of boys would go home and fail totally to honour their appointments.

This statement is an illustration of measures taken to address the challenges facing adolescent boys with regards to accessing VL test at the public facilities in the study area. The reality of the social challenges facing the sampled adolescent boys in terms of accessing VL testing in public facilities in the study area was additionally revealed during in-depth interviews with some of the boys. A number of the boys have changed healthcare facilities where they have appointments several times due to discomfort they experience with the people they interact with on the queue as highlighted by a 17 year-old boy during an IDI:

Attending healthcare facilities near home is most distressing since healthcare workers in those places are likely to know you and you also meet a number of villagers on the queue who knows you and are likely to talk about you. *An atemo gande yore duto tee nyaka ayud thieth. Sani aseloko osuptende ariyo, kendo pod adhi medo loko ka pod ok amor kod osuptal mayud manyien* (I often try all means to access medication and I will continue changing health facilities where I get the services. Right now I have changed two times and I will continue doing so as long as I still get discomfort in the current facility).

Facility-related factors and social factors related to the patient are indicated by the 17 year-old adolescent boy as interacting and presenting a challenge with regards to honouring VL testing appointments. During one of the interviews with comprehensive care-in charge (CCC) in one of the facilities, it emerged that a number of boys on ART treatment often change facilities from which they obtain drugs of take VL testing, as stated by one CCC:

The boys, especially those who are older, are difficult to retain in one facility for long. For one, they always avoid queues for fear of being identified as sick by people they know and also for “hating” to be seen lining up with women, children and old people. For facilities without playing fields where the boys may engage in football or basketball while waiting for their turn to see the doctor or have their VL tested, they (boys) will just go back home and postpone the appointment altogether.

This statement provides the reason why adolescent boys may have low VL test uptake in the study area and perhaps low viral load suppression and HIV-related deaths compared to their female counterparts. The researcher therefore assessed the level of VL testing among the sampled adolescent boys in the study area. In this regard, the researcher asked the boys to respond to statements related to viral load testing and the results are presented in Table 3.

**Table 3: Level of VL Testing**

| Viral Load Suppression Level                                | Yes  | No   | Neutral | Mean | SD   |
|---|------|------|---------|------|------|
| I frequently get my VL counts tested and measured           | 27.4 | 50.5 | 22.1    | 2.54 | 1.26 |
| I fully understand the importance of knowing my VL counts   | 31.6 | 52.9 | 15.6    | 2.59 | 1.28 |
| I am always ready to honour appointments for VL testing     | 7.6  | 67.3 | 25.1    | 2.16 | 1.00 |
| My VL count has significantly improved since ART initiation | 7.3  | 41   | 51.7    | 2.43 | .840 |
| I am satisfied by the current VL testing process            | 9.2  | 35.7 | 55.1    | 2.39 | .969 |
| Overall Mean  |      |      |         | 2.42 | 1.07 |

**Interpretation Key:** 1.00 – 1.44: Strongly Disagree; 1.45 – 2.44: Disagree; 2.45 – 3.44: Neutral; 3.45 – 4.44: Agree; 4.45 – 5.00: Strongly Agree

From the interpretation key adopted for understanding the results based on the Likert Scale, the results in Table 3 illustrates that the sampled adolescent boys disagreed (M=2.42; SD=1.07) that the VL testing services at the health facilities in the study area are satisfactory. They disagreed that they are always ready to honour appointments for VL testing (M=2.16; SD=1.00), with only 7.6% (n=20) of them agreeing; that they are satisfied with the current VL testing process (M=2.39; SD=.969), and that their VL count has significantly improved since ART initiation (M=2.43; SD=.840). This findings imply that the boys are not giving priority to VL testing appointments probably because they are not satisfied with the environments in the public health facilities where these services (VL testing) are offered.

During FGDs with some of the selected boys, it was revealed that most of the adolescent boys in this study area prioritize taking up income generating activities for purposes of fending for their families instead of honouring medical appointments for drugs or VL testing. For instance, one 16 years old boy stated that: I often miss out on honouring medical appointment to attend to *pango squad* (*Boda Boda* – motor cycle transportation services), *Ywayo sut* (fishing expedition), and *Kunyo Milu* or *Domba* (mineral mining). Likewise, to a number of my friends, I must do this for me and our children to get what to eat. I and my small siblings live with our old grandmother hence we must do almost everything to make sure that food and other essential items at home are available.

