

Facilitators and Barriers to retention in HIV care among HIV infected MSM attending Community Health Center Yaba, Lagos Nigeria

Abstract

Background: The burden of HIV infection among men who have sex with men (MSM) has posed a huge public health threat to the developing country like Nigeria. Identification of effective strategies to improve their retention in HIV care especially for young HIV infected MSM is critical for overall success in scaling down the national burden of HIV/AIDS. The aim of this study was to assess the facilitators and barriers to retention in HIV care among HIV infected MSM attending community health center, Yaba Lagos Nigeria.

Methods: A two months (May –June, 2016) exploratory qualitative research study was conducted among 181 respondents enrolled into HIV care within 12 months that attend community health center, Yaba Lagos Nigeria. A pretested and semi-structured questionnaire was used to collect information on the specific facilitators and barriers to retention in HIV care among respondents. Data entries and analysis were done using SPSS package version 20. Descriptive statistics was used to summarize quantitative variables, and frequency tables were generated for the relevant variables.

Result: The mean and median age (in years) of the participants sampled was 25.86 and 24.00 respectively. The study identified friendly clinic service 44%, having positive relationship with clinic staff 16%, friendly and secured environment 20% as the major facilitators to retention in HIV care while implicating distance 36% and self -denial 21% as major barriers to retention in HIV care among the respondents.

Conclusion: Majority of the respondents were retained in HIV care services due to the available friendly clinic services and conducive environment instituted at the service provision site.

Key words: Facilitators, Barriers, Retention, HIV care, HIV, MSM,

Introduction

Successful HIV management requires timely linkage to care, early initiation of antiretroviral therapy (ART), adherence to treatment, and retention in care (Ulett, et al., 2009). Research has

shown that 17% of men who have sex with men (MSM) are living with HIV in Nigeria (UNAIDS, 2014) and in 12 months follow up study on retention in HIV care conducted in 21 cities in United States, about 64% of MSM were not retained in HIV care (Hall, et al., 2013), underscoring the need to improve linkage and retention in care for this population. Evidence from the behavioral models conducted by Stein et al. (2007) for vulnerable population revealed that individual and structural barriers impede retention in HIV care among Men who have sex with men. Studies have revealed that ART adherence by key populations were affected by a combination of individual and structural -level barriers; those who experienced a combination of both individual and structural level barriers simultaneously may experience heightened difficulties in adhering to treatment (Murphy, et al., 2001). At the individual level, multiple cohort and survey studies have revealed that younger age, ethnicity, use of intravenous drugs are associated with poor retention in HIV care (Mugavero, et al., 2012; Mugavero, et al., 2009; Fleishman, et al., 2012; Yehia, et al., 2012; Giordano, et al., 2005; Giordano, et al., 2009).

Conversely, patients receiving case management services and with fewer individual unmet needs are more likely to consistently engage in care than counterparts (Cunningham, et al., 2007; Rumpitz, et al., 2007). Also, individual level- factors identified to affecting adherence to medication for MSM not specifically mentioned include not having healthcare insurance, having dropped out of school, homelessness as well as the existence of a mental disorder (Rudy, et al., 2009). It was found that the type of medical insurance could influence their usage of healthcare services (Agwu, et al., 2011). Those who were in receipt of publicly funded insurance were more likely to discontinue their treatment than those who had no insurance or private medical coverage. The individual's on- going development of sexual identity and "coming out" since difficulty with self-acceptance or disclosure may affect the willingness to be retained in care (Rethemiotaki, 2021). Homophobia, individual's perception of the need for the care, personal/family resources, community resources, racism, stigma, and discrimination especially when codified by law, social mores, or religious institutions, incarceration, distrust of practitioners, privacy concerns, isolation, fear of disclosure, language barriers, shame and substance abuse, competing life activities such as family responsibilities and work schedule may preclude or limit retention in HIV care (Garland, et al., 2011; Kempf, et al., 2010; Quinlivan, et al., 2013; Messer, et al., 2013; Moneyham, et al., 2010; Rajabiun, et al., 2007). At the structural level, features of the HIV Clinic and the patient-provider relationship have been implicated as key

