

Factors affecting utilization of HIV care services among men in TASO Masaka, Uganda: An exploratory study

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Magala I, Tapati D, Nalubega R. Factors affecting utilization of HIV care services among men in TASO Masaka, Uganda: An exploratory study *J Clin Microbiol Infect Dis* 2018;1(1):9-11.

More than three decades after the first case of AIDS was notified in Uganda, HIV pandemic continues to pose unprecedented challenges with latest Government estimates indicating 138,700 new cases, adding to the already 1.6 million people who are living with HIV in the country. The government response to containment and prevention of HIV/AIDS has been through the prevention and care programs initiated in 1986 and later the National HIV/AIDS Strategic Plan through 2007/2008-2011/2012

cycles, with three service areas of prevention, care and treatment, and social support. Concerted efforts and scale up of care by the Ugandan Government and external donors led to a decline in HIV prevalence from 18% in 1992, to 6% by 2004/2005, making Uganda the most convincing success stories in combating the spread of HIV and reversing the trend of HIV epidemic. However recent upsurge of HIV prevalence in Uganda from 6.4% in 2004-2005, to 7.3% in 2011, especially among them who have multiple sexual partners and are more vulnerable to unprotected sex, like fisher folk, long-distance truck drivers and youth raises tremendous concerns.

INTRODUCTION

The AIDS Support Organization's (TASO), Masaka, Uganda reveal a gender gap with the total clientele of 7371 at TASO, Masaka, of whom 5130 (69.5%) are women and 2241 (30.4%) are men as per the first quarter in 2016. There is limited evidence of factors which affect utilization of HIV care services among men in the area and also a dearth of evidence in general literature around how such non-adherence by men might affect them and their families. There is increased AIDS-related mortality among men in Africa. In this backdrop, the study aimed at identifying the factors which cause men's low utilization of HIV care services and to explore how the low utilization of HIV care services among male clients affect their families in Kingo and Buwunga sub-counties of TASO, Masaka, Uganda. The study aimed at adding to TASO's existing community engagement models of HIV care services and how to optimally utilize these models among people/communities who need it the most.

RATIONALE

Despite prevention efforts, literature has consistently reported low utilization of HIV care services. Reasons for low utilization of HIV care services, regardless of their availability is often attributed to socio-demographic characteristics, access to facility, HIV related prevention awareness. IV risk perception and HIV/AIDS-related stigma and discrimination (1-4).

While there is much literature on barriers to service utilization, a significant body of literature in Sub Saharan Africa also, with lesser uptake among men, among whom high risk behavior is more predominant. Evidence shows 12% women compared to 7% of men who participated in HIV testing in the previous twelve months and 17% of men to 34% of women who ever had undergone HIV testing (5,6).

Studies also highlight that in Sub-Saharan Africa, men's utilization of HIV testing and treatment impacts the household since they are household heads and often control decisions and resources that are essential for HIV prevention and care among women and other family members (7).

Additionally, literature from sub Saharan Africa also show that improving men's utilization of HIV prevention and treatment facilities might directly or indirectly encourage women's utilization of these services, since in most

societies of Africa women need the consent of their male partner to seek HIV testing and treatment (8).

While implementation studies in The AIDS Support Organization's (TASO), Masaka, Uganda reveal a gender gap with the total clientele of 7371 at TASO, Masaka, of whom 5130 (69.5%) are women and 2241 (30.4%) are men as per the previous quarter in 2016, there is limited evidence of factors which affect utilization of HIV care services among men in the area and also a dearth of evidence in general literature around how such non-adherence by men might affect them and their families.

In this backdrop, this exploratory study is being proposed by TASO hypothesizing that better uptake and utilization of HIV care services will have positive impacts on the lives of HIV affected men and their families.

LITERATURE REVIEW

According to study of the 937 men that participated in the study, 357 had been offered an HIV test and 97 had taken the test. Younger age, household wealth, living in a village under demographic surveillance, and knowing that HIV testing is available at primary health facilities were all positively associated with the probability of being offered an HIV test. Household wealth and literacy were found to be positively associated, and distance was found to be negatively associated with the probability of having taken an HIV test. Qualitative findings indicated that the limited uptake of HIV testing was linked to poor knowledge on service availability and to low risk perceptions (9).

Health care facilities have achieved limited HIV testing and treatment coverage in men, with barriers including confidentiality concerns, distance to the facility, inconvenient hours, and perceptions that facilities provide women-centered services. Other barriers to male engagement include stigma, poverty, and feelings of compromised masculinity associated with seeking health care (10).

METHODS

The study targeted 50 male clients with missed appointments, file review of missing male clients. 2 focus group discussion with male clients who visit the TASO clinic. 5 Key informant interviews with district and sub-county level stakeholders in Masaka and 20 questionnaires conducted

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Received: January 17, 2018, Accepted: February 27, 2018, Published: March 03, 2018



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through home visits among clients who are irregular in seeking HIV care services from the TASO clinic.