Based on the statement attributed to the 16 year-old adolescent boy, the adolescent boys in this study area prioritize on taking up paternal responsibilities of looking after their families as expected of them by the society, instead of ensuring that they honour medical appointments. These boys seem to be fitting appropriately to masculinity demands that a “man” should be strong, resilient, and disease-free.

#### IV. Discussion

The study has found that queuing with children and women for purposes of accessing VL testing at the public facility presents a significant challenge to the adolescent boys (Table 2) perhaps due to the fear losing the respectability trait of ‘being a man’, who should be strong, resilient and disease-free as socially constructed by the society. These observations have been made in a number of previous studies with men (Siu, Seeley, and Wight 2013; Russell, 2019; Leddy et al, 2021). The revelation that being seen by village mates picking drugs from the facility closer to their home make them skip Drug/VL test appointments probably explains why the boys are not performing better than their female counterparts because primary healthcare services in Kenya are primarily provided at levels 1 to 3: community services; dispensaries, and health centres (PRIMASYS, 2017). Facilities offering services at these levels are located within the villages where the adolescent boys are living, and there are high chances that the healthcare workers in such places are people who know the boys. These are healthcare system barriers which were also highlighted in an earlier study done in Nairobi (Kenya) by Okal et al (2020), and which showed that facility location and set up are critical factors hindering access to testing services in the HIV and AIDS treatment continuum. A number of boys found to be changing facilities from which they seek for VL testing services ostensibly due to stigma occasioned by masculinity conceptions. This observation concurs with findings showed in Nanyeenya et al (2023) which highlighted that the fear of being identified as a sickling “man” seeking for help (in the form of healthcare) hinders scale up of VL testing in Uganda.

The researchers have also showed that adolescent boys in the study area have designed ways of waiting for the long queues to recede by playing football on spaces created within the facilities. A number of facilities, having known this maneuver by the boys, have created pitches and open places within their precincts to cater for football, basketball, or volley ball games for purposes engaging the boys as they await to see the doctor. These undertakings are geared towards solving the problem of inconvenient clinic times which some previous studies (see Okal et al, 2020) identified as forming a barrier to HIV and VL testing access among men in Nairobi. Thinn et al (2019) also revealed in a study done in Myanmar that VL testing program based factors such as wait time on the queues are significant barriers to accessing the service. It should also be understood that in the event that there are no such playing spaces at the facility, a number of boys would go back home in finding long queues at the facility, hence leading to missed appointments. This could explain the cause of low VL testing uptake in most public facilities in Kenya.

The study also found that the sampled adolescent boys are not giving priority to VL testing appointments probably because they are not satisfied with the environments in the public health facilities where these services (VL testing) are offered to them (Table 3). The boys are always not ready to honour appointments for VL testing and are not satisfied with the current VL testing process. Their VL count has also not significantly improved since ART initiation. The findings have also revealed that a number of the sampled boys often fail to honour VL test appointments to attend to menial jobs such as fishing expeditions to augment family food basket. It should also be noted that majority of the sampled adolescent boys are orphans (53.6%) and live with their distant relatives including their grandparents hence they (the boys) are called upon to take care of their old guardians. Reneging on the role to provide for the family in order to queue at the health facility for VL testing is an ambush to the boys' responsibility version of masculinity as constructed by the society (Mukumbang, 2021). The boys mainly skip VL appointments for purposes of taking up paternal responsibilities to fend for the family.

### **V. Conclusion**

Viral load testing is significant in identifying ART failure and taking up remedial steps to improve the lives of HIV and AIDS patients. Our study has revealed that adolescent boys in the study area have continued to skip long queues that include women and children VL testing at the public facilities due to masculinity-related factors such as the fear of being viewed as weak as opposed to being strong, resilient, and disease-free like a “man”. We have also revealed that the adolescent boys often dishonor VL testing because they prioritize taking up menial jobs to help in feeding their households rather than spending their time queuing at the facility for VL testing services.