structural factors that limit retention in care among HIV infected MSM(Ulett,et al.,2019). Studies had revealed that the clinic –level barriers such as transportation problems, and lack of the clinic staff to consistently answer and return phone call impede retention in care(Rajabiun, et al., 2007; Mallinson, et al., 2005; Christopoulos, et al., 2013), unstable housing conditions and lack of attendance at school acted as barriers to health care retention(Rudy, et al., 2009). Distance to clinic and transportation have been identified as major barriers to retention in HIV care in a wide variety of settings in Africa and Asia. In a study conducted in rural Uganda, 50% of patients lost to follow up were as a result of transportation problem and 42% was attributed to excessive distance(Geng,et al.,2010).Financial constraint contributed about 34% limiting factor to retention in HIV care in South Africa(Hussen,et al.,2015).Studies have identified possible facilitators such as attaining self-sufficiency through the development of a positive gay and HIV-positive identity, having a positive provider-patients relationship, and access to transportation as powerful tools that enhance retention in care (Kempf,et al.,2010; Quinlivan,et al.,2013; Messer,et al.,2013; Moneyham,et al.,2010; Hussen,et al.,2015). Several studies have identified that engaging African American and Latino MSM in social support group interactions serves as a powerful force to retaining them in care(Bauermeister,et al.,2010).Survey conducted among HIV-Infected Ghanaian Men Who have Sex with Men revealed that fear of being seen in HIV-related health facility, financial difficulties, and health system challenges as major barriers while engagement in care included social support, fear of mortality from HIV, knowledge of effectiveness of HIV treatment,prior relationship and familiarity with hospital personnel, and positive experience in healthcare setting were identified as major facilitator for retention in HIV care (Ogunbajo, et al.,2018).Evidence had shown that reassurance about health, feeling and looking better, receiving treatment, avoiding infecting others, good relations with healthcare workers, and social support for African American Men Who Have Sex With Men were the key facilitators to healthcare utilization while the barriers included HIV stigma, concerns about confidentiality, negative perceptions of healthcare workers, convenience and availability of testing/treatment facilities, cost, and lack of social support (Jemmott, et al.,2019).

Care, et al. (2018) reported that services tailored to meet multiple patient needs, effective patient-provider communication, and providers who show empathy and respect for their patients were the major motivators for healthcare retention while respondents were less likely to be care-engaged when these factors were absent. Research conducted among men who have sex with

men (MSM) in Vietnam by Philbin et.al. (2018) showed that lower-income, 'hidden' MSM from rural areas, stigma by the healthcare system, family, and other MSM and healthcare access, economic barriers and lack of MSM-friendly services were the notable barriers to retention in HIV care.

The goal of this study was to assess the facilitators and barriers to retention in HIV care among HIV infected MSM attending community health center, Yaba Lagos Nigeria. An understanding of the barriers and facilitators that may impact the access to retention in HIV care is essential for improving the continuum of care for MSM in Nigeria. Our research suggests the need for multiple strategies to reach diverse types of MSM as well as to address barriers in access to health services such as stigma and costs. Exploring the MSM specific factors that affect their retention in HIV care will go a long way in providing a good insight on how to retain them in care and invariably cut down the spread of HIV infection not only among MSM but also to the general population.