RESULTS

Male Clients who were in relationships with partners who were also in care sought services better than those who were not married. In addition to infrastructural level influences on individual's testing behavior, studies have also demonstrated that being married, higher levels of education, urban residence, and knowledge of HIV are significantly associated with receiving an HIV testing (11).

Non-disclosure of sero-status was also a key factor for service utilization of men. 60% of men who were missing appointments know their spouses HIV sero-status.

Male Clients who dropped out or had poor adherence had history of high viral load, habits like drinking alcohol, smoking and over-representation.

30% of client continued to miss due to fear of reprimands by health workers on why they missed the first time.

Health workers lacked skills to address masculine constructs that prevent men from seeking care. Limited male engagement while at the clinic as men while waiting for treatment, it is noted that activities that engage men should be implemented as well as reducing on waiting time.

Community-based testing interventions (particularly home and mobile) have high acceptability and reach more men than health care facility-based approaches. For men testing HIV positive, providing immediate antiretroviral therapy (ART) is associated with high retention and viral suppression. This strategy of "collapsing the cascade" provides streamlined services and reduces loss to follow-up (10).

DISCUSSION

Why men

Some groups, including men, have specific health needs that require a better-informed and planned response. Particular health issues of concern for men include lower life expectancy, higher levels of avoidable mortality and higher rates of mortality from most common causes of death including heart disease, cancer, suicide and respiratory diseases.

Causes of men's health issues are multifaceted and include factors such as health literacy and attitudes, lifestyle behaviors, social and cultural norms, lack of health service responsiveness, and biological differences between men and women. These factors mean men across all socioeconomic groups face unnecessary rates of mortality and morbidity (12).

While there is evidence that biological factors contribute to men's poorer health outcomes, studies indicate that disparities are due mainly to modifiable social factors. Men are more likely to face a range of lifestyle risk factors such as smoking, risky alcohol consumption and insufficient fruit and vegetable consumption; they have greater participation in a range of high-risk activities; and use health and community services less and at a later stage in an illness. In addition, traditional masculine values such as stoicism, suppression of emotion and self-reliance have been shown to negatively affect the health behaviors of some men.

Factors affecting health seeking behavior

Barriers to healthcare utilization exist for all the wealth categories along three different axes including: the health seeking process; health services delivery; and the ownership of livelihood assets. Income source, transport ownership, and health literacy were reported as centrally useful in overcoming some barriers to healthcare utilization for the 'least poor' and 'poor' wealth categories (13).

The other issue for men is long waiting time and attitude of health care workers were also reported as affecting utilization of the health facility. In most rural communities with PHC facilities, other orthodox options of care may be absent coupled with financial constraints. Most of the perceived factors affecting utilization of health facilities are related to

accessibility in terms of skilled manpower; cost; quality service and distance (14). Community-based interventions should be tailored to the needs of men to maximize uptake, including flexible hours, multiple follow-up visits, and convenient and private access to care. Integrating HIV testing into screening for chronic disease can reduce stigma and increase program efficiency (15,16).

Families are greatly impacted by male health seeking behavior, Men's partners and families also feel the economic and social impacts of men's ill health. These include reduced income, increased costs of medical care, the need for family members to become caregivers, and men's reduced ability to fulfill their roles as partners, fathers or caregivers due to physical or mental health problems or premature death (12).

Life course approach

Men's experience of health and wellbeing, health-related attitudes and behaviours and service use change substantially over the life course as a result of both the biological process of ageing and different roles (for example, fatherhood, employment, after leaving full-time work).

A life-course approach takes account of and responds to these differences, as well as identifying the critical transition points that present opportunities for intervention, such as school to paid work, becoming a parent, and leaving full-time work.

CONCLUSIONS

Conventional gender constructs affect men's HIV care seeking behavior and health workers. There is need for male friendly services that addresses these constructs and sustain men in care. Community-based HIV interventions can overcome barriers associated with facilities and increase men's engagement in care. Social and livelihood interventions can reduce stigma and poverty. Informants reported a clear and hegemonic notion of masculinity that required men to be and act in control, to have know-how, be strong, resilient, disease free, highly sexual and economically productive. However, such traits were in direct conflict with the 'good patient' persona who is expected to accept being HIV positive, take instructions from nurses and engage in health-enabling behaviours such as attending regular hospital visits and refraining from alcohol and unprotected extra-marital sex.

The current state of evidence strongly suggests that community-based test-and-treat strategies can reduce the gender disparity in HIV testing and treatment by achieving higher levels of ART coverage and viral suppression in HIV-positive men.

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