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**Exploring the use of Healthcare Services and Antiretroviral Therapy among HIV  
Positive Men Who Have Sex with Men (MSM) in Nigeria: A Qualitative Study**

**By:**

**Abisola Olatokunbo Balogun  
140132674**

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*“There 's really no such thing as the 'voiceless '. There are only the  
deliberately silenced, or the preferably unheard. ”*

*-Arundhati Roy*

## ABSTRACT

Despite the large body of evidence suggesting that African MSM have poor healthcare seeking behavior, there remains a paucity of research especially qualitative research exploring healthcare seeking practices among Nigerian MSM. This thesis provided a nuanced exploration of the ‘lived’ experiences of HIV positive MSM as they seek to access healthcare services including adhering to antiretroviral treatment (ART) in Nigeria. The central argument of this thesis is that highly valued legal, societal and religious guiding precepts of Nigerian society coupled with the double stigmatizing identities of being both HIV positive and MSM are propagating the everyday stigma, discrimination and extreme violence, which they experience. These stigma, discrimination and violence further act to negatively influence the healthcare seeking practices of HIV positive MSM, especially the extent in which they are able to gain access to healthcare services and adhere to ART. In exploring the lived experience of HIV positive MSM, a qualitative approach using Focus Group Discussions (FGDs) and an Semi-Structured Interview were employed. A total of 4 FGDs and 21 interviews were conducted in both Lagos and Abuja, Nigeria, between January and May 2016. Data were analysed iteratively using both thematic and individual analysis in order to obtain a comprehensive picture of the men’s lived experiences. Findings reveal that HIV positive MSM access sexual and HIV related healthcare services from facilities which are specifically targeted at their population. This is due to the experience of stigma and discrimination as well as the fear of persecution at general healthcare facilities. When they do seek healthcare services from general healthcare services, in a bid to conceal their sexual orientation and avoid stigma or persecution, they falsify symptoms and this leads to misdiagnosis and in some cases death. This thesis reported on a form of stigma ‘Kito’, which is driven by the criminalisation of homosexuality, poverty, social media, religion and norms of the society. This thesis also revealed that HIV positive MSM living in Nigeria lacked knowledge about the transmission of HIV through anal sex and therefore engaged in anal sex as a protective behavior leading to their acquisition of HIV infection. MSM encounter challenges to adhering to ART which fall under patient, ART and social or structural related challenges. The study also highlighted that HIV positive MSM in Nigeria adopt strategies such as setting alarms, repackaging and breaking their ART in smaller easier to swallow pieces, selectively disclose their HIV status and conceal their ART in order to maintain optimal adherence

to ART. Findings from this research can inform public health interventions geared at improving engagement with healthcare services including access and adherence to ART among this key population. Additionally, it raises the question of what an effective health education strategy for non-heterosexual men should look like in a context which is highly heteronormative and where same-sex practices and identities are criminalised.

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## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
DFID	Department for International Development
FMOH	Federal Ministry of Health
FSW	Female Sex Worker
GHAIN	Global HIV/AIDS Initiative Nigeria
HAI	Heartland Alliance International
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Biological and Behavioural Surveillance Survey
ICARH	International Centre for Advocacy on Rights to Health
IDU	Intravenous Drug User
MARPS	Most-at-risk populations
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
PC	Population Council
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
SSMPA	Same Sex Marriage Prohibition Act
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infections
USAID	US Agency for International Development
WHO	World Health Organisation

## CHAPTER 1: INTRODUCTION

### **1.1 Introduction**

Nigeria is among the 31 countries in sub-Saharan Africa where same sex relationships and its expression is criminalised (Schwartz et al, 2015). In relation to HIV, anti-discrimination laws exist but in their execution, they remain dormant (Kareem et al. 2016). In the West, the HIV epidemic has been associated with homosexual transmission, however, in sub-Saharan Africa, specifically, Nigeria, it is associated with heterosexual transmission (Bashorun et al. 2014; Awofala & Ogundele 2016). This focus on heterosexual transmission means that homosexual transmission of HIV is largely ignored in national surveillance systems. There remains a paucity of research exploring MSM engagement with care, despite the obvious gap. This study therefore aims to fill this knowledge gap by providing thick description of the lived experiences of HIV positive MSM as they access healthcare services and including adhering to antiretroviral treatment in the heteronormative context of Nigeria.

An in-depth understanding of this issue is imperative for a number of reasons. First, there is consistent evidence across African and including Nigeria of the extremely high (in comparison to the general population) and rising HIV prevalence in MSM populations (Charurat et al., 2015; Holland et al., 2015; FMOH, 2014). Second, African MSM have been reported to engage in high sexual risk behaviours which along with their biological tendency increases their susceptibility to HIV (Sekoni et al., 2015; Bezemer et al., 2014; Lane et al., 2011; Allman, 2007). Third and perhaps most importantly, is that the widespread criminalisation, stigmatisation and discrimination of same sex relationships, characteristic of most African countries have been attributed to the poor engagement with healthcare services observed in this population (Jobson et al., 2015; Aho et al., 2014; Allman, 2007).

This thesis argues that because of their HIV status and sexual practices, HIV+MSM living in the criminalised context of Nigeria experience immense stigma, discrimination and extreme violence from family members, friends, healthcare workers, the police and society, which impacts negatively on their healthcare seeking behaviour. Stigma and discrimination are perpetuated by religious, cultural and legal structures which govern the society. Within these structures, homosexual practices of MSM are perceived to be unnatural, immoral, demonic and alien or against traditional 'African' culture. In a

similar way, being HIV positive attracts stigma, discrimination and violence because of fear of the unknown source of HIV, the generally poor knowledge of HIV transmission and the association of HIV to death. HIV positive MSMs' general experience of HIV and being MSM in Nigeria was therefore undesirable especially when their societally stigmatised attributes became publicly known. This had negative impacts on their healthcare seeking behaviours as they generally tended to avoid general healthcare facilities because of fear of persecution, stigma and discrimination.

A qualitative approach was employed in understanding how HIV+ MSM living in Nigeria are able to access healthcare services and adhere to their ART. This approach was useful in capturing the multiple narratives of homosexual and bisexual identifying men in relation to their illness and healthcare seeking behaviours as well as the management of their non-heterosexual identities in both Lagos and Abuja. Using FGD and in-depth qualitative interviews, allowed the presentation of a comprehensive picture of the men's lived experiences.

## **1.2 Research Question**

*How do HIV Positive MSM experience accessing healthcare services and adhering to their antiretroviral treatment in Nigeria?*

## **1.3 Sub research Questions**

- How do HIV+MSM experience homosexuality and HIV in the Nigerian social context?
- How do HIV+MSM experience, understand and manage their illness?
- How do Nigerian HIV+MSM experience accessing HIV related health services in Nigeria?
- How is adherence to ART experienced by Nigerian HIV+MSM?

## **1.4 Thesis Structure**

Chapter Two consists of two parts, the context and the background empirical literature on the research topic. The first part, the context, provides background information about the Nigerian healthcare system. It explores the specific role of Civil Society Organisations (CSOs) and Non-Governmental Organisations (NGOs) in the Nigerian HIV/AIDS National response. Furthermore, it provides an overview of the HIV/AIDS epidemic in Nigeria and shows how the genesis of HIV epidemic in the female



population positioned the focus of HIV surveillance, prevention and control efforts on the maternal population while largely ignoring other critical populations such as the MSM populations. This first part concludes with a section describing MSM in Nigeria including the Same Sex Marriage Prohibition Act (SSMPA) which indirectly criminalises homosexual identity and practice, characteristics of Nigerian MSM and finally, the key role MSM play in the Nigerian HIV epidemic. The second part of this chapter is a detailed overview of the existing literature on African MSM. It provides a description of the HIV burden in African MSM populations and some specific behaviours which have been reported to put them at high risk for HIV. It then explores African MSM engagement with healthcare services, including what is known about their adherence to ART. The chapter concludes with a brief consideration of conceptualisations of stigma and discrimination in the literature. The literature review section sets the stage for the study by revealing gaps in the literature requiring further exploration.

Chapter Three begins by detailing the study design including the philosophical positioning underpinning the research. This is followed by a section discussing the issues requiring consideration when researching vulnerable populations, focus group discussion (FGD) and interview, used in this research. A description of the study area including the rationale for selecting the study area is also provided. Additionally, the steps involved in gaining ethical approval needed to conduct research in Nigeria were discussed. The study concludes with a section on how rigour was ensured in the research, and a reflection on my positionality.

The next four chapters are findings chapters and they are divided into two parts, Part one on homosexuality and HIV in Nigeria as well as stigma and discrimination and Part two on MSM experiences of HIV, accessing healthcare services and adhering to ART. These chapters draw on interview and focus group discussion (FGD) data. Chapter Four is the first empirical data chapter and presents participants accounts of their experiences of being sexually non-conforming and HIV positive in Nigeria. It specifically presents a description of how Nigerian MSM form their sexual identities and their understanding of these identities. It is followed by a detailed description of MSM sexual partnerships which are important to contracting HIV. The chapter concludes with a detailed description of how they are perceived in their society and the socio-legal and religious

implications of being a man who engages in same-sex sexual practices in the heteronormative Nigerian context.

Chapter Five is the second empirical data chapter which presents participants' accounts of their experiences of stigma and discrimination in Nigeria. This chapter reports the different forms of stigma and discrimination participants encounter. It addresses the research question related to Nigerian HIV+MSM experiences of stigma and discrimination.

Chapter Six presents detailed accounts of participants' experiences of HIV including the processes they go through from the initial stages when they begin experiencing health challenges to the post HIV diagnosis phases. It then describes the self-management of their illness specifically in relation to whether they opt for formal healthcare, traditional healers or self-treatment. Finally, their source of information and knowledge about HIV are explored. This chapter seeks to provide an answer to the research question related to HIV+MSM experiences, understanding and self-management of their illness.

Chapter Seven focuses on addressing the research question related to participants' experiences of accessing HIV-related healthcare services in Nigeria. It reports on participants' experiences accessing healthcare services from general healthcare facilities and facilities providing MSM specific and friendly services. It then presents findings on the influence of social status on access to healthcare services in Nigeria. Next, it addresses specific interventions which facilities providing services tailored to the MSM population put in place to enable access to healthcare services. The chapter concludes with a section highlighting issues for consideration within these facilities providing MSM specific and friendly services.

Chapter Eight, the final findings chapter, seeks to address the research question pertaining to HIV+MSM understanding and response to the medical expectation that they adhere to their ART. The chapter begins by presenting participants' accounts about their understanding of ART and adherence and the processes they undergo in order to initiate ART. It then highlights key benefits and motivators for adhering to ART. Next, it highlights challenges and facilitators of ART adherence reported by participants. The chapter concludes with a consideration of strategies which participants deploy in order to maintain optimal adherence to ART.

The final chapter of the thesis, Chapter Nine, is the discussion and conclusion chapter. This chapter discusses the key findings of this research within the context of the wider literature. The chapter begins by discussing homosexuality and HIV in the Nigerian context. It then discusses HIV positive MSM experiences of stigma and discrimination in the Nigerian context. In the section that follows, key drivers of stigma and discrimination in the Nigerian society are discussed. This chapter then moves on to discuss a new form of stigma within the MSM community that adds to the existing conceptualisation of stigma. This is followed by a discussion of how participants in this study deal with stigma. The following three sections provide a critical discussion of participants' knowledge about HIV and its transmission and how they access HIV-related healthcare services and adhere to their antiretroviral treatment in the Nigerian context. The chapter concludes with recommendations for policy, practice and future research as well as the limitations of the study.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter is divided into two parts: the context and the empirical research. The first part provides the context in which this research was conducted. Section 2.2.1 describes the Nigerian healthcare system, highlighting its complexity and plurality. It also discusses the role of Non-Governmental Organisations (NGOs) and Civil Society Organisations (CSOs) particularly in the Nigerian HIV/AIDS national response. In Section 2.2.2, the HIV/AIDS epidemic in Nigeria generally and particularly as it pertains to key populations including MSM was described. This is followed by Section 2.2.3, which outlines the Nigerian ART programme as well as progress that has been made since 2004 when it commenced. Finally, the place of MSM as a priority population in the Nigerian HIV epidemic as well as the social and legal factors that drive the HIV epidemic in MSM populations in Nigeria and influence their health seeking practices is discussed in Section 2.2.4.

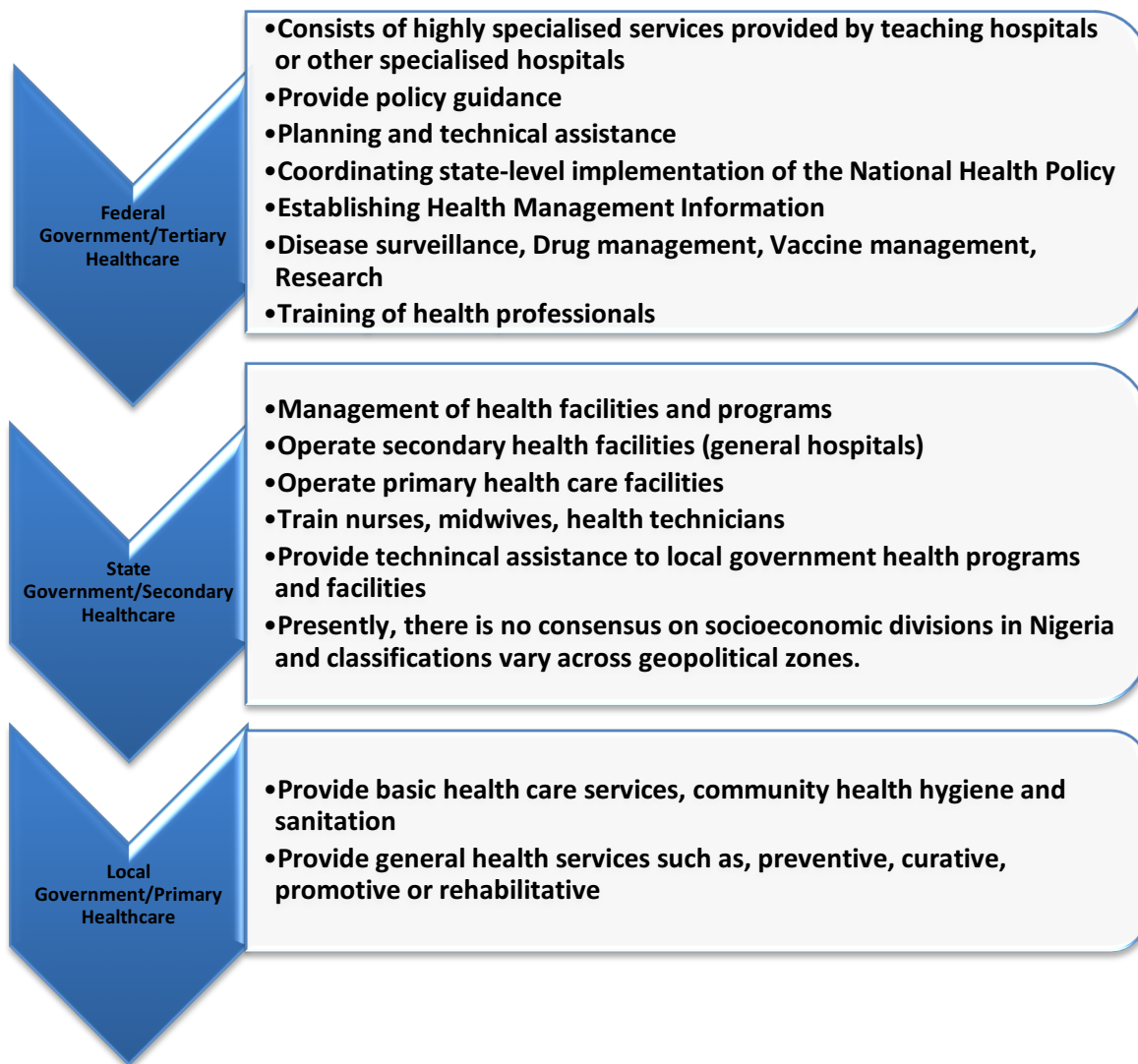
The second part of this chapter provides key empirical and contextual research related to African MSM, stigma and discrimination, access to healthcare services and adherence to ART. Section 2.3 presents a comprehensive review of MSM in Africa with a focus on their engagement with healthcare services and adherence to ART. It gives an overview of the existing literature on the lived experiences of African MSM in terms of their sexual risk behaviours which increase their susceptibility to HIV, their HIV knowledge, testing and risk perception and the legal context in which they experience homosexuality. In addition to this, the review covers ways in which stigma and discrimination have been conceptualised in the literature and shows how criminalisation, stigmatisation and discrimination may hinder African MSM from adequately engaging with healthcare. The chapter concludes with Section 2.4, which are the key messages and gaps. The literature search strategy is available in the Appendix 7.

## **2.2 Context**

### **2.2.1 The Nigerian Healthcare System**

The Nigerian national healthcare system is complex with a mix of biomedicine and traditional systems of health service delivery (WHO, 2002; Amzat, 2014). While approximately 70% of Nigerians utilise traditional healthcare services even for their HIV care (Kombe et al, 2009), this research is particularly interested in the use of biomedicine. Biomedicine is provided through formal and informal as well as public and private sector led services. The formal public healthcare sector is organised based on the three tier systems of administration as specified by the National Health Policy – with federal, state and local government providing tertiary, secondary and primary healthcare respectively (FMOH, 2005). The failure of the National Policy to achieve what is stated can be attributed to weak legislations, which have meant that the aspirations of the document are only been partially obtainable. The focus of this research is on HIV services, which are provided at the primary, secondary and tertiary levels (FMOH, 2016). This research has looked at individuals patronising both government and private owned HIV services. Fig 2 below shows the responsibilities of Federal, State and Local Government in the Nigerian Healthcare System.

**Fig 1: Responsibilities of Federal, State and Local Government in the Nigerian Healthcare System**



Adapted from WHO, 2002 & FMOH, 2005

In Nigeria, healthcare services are underfunded, understaffed and underequipped to handle the healthcare needs of the general populace (Obansa & Orimisan, 2013). For disadvantaged populations, like MSM, FSW and IDUs, who have an increased HIV burden, the situation is direr. In Nigeria, availability of healthcare facilities does not always translate to availability of quality healthcare services and facilities are often far from those who live in either rural or difficult to reach parts of Nigeria (FMOH, 2016). This poses a problem for HIV infected individuals as rural areas have a higher HIV prevalence compared to urban areas (WHO, 2007). As a result of the inadequacies of government healthcare services, there is a burgeoning private healthcare sector, which is comprised of for-profit, nongovernmental organizations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), traditional and spiritual healers

(FMOH, 2005; WHO, 2002). All of these factors contribute to worse outcomes and experiences for key populations affected by HIV including MSM.

According to the National Health Accounts (NHA), healthcare in Nigeria is financed through different sources: out-of-pocket (OOP), tax revenues, donor funds and health insurance (private, public, social and community) (Lawanson, 2014). Government contributes 20.6% while donor funds account for 10.3% of total healthcare expenditure in Nigeria (Soyibo et al, 2005). As it relates to the HIV/AIDS national response in Nigeria, the government contributed approximately \$7.3million in 2010 a 73% increase from 2007 (NACA, 2010). Although the Nigerian government has promised to increase domestic funding for HIV prevention and treatment efforts, majority of the funding for implementation of HIV services and treatment comes from foreign donors such as PEPFAR, USAID and DFID (NACA, 2010). OOP, the most common source of healthcare financing is estimated to be responsible for 69% of healthcare expenditure (Lawanson, 2014; Uzochukwu et al., 2015). For 4 in every 100 Nigerian households, more than half of their total expenditure is on healthcare. Given that the MSM population is a disadvantaged population, the combination of high OOP expenditure and high proportion of their expenditure going towards healthcare, the cost of meeting their healthcare needs can be prohibitive (Allman et al., 2007; Ayoola et al., 2013; Crowell et al., 2017).

### **2.2.1.1 The role of CSOs in the HIV/AIDS National Response**

Civil society organisation (CSO) encompasses local and international nongovernmental organisations (NGOs), community-based organisations, faith-based organisations, support groups for people living with HIV/AIDS (PLWHA), professional associations and trade unions (Ogbogu & Idogho, 2006). CSOs that are local and well accepted in communities provide a platform, which enables government policies to be challenged and also provide a voice for marginalised populations, while promoting unity and capacity building in these groups (Ogbogu & Idogho, 2006). They occupy the space between individuals and the state (Mohan, 2002). CSOs in the initial stages of the HIV epidemic in Nigeria had the role of providing program implementation (ActionAid, 2001). During this time, there was a proliferation of HIV- related NGOs including STOPAIDS, the Association for Reproductive and Family Health, Society for Family Health and Action Health Incorporated. After Nigeria became a democratic country in 1999 and with the establishment of HIV/AIDS Emergency Action Plan (HEAP) the role

of CSOs was broadened beyond HIV program implementation to include prevention, care and support, capacity building, research, and coordinating, supervising and monitoring program for PLWHA (Ogbogu & Idogho, 2006).

Initially, there were only a few NGOs working in Nigeria but since funding became available through PEPFAR, Global Fund, DFID and other international donors, there has been an explosion in the numbers of NGOs (Smith, 2012). The U.S PEPFAR and Global Fund for AIDS, Tuberculosis and Malaria have since 2002 contributed \$2.25 billion to the HIV/AIDS response in Nigeria most of which was given to NGOs (Smith, 2012). Given the significant amount of funding contributed by NGOs, they play a crucial role in the strengthening of the Nigerian healthcare system and the national response to HIV/AIDS epidemic in Nigeria. Some of the roles they have played include: education of the public and outreach, advocacy, media relations and provision of healthcare services (Numeh & Ejike 2004).

### **2.2.2 HIV/AIDS epidemic in Nigeria**

Globally, an estimated 33.3 million people were living with HIV/AIDS in 2010, of these, 22.5 million resided in sub-Saharan Africa and over 3 million in Nigeria (Oku et al., 2014). This makes Nigeria the country with the second highest burden of the disease in the world after South Africa<sup>1</sup> (NACA, 2014). The HIV epidemic in the general population in Nigeria, like many other African countries, stabilized in 2014 at 4.1%. However, in the MSM population, the same has not been the case, the HIV prevalence has continued to increase and was 22.9% in 2014 (NACA GARPR, 2014; FMOH, 2015). The Nigerian HIV epidemic which had previously been described as being in a “state of generalized epidemic involving all geographical areas of the country” (Daniel et al., 2008 p.222) can now by WHO definition be described as a mixed epidemic. This is because HIV is being acquired in more than one subpopulation such as the MSM, IDU and FSW populations as well as in the general population. Furthermore, the country has a high and persistent burden of HIV characterized by its highly complex and heterogeneous epidemic, which is highest among Most-at-risk-populations (MARPs) particularly those with multiple sexual partners and high risk sexual behaviours (NACA, 2013). MARPs refer to populations with the highest susceptibility to HIV, because of biological, behavioural or occupational and include transport

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<sup>1</sup> South Africa has 5.6 million people living with HIV



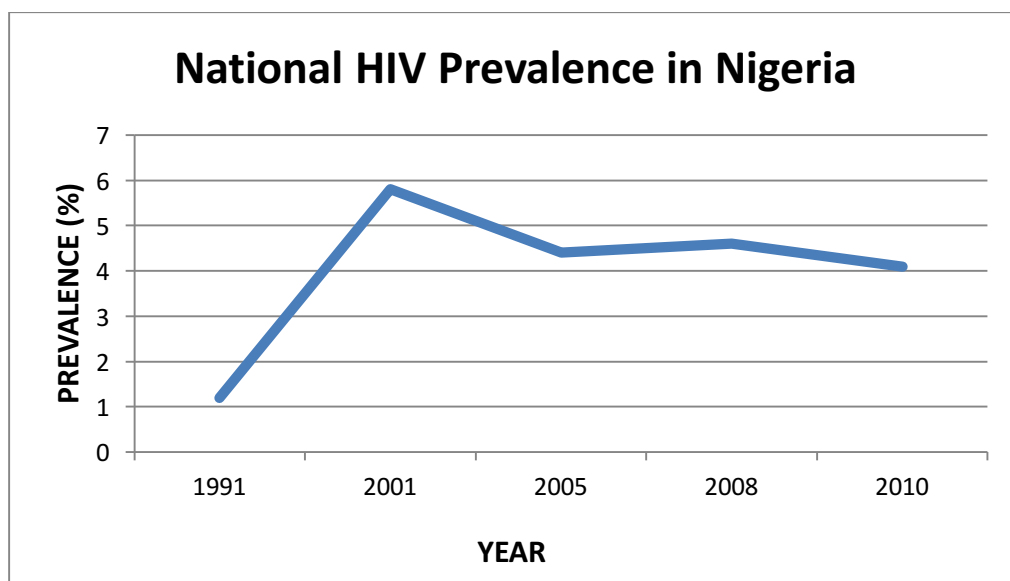
workers, female sex workers (FSW), uniformed men (military and police), injection drug users (IDU) and men who have sex with men (MSM) (NACA, 2013). The Nigerian HIV Integrated Biological and Behavioural Surveillance Survey (IBBSS)<sup>2</sup> showed that the epidemic in Nigeria is indeed driven by HIV transmission both within networks involving MARPs and also within segments of the general population who have multiple partners and/or belong to sexual networks which facilitate the spread of HIV (Charurat et al., 2015; NACA, 2013).

In 1985, the first cases of HIV/AIDS in Nigeria were identified and later reported in 1986 at an international conference (Nasidi et al. 1986). These cardinal cases were a 13-year old sexually active girl and a female sex worker from a neighbouring West African country, who both happened to reside in Southern states in Nigeria (Balogun, 2010). As a result, HIV/AIDS was believed to have spread from the South to the North of Nigeria. However, in later years and as the disease began to gain momentum, the Northern states most especially those in the North-Central geopolitical zone of Nigeria began to record greater incidents of the disease (NACA, 2014). No part of Nigeria is left unaffected by the disease; moreover, its spread and prevalence depict an urban to rural pattern with higher prevalence rates in the urban centres of the country (Oono et al., 2015). The prevalence of HIV also varies from state to state with as low as 1.0% in Kebbi and as high as 12.7% in Benue state in 2010 (Bashorun et al., 2014). As at 2014, FCT had the fifth highest HIV prevalence (7.5 %) in the country, while Lagos had a much lower HIV prevalence of 2.2% (NACA 2014). HIV is an epidemic that is most severe in the younger population, 60% of those infected with HIV in Nigeria in 2006 were between the ages of 15 and 29 (Ogundipe and Obinna, 2011; Allman et al., 2007). As a result of the HIV epidemic, there has been a marked decrease in adult life expectancy in the country to 48.4 years (Oku et al., 2014). Fig 2 below illustrates the pattern of the change in HIV prevalence since the 1<sup>st</sup> case in Nigeria in 1986.

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<sup>2</sup> See description on page 12

**Fig 2: Pattern of HIV prevalence in Nigeria**



Source: FMOH, 2010a

Crucially, the role of anal sex in the propagation of HIV appears to be missing from the narrative. This can be ascribed to a number of factors. One of these could be that the cardinal cases of HIV in Nigeria were among females, therefore reinforcing the belief that HIV is spread primarily through heterosexual contact (Nasidi and Harry, 2006). Moreover, sociocultural, economic and political factors have been ascribed to the propagation of HIV/AIDS in Nigeria (Hellandendu, 2012). These sociocultural and political factors also reinforce the missing narrative regarding transmission through anal sex. Sociocultural factors here refer to traditional practices, such as dry sex<sup>3</sup>, high fertility preferences, male and female circumcision, traditional forms of grooming including ritual barbing, tribal marking and purification rituals<sup>4</sup>. Economic factors refer to rural-urban migration, living arrangements, opportunity for travel, employment opportunities and access to cash income (Hellandendu, 2012). Political factors refer to the initial AIDS denial of the government and reluctance to commence any HIV prevention initiatives. Additionally, according to the 2014 Global AIDS Response Country Progress Report, the key drivers of the Nigerian HIV epidemic were reported

<sup>3</sup> Dry sex refers to the traditional practice of using herbs, antiseptics or absorbents to dry vaginal secretions before sexual intercourse, it is believed to increase the enjoyment of sexual intercourse for the man

<sup>4</sup> Purification rituals refer to the requirement of the widow's husband's relations or friends to have sexual intercourse with her as part of 'purification'

to be low individual risk perception, multiple concurrent sexual partnerships, transactional and inter-generational sex, ineffective and inadequate access to quality HIV related healthcare services, with a substantial contribution from HIV related stigma and discrimination as well as gender inequalities and debilitating poverty (NACA GARPR, 2014).

The Antenatal Care (ANC) Sentinel Surveillance which measures HIV prevalence among pregnant women as well as the National HIV/AIDS and Reproductive Health Survey which assesses knowledge and risk behaviours in the general population have been the major sources of HIV surveillance in the country. In 2007, with subpopulations within the country gaining more importance in the HIV epidemic, the Federal Ministry of Health authorised the first Integrated Biological and Behavioural Surveillance Survey (IBBSS). This survey specifically measured HIV prevalence among Nigeria's MARPs<sup>5</sup>, at the state level (FMOH, 2007). A second round of the IBBSS was conducted in 2010 and the most recent round conducted in 2014. The states covered by the IBBSS included Kano, Kaduna, FCT, Rivers, Cross River, Enugu, Lagos and Oyo (FMOH, 2014). The IBBSS is conducted among groups who are classified as having high risk of contracting or transmitting HIV or any other STI because of their risk behaviours or their occupation (FMOH, 2010a; FMOH, 2014).

This new survey revealed previously unknown high-risk groups and also the sexual behavioural linkages among high-risk groups and the general population in Nigeria (FMOH, 2007) The mode of transmission study conducted in the country attributed 23% of new cases of HIV to the high-risk groups in Nigeria including FSW, IDU and MSM. Additionally, in 2009, MSM accounted for 10.3% of new infections in Nigeria (FMOH, 2010a, FMOH, 2014).

### **2.2.3 Antiretroviral treatment in Nigeria**

Antiretroviral treatment (ART) is defined by WHO as a combination of three or more antiretroviral (ARV) drugs used in treating HIV infection requiring lifetime adherence (WHO, 2016). Although ART was discovered in 1996 (Lange & Ananworanich, 2014) it was not introduced in Nigeria until the early 2000s (FMoH/WHO, 2003). Before the introduction of ART in Nigeria, the only available treatment was for opportunistic infections, which often involved palliative care (Daniel et al., 2008). In 2002, the

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<sup>5</sup> Nigeria's MARPs)

Nigerian government commenced its ART treatment program with \$3.5 million dollars' worth of antiretroviral drugs (ARVs) imported into Nigeria from India. This program was mandated to provide 10,000 HIV infected adults and 5000 children with ART before 2003 (Shaahu, Lawoyin and Sangowawa, 2008). Generic forms of Nevirapine, Lamivudine and Stavudine were distributed from 25 treatment centres spread across the six geopolitical zones of Nigeria (Iliyasu et al. 2005). These generic drugs cost approximately \$368 per person per year, and were subsidized at \$7 per person per year (FMOH, 2010b).

The ambitious Nigerian ART program was successful until 2004 when it experienced a shortage of ART supply, leaving patients without treatment for up to 3 months (Monjok et al., 2010). The program resumed again after the federal government procured ARV drugs worth \$3.8 million dollars. Four years after the inception of the ARV program, a program with the aim of providing ARV drugs to patients at no cost to them was introduced. This program served 250,000 HIV positive Nigerian citizens at 74 treatment centres spread across Nigeria (FMOH, 2010b). In 2010, the Nigerian ART program was the largest in sub-Saharan Africa and provided 300,000 HIV positive individuals with ARTs. However, approximately 1.5 million eligible patients remain without access to the treatment (Oku et al., 2014; Monjok et al., 2010; FMOH, 2010b). The ART coverage in Nigeria has also increased from 13% in 2011 to 22% in 2014, with approximately 747,000 people now having access to ART.

The Nigerian government prescribes National Guidelines for HIV/AIDS Treatment and Care biennially, as more potent treatments become available and to keep up-to-date with global best practices for HIV treatment (FMOH, 2010b). According to the 2010 guidelines, which retained some concepts from the 2007 guidelines, HIV infected individuals are recommended the use of a combination of at least two different classes of ARV. The recommended first line regimen for treatment includes either a combination of zidovudine (ZDV) or tenofovir (TDF) and lamivudine (3TC) or a combination of emtricitabine (FTC) and Nevirapine (NVP) or efavirenz (EFV) to be started by patients with CD4 cell counts of  $\leq 350$  cells/mm<sup>3</sup> irrespective of gender or patients who have WHO clinical stage 3 or 4 HIV irrespective of CD4 cell count (National Guidelines for HIV, 2010). Due to high and intolerable incidence of lipodystrophy, Stavudine was removed from the list of recommended ARVs for first

line regimen. The second line regimen remains the same with a protease inhibitor (PI) and a non-nucleoside reverse transcriptase inhibitor (NNRTI) (FMOH, 2010b).

HIV treatment falls into five groups of ARVs that attack HIV in a number of ways, they are, nucleoside/nucleotide reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI), protease inhibitors (PI), fusion or entry inhibitors (FI) and integrase inhibitors (II). While the NNRTI stop HIV from replicating within the cells by inhibiting reverse transcriptase protein, the PI impede protease, a protein involved in the replication of the HIV virus ((World Health Organization 2016; FMOH, 2010b).

#### **2.2.4 The Case for Men who have Sex with Men (MSM): Homosexuality in Nigeria**

The term ‘men who have sex with men’ (MSM) describes a sexual practice rather than a specific group of people and is the preferred term in the public health context (WHO, 2011). Additionally, because the sexual transmission of HIV is fuelled by high risk behaviour as opposed to sexual identity, the term ‘MSM’ encompasses the true identity of most African MSM. In the African context, MSM may constitute self-identified gay and bisexual men, men who do not accept their gender, men who engage in male-male sex but self-identify as heterosexual and finally, married and unmarried heterosexual men who engage in sex with other men (WHO, 2011).

In Nigeria, male same sex sexual practices are akin to homosexuality, which is considered to be an unnatural offence and is criminalised by Nigeria’s federal law. On December 17<sup>th</sup> 2013, the House of Representatives and Senate passed the *Same Sex Marriage (prohibition) Bill* and on the 7<sup>th</sup> of January 2014 President Goodluck Jonathan signed the bill (Anon, 2013). Under this law, any form of direct or indirect public display of affection between individuals of the same sex attracts a sentence of 10 years’ imprisonment. Furthermore, anyone who registers operates or participates in gay clubs, societies or organizations as well as anyone who witnesses or supports same sex weddings faces up to 10 years’ imprisonment. Finally, anyone who enters into a same sex marriage contract or civil union faces up to 14 years imprisonment (Same Sex Marriage (Prohibition) Act, 2014). In the 12 Northern states<sup>6</sup>, which operate under the

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<sup>6</sup> These states are Zamfara, Kano, Sokoto, Katsina, Bauchi, Borno, Jigawa, Kebbi, Yobe, Kaduna, Niger and Gombe

Islamic Sharia law, male same-sex acts are punishable with death by stoning (Global Legal Research Centre, 2014).

Prior to the passing of the Same Sex Marriage (prohibition) Bill, there was an already established hostile and intolerant atmosphere (Schwartz et al., 2015). However, immediately following, there were several reported cases of arrests and homophobic violence against the MSM group (AmnestyUK 2015). The result of the homophobic atmosphere is MSM going further underground and away from healthcare services. This is despite the fact that they are disproportionately affected by HIV.

Nigeria's MARPs<sup>7</sup> is estimated to constitute only 1% of the adult population in Nigeria but account for 23% of the HIV incidence in the total adult population (FMOH, 2010a; Charurat et al., 2015). These groups are also considered as KPs most vulnerable to HIV. Among all the KPs surveyed in the IBBSS, MSM were the only population that recorded an increase in HIV prevalence from 13.5% in 2007 to 17.2% in 2010 and most recently in 2014, 22.9% (FMOH, 10a; FMOH, 2014). These results demonstrate that despite the small size of the MSM population, they are still at very high risk of acquiring HIV. Table 2 below presents a summary of socio-demographic characteristics and markers of engagement with healthcare services of a total of 3611 Nigerian MSM sampled from Cross River, Enugu, FCT, Kaduna, Kano, Lagos, Oyo and Rivers as reported in the 2014 IBBSS study. The table shows that Nigerian MSM are young (23.6years), single and highly mobile. The high HIV prevalence of Nigerian MSM (22.9%) reflects a substantial increase from 17.2% in 2010. The 2014 IBBSS revealed that a high percentage (27.1%) of MSM access treatment from the pharmacies or chemists. In terms of source of HIV information, the study revealed that Nigerian MSM obtain information mainly from television and radio. While NACA had made a statement guaranteeing all Nigerian citizens access to HIV treatment, care and other healthcare services, many Nigerian MSM are unable to access healthcare services and only 18% had access to HIV prevention programming in 2010 (FMOH 2010a).

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<sup>7</sup>MSMs, FSWs and IDUs

**Table 1: Characteristics of Nigerian MSM**

<b>Mean Age: 23.6 years</b>	
<b>Characteristic</b>	<b>Percentage (%)</b>
Marital Status (Married)	4.4
Education (Tertiary)	28.3
Mobility (more than a month away from home)	51.7
HIV prevalence (2014)	22.9
Consistent Condom Use with all partners	49.0
<b>Sources of Treatment for STIs</b>	
Pharmacy	27.1
Public Hospital	25.3
Private Hospital	20.8
NGO	10.7
<b>Source of HIV information:</b>	
<b>Television and Radio</b>	76.8 and 77.9
<b>Internet</b>	29.8
<b>Healthcare Worker</b>	44.5

Source: (FMOH 2014)

## 2.3 Empirical Research

### 2.3.1 African MSM in the Literature

MSM in the literature and HIV programmes are defined as men who have sexual intercourse, either anal or oral, with other men, whether or not they self-identify as homosexual (Ayoola et al., 2013; Wolf et al., 2013; Henry et al., 2010). This definition is crucial in the understanding of African MSM, who may not self-identify as homosexual or gay but rather heterosexual. The term MSM is equally important in the context of public health and HIV/AIDS because it describes a behavioural phenomenon and not a specific population and also because one of the ways in which HIV is transmitted is through high-risk behaviours (Allman et al., 2007; Ayoola et al., 2013). Despite claims of homosexuality<sup>8</sup> being “un-African” and a Western or colonial import, there are a number of anthropological, epidemiological, clinical and sociological studies which document the occurrence of male same sex practices across the African continent dating as far back as the 17th century and before the discovery of HIV (Smith et al., 2009; Hoad, 2007; Sanders et al., 2007; Kiama, 1999).

In the Western context male same sex acts has long been recognized as a significant means of the transmission of HIV but its contribution to the HIV epidemic has only recently been noted in the African context (Bezemer et al., 2014; King et al., 2013). Over a decade ago, the first epidemiological study providing data on MSM vulnerability to HIV and STIs in SSA was conducted in Senegal (Wade et al., 2005). This study was conducted with the aim of understanding the vulnerability to HIV and other STIs of African MSM as well as the HIV epidemic in their group. The authors concluded that MSM in their study had a high prevalence of HIV, which may have been correlated with some high-risk behaviours including inconsistent and incorrect condom use during receptive and insertive anal sex and having multiple sexual partners (Wade et al., 2005). Another study conducted in Senegal reported the need for healthcare services and information which were non-stigmatising to MSM (Niang et al, 2003). Although there remains a paucity of research on African MSM, which has been attributed to the criminalisation of homosexuality, social exclusion, stigma by association and difficulty in reaching the population (Henry et al., 2010; Cáceres et al., 2008), these pioneer studies conducted in Senegal paved the way.

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<sup>8</sup> Or male same-sex sexuality



This section of the literature review presents empirical research on MSM across the African continent and in Nigeria. Majority of these empirical studies were quantitative in nature. Additionally, the section provides an overview of the HIV epidemic as well as high risk behaviours and health seeking behaviour that have been demonstrated to increase the susceptibility of African MSM to HIV. It concludes with accounts of the criminalisation, stigmatisation and discrimination of African MSM.

### **2.3.2 HIV Burden in African MSM populations**

Globally, sex between men accounts for an estimated 5 to 10% of HIV infections (Okal et al., 2009). While many African nations are reporting a decrease in the HIV prevalence in the heterosexual population, studies reveal a high and rising trend among African MSM populations. The MSM populations have more than three times higher HIV prevalence than the general population ( Nelson et al. 2015; Charurat et al. 2015; Magesa et al. 2014; Park et al. 2013; Saavedra et al. 2008). Park et al (2013) in their study found that across SSA, the pooled HIV prevalence among the general population was approximately 5% while in MSM population it was approximately 17.9%. In Kenya, studies reported that the HIV prevalence in the general population was 6.1% (UNICEF, 2013) while among MSM it ranges between 38% and 43% (Sanders et al., 2007). Specifically, in Nigeria, Vu and colleagues (2013) conducted a study in Abuja, Ibadan and Lagos, which revealed the HIV prevalence among MSM to be 4-10 times that of the general population.

Furthermore, evidence of rising prevalence of HIV among MSM were reported by Charurat et al. (2015), Holland et al. (2015) and Jobson et al. (2015). In Nigeria, for example, the most recent IBBSS conducted in 2014 revealed an HIV prevalence of 22.9% among the MSM population, this was a 5.7% rise from the HIV prevalence in 2010 and a 9.4% rise from 2007 when the survey was first conducted (FMOH, 2014; FMOH, 2007; FMOH, 2010a). This higher HIV prevalence observed in MSM populations compared to general population across Africa has been attributed to the high risk of HIV transmission associated with the practice of anal sex (Holland et al., 2015; Okal et al., 2009). Other risk factors responsible for the significantly higher HIV prevalence include poor HIV knowledge, testing and risk perception, poor access and utilisation of HIV testing, care and treatment facilities coupled with structural and social stigma, discrimination and the criminalisation of MSM. (Park et al., 2013; Vu, Adebajo, et al., 2013; Geibel et al., 2010; Saavedra et al., 2008; Niang et al., 2003).

In Jobson and colleagues (2015) review of MSM risk behaviour, HIV risk factors were categorized into the following:

**Drivers of HIV risk behaviours** are further broken down into broad level risk factors within the public policy and socio-cultural contexts and describe the criminalisation of same sex sexuality as well as widespread homophobia, stigmatisation and discrimination across most of sub Saharan Africa.

**Drivers of risk in MSM local environments**, which they subdivide into sexual identity, sexual behaviour and HIV risk, contexts of sexual interactions, MSM relationships, violence and male sex work and transactional sex.

High risk sexual behaviours that make MSM susceptible to contracting and transmitting HIV identified in the literature are listed and discussed in the section to follow.

### **2.3.3 High Risk Behaviours**

#### **2.3.3.1 Bisexual Partnerships**

Bisexual partnerships in the literature and according to Beyrer et al. (2010) have been defined as men having sex with at least a woman and man. Bisexual partnerships are common among African MSM with over two thirds reporting both male and female sexual partnerships (van Griensven, 2007). Sex with both men and women has been reported in studies of MSM in sub-Saharan Africa (Sekoni et al., 2015; Bezemer et al., 2014; Lane et al., 2011) with studies indicating that African MSM have frequent sexual and marriage partnerships with women (Sheehy et al., 2014; Dahoma et al., 2011; Geibel et al., 2010; Ntata et al., 2008; Niang et al., 2003). Researchers have attributed the trend of bisexual partnerships to the highly patriarchal African context, where men are expected to live up to social and cultural expectations of getting married and having children (Allman et al., 2007).

In three cities in Nigeria, Sheehy and colleagues found that 48.1% of the respondents reported bisexual relationships and high levels of risky sexual activity with the women with 66% of the men having unprotected vaginal sex and 56% having multiple casual partners (Sheehy et al., 2014). Studies conducted in other parts of Africa have shown similar results, with bisexuality ranging from 16.9% to as much as 88% (Aho et al., 2014; Park et al., 2013; Geibel et al., 2010; Niang et al., 2003). In Abidjan, Cote d'Ivoire more than half of the men self-identified as bisexual, while only 40.2%

reported as homosexual. Furthermore, 56.1% of the respondents reported having had vaginal sex with a female partner in the past year prior to the study, with 29% of them having had at least 3 female partners (Aho et al., 2014). Likewise, in Cameroon, almost half of the respondents reported bisexual activity in the previous 6 months before the study (Henry et al., 2010). Wade et al. (2005) in their study reported bisexual practices (94.1%) in almost all their study participants. So also in Angola, the most frequently selected category by participants in a study conducted by Kendall et al (2014) was the bisexual category, confirming that most men self-identified as bisexual.

However, in South Africa, where homosexuality is not criminalised and stigmatisation and discrimination of homosexuality are illegal, lower rates of bisexuality have been reported. In Cape town, for example, only 18% of MSM self-identified as bisexual and the average number of female partners 6 month prior to the study was less than 1 (0.49) (Baral et al., 2011). Baral and colleagues (2009), attributed the low bisexuality observed in the South African studies to be as result of a social and legal context that ‘tolerates’ homosexual men in this setting (Baral et al., 2009). In an attempt to conform to heteronormative expectations characteristic of African societies, these men may use a strategy described by Goffman as passing<sup>9</sup>, whereby they take up heterosexual roles (Goffman, 1963). Qualitative studies have revealed that while some of the MSM are attracted to females, others used their relationship with women to meet up to social and cultural expectations of being a heterosexual African man (Vu, Adebajo, et al., 2013; Kiama, 1999). Internalized homonegativity defined as the internalisation of negative beliefs about homosexuals by homosexuals themselves (Ross et al. 2013; Berg et al. 2013), has been linked with bisexuality and poor healthcare seeking practices among MSM (Vu et al., 2012). The implication of these bisexual partnerships, which seems to be the norm for most African MSM, is the potential for bridging between MSM populations and the general population, which has been reported in a number of empirical studies (Merrigan et al., 2010; Wade et al., 2005).

### **2.3.3.2 Multiple Concurrent Sexual Relationships**

Multiple concurrent relationships have been defined as having more than one sexual partner at the same time (Mah and Halperin, 2010). Multiple sexual concurrencies expedite the spread of HIV within sexual networks and also foster already established chains of transmission (Beyrer et al., 2010). Concurrent relationships are a major

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<sup>9</sup> Passing as conceptualised by Goffman is when individuals with an unknown stigma (in this case sex with men) “pass” as normal in public

determinant of high HIV prevalence observed in African MSM (Dahoma et al., 2011). In Cape Town, during the six month prior to the study, 17.1% of the respondents reported both male and female concurrent sexual partnerships with an average number of male sex partners of 4.1, while 17.7% of the study participants reported more than 5 male partners (Baral et al., 2011). In Malawi, the numbers were even higher with 50% of the MSM in concurrent sexual relationships (Wirtz et al., 2013). Likewise, in a study conducted in Cote d'Ivoire, respondents had a higher number of casual male partners than regular partners because of frequent "one-time" or "group sex" (Aho et al., 2014). Wirtz and colleagues (2013) attribute these short-term frequent relationships and high-risk behaviours to a need for the men to maintain clandestine same sex sexual partnerships in a sociocultural context, which opposes their sexual identity and behaviour.

### **2.3.3.3 Unprotected Anal Intercourse (UAI), Consistent and Correct Condom Use (CCU)**

Unprotected anal intercourse (UAI) has been described as inconsistent use of condom during receptive or insertive anal intercourse with a male partner (Aho et al., 2014). Baggaley et al. (2010) revealed in their study that unprotected receptive anal sex carries as much as 18 times the HIV risk as vaginal sex. In Nigeria, Vu, Andrinopoulos and colleagues (2013) found a correlation between UAI at last intercourse and being married or living with a woman and an even higher correlation with self-identifying as bisexual or straight as opposed to homosexual. In that same study, they found that 67% of the MSM who had female sex partners reported UAI at last intercourse (Vu, Andrinopoulos, et al., 2013).

Qualitative investigations have shown that perceived closeness and trust in sexual partner were important risk factors for UAI among MSM (Taegtmeyer et al., 2013; Henry et al., 2010). Henry and colleagues (2010) established in their study that not knowing HIV status, lack of exposure to HIV prevention services, hiding one's sexual orientation, having a high number of partner and frequency of sexual intercourse and finally, having had one female partner in the previous 6 months of the study to be factors associated with UAI (Henry et al., 2010). High use of oil based lubricants with or without condoms has been documented across African studies of MSM (Aho et al., 2014). The use of oil based lubricants is associated with condom breakage due to the decreased structural durability of condoms when used with the lubricants. However,

studies have reported high costs and low availability of water based lubricants as reasons for using the alternative oil based lubricants (Aho et al., 2014; Kendall et al., 2014, Ayoola et al., 2013).

Kendall et al. (2014) in their study conducted in Angola found that condom use was low among MSM and ranged from 11.5% with a transwoman partner and 36.1% with a male partner during anal or vaginal sex. In a study conducted in Cameroon, inconsistent condom use was even higher with 64.1% of the respondents reporting inconsistent use of condoms during intercourse with male partners and 48.5% with both male and female partners. Of those who used condoms, 90% used lubricants and 26.3% used lotions, saliva, Vaseline and other condom incompatible lubricants (Park et al., 2013). Participants in a study conducted by Taegtmeier and colleagues (2013) reported infrequent condom use, flat out non-use of condoms and simply not liking condoms. This study further revealed that participants had unprotected intercourse regardless of knowledge of their HIV seropositive status and because of their perception of unprotected sexual intercourse being more pleasurable than protected sexual intercourse (Taegtmeier et al., 2013).

#### **2.3.3.4 HIV knowledge, Testing and Risk Perception**

The literature is replete with evidence showing poor HIV knowledge, testing and overall risk perception among African MSM. According to the 2010 Nigerian IBBSS, only 33.1% of the MSM sampled correctly identified ways of preventing the sexual transmission of HIV and rejected the major misconceptions about HIV transmission (FMOH, 2010). Similarly, HIV knowledge in a study conducted in Cote d'Ivoire was low with only 38.8% knowing that anal sex carried a high risk of HIV transmission, even though anal sex was reported among 90.3% of the men in the past 12 months (Aho et al., 2014). For most of the MSM in the study conducted in Nigeria by Merrigan et al (2010), information about HIV came from either radio or television sources, a finding similar to that of the Niang et al (2003) study conducted in Senegal.

HIV testing among African MSM like HIV knowledge has been demonstrated to be low in a number of studies. MSM respondents in a study conducted in three cities in Nigeria<sup>10</sup>, had a trend of never testing for HIV (Vu, Andrinopoulos, et al., 2013). In this

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<sup>10</sup> These 3 cities were Lagos, Ibadan and Abuja

study, respondents from Ibadan were more likely not to test for HIV than those in Abuja or Lagos. This trend of never testing is not only observed in Nigeria but across African countries (Wirtz et al., 2013; Knox et al., 2011). For example, a study by Wirtz et al (2013), 94.1% of the participants who had previously been undiagnosed, did not know their HIV status or self-reported as being negative because they had never been tested for HIV.

A contributing factor to the disproportionately high HIV epidemic among African MSM populations and their sexual network is their low HIV risk perception. The study by Merrigan et al. (2011) showed a low risk perception of HIV among Nigerian MSM participants. Likewise in the study conducted by Baral and colleagues (2009), though participants reported that their biggest health risk was HIV/AIDS, they were more likely to report that HIV is more likely to be transmitted through vaginal intercourse than anal intercourse, showing a link between poor HIV knowledge and risk perception. Some common myths like the belief that anal sex is less risky than vaginal sex or sex with a woman carries a higher risk of HIV, or bisexual men are more at risk for HIV, are shown to reduce the MSM risk perception and increase risk behaviour (Taegtmeier et al., 2013; Kajubi et al., 2008).

#### **2.3.3.5 Sexual Identity among African MSM**

African MSM in the literature identify with a range of sexual identities on the heterosexual-homosexual continuum. African MSM also involved in sexual partnerships with women are likely to refuse ideas of same sex sexuality and identify more with their heterosexual counterparts (Sanders et al., 2007). This observation is most prominent in cultural contexts where there is a distinction in terms used to describe men who have sex with men exclusively (MSME) and those who have sex with women (MSMW). In Kenya for example, MSME who are receptive in anal intercourse are sometimes referred to as queens in local terminology or "basha" and are likely to self-identify as homosexual, while MSMW are sometimes referred to as kings or "shoga" and are likely to self-identify as straight as well as reject associations with homosexuality (Moen et al., 2014; Sanders et al., 2007).

Though the association remains unclear, studies in Malawi and Swaziland, showed that men who reported being gay or bisexual and engaged in anal sex also reported they were not male and quite often separated gender and sexual identities (Kennedy et al.,

2013; Wirtz et al., 2013). Some African MSM may not think of sexual intercourse with other men in terms of gender identity or sexual proclivity and may just identify using local terms that describe sexual proclivity. This may be because they take on the penetrative role in anal sex, engage in male same sex practices recreationally or for money, engage in sexual intercourse with females as well or are married (Wolf et al., 2013).

#### **2.3.4 Criminalisation, Stigmatisation and Discrimination of African MSM**

“Any person who has carnal knowledge of any person against the order of nature...or permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony, and is liable to imprisonment for fourteen-years” (Same Sex Marriage (Prohibition) Act, 2014).

The above is an excerpt from the existing Same Sex Marriage Prohibition Act (SSMPA)<sup>11</sup> in Nigeria, which criminalizes consensual same-sex sexual activity in both private and public spaces. In addition to the criminalisation of homosexuality, the SSMPA prohibits marriage and civil unions between same sex couple and only recognises marriage and civil unions between a man and a woman (Global Legal Research Centre, 2014). Aside from Nigeria, homosexuality is also criminalised in 35 African countries, with 4 of them (Northern Nigeria, Mauritania, Sudan and Southern Somalia) imposing the death penalty (Magesa et al., 2014; McAdams-Mahmoud et al., 2014; Taegtmeier et al., 2013; Altman et al., 2012).

The daily lived experiences of African MSM are replete with accounts of rebuttal, stealth, stigmatisation and discrimination as a result of the criminal laws forbidding same sex activities (Allman et al., 2007). Criminalisation of individuals has been reported to have either a direct or indirect effect on overall health and wellbeing, including HIV care seeking practices (Jobson et al., 2015). This point has been demonstrated in a number of studies including that of Risher and colleagues (2013), who established a strong association between their participants' fear of seeking healthcare and having previously experienced legal discrimination.

All participants in a study conducted in Cote d'Ivoire reported that they had experienced some form of violence, stigma and discrimination from family, friends, co-workers or

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<sup>11</sup> Chapter 21 articles 214 and 217 of Nigeria's criminal code, criminalizes same-sex consensual relationships

strangers as a result of their sexual orientation (Aho et al., 2014). One participant in describing his experience of stigmatisation stated,

*“Our close neighbours, they're always bad-mouthing, slandering. They generally say that gays are damned, they are losers, aliens. Being gay is synonym of all that is negative, of all that is lost in this world. He is a synonym of malediction and horror”- Unemployed man, 32 years' old*

A qualitative study conducted in Kenya revealed that MSM often experienced police harassment, arbitrary arrests and extortion of money for sexual services as well as verbal and physical abuse from members of the society (Okal et al., 2009). Similarly, in Malawi, Namibia and Botswana, between 5 and 10 percent of the MSM sampled had been denied housing for reasons other than their inability to pay, while 17.6%, 18.3% and 20.5% respectively reported fear of seeking healthcare on the basis of their sexuality (Baral et al., 2009). In a study conducted by Kendall et al. (2014) in Angola, 70.4% of the participants reported episodes of homophobia and discrimination as a result of sexual orientation, with 40.1% reporting that these events had occurred at work, school, business or recreational areas. Likewise, in the study by Wirtz et al. (2013), an excess of 20% of the participants reported perceived and experienced stigma and discrimination with 7% reporting being raped and 11.4% reporting physical violence in the past. Furthermore, over 10% had reported physical abuse from friends, acquaintances, partners or strangers because of their sexual orientation.

Although both the social and legal context for homosexuals in South Africa is less oppressive due to laws protecting homosexuals and HIV infected individuals, stigmatisation and discrimination are still a part of the daily reality of MSM in the country. For example, in a peri-urban township in Cape Town, 5% of the sample reported that they had been denied housing or health care, while 10.5% reported blackmail, 8% reported having been beaten by a police or government official because of their sexual orientation, 11% reported rape by a man and an overall 24.5% reported experiencing at least one human rights violation (Baral et al., 2011).

The criminalisation, stigmatisation and discrimination of MSM have severe public health and social implications of human rights violation, including a significant increase of the HIV prevalence among MSM. It has been noted that criminalisation, stigmatisation and discrimination of MSM may lead them to travel to more distant clinics where they can retain anonymity in their social environment (Risher et al., 2013;



Wolf et al., 2013; Cloete et al., 2008). Additionally, stigmatisation and discrimination may lead to fear of seeking HIV related services as well as delayed health care seeking, denial of care, poor access to HIV related services, poor medication adherence and blackmail, all of which have been demonstrated to prevent MSM from engaging with HIV related health care services (Aho et al., 2014; Fay et al., 2011; Knox et al., 2011).

In a study conducted in Tanzania by Anderson et al (2015), participants reported experiencing four types of abuse: physical, verbal, moral and sexual from family members, partners, neighbours, co-workers and the police. Participants who were more likely to self-identify as gay/homosexual experienced the highest level of violence and there was a significant relationship between HIV status and higher level of violence.

Wolf et al. (2013) stated that the implication of self and enacted stigma and discrimination is the production of disabling obstacles to accessing prevention, care and treatment services by African MSM. Due to enacted stigma, MSM are hindered and discouraged from not just accessing and utilizing health care services (Baral et al., 2010; Poteat et al., 2010). Papworth et al. (2013), contend that key populations [including MSM] are restricted from accessing suitable healthcare as a result of criminalisation and public neglect as well as policy level gaps and community level stigma. Like Wolf and colleagues (2013), they argue that these issues have to be addressed if the health care needs of the population are to be tackled.

Sekoni et al. (2015) maintain that when the rights of individuals are not recognized they lack incumbent support from their families and societies, thereby putting them at higher risk for poor health outcomes. Additionally, individuals who face social exclusion as a result of discrimination tend to have fewer economic opportunities and are susceptible to both poor physical and mental health (WHO, 2001).

### **2.3.5 Engagement with Health Care Services**

#### **2.3.5.1 Health Services Access and Utilisation**

Despite access to healthcare being a highly complex concept, many attempts have been made at conceptualising it. Although, there is a general understanding and consensus that access describes factors which influence the initial utilisation of healthcare services, there has been disagreement on which aspects make up the concept and if more importance should be given to the characteristics of providers or the process (Frenk, 1992). Access to healthcare services has been defined in terms of the attributes of

healthcare services (Salkever, 1976), the 'fit' between characteristics of providers and healthcare services and characteristics and expectations of healthcare service users (Penchasky and Thomas, 1981), healthcare resources that influence the utilisation of healthcare services (Donabedian, 1973) and the use of healthcare services qualified by the need for those services (Waters, 2000).

Access according to Adey and Andersen (1974) is entry into the healthcare system and takes into consideration dimensions such as predisposing, enabling factors and need for healthcare. However, access goes beyond merely gaining entry into healthcare system and warrants a renewed understanding. This warranted a renewed conceptualisation of access by Levesque et al (2013). Using a patient-centred approach, they defined access as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled" (Levesque et al, 2013). From this definition, access to healthcare services is realised when HIV positive MSM and other disadvantaged groups are able to identify their healthcare needs, comfortably seek healthcare services, reach and obtain adequate and appropriate services and have their needs fulfilled. The definition proffered by Levesque et al (2013) provides the working definition of access to healthcare in this thesis.

### **2.3.5.1a Factors That Shape Access to Healthcare services**

A number of factors have been suggested to shape the extent to which access to healthcare services is realised. These factors have considered individual, social, economic and geographic attributes. The Andersen's behavioural model of health service utilisation or Andersen's model (1995), for example, is among the pioneer models and consists of four domains, environment characteristics, population characteristics, health behaviour and outcomes which shape access to healthcare. In this model, the environment and population characteristics shape health behaviours and invariably, health outcomes (Guilcher et al. 2012). Another model postulated by Carrillo et al (2011), the Health Care Access Barriers Model (HCAB) differs from Andersen's model in that it considers only the modifiable healthcare access barriers, financial, structural and cognitive as factors which shape access to healthcare services. These factors according to Carrillo et al (2011) correspond with decreased screening, late presentation to care and lack of treatment, which generally result in reduced health

outcomes. Financial access barriers in this instance are barriers pertaining to the cost of care. Structural factors are institutional and organisational barriers such as availability of care, transportation and waiting times. Cognitive barriers are those barriers pertaining to knowledge and communication such as awareness of prevention, health literacy, understanding of diagnosis and treatment as well as availability of interpreter services and translated materials (Carrillo et al 2011). Important to note is that each of these barriers, financial, structural and cognitive reinforce one another and are able to impact healthcare access individually as well as concurrently.

In low-middle income contexts similar to Nigeria factors that shape access include financial, organisational and structural. These factors are similar to those postulated by Andersen (1995) and Carrillo et al (2011) however, they may have greater impact on access to healthcare because of the less developed healthcare systems as well as individual beliefs. A literature review of factors that shape access to healthcare among poor and vulnerable populations in Uganda revealed factors related to both the supply and demand side (Kiwauka et al 2008). These factors included perceived poor quality of services, lack of drugs, poor knowledge and awareness, cost, distance, lack of time, lack of referrals, long waiting times, poor healthcare worker attitude, dear, male dominance, cultural beliefs and poor infrastructure (Kiwauka et al 2008). Musoke et al (2014) in their Uganda study added other factors that shape access to healthcare. Such factors including illiteracy, poverty, under funding of the health sector, inadequate water and poor sanitation facilities are unique to developing countries because of their developing healthcare systems. A study conducted in Nigeria by Ibiwoye and Adeleke (2008) proposed that an important barrier to access that should not easily be dismissed in developing countries is internal inefficiency. They further suggest that cost is the factor that has the most impact on shaping access to quality healthcare.

Pertaining to marginalised populations such as men who have sex with men, factors such as stigma, discrimination, fear of persecution coupled with those existing factors which shape access in developing contexts may negatively impact the extent to which they are able to negotiate access into the healthcare centres (Lane et al, 2008; Wirtz et al, 2014; Park et al, 2014; Charurat et al 2015). These studies propose that for marginalised populations environmental, social, structural, health service delivery, process barriers and economic barriers may shape how these individuals access healthcare (Scheer et al, 2003; Levesque et al, 2013; Roberts and Fantz, 2014). A study

of gender nonconforming people in the United States conducted by Cruz (2014), revealed that participants postponing healthcare seeking did so due to stigma, discrimination and affordability. This finding was corroborated by another study conducted by Gonzales and Henning-Smith (2017) in the US on access barriers for gender nonconforming individuals. This study revealed how employment-based discrimination poses an economic barrier by preventing them from getting health insurance which results in their inability to access quality healthcare (Gonzales and Henning-Smith 2017). In other cases, factors such as fear of prognosis, shyness, perceived stigma and confidentiality concerns shaped the access to healthcare (Rispel et al 2013; Bowring et al 2015; Shaver and Stephenson 2016). Specifically, for gender nonconforming men, when healthcare services were available it was the availability of services that cater to their unique healthcare needs which posed a barrier to accessing healthcare services (Lane et al 2008; Bowring et al 2015; Rosenkrantz et al 2017). In this case, normative societal and cultural ideologies of how masculinity and sexuality should be expressed and enacted shape the extent to which these individuals are able to negotiate access and navigate the healthcare system.

### **2.3.5.1b Socio-Cultural Context in Nigeria and How it Shapes Access to Healthcare Services**

Religion has been described as the “prime site for construction of gender as well as sexuality” (Pereira and Ibrahim, 2010). This is the case in Nigeria where the social and legal contexts are heavily regulated by religious and cultural norms (Ojo 2007; Obadare 2015). Nigeria is a pluralistic country where adherents of the three major religions Islam, Christianity and African Traditional Religion, coexist (Kitause and Achunike, 2013). Sexual behaviour is controlled by these three major religious groups, which set their regulations to assess their adherents’ loyalty to their religious doctrines and determine the extent to which they are spiritually mature (Ojo, 2005). ‘Sex drives’ in both Islam and Christianity are seen as natural and solely for marriage and more importantly, reproduction (Ojo, 2005; Pereira and Ibrahim, 2010 ). It is perhaps for this reason, that homosexuality is vilified (Pereira and Ibrahim, 2010). As was discussed in Section 2.3.4, this vilification of homosexuality is a major reason for the criminalisation and subsequent discrimination, stigmatisation and extreme violence against gender nonconforming individuals, which shape the extent to which they are able to engage with healthcare.

In Nigeria, the 'hegemonic' form of masculinity is the heterosexual male (Uchendu 2007; Groes-Green 2009). This form of masculine expression is strictly regulated, evidence of which is the anti-homosexuality bill that criminalises sexual relations between individuals of the same sex. The society can also be said to be highly heteronormative in the sense that it privileges heterosexuality over homosexuality and assumes heterosexuality to be the norm (Page and Peacock, 2013; Gaudio 2014). In this heteronormative context once a man reaches a certain age, social and cultural expectations require that he gets married to a woman and they procreate (Ikpe, 2004). Although the social system seems to be shifting, the Nigerian context remains highly patriarchal, in the sense that male agency is privileged not just over the female but over other male figures who do not quite meet the standard (Izugbura, 2004; Asiyanbola, 2005; Ouzgane and Morrell, 2005; Essien and Ukpong, 2012; Makama, 2013). This standard is dictated partly by social, cultural and religious systems which posit male dominance, where the man makes the majority and the most important decisions in society and holds power and authority (Balogun and Bissell, 2018). Beliefs that an African man should portray strength and power and should not seek health pose a barrier to accessing healthcare services (Varga, 2001; Piere 2007). This has been demonstrated through several studies that have assessed men's help seeking behaviour (Mahalik et al 2007; Cheatham et al 2007; Pearson and Makadzange 2008; Farrimond 2012; Vogel et al 2011; Nyamhanga et al 2013).

There remains a paucity of empirical qualitative research on access to healthcare services among Nigerian MSM. Where studies have been conducted, they have been with aim of characterising the HIV epidemic in the MSM population as well as identifying risk behaviours, documenting the social acceptance of Nigerian MSM and assessing the impact of stigmatisation, discrimination and criminalisation on Nigerian MSM (Allman et al., 2007; Merrigan et al., 2010; Sathane et al., 2016; Okanlawon et al., 2013; Vu, Andrinopoulos, et al., 2013; Sekoni et al., 2015; Adebajo et al., 2015; Schwartz et al., 2015; Keshinro et al., 2016). Most recently, Crowell and colleagues (2017) conducted a study characterising access to healthcare among men who sell sex to men (MSS) (a sub population of MSM) in Nigeria. This quantitative study provided evidence that MSS were more likely than MSM to avoid seeking healthcare services because they engaged in sexual intercourse with other men (Crowell et al., 2016).

Studies across Africa have also shown that MSM avoid accessing healthcare services mainly because of the fear of prejudice, stigma and denial of healthcare services (Niang et al., 2003; Baral et al., 2011; Lane et al., 2011; Kennedy et al. 2013; Okanlawon et al., 2013; Hunt et al., 2017; Muller, 2017). For example, participants in Niang et al, study delayed seeking healthcare for STIs and concealed their STIs because of fear that their sexual orientation would be exposed. Wolf et al. (2013) in their study revealed that African MSM delay healthcare seeking and when they do not delay, they are often reluctant to disclose their sexual histories or preferences to HCPs because of fear of rejection, ridicule or other negative reactions. They further argue that access and coverage of HIV services for MSM are insufficient to reverse the epidemic among the population and there is a need for provision of targeted structural, behavioural and biomedical services for the benefit of both the MSM population as well as the general population. A recent study conducted in Zimbabwe reported that equal access to healthcare services for MSM was contingent upon conforming to heterosexual norms and many times healthcare workers displayed overt discrimination to heterosexually non-conforming men (Hunt et al, 2017). As a result of the tough decisions MSM face when seeking healthcare services from both public and private healthcare providers, they resort to seeking health services from quack or untrained doctors or self-medicate (Okanlawon et al., 2013; Muller, 2017).

Rispel et al. (2011) in their study conducted in South African cities identified barriers to MSM health service utilisation, which they categorised as structural and/or individual factors. The structural factors identified were a lack of targeted health care services, services aimed at only heterosexual populations, poor healthcare providers, stigmatisation and discrimination. While the individual factors included not testing for HIV or utilising health services, non-disclosure of sexual orientation and poor awareness of health related information. In Uganda, Wanyenze and colleagues (2016) also reported several barriers to accessing HIV healthcare services among MSM. In their study, a little over half of the participants experienced difficulty accessing healthcare services with the main challenges being stigma associated with being MSM, inability to finance care, and a lack of healthcare personnel to handle their specific healthcare needs. Furthermore, a majority of participants strongly agreed with the statement “I am not comfortable explaining my sexual practices and related illnesses to health workers” and felt that health workers would not attend to them if they knew they were MSM. Additional qualitative findings reported by participants included the fear of

being segregated or exposed as MSM at healthcare facilities, limited access to MSM-specific services, and high mobility of MSM which made accessing healthcare services difficult. MSM in this study mentioned that the harsh legal context for MSM, made it difficult for organisations that support them to print out health education materials tailored to their population (Wanyenze et al., 2016). Wolf and colleagues (2013) proposed that there is a need for focused services for key populations (KP) in African countries where majority have mixed epidemics.

Park et al. (2013) in their study showed a correlation between fear of seeking healthcare and nondisclosure of sexual preferences to a HCP and between higher sexual risk behaviour and higher likelihood of being HIV seropositive. Non-disclosure of sexual preferences in this study was as a result of perceived stigma and enacted discrimination in the form denial of healthcare (Park et al., 2013). Risher et al. (2013) explained that fear of seeking health care may be a form of perceived stigma and the avoidance of health care may be a coping mechanism used in dealing with enacted stigma and denial of healthcare. Participants in many of these studies reported discomfort in sharing their sexual orientation or gender identity with healthcare workers because of their poor attitudes. A study conducted by Hunt et al (2017) revealed that healthcare workers attitudes were based on their religious beliefs and prejudices against MSM. This study further reported that it was as a result of lack of knowledge as well as experience of working with MSM that healthcare workers often stigmatised MSM clients. This is not surprising given that a lot of African countries are religious and healthcare workers from these countries may not be adequately trained to cater to the needs of MSM.

A Tanzanian study conducted to understand access to healthcare among MSM identified four themes: becoming third class citizens in healthcare; “appraising perceived threats related to one’s sexuality”, “balancing the seesaw of visibility” and “seeing public healthcare as the last resort” (Larsson et al, 2016). In the first theme identified, MSM reported their experiences of discrimination and threats of denial of treatment as well as the general unwelcoming treatment they got from healthcare workers who used derogatory words when addressing them. In the second theme identified, participants reported feeling discouraged to seek healthcare services particularly because they lacked the ability to protect themselves if their sexual practices became known. In the third theme identified, participants described how they adapted several strategies to avoid their sexual practices being revealed. They further expressed that although they

had to pay for the services they received they preferred accessing healthcare services from private hospitals. They believed that they received better and friendlier treatment because they were paying for their treatment. In the final theme, participants expressed that they accessed treatment from pharmacies because it was more convenient and they were not queried about their symptoms and source of infection (Larsson et al, 2016)

Lane et al. (2008) in their study found that MSM who self-identified as gay had the tendency to seek health care from providers who recognize the need to respect their privacy, while those who were either bisexual or self-identified as straight had the tendency to present as heterosexual and avoid talking about their sexual orientation with the HCW. Stereotypically, an African man is strong and does not display any form of fragility, even when suffering from an illness. This propensity to live up to society's idea of masculinity may result in poor health seeking for the African MSM who want to live up to the expectations of his heteronormative society (Sekoni et al., 2015).

#### **2.3.5.2 Adherence to ART**

The World Health Organization (WHO) defines antiretroviral treatment (ART) as a treatment that suppresses HIV replication, reduces the likelihood of viral resistance and increases the survival of individuals infected with human immunodeficiency virus (HIV) (Who.int, 2015). ART, according to the Department of Health and Human Services (DHHS) guidelines, is further defined as a

‘...Regimen containing at least 3 antiretroviral drugs- 2 nucleoside reverse transcriptase inhibitor (NRTI) medications plus a protease inhibitor (PI), a nucleoside reverse-transcriptase inhibitor (NNRTI), or an integrase strand transfer inhibitor (INSTI)’(DHHS, 2013) to be taken daily for the rest of the patient's life (Viswanathan et al, 2015).

Participants of the World Health Organization (WHO) Adherence meeting defined adherence as “the extent to which the patient follows medical instructions” (Sabate, 2001). The implication of this definition being that the patient passively follows the healthcare provider's instructions. It is however understood that adherence is a dynamic and active process, which involves good patient-provider relationships (Sabate, 2003) and goes beyond mere medication taking and extend to a number of other health behaviours such as maintaining a balanced diet and getting adequate rest.



Following this, a new definition of adherence to long term medication was adapted by WHO from a combination of Haynes' (1979) and Rand's (1993) definitions. Adherence was now defined as

“The extent to which a person's [health] behaviour- taking medication, following a diet, and/or executing lifestyle changes- corresponds with agreed recommendations from a health care provider” (Sabate, 2003).

In the more specific context of HIV, adherence to antiretroviral treatment is considered to be the “ability of the person living with HIV/AIDS to be involved in choosing, starting, managing and maintaining a given therapeutic medication regimen to control HIV replication and to improve immune function” (Glass and Cavassini, 2014).

ART was introduced as the standard care, globally in 1996, and since then it has changed HIV from a death sentence to a manageable chronic disease (Kobin and Sheth, 2011; Bartlett, 2002). More specifically, in Sub-Saharan Africa there has been a large scale up of ART, through global health initiatives such as the U.S. President's Emergency Program for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) (UNAIDS, 2008). The implication of the large scale up is increased access to ART, and that treatment is readily available to more people who must take it consistently to ensure its sustained potency (Monjok et al, 2010). Like the WHO recommendation, the Nigerian National Guidelines for HIV and AIDS Treatment and Care, require all persons eligible for ART be prescribed as soon as possible and in a comprehensive manner, meaning the individual should also have access to HIV counselling, laboratory tests, management of opportunistic infections (OIs), routine treatment and follow up.

The benefits of maintaining optimal adherence to ART include: achieving the virologic goal of ART, reducing the chances of developing resistance to the treatment, reducing the chances of transmitting resistant virus to others, halting disease progression and death and finally, improving overall quality of life (Nachega and Mills, 2007). Virologic goal, which is the rapid and sustained suppression of viral load to an undetectable level of 50 copies/mL or below, requires not only the attainment but maintenance of optimal adherence (Glass and Cavassini, 2014).

Paterson et al. (2000) in their pioneer study showed that unlike other chronic disease medication, a high level of adherence ( $\geq 95\%$  adherence) has to be maintained over the

course of an HIV positive patient's life in order for the antiretroviral regimen to work effectively. Since this discovery, an adherence level of 95% or greater was recommended (Paterson et al., 2000; Bangsberg et al., 2003). However, more recent evidence revealed that the Patterson et al study was conducted using older unboosted PIs, and that the benefits of ART could be attained at a lower level of adherence of 80% using more potent modern ART regimen such as boosted PIs and NNRTIs (Viswanathan et al., 2015; Shuter, 2008; Nachega and Mills, 2007).

In a study with a group of mostly non-white male IDUs living in California, those on NNRTI achieved viral suppression of <400 copies/mL at 54% to 100% adherence, while those on PIs achieved viral suppression of <400 copies/ml at 95% to 100% adherence, showing that viral suppression could be achieved more easily on NNRTI (Bangsberg, 2006). In a similar study conducted in the United States with MSM taking ART, only 80% treatment adherence was needed for viral suppression on boosted PIs, compared to IDUs on older unboosted ART regimen, who needed to maintain a level of more than 95% treatment adherence to achieve viral suppression (Viswanathan et al., 2015). The general consensus after these studies was that depending on the ART regimen prescribed a high level of adherence to ART should be maintained (Bartlett, 2002; Orrell et al., 2003b; Uzochukwu et al., 2009).

In addition to ART suppression and viral replication, ART is also one of the proven ways of limiting transmission of HIV apart from consistent condom use. Antiretroviral treatment has been demonstrated to stop transmission of HIV by stopping viral replication and lowering the amount of virus in the genital compartments (Cohen & Gay, 2010; Fidler et al., 2014) by decreasing the HIV viral load in genital fluid and serum, which determine both sexual and vertical transmission of HIV (Katz et al., 2002). Additionally, Cohen and colleagues (2011) revealed in the pivotal HPTN 052 randomized clinical trial, that HIV transmission through vaginal sex could be reduced by 96% if the HIV infected partner took ART early and consistently. More recently, in 2010, the Partners Study, which included both European homosexual and heterosexual serodiscordant couples, demonstrated zero transmission of HIV when the HIV positive partner had undetectable viral load (Rodger et al., 2016).

Studies conducted in both developed and developing countries have identified a number of factors responsible for non-adherence and have categorized them into four themes:

regimen/medication related, social and psychological, institutional/healthcare system related and patient related (Heyer & Ogunbanjo 2006; Mills et al. 2006; Roberts et al. 2014). Regimen related factors that influence adherence include the complexity of the regimen, side effects, pill burden, toxicity, combination of drugs and belief that the medication works and have been cited as reasons for poor adherence (van Servellen et al. 2002; Mills et al. 2006; Uzochukwu et al. 2009). Institutional factors include patient-provider relationship, drug stock-outs and financial barriers to purchasing drugs (van Servellen et al. 2002; Mills et al. 2006; Uzochukwu et al. 2009). Patient related factors include mental health, self-efficacy, treatment attitudes, socio-economic factors, forgetfulness and financial barriers (van Servellen et al. 2002; Mills et al. 2006; Uzochukwu et al. 2009). These factors make it increasingly difficult to maintain the high level of adherence required to benefit from ART (Miller and Hays, 2000).

Access adherence to treatment has been demonstrated to be crucial for community viral suppression (Holland et al., 2015; Papworth et al., 2013). Furthermore, Park et al. (2013), maintain that access to ART for MSM is an important tactic for reducing transmission in their sexual networks. However, there remains a dearth of empirical research on ART coverage in the MSM population and MSM specific barriers which impede the utilisation or adherence of ART by African MSM. MSM face great challenges adhering to ART, which has the potential to reduce treatment response (Graham et al., 2013). Studies conducted in Nigeria and Cameroon have shown that ART coverage is low and when ART is available a majority of the HIV positive individuals do not use them (Charurat et al., 2015; Holland et al., 2015b), thereby indicating poor utilisation of ART. In the Holland et al (2015) study for example, only a quarter of MSM were taking ART when over 500 MSM and FSW were eligible for treatment. Challenges of maintaining optimal adherence to ART have been attributed to stigma, discrimination and social isolation of MSM (Graham et al., 2013). In a study conducted by Cloete et al (2008) in South Africa, respondents reported taking ‘cocktail breaks’<sup>12</sup>. These cocktail breaks have a deleterious effect on the health of HIV positive individuals on ART and can result in the development of treatment resistant strains of the HIV virus rendering the treatment ineffective<sup>13</sup>. Even though this is an issue also common with the general population, it may be particularly relevant to MSM populations given the higher impact it would have on their ability to adhere.

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<sup>12</sup> “Cocktail breaks” refer to taking breaks from ART regimen

<sup>13</sup> ART requires at least 95% adherence for the duration of the individuals life to work effectively, this is discussed in more detail in Section 2.4

Additionally, respondents in the study disclosed that they engaged with alternative forms of treatment rather than strictly to ART (Cloete et al., 2008).

### **2.3.6 Stigma and Discrimination**

#### **2.3.6.1 Defining Stigma**

As reported above, stigma and discrimination have both been cited as reasons for poor MSM engagement with healthcare services. Since Erving Goffman's (1963) conceptualization of stigma in his seminal work, the term has been conceptualized in various ways by researchers from key behavioural science disciplines. The stigma theory is eminent in the HIV/AIDS literature as well as literature on marginalized populations like MSM. All conceptualizations of stigma have in one way or the other expatiated on Goffman's initial conceptualization of stigma or sought to put it to test (see Kurzban and Leary, 2001; Link and Phelan, 2001; Jones et al., 1984; Page, 1984; Katz, 1981).

The term stigma has its origins in ancient Greece where it was used to describe tattoo marks that were either cut or burned into the skin of individuals who devoted their lives to service of the temple (Goffman, 1963). Later, it came to have a more secular symbolism that which distinguished slaves or criminals as outcasts and as individuals to be avoided (Goffman, 1963). The use of this term is also noted in early orthodox Christianity, initially to describe bodily markings, which correspond to the crucifixion wounds of Christ and then much later to represent unholiness (Osborne, 1974). Today, it has come to signify blemishes either visible or invisible, undesired attributes and disgrace, consistent with its Greek origins (Herek, 2004).

In Goffman's definition of stigma, he describes an individual who is "reduced in our minds from a whole and usual person to a tainted discounted one" as a result of the discrediting attribute(s) (Goffman, 1963 p.12). Goffman maintains that stigma should be understood from "a language of relationships not attributes" (Goffman, 1963 p.12). The implication of this is that an attribute, which is considered stigmatizing to an individual or in a particular cultural context, may not be considered stigmatizing in another. Jones et al (1984) definition of stigma as an attribute that ties an individual to stereotypes, offers a conceptualization that links the attribute to a stereotype.

According to Scambler (2009) the stigmatised individual is one

“who [is] pejoratively regarded by the broader society and who [is] devalued, shunned or otherwise lessened in [his] life chances and in access to the humanizing benefit of free and unfettered social intercourse” (p.218)

Similarly, Katz (1981) offers a definition of the stigmatised as an individual who possesses

“[...] attributes that do not accord with prevailing standards of the normal and good [and are] often denigrated and avoided-openly in the case of known criminals and other transgressors, or covertly and even unconsciously [...] when the disdained person is an innocent victim of misfortune” ( p.1)

Crocker et al. (1998) also defined the stigmatised as an individual whose

“social identity, or membership in some social category, calls into question his or her full humanity-the person is devalued, spoiled or flawed in the eyes of others” (p.504)

These definitions of stigma and the stigmatised individual take into account both the intentional and unintentional discrediting of individuals.

Although Goffman’s definition of stigma has been regarded as the most original it was critiqued by Link and Phelan (2001) to be too individualistic, focusing solely on the stigmatised individual. This resulted in their conceptualization, which integrated labelling, stereotyping, separating, status loss and discrimination (Link and Phelan, 2001). They defined stigma as existing when “elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (Link and Phelan, 2001 p. 377).

Link and Phelan’s (2001) definition of stigma takes into consideration the interaction between powerful and powerless groups in societies and how powerful groups may use their control of resources to exploit the stigmatised powerless, which indicates that stigma does not lie within an individual but in the social context and is especially prominent in situations where there are scarce economic resources (Major and O’Brien, 2005; Becker and Arnold, 1986).

Against this backdrop, power may be religious or political characterized by high status, wealth or social dominance and may be confined to a selected minority or majority (Becker and Arnold, 1986). Link and Phelan's definition is similar to that of Parker and Aggleton's (2003) which is a social process that works together when culture, power and difference are involved. This reference to power in the definition of stigma is very important as it makes it a much focused and easier to analyse concept and also provides a rationale for stigmatisation (Major and O'Brien, 2005; Gilmore and Somerville, 1994).

It is important at this point to note that these definitions of stigma have a commonality, which is the assumption that individuals who are stigmatised possess a characteristic that is devalued by the greater society (Major and O'Brien, 2005). Furthermore, Stafford and Scott (1986) note that common among all stigmatised individuals is that their devalued identity "generate ridicule and scorn" (p.77). Whether it is an HIV positive individual or a Nigerian MSM, both possess characteristics that make them subject to disdain in the Nigerian context and are regarded similarly in almost every society, culture and context. Thus, stigma does not lie in an individual but in the social context (Major and O'Brien, 2005). According to Becker and Arnold (1986), another common feature of the stigmatisation process is social stratification, which makes class differences salient in the stigmatisation process.

Ainlay et al. (1986), state that stigma is difficult to define because of its nebulous nature. Moreover, attributes which individuals find discrediting may vary as well as their reactions. Perhaps this is the reason that since Goffman, no other researcher has come up with an explicit definition of stigma. The working definition of stigma adopted for this thesis is a combination of Link and Phelan's and Parker and Aggleton's, which takes into consideration the influence of power, culture and difference.

Much of the literature on stigma especially in relation to HIV/AIDS and other attributes considered 'discrediting', in this case homosexuality, is focused on misunderstanding of the illness and behaviours (Parker and Aggleton, 2003). Although Goffman's formulation of stigma as a "discrediting attribute" has previously been critiqued as implying a static cultural or individual characteristic by its focus on an individual's attributes, however, it is useful in this analysis of the joint stigma of being both HIV positive and MSM. While it is acknowledged that stigma indeed functions as a result of

difference, it also functions to validate prevailing social and structural inequalities and inequities.

### **2.3.6.2 Categorisation of Stigma**

Goffman (1963) initially organized stigma into three categories of attributes and behaviours, which may subject an individual to stigmatisation. He described the first as “blemishes of individual character”, which originate from perceptions of the stigmatised character as weak and his behaviour as immoral (Goffman, 1963 p.14). For example, a HIV negative homosexual man who may be perceived as engaging in immoral behaviour and also an HIV infected individual whose behaviour considered to be promiscuous may be assumed to have led to their acquiring HIV. The second he described as “abominations of the body”, which are physical deformities, congenital or otherwise (Goffman, 1963 p.14). The third category he called “tribal stigmas”, which are experienced as a result of an individual’s devalued racial, ethnic or religious affiliations (Goffman, 1963 p.14). The HIV positive MSM may fit into all three categories, the first because he is seen as responsible for his illness, the second, if he suffers from wasting syndrome; and the third because of his perceived affiliation with a homosexual group (Varas-Diaz, Alfonso and Serrano-Garcia. 2005).

Some stigma scholars have attributed the development of stigma to evolutionary adaptations which causes humans to ostracize individuals who have some characteristics that make them unreliable for social dialogue, who are either infectious or perceived to be and who are members of the deviant group (Park et al., 2003; Kurzban and Leary, 2001).

Goffman (1963) further described the discredited and discreditable as two ways in which individuals may bear their stigma. A discredited individual is one who is well aware that he carries a stigma and whose stigma is obvious to others, while a discreditable individual is one whose stigma is not immediately obvious or recognized by others. Jones et al (1984) developed a similar idea but instead used the terms marked and markable.

Page (1984) argues that individuals with physical or tribal stigmas are more likely to be discredited rather than discreditable while those with conduct stigmas are more likely to be discreditable rather than discredited. Table 3 below categorises stigmatised individuals with physical and conduct stigmas as either discredited or discreditable.

**Table 2: Categories of stigmatised individuals applied to HIV positive MSM**

<i>Types of Stigma</i>	<i>Discredited/Marked</i>	<i>Discreditable/Markable</i>
<i>Physical</i>	HIV positive presenting with Kaposi Sarcoma	Trans-sexual
<i>Conduct</i>	Prominent MSM	Secret MSM

*Adapted from Goffman (1963)*

Homosexual men in the Nigerian context may face stigmatisation as a result of their sexual orientation and HIV status. So also, a homosexual man in the advanced stages of HIV, who may face both physical and conduct stigma. Yet Goffman’s early categorization of stigmatizing attributes fail to address this and as such have been critiqued as defective because it does not account for stigma which stem from an individual’s multiple social identity

### ***Dimensions of Stigma***

Rather than focusing on types of stigmas, researchers have shifted their focus to the dimensions of stigma. Jones et al (1984) identified six dimensions of stigma through which differentiation of stigmatizing conditions may be made, they are: concealability, course, disruptiveness, aesthetic qualities, origin and peril. Crocker et al (1998) later categorized these dimensions of stigma into two types, which are pertinent in understanding the experience of stigmatised individuals such as HIV positive MSM, they are visibility and controllability. These dimensions and a short description are thus specified.

#### ***i. Concealability***

This first dimension according to Jones et al. (1984) describes the extent to which a condition is discoverable or obvious to onlookers, or put in their terms, “potential markers”. This dimension of concealability is closely related to Crocker et al.’s (1998) dimension of visibility, which they describe as, the extent to which stigmatised conditions can be hidden from onlookers. It is assumed that the more visible the



stigmatizing condition is, the more difficult it will be to conceal, therefore an HIV infected individual in the later stages of the disease may find it harder to conceal his status than if he was asymptomatic. Crocker and colleagues (1998) maintain that individuals with visible stigma are more likely to be judged on face value and not by their personality or capabilities (Crocker et al., 1998). Furthermore, possessors of visible stigmatizing conditions may be well aware of their stigmatizing conditions, as in the case of an effeminate homosexual man. Becker and Arnold (1986), note that successfully concealing stigmas may have an effect on an individual's identity, "hidden stigmas may [...] profoundly affect identity as they engage the individual directly in the broader sociocultural context while completely sidestepping social interaction" (p. 50).

The 'discredited' (Goffman, 1963) or 'marked' (Jones et al., 1984) are unable to conceal their blemish and as such are immediately judged based on perceptions held about them. While the 'discreditable' or 'markable' are able to conceal their stigmas and engage in social interaction without being judged by their attributes, because their stigmatizing condition is not immediately apparent to onlookers. This dimension of stigma is relevant in the discourse of HIV positive African MSM especially those who are symptomatic and may be able to conceal their sexual practice but not their illness.

### ***ii. Course***

The course of the devalued attribute according to Jones and colleagues (1984) refers to the changes in the salience of the devalued attribute over time. Jones et al state that while some attributes can be changed over time like having acne, some like being blind cannot. In relation to HIV infection, an infected individual can change from asymptomatic to symptomatic and vice versa depending on how well he is able to maintain adherence and manage his illness.

### ***iii. Disruptiveness***

The dimension of disruptiveness according to Jones et al. (1984) is one that is not theoretically discernible. It refers to a characteristic of the devalued attributes that stops or makes social interactions difficult. It ties in with the other dimensions because the more discernible, threatening and unattractive an attribute is, the more salient to the social interaction it becomes. In the same way the closer and HIV infected MSM is to AIDS the more unattractive he becomes and the more difficult social interactions will be.

### ***iii. Aesthetic Qualities***

According to Jones et al. (1984), the dimension of aesthetics refers to the attractiveness of the devalued attribute. Jones and colleagues (1984) consider the dimension of aesthetic to be an important one; they argue that the role of this dimension is to arouse an affective, emotive response that humans possess to mark some attributes as discrediting. In the case where an HIV positive MSM is symptomatic and has lesions or wasting syndrome, he is likely to be stigmatised because his appearance is not aesthetically pleasing.

### ***iv. Origin***

Origin of a stigma according to Jones et al. (1984) refers to how the stigmatised individual obtained the stigmatised attribute. Salient in this dimension is whether or not the individual had the attribute from birth or during the individual's life and the role the individual played in getting the attribute (Jones et al., 1984). In the case of an HIV positive MSM, many may wonder how he came to be infected, when his sexual orientation is revealed his status may be ascribed to his 'immoral' sexual behaviour.

### ***v. Peril***

Peril is the final dimension postulated by Jones et al. (1984), and it refers to the danger that the stigmatised individual may cause. This dimension is very relevant in the discourse of HIV+ MSM as both their HIV status and sexual practices are perceived to be 'dangerous' in the Nigerian context.

### ***Stigma Mechanisms***

While stigma has been categorized according to its types and dimensions, it has also been categorized according to stigma mechanisms. Stigma mechanisms have been described as ways in which stigmatised individuals respond to the realisation that they possess a stigmatised attribute and are grouped into internalized, enacted and anticipated stigma (Earnshaw and Chaudoir, 2009). Internalized stigma also called self-stigma describes stigma as an acceptance of the negative stereotypes related to the stigma (Link, 1987). A number of detrimental effects such as poor physical health, increased shame and anxiety, decreased self-esteem, decreased social support, increased physical symptoms as a result of HIV seropositive status, decreased quality of life as

well as decreased commitment to antiretroviral treatment have been shown to be associated with internalized stigma for the HIV infected individual (Kalichman et al., 2009; Roura et al., 2009; Sayles et al., 2008; Holzemer et al., 2007; Lee et al., 2002; Berger et al., 2001; Fife and Wright, 2000).

Enacted stigma has been described as stigma experienced as prejudice, stereotype and discrimination from the society (Fuster-Ruizdeapodaca et al., 2014; Scambler and Hopkins, 1986). Enacted stigma also has some of the same negative effects of internalized stigma including increased shame, decreased physical health and increased HIV symptoms, decreased commitment to antiretroviral treatment (Sayles et al., 2008; Holzemer et al., 2007; Peretti-Watel et al., 2007). Anticipated stigma has been described as an individual's expectation of the experience of prejudice, stereotype and discrimination from society (Markowitz, 1998). Just like internalized and enacted stigma, anticipated stigma is associated with similar detrimental effects (Berger et al., 2001). Anticipated stigma has been said to influence the stigmatised individual's interaction with members of the society, including the way they disclose HIV status and access healthcare services (Smith et al., 2008; Sayles et al., 2008; Derlega et al., 2004).

A study by Fuster-Ruiz De Apodaca and colleagues (2014) demonstrated that enacted stigma has a direct negative influence on the quality of life of HIV infected, while internalized stigma has an indirect influence on the quality of life and is mediated by dimensions of group identification, through in-group affect. The role stigmatisation plays is important in understanding the motivations for devaluing powerless members of the society. One such explanation proffered is that the stigmatisation process serves as an 'ego boost' for the stigmatiser and his affiliations (Crocker and Lutsky, 1986; Goffman, 1963). The stigmatiser may choose to respond to the stigmatised either by being hostile towards him or outrightly rejecting social interactions or by being sympathetic of his plight, which he may show, by being friendly or helpful (Katz, 1981). According to Crocker et al (1998), stigma functions to make the stigmatiser feel as though they are just, upright citizens, who belong to virtuous groups of the society and have unerring ideologies.

Crocker and colleagues (1998) describe a number of theories, which they categorize into self-enhancement, in-group enhancement, systems justification and terror management theories. The theories explain why individuals stigmatise others who do

not share their beliefs or physically appear like they do and are useful in understanding why HIV+MSM are stigmatised in the African context. The self-enhancement theories postulate that derogation, discrimination and aggression result from an individual's perceived feeling of superiority over the devalued other and a desire to boost one's self esteem (Crocker et al., 1998; Wills, 1981). Downward comparison theory is a self enhancement theory, that involves making comparisons to disadvantaged others with the purpose of magnifying one's self esteem (Dovidio et al., 2000; Crocker et al., 1998; Wills, 1981).

Downward comparison, according to Dovidio et al. (2000) can be active or passive; active when a disadvantageous environment is created through discrimination and passive when individuals who are less fortunate in a pertinent aspect of life are sought. The in-group enhancement theories, one of which is the social identity theory posit that individuals are motivated to derogate devalued individuals in order to keep a positive social or collective identity and not just their personal identity (Tajfel and Turner, 1986). In-group enhancement may also be achieved by downward comparison. Perhaps the system justification theory which postulates that political and economic outcomes within which inequalities develop exist in every society and for this reason the higher social status are justified in their discrimination of the lower social class (Crocker et al., 1998) may be best to explain the role of stigmatisation.

Additionally, societies construct what is socially, culturally and morally acceptable and use social domination to ensure conformity to these norms (Becker and Arnold, 1986). Because different societies are governed by varying social and cultural norms and values, what is stigmatised will differ across cultures, eras and according to its connotation in the cultural context (Becker and Arnold, 1986, Coleman, 1986). It is for this reason that homosexuality which was once socially and culturally unacceptable globally is now becoming more acceptable in Western parts of the world and remains unacceptable in much of the African context.

Devine and colleagues use Tajfel and Turner (1986) theory on social identity conception to explain how societies divide people into the non-deviant 'in-group' (us) and the deviant 'outgroup' (them) in order to safeguard their social status as "healthy and non-deviant" as well as eliminate interactions with infected individuals whose social identities threaten core moral and religious ethics. The social identity conception

is premised upon three notions, the first being that salience of group memberships is the basis of an individual's identity; the second being that there is a need for people to maintain their self-esteem and the third that different group membership possess positive esteem implications (Tajfel and Turner, 1986).

This discussion of stigma and its processes cannot be complete without mentioning the importance of fear. Fear is particularly salient in discussions of why stigmas endure through and across social, cultural and historical milieu. Sontag (1979) states that some physical characteristics and ailments are feared because they are unknown, unpredictable and unexpected. Fear of contagion, fear of stigma by association (also called courtesy stigma), fear stemming from threats and fear of exhausting scarce resources have been attributed to the persistence of stigma (Gilmore and Somerville, 1994; Coleman, 1986; Gibbons, 1986).

### **2.3.6.3 HIV/AIDS and Sexual Stigma**

Sexual stigma has been defined as the “negative regard, inferior status and relative powerlessness that society collectively accords to any non-heterosexual behaviour, identity, relationship or community” (Herek, 2007). It is regarded as the socially shared devaluation of homosexuality compared to heterosexuality and leads to the disdain of non-heterosexual individuals in a society (Herek, 2007). Like sexual stigma, HIV/AIDS stigma is a social construct, which transcends realistic avoidance of acquiring the disease out of fear to display its true nature as a social phenomenon. (Devine et al, 1999). More so, the disease AIDS, threatens social values of morality and religion, that aim to control the way the body is used. They further stated that AIDS stigma could also be a personal phenomenon, “reflecting a potential threat to physical well-being” (p. 1213). The experience of HIV/AIDS stigma including how it is conveyed is said to vary across sociocultural contexts and may result from breaking social conventions (Earnshaw and Kalichman, 2013; Phelan et al, 2008).

Perhaps HIV/AIDS stigma remains salient across cultures and societies because it is a contagious, severe disease, which is perceived as a threat to the physical health of non-infected members of the society (Kurzban and Leary, 2001; Crandall et al, 1997). In some African cultures, certain beliefs about diseases being associated with moral or personal pollution, witchcraft, or wrath of ancestors still prevail (Goldin, 1994). For

example, the traditional belief held by Yorubas<sup>14</sup>, that good or bad health are brought by ancestral beings and an incurable disease like HIV/AIDS may be seen as punishment or witchcraft may play an important role in sustaining HIV/AIDS stigma within the culture.

According to Gilmore and Somerville (1994), three characteristics of HIV/AIDS predispose an infected individual to stigmatisation, they are:

1. Intimate contact is required for transmission to occur
2. Because it may be impossible to know when an individual is infected, one would have to either abstain or take precautionary actions
3. Because it is often attributed to sexual intercourse, it challenges strongly held religious, cultural and political values of chastity and the appropriate use of the body.

Laws, policies and politics, which are detrimental to HIV infected individuals, have been reported to constitute the structural drivers of HIV/AIDS stigma. Whereas, stigmatising thoughts, feelings and behaviours directed towards stigmatised individuals constitute interpersonal drivers of HIV/AIDS stigma (Earnshaw and Kalichman, 2013).

According to Herek (1990), AIDS from when it was first identified has been thought of in terms of social categories and not individuals and Goldin (1994) asserts that the use of the term 'risk group' as opposed to 'risk behaviour' gives attention to already stigmatised individuals making them doubly stigmatised. Devine and colleagues (1999) argue that individuals infected with HIV are regarded by uninfected as the 'outgroup' and struggle to maintain their social status as the normal 'in-group'.

Goldin (1994) states that although Goffman did not write about AIDS his early typology of stigmas is useful and applicable to the context of AIDS stigma. She states that AIDS stigma may be associated with,

“the devastating medical progression of opportunistic infections; moral transgressions, especially in depictions of male homosexuals' unnatural passions and [finally] affliction transmitted through race and nation, equally contaminating all members of the group, depicted in this case as the AIDS 'risk group' (p. 1360).

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<sup>14</sup> One of the 3 major ethnic groups in Nigeria

The cultural context has been said to have an influence on the extent of distress faced from being either or both HIV positive and MSM, and this seems to have a multiplicative effect when layered (Cloete et al, 2013). Further, when HIV/AIDS stigma is combined with sexual, race, gender or any other stigmatised attribute or characteristic it is referred to as multiple stigmas. This document is however concerned with stigma resulting from HIV positive status and sexual practices (sexual stigma<sup>15</sup>).

Two major conceptualizations have been used to explain possessing multiple stigmas. The first conceptualization proffered is what Reidpath and Chan (2005) refer to as layered stigma, which is when HIV stigma is layered on other stigmas such as marginalized group membership or gender stigmas. The second conceptualization is referred to as intersectional stigma, which Crenshaw (1996) describes simply as the product of interaction of HIV stigma with other stigmas.

Also called compound stigma, layered stigma occurs when various stigmas distinctly contribute to the overall stigma experience. As illustrated below, layered stigma will be experienced by an effeminate Nigerian HIV positive MSM as a culmination of the stigma of his MSM membership, the stigma associated with having sex with men and the stigma of being HIV positive (Nyblade, 2006).

**MSM (marginalized group member stigma) + sex with men (HIV-related stigma) + HIV+ status (HIV stigma) = TOTAL (LAYERED) STIGMA**

A more advanced and complex conceptualization of layered stigma is offered by Reidpath and Chan (2005 p. 431), in which they describe layered stigma in terms of shared stigma and synergistic stigma both defined as the extent to which the stigmatised attributes overlap and surplus stigma resulting from the combination of the stigmatised attributes. In this case, the layered stigma experienced by an effeminate Nigerian HIV positive MSM would be a summation of the stigma experiences from having sex with a man and being HIV positive as both shared and synergistic and then the excess of the stigma from being both HIV positive and having sex with a man; this is illustrated below.

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<sup>15</sup> Sexual stigma has been defined by Risher et al (2013) as “the shared belief system that denigrates and discredits homosexuality with respect to heterosexuality”

**Sex with men (HIV-related stigma) + HIV+ status (HIV stigma) + Shared stigma + Synergistic stigma = TOTAL (LAYERED) STIGMA**

These additive models have been critiqued because though complex they tend to oversimplify how multiple stigmas are truly experienced by the stigmatised and have the implication that the different types of stigmas can be compartmentalized or separated, when in reality multiple stigmas are usually experienced as a whole (Earnshaw and Kalichman, 2013; Purdie-Vaughns and Eibach, 2008).

Another critique of these models is the implication that one stigma is more salient than the other. Using the HIV positive Nigerian MSM as an example, the additive model assumes that the stigma experienced from being HIV positive is more salient than that experienced from being an MSM, which may not be the case (Earnshaw and Kalichman, 2013). Reidpath and Chan's (2005) conceptualization which seeks to address these limitations does not account for the experience of more than two stigmatised attributes, despite the fact that many stigmatised individuals usually have more than two stigmatised attributes.

The conceptualization of stigma as intersectional may be more apt, in that it addresses the challenges of additive models. Intersectionality as defined by Berger (2004) is the

“...interlocking forms of oppression which can be identified as separate, singular systems but whose explanatory power is greatly enhanced when they are seen as interactive and interdependent on each other”. (p.30)

This conceptualization asserts that multiple stigmatised attributes are experienced simultaneously although an understanding of each separate stigmatised attribute is needed to fully comprehend the experience of the stigmatised (Earnshaw and Kalichman, 2013). All stigmatised attributes an individual possesses carry equal weight, so an HIV+MSM residing in Nigeria will experience the stigma of being HIV positive distinctively because he is a man, he is effeminate and he has sex with men. In other words, intersectional stigma is multiplicative as opposed to additive.

An intersectionalist approach according to researchers is best in understanding the effects of multiple stigmas. This approach gives insight into how stigmatised individuals experience stigma as opposed to how societies bestows the stigma on them



(Herek, 2002; Pryor et al., 1999; Crandall et al., 1997). Studies suggest that the way in which HIV stigma presents is dependent on the other stigmatizing attributes an individual possesses and as such will influence disclosure of their stigmas (Smith et al., 2008; Derlega et al., 2004). According to Cloete and colleagues (2013), multiple stigmas would be most salient in heteronormative contexts like that in Nigeria where masculinity and male-roles are highly regarded and HIV/AIDS are considered taboo.

#### **2.3.6.4 Discrimination**

Much of the published literature, which discusses stigma, also discusses discrimination. In fact, Goffman (1963) and Jones et al. (1984) note that part of the experience of stigmatisation is the possibility that one would also experience discrimination. Parker and Aggleton (2003) note that there is no theoretical background that provides a framework for discrimination and its meaning is often taken for granted as though it were obvious. Initially, sociologists considered discrimination as a “cultural phenomenon of dislike of the unlike”, however, today discrimination “concentrate(s) on patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege” (Marshall, 1998).

Discrimination has been defined as behavioural indications, which result from prejudice (Earnshaw and Kalichman, 2013; Earnshaw and Chaudoir, 2009). The Oxford English Dictionary (1971) defines it as the process of making “an adverse distinction with regard to; to distinguish unfavourably from others” (p.746). The phrases “adverse distinction” and “distinguish unfavourably” seem to indicate a process whereby the life chances of powerless members of the society are significantly reduced because they possess a devalued identity.

Krieger (2000) distinguishes between two types of discrimination, *de jure* and *de facto*. *De jure* refers to discrimination sanctioned by law, evidenced by laws like the Same Sex Marriage Prohibition laws in Nigeria. *De facto* refers to discrimination without legal premise but which is authorised by convention an example is the denial of PLWHA or MSM from housing, employment or education (Krieger, 2000). She maintains that discrimination, like stigmatisation is socially constructed and involves the unfair treatment of members of a socially defined group. Crandall and Eshleman (2003) argue that by using political, social, cultural or religious power, dominant groups decrease access to essential necessities of life such as healthcare, education, housing and

workplace to exploit members of marginalized groups. Link and Phelan (2001) in the same way state that through the use of power, stigmatised individuals are exposed to toxic physical and social surroundings as well as poor quality healthcare.

### **2.3.6.5 Coping Mechanisms**

Individuals may cope with stigma using a number of mechanisms. Major and O'Brien (2005) state that while some individuals may adapt a 'problem-focused' approach, others may adapt an 'emotion-focused' approach or both approaches. Miller (2006) identified other coping mechanisms and categorized them into engagement also called "approach or fight motivation" and disengagement also called "avoid or flight motivation" (Miller, 2006). According to both Ainlay and colleagues (1986) and Becker and Arnold (1986), stigmatised individuals may use a range of tactics from eschewing and doubting to neglecting in order to cope with their devalued identities.

Becker and Arnold (1986) state that individuals who do not conform to cultural expectations may end up blaming themselves for their devalued identity. When they do not blame themselves, they may blame it on the discrimination they face by the society (Crocker and Major, 1989). Another coping mechanism stigmatised individuals use is to detach themselves from areas which they are likely to be discriminated against or stereotyped (Keller and Dauenheimer, 2003; Major and Schmader, 1998) or strive to work hard to become achievers (Miller and Myers, 1998; Allport, 1954).

Goffman (1963) proposed that individuals could engage in passing, covering or concealing their stigmatised identity. Goffman (1963) asserts that individuals may manage their stigma by either covering or passing. Individuals who pass try to conform to societal norms during social interactions. They are able to control how frequently they pass as 'normal'. Page (1984) mentions that those with physical stigmas may not have as many opportunities to pass because of the visibility of their stigma, while those with conduct stigmas may be able to pass more frequently due to reduced visibility of the stigmatizing attribute. People with invisible conduct stigmas who are able to pass more frequently may control to whom they reveal their stigmatizing conditions. Furthermore, the degree to which an individual with a stigmatizing attribute passes is dependent on whether or not he accepts that he possesses a stigmatizing attribute. Covering on the other hand involves attempting to reduce the tension that may be caused as a result of their stigma.

Apart from these methods, individuals are also likely to either accept or reject that the stigmatised trait they possess is actually inferior (Page, 1984). Individuals who accept may consider changing their identity to conform to societal norms and steering themselves back toward the road to 'normality'. Individuals may change their image, while others who possess tribal or conduct stigmas which are considered hidden, may use a process of individual adaptation. Becker and Arnold (1986), state that normalization, which is the process that stigmatised individuals go through in order to conform to societal norms is a convoluted one, which may require a lot of effort.

Rejection on the other hand takes a number of forms and could be passive or active (Coleman, 1986). In the case of passive rejectors, these individuals may not agree that their devalued trait is inferior but will not protest publicly. However, active rejectors will outwardly state that their devalued trait is in fact not inferior. They could either verbally state this by organizing protests or non-verbally by wearing a symbol that reveals the devalued attribute (Coleman, 1986).

Finally, stigmatised individuals may seek the support of others with the same stigma. Allport (1954) discusses how the tendency of stigmatised individuals to connect with individuals who share their stigma may be a coping mechanism. For these individuals the groups may provide emotional, informational and instrumental support, which boosts their self-esteem (Major and O'Brien, 2005; Bat-Chava, 1994). By forming social coalitions in the form of support or collective groups with individuals with the same stigma their interactions and perception of their stigmatised identity begin to change and they may decide to come together as a collective voice to legitimize themselves or for support (Becker and Arnold, 1986). Collective experience is particularly important in discourse of the stigmatisation process, without this stigmatisation process will be incomplete.

## 2.4 Chapter Summary

This chapter attempts to tie together previously published and unpublished articles, books and reports on African MSM including the HIV epidemic in their population, their high risk behaviours as well as their experiences engaging with healthcare services and adhering to antiretroviral treatment in a criminalised context characterised by stigma, discrimination and extreme violence. It also provided various conceptualizations of stigma, its types, dimensions, mechanisms, roles and process were described as well as discrimination and coping mechanisms adopted against stigmatisation and discrimination. Findings from the review reveal that there is a paucity of qualitative research exploring the health seeking practices of Nigerian HIV positive MSM especially as it relates to their access to healthcare services and adherence to ART. Where research has been conducted, they reveal that the belief of homosexuality being ‘un-African’ coupled with misconceptions about HIV drive stigma, discrimination and violence enacted against MSM. As a result, African MSM are driven away from life-saving healthcare services, including HIV prevention, care and treatment. There remains a lack of health policies or legislation targeted at this group. Instead punitive laws, which indirectly curtail the progress made in mitigating the spread of HIV, have been passed. Furthermore, the sociocultural context of marked homophobia, stigmatisation and discrimination against MSM in Nigeria remains an impediment for researchers wanting to study the MSM population. It is against this background that the decision to undertake this study was made. In the section that follows, the methodological approach employed in exploring how HIV positive MSM access healthcare services and adhere to their treatment is provided in detail.

**CHAPTER 3: USE OF HEALTHCARE SERVICES AND ANTIRETROVIRAL  
THERAPY AMONG HIV POSITIVE MEN WHO HAVE SEX WITH MEN  
(MSM): A QUALITATIVE APPROACH**

**3.1 Introduction**

As described in Chapter Two, most research that has been conducted on the MSM population in Nigeria is quantitative in nature and as such there is a critical need for qualitative inquiry in order to gain an in-depth understanding of their experiences. This chapter provides a detailed description of the qualitative research methods employed in exploring access to healthcare services and adherence to ART among HIV positive MSM in Nigeria. In Section 3.2, the research aim and objectives are restated. This is followed by a detailed description of the study design in Section 3.3. In this section, the interpretive constructionist philosophical position which guides the study is described. This is followed by a discussion about researching vulnerable populations and sensitive issues. Additionally, the procedures employed in conducting FGDs and semi-structured interviews, both utilised in this study, are detailed.

Section 3.4 provides the background to the study areas, as well as the rationale for the selection of those areas. In section 3.5, the processes involved in data collection are explained, and includes a section on the dilemmas of negotiating access to a population established as 'hard-to-reach'. I also describe the process of obtaining ethical clearance in Nigeria and the different on-the-spot adjustments to the research protocol that had to be made in order ensure that data were collected in the most culturally appropriate and sensitive manner are discussed. In addition to this, the selection of study participants is described as well as the demographic characteristics of the selected participants. Section 3.6 outlines the processes of data management and analysis and describes the process of thematic analysis employed in this research. This is followed by Section 3.7 which is a discussion of the importance of and steps taken to ensure that reflexivity was maintained throughout the study and that the researcher's positionality was explored. Section 3.8 on ensuring rigor and trustworthiness argues that the traditions of qualitative research differ from that of quantitative and as such different measures to ensure validity and reliability of the study have to be taken. The chapter ends with a summary of the key messages.

### **3.2 Research Aim and Objectives**

To reiterate, the central aim of the study as stated in Chapter One was to explore the lived experiences of HIV positive MSM in terms of their accessing healthcare services and adhering to their treatment. A qualitative methodology using focus group discussions (FGDs) and in-depth interviews was employed in order to achieve the aforementioned aim of this research. The main research question was:

*How do HIV Positive MSM experience accessing healthcare services and adhering to their antiretroviral treatment in Nigeria?*

The objectives are listed below:

1. To describe the social context (of stigma and discrimination) of Nigerian HIV positive MSM lives and its impact on their lived experiences including their access to healthcare services and adherence to ART by conducting 21 in-depth interviews and 4 FGDs in both Abuja and Lagos
2. To provide an account of how Nigerian HIV positive MSM experience, understand and manage their illness using a qualitative approach
3. To gather narratives of Nigerian HIV positive MSM experiences of accessing healthcare services in Nigeria including the barriers and facilitators they encounter.
4. To understand Nigerian HIV positive MSMs' motivations for adhering to ARVs and how they understand and respond to the medical expectation that they adhere to their ARVs
5. To understand the challenges, facilitators and strategies employed by Nigerian HIV positive MSM to adhere to their ART

### **3.3 Study Design**

#### **3.3.1 Underlying Philosophy of the Study**

Qualitative studies have a philosophical position guided by the researcher's ontology, which is what the researcher believes about the nature of reality, as well as epistemology, which is what the researcher believes about the nature of knowledge (Ritchie et al. 2013). This study takes a broadly interpretive constructionist philosophical position. The interpretive constructivist paradigm acknowledges that there is a reality, which is changing, cannot be easily measured, and can only be perceived by individuals whose realities are influenced by their perspective and experiences (Rubin

& Rubin 2012). Some researchers are more inclined to a positivist orientation, which assumes a singular, observable, stable and measurable reality that exists somewhere out 'there' and is often synonymous with quantitative research. However, qualitative researchers tend to be situated in interpretivist traditions, which assume multiple realities that are observable, socially construed and based on individual interpretations of reality (Denzin and Lincoln 2011; Rubin and Rubin 2012). This philosophical standpoint is well suited to this study because my interest lies in how the 'subject' of my research, the Nigerian HIV positive MSM, understands and constructs meaning around his lived experiences as well as viewing this world through his lens (Bryman 2015).

### **3.3.2 Researching Vulnerable Populations and Sensitive Issues Using Qualitative Research Approaches**

The three main features of qualitative inquiry are that it aims to gain in-depth understanding of the world by interaction with its actors, it seeks to collect data in 'natural' settings as opposed to artificially constructed settings and finally, its inductive nature as opposed to deductive ((Bryman & Burgess 1999). Other features of qualitative inquiry that make it appropriate for this research include its significance when there is a paucity of research conducted on a particular issue, its ability to offer a holistic account of a complex picture of the research issue and its use of the researcher as the key instrument of data collection (Creswell 2014).

Qualitative research is often used to capture a participants' experience of reality which cannot be captured using quantitative research. Generally, qualitative inquiry focuses on the process, meaning and understanding of realities and experiences (Mason 2002). I was most interested in how these individuals being studied interpret their experiences and the meanings they ascribe to these experiences as opposed to merely attempting to explore statistical regularities (Merriam 2009). Through the use of a qualitative approach in this context, I developed an understanding and assumed my role as the primary data collection and analysis instrument. I was able to see the individuals being studied as more than just statistics.

Furthermore, qualitative research approaches are most suitable for researching vulnerable populations and sensitive issues (Daly 1992). This research described the experiences of HIV positive MSM in relation to how they navigate and negotiate access into the healthcare system and adhere to their ART in a heteronormative and

criminalised context. In Nigeria, the HIV positive MSM embodies a vulnerable persona because he experiences significantly reduced autonomy due to his poor social standing in a context which is not only heteronormative but also patriarchal (Silva 1996). On one level, he is marginalised due to his HIV status and on another level he is marginalised due to his sexual practices, which are considered taboo. Unlike other subjects of research, who may be easily located, he is also considered ‘hard-to-reach’ or hidden. This is because no sampling frame exists from which he can be recruited and he is forced to lead a stealth life, since discovery of his identity could be potentially threatening to his wellbeing (Heckathorn 1997).

This research is considered sensitive because it required the exploration of practices considered to be ‘deviant’, distressing and difficult to disclose and would otherwise have been kept confined within the ‘private space’ of the men who were interviewed (Wellings et al. 2000). Moreover, the accounts from these men were both socially and politically charged and potentially incriminating. It was therefore important as a researcher to approach the ‘private space’ of this vulnerable population with great sensitivity and an understanding that the research could have an adverse impact on both the researcher and the researched. Therefore, every single step of the research process from negotiating entry to developing rapport to the commencement of formal data collection and analysis and to the end of the study was considered with utmost sensitivity. This was accomplished by following the steps explained in Section 3.5.

The methods utilised in this study included focus group discussion (FGD) and semi-structured interviews, which would be elaborated in the following sections. Briefly, focus group discussions involve the use of group interaction to elicit data (Kitzinger & Farquhar 1999), while semi-structured interviews involve the use of a mix of unstructured and structured questions to elicit specific information from individuals (Merriam 2009). A thorough exploration of the men’s’ lives necessitated the use of multiple approaches to qualitative research. These data collection techniques were used in order to obtain rich and comprehensive explanations of how HIV+ MSM navigate and negotiate access into the healthcare system and adhere to their antiretroviral treatment.

Moreover, because data are confined by context and the same respondent may give different responses to the same questions given different situations, using the interviews



to supplement the FGDs ensured that a comprehensive picture of their experiences was obtained. The use of interviews to supplement the FGDs also meant that issues raised during the FGDs could be investigated more in-depth during the interviews. It also ensured that the disadvantages which are likely to occur with the use of one data collection method were dramatically reduced and each method could be used as a check for the other, in other words, triangulation (Bryman, 2015).

### **3.3.3 Conducting Focus Group Discussions (FGDs)**

A total of 4 FGDs were conducted, 3 in Abuja and 1 in Lagos. I moderated the FGDs in Lagos alone, while the discussions in Abuja were moderated by me and an assistant who self-identified as MSM. The role of the assistant was to take notes so that I could pay closer attention to the FGD and come up with follow up questions. All FGDs were conducted prior to the interviews using a pre-structured topic guide available in Appendix 2. The FGDs started with an ice-breaker question asking what participants will do with an unlimited amount of money they had won from playing the National Lottery. This question along with familiarisation visits to the NGOs before the start of data collection was used in building rapport with the study participants and also enabled easy transition to the main questions.

Before the commencement of the discussions, participants were provided with information sheet that explained the aims of the study, asked to voluntarily sign the consent forms (Appendix 4) as well as for permission to audio record the interviews and if they had any questions. At the commencement of the discussions, ground rules were set, for example, I asked FGD participants to turn their phones off or put them on silent mode in order to minimize distractions. After setting ground rules, participants were asked to introduce themselves using pseudonyms, in order to maintain confidentiality. FGD participants were encouraged to speak without inhibition as there were no wrong answers. They were also encouraged to speak one after the other as discussions often got heated. FGDs were concluded by asking participants if they had further contributions or questions.

FGDs were conducted in a conference room space provided by the NGOs. An example is shown in Fig. 3 below. Participants were provided with refreshments amounting to 1500naira/participant which was equivalent to £4.50 at the time of the study. FGDs lasted approximately 1hr45min. A limitation of the FGDs was when a question was asked and only a few of the participants engaged in the discussion, this made analysis a

bit challenging in terms of whether to consider those who hadn't commented on an issue as agreeing with what everyone had said, disagreeing or just not having an opinion about the topic being discussed.



**Figure 3: Picture of FGD Seating Arrangement at ICARH, Abuja**

### **3.3.4 Conducting Semi-Structured Interviews**

Semi-structured interviews are a form of in-depth interviews whereby the researcher asks participants pre-structured, open-ended questions with the aim of exploring their views towards an issue (Given 2008; Jamshed 2014). Semi-structured interviewing was particularly useful for this research because it provided an opportunity to gain a more in-depth understanding of the daily lived experiences of HIV positive MSM living in Nigeria especially when the narrative interviews had failed to do so. Additionally, it was a suitable approach because it gave me more control over the topics discussed compared to if I had used unstructured interviews. Although the questions were pre-structured, I had more flexibility in the order in which I asked the questions and often times during the interview sessions, I skipped over some questions which the participant had already answered.

Interviews were conducted with purposively selected participants from FGDs to get more detail into their lived experiences. In Abuja, 13 interview participants were selected, while in Lagos, 8 participants were selected making for a total of 21 interviews. The demographic characteristics of interview participants in Abuja differed from those in Lagos in terms of their self-identified sexual orientation. In Abuja, all participants were single and a majority self-identifying as homosexual. In Lagos, there was one married man and another who was separated both of whom identified as bisexual and the majority of the participants self-identified as bisexual. The detailed demographic profile of the participants is available in Section 3.5.4. The topic guide was developed in English. Interviews were conducted in either English or Pidgin English<sup>16</sup>. Participants who were not fluent in English were encouraged to speak in Pidgin English

Interviews were conducted in office spaces provided by the NGOs. At commencement of the interviews, introductions were made and participants were provided with information about the study, with emphasis on the voluntary nature of the study. Participants were also required to initial a consent form in order to protect anonymity and confidentiality and permission was sought to record the interviews. Participants were provided with refreshments amounting to 1500naira/participant which was equivalent to £4.50 at the time of the study. Each interview lasted approximately 1hr long. Due to the nature of the research, it was impracticable to conduct a pilot test. Initially, a topic guide (see Appendix 1) was created, which asked a broad question, “Tell me about your health or life in relation to your illness”. This initial question was tested on the first few participants. After the first two interviews, I realised that participants appeared to be unfamiliar with this form of enquiry and had anticipated more structured questions. They responded either by seeking clarity about the question or giving a short narrative before asking to move on to the next question.

Prior to data collection, I had anticipated this happening and I had designed a 23-question semi-structured interview topic guide divided into 3 sections (see Appendix 1). These 3 sections sought to explore their social context, understanding, experiences and management of HIV and finally, their experiences of accessing healthcare services as well as adhering to ART. Subsequently, all interviews were conducted using the semi-structured interview guide. Although the majority of the study participants were highly

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<sup>16</sup> This is a variation of English spoken widely across Nigeria.

educated to tertiary level, they were classed as being low to middle class based on their occupational status and income level.

### **3.4 Study Area**

#### **3.4.1 Rationale for Selecting Study Area**

As discussed in Chapter One, the HIV burden in the MSM population in Nigeria is not only considerably high but also rising rapidly in comparison to their male counterparts in the general population and other most at risk populations for HIV. At the time prior to data collection, the three states with the highest HIV prevalence among MSM in Nigeria were Abuja, Kaduna and Lagos, with an HIV prevalence of 37.6%, 16.2% and 15.8% respectively (FMOH 2010a). Though, Kaduna had the second highest HIV prevalence, it was excluded as a study site for a number of reasons. First, for personal safety, there was political unrest in the state at the time when the research was being designed and it was listed amongst the states advised against travel by the UK foreign affairs. Second, and as would be discussed later, this study used a gate keeper organisation to gain access to potential participants and the gatekeeper organisation did not have a site in Kaduna. Therefore, it would have been impossible to gain access to potential research participants.

The other rationale for the selection of these two states was more pragmatic. Having grown up in Nigeria (Lagos to be specific) and studied and worked briefly in both public and the private health sector in Lagos and Abuja, I am conversant with the health system and how it operates generally. However, my knowledge of the health system especially as it pertained to HIV was poor and I was driven to undertake this research because of my strong desire to observe first-hand how this aspect of the Nigerian healthcare system operates in practice. Conducting my research in the capital city (Federal Capital Territory (FCT)) and most urban city (Lagos) of Nigeria provided me with this opportunity.

#### **3.4.2 Background to the Study Area**

Located in the South-Western part of Nigeria and with a population estimated to be about 21 million as at 2016, Lagos has the highest population in Nigeria and is the second fastest growing population in Africa (Anon 2017). Although Lagos predominantly constitutes the Yoruba tribe, there has been an influx of people from the various tribes seeking job opportunities and prospects from the urban and financial hub

of Nigeria. As a result of this influx, there is now a mix of the different tribes in Nigeria. Majority of Lagosians identify as Christians, while others identify as Muslims and a minority, traditional or indigenous beliefs. The major language spoken by Lagosians is Yoruba. Interestingly, the participants recruited in Lagos revealed the ethnic and religious demographics characteristic of the state, with only two Yoruba participants and the rest either Igbo or from other minority tribes and all Christian.

Abuja, the capital city of Nigeria is located within the FCT, in the North Central geopolitical zone. Abuja has an estimated population of over 1.4 million (NPC 2013) and is the state with the fifth highest HIV prevalence (8.6%) in the country (NPC 2013). Like Lagos, it has had an influx of people from various tribes and currently has all tribes represented. However, the Hausa tribe remains the predominant tribe, with Hausa as the major language spoken. The major religion practiced is Islam, however, as will be observed, majority of the study participants from the organisations in Abuja identified as Christians with only one participant identifying as Muslim. This may be because majority of the Abuja participants were from the Igbo tribe and Igbos are predominantly Christian.



Source: UN.org

Figure 4: Map of Nigeria

### 3.5 Data Collection

#### 3.5.1 Negotiating Access to Nigeria’s Most Hidden Population

There was no doubt that negotiating access to MSM, particularly HIV positive MSM in Nigeria would not be without its challenges. The negotiation process began with the search for an organisation willing to take on the role as the gatekeeper for the research. This was an important first step due to the illegality of same sex sexual activities and the stigma associated with the research in Nigeria. The Gatekeeper Organisation (GO) that was approached is an international organisation called Heartland Alliance International (HAI). HAI has facilities in both Lagos and Abuja. They provide HIV prevention and human rights protection services to Nigeria’s MARPs, including MSM, using a comprehensive, rights-based approach (Heartland Alliance 2017).

HAI was selected because it was among the few organisations providing psychosocial support as well as healthcare services to MSM in both my study sites, Lagos and Abuja. Approaching the field with the support of a GO was essential in that it facilitated my

access to this hard-to-reach and hidden population. Not only did the GO enable my access to this population, they also ensured my safety and expedited the process of building trust between myself and the research participants. Additionally, this step was imperative some participants prior to the interview sessions mentioned that they would not have spoken to me about such a sensitive and emotive topic if I did not have the backing of the GO.

During the initial briefing meeting with my contact person at HAI, I was informed that the organisation only provided referrals for HIV services including ART to Population Council (PC) and International Centre for Advocacy on Rights to Health (ICARH). I was advised that in order to maximise the range of participants to sample it was necessary to include