Method

Sampling Method

A two months (May –June,2016) exploratory qualitative research study was conducted among 181 respondents enrolled into HIV care within 12 months that attend community health center, Yaba Lagos Nigeria. Both phone interviews and focus groups were administered to the respondents during the study. Researchers had described focus groups as both enabling and constraining for facilitating conversations about sexual behavior and HIV prevention(Newman, et al., 2017).The interviews and focus groups were conducted by two trained, master's level interviewers with experience working in public health, HIV and with MSM. Phone in-depth interviews lasted approximately 100 minutes and focus groups lasted around 120 minutes. Interviews and focus groups occurred in a private room at the community health center and refreshment was given to compensate for their time. A pretested semi structured interviewer-administered questionnaire was used to collect the barriers and facilitators' data to Retention in HIV care. A convenience sampling was used to select the respondents; these selected participants was stratified into two age groups (≤ 24 years and ≥ 25 years and above).The inclusion criteria included HIV infected self –reported MSM that have been receiving ART only in at community health center, Yaba Lagoswithin 12 monthswith age bracket of bracket of 16 years and above, and able to provide a written informed consent while HIV infected non –MSM less than 16 years and who not consent to the study were excluded.

Statistical Analysis

Excel sheet was createdand dataentries from the questionnaire were entered accordingly. After which analysis was done using SPSS version 20. Descriptive statistics was used to summarize quantitative variables. Frequency tables were generated for the relevant variables.

Ethical Approval

Ethical approval for this study was received from Health Research Ethics Committee (HREC) of the Lagos University Teaching Hospital (LUTH), Idi-Araba, Lagos. Permission was obtained from Population Council before commencing the study. Population Council data access and usage application form for this study was obtained from the organization, filled, submitted and a go ahead approval was received from HIV unit Deputy Director. Sufficient information that was enough to make an informed decision on whether or not to participate in the study were adequately explained to each respondent and signed informed consent obtained. They were

assured of absolute confidentiality in the information provided and non-participation or withdrawal attract no penalty. For the written informed consent, see appendix 4.

Study Limitation

The limitations encountered during the study assessment period were sexual harassment.

Results

Characteristics of the Respondents

From **Table 1**, it was revealed that the mean and median age (in years) of the participants sampled was 25.86 and 24.00 respectively. Majority of the populations 47% were within the age bracket of ≤ 24 years, and 53% of them was within the age group of ≥ 25 years. Most of the participants 56% was from Igbo ethnic background, 42% of them was of Yoruba origin and only 2% of the respondents was from Hausa ethnic background. However, majority of the sampled population 86% were predominantly Christians while 14% of them were Muslims. Most of participants 86% were mainly single, 6% married, 4% engaged, 3% separated and 1% of the respondent was cohabitating. It is worthy to note that all the participants sampled were all males. It was revealed that majority of the participants 34% were Students, followed by Artisans 27%, and Professionals 22%. Also, Civil Servant were 2%, those who were Self-employed was 14%, and Unemployed was 2%. It was shown that most of the participants 81% were bisexual by sexual orientation and 19% of them had sexual preference only for men. Most of the population sampled 72% played both penetrative and receptive sexual role. Also while 18% of the participants engaged only in penetrative role, 9% of the respondents preferred receptive role as a sex role preference. It was found that 2% of the participants had no formal education, more than half of the participants 61% had finished their secondary education, 32% of them had tertiary degree, 2% primary and 3% of the respondents had their master degree.

Table 1: Socio-demographic Characteristics of Respondents

Variables	Frequency (n = 181)	Percentage (%)	Variables	Frequency (n = 181)	Percentage (%)
Age group (Years)			Occupation		
≤24	85	47	Student	61	33.7
≥25	96	53	Unemployed	4	2.2
Mean age	25.4		Artisan	48	26.5
Median age	24		Professional	39	21.6
			Civil	4	2.2
			Self-employed	25	13.8
Ethnic group			Sex partner		
Hausa	4	2.2	Both Male & Female	147	81.2
Igbo	101	55.8		34	18.8
Yoruba	76	42			
Religion			Sexual Orientation		
Christianity	156	86.2	Receptive	17	9.4
Muslim	25	13.8	Penetrative	33	18.2
			Both	131	72.4
Marital Status			Educational Level		
Single	156	18.2	None	3	1.7
Married	10	5.5	Primary	4	2.2
Engaged	8	4.4	Secondary	110	60.8
Separated	6	3.3	Tertiary	59	32.6
Cohabitation	1	0.6	Master	5	2.8

Facilitators to Retention in HIV care among Respondents.

Out of the total number of 181 enrolled into HIV care, 167 participants were retained in HIV care within 12 months. From Table 2 below, it was found that majority of the participants 44% testified that the major facilitator for their retention in HIV care was the friendly clinic services they have been receiving, 16% was having a positive relationship with clinic staff, and 20% of them attributed it to friendly and secured environment. Similarly, 5% of the respondents identified less clients' waiting times as a source of their motivator, 8% was the availability of free HIV care services and drugs, 2% of the participants said that their continual interest to access HIV care at the study site was as a result of their proximity to the clinic, 1% different participants observed appointment reminder phone calls and provision of confidential healthcare services as reasons for their retention in care over time. Also, while 0.6% of the participants claimed the availability of support group as retention enhancer, the remaining 0.6% believed to

have been retained because of good adherence counseling support received throughout the assessment period.

Table 2: Facilitators to Retention in HIV care among Respondents.

Facilitators Variables	Frequency (n=167)	Percent (%)
Presence of support group	1	0.6
Appointment reminder phone calls	2	1.2
Client-friendly clinic services	73	43.7
Flexible appointment schedule	2	1.2
Free healthcare services and drugs	14	8.4
Friendly and secured environment	34	20.4
Good adherence support in place	1	0.6
Having positive relationship with clinic staff	27	16.2
Less clients' waiting time	8	4.8
Provision of confidential healthcare services	2	1.2
Proximity to the clinic	3	1.8

Barriers to Retention in HIV care among Respondents.

Of the total number of 181 recruited, 14 participants that were lost to follow up. Out of the 14 respondents, 3 (21%) of the participants attributed the reason to full time job, 2 (14%) of them missed out because of death that snatched them away during the assessment period. Similarly, most of the participant 5 (36%) attributed distance as a major barrier to retention in HIV care, 3 (21%) self-denial and another 1 (7%) of them trust in the efficacy of herbal medication.

Table 3: Barriers to Retention in HIV care among Respondents.

Barriers Variables	Frequency (n = 14)	Percent (%)
Full time job	3	21.4
Death	2	14.3
Distance	5	35.7
Self-denial	3	21.4

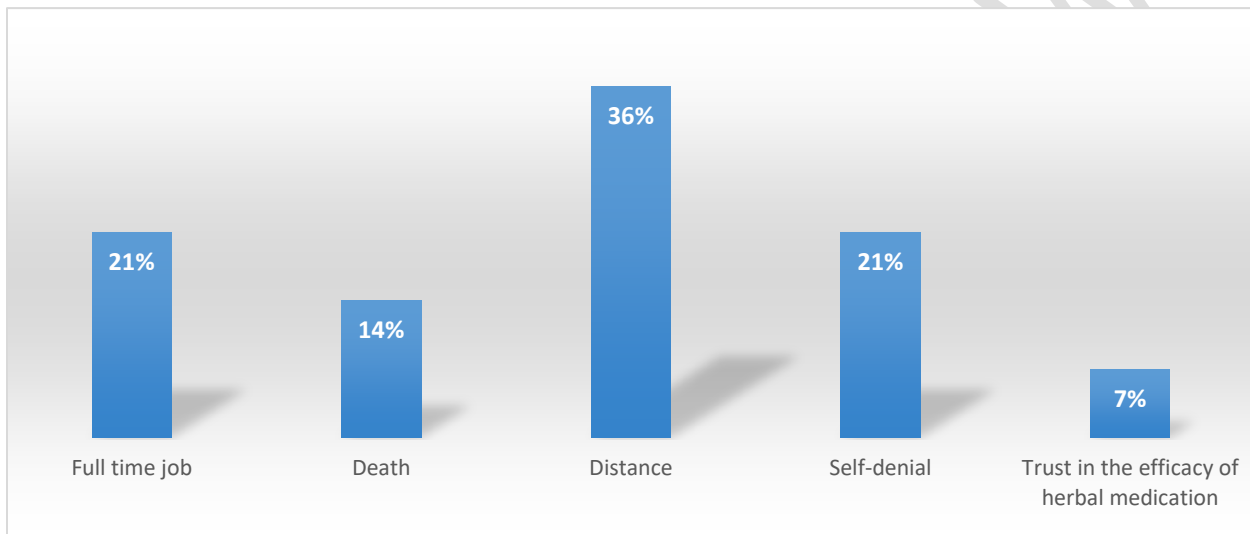


Figure 1: Barriers to retention in HIV care among Respondents

Discussions

Of 167 participants retained in HIV care for one year, majority of the participants 44% ascribed friendly clinic services they have been receiving and 16% of them attributed having a positive relationship with clinic staff as strong facilitators to their retention in HIV care. This may not be unconnected to the previous study that revealed that having a positive provider-patients relationship enhances retention in care (Ulett, et al., 2019; Kempf, et al., 2010; Messer, et al., 2013; Moneyham, et al., 2010). It was also found that 20% of respondents observed friendly and secured environment as a factor that encouraged them to remain in HIV care over time. Similarly, 5% of the participants identified less clients' waiting times as a source of their motivator for accessing HIV care services over time, 8% of them attributed their retention enhancer to the availability of free HIV care services and drugs, 2% of the participants said that their continual interest to access HIV care at the study site was as a result of their proximity to the clinic, 1% of two different participants observed appointment reminder phone calls and

provision of confidential healthcare services as reasons for their retention over time. This finding was in line with a study conducted by Ulett et al, 2019; Care, et al. (2018); Jemmott, et al. (2019). Also, while 0.6% of the participants claimed the availability of support group as his retention's enhancer and this was in line with the past study that revealed that social support group serves as a powerful tool to retention in care (Bauermeister,et al., 2010) and the remaining 0.6% of respondent believed to have been retained because of good adherence counseling support received throughout the assessment period.

Conversely, of the 14 participants that did not utilize the HIV care in this study, as shown in **table 3**, 21% of the participants attributed full time job as major barrier to retention. This finding was similar to other study that identified a competing life activity such as full time job as a major barrier to retention in care (Moneyham, et al., 2010). Also, 14% of respondents was lost out of care because of death that snatched them away during the assessment period. And this is an unavoidable circumstance more especially if a patients did not adhere to medication which was also implicated in other study (Mellins, et al., 2011). Similarly, most of the participant 36% attributed distance as a major barrier for not being retained in the clinic. And this was consistent with other study conducted in rural Uganda that has the same economic status with Nigeria which revealed that 42% of barrier to retention in care was distance (Geng, et al., 2010). Also, 21% of barrier to care utilization was found to be self-denial and this outcome was similar to the previous study that stated that difficulty with self-acceptance affect the willingness to be retained(Rethemiotaki,2021), and finally, 7% of them did not utilize the care because they trusted in the efficacy of herbal medication.

Conclusion

Engagement and retention in care has been linked to improved health outcomes, better medication adherence and increased overall survival (Magnus, et al., 2010; Ulett, et al., 2019). This study was able to reveal several important individual, healthcare provider, and structural-level factors that might determine how MSM may or may not be retained in HIV care. The study focus group participants also suggested some innovativestrategies to improve retention in HIV care among MSM. Future efforts to initiate and sustain HIV care among Nigeria MSM depends on close collaboration between the government, community-based organizations, HIV care facilities and staff, and MSM themselves to create a more socially and culturally tolerant

environment and a robust and comprehensive HIV care system. Therefore, improving retention in HIV care among these underserved groups begins with addressing the relevant social, economic, geographical, and political forces that are acting against them.

COMPETING INTERESTS DISCLAIMER:

Authors have declared that no competing interests exist. The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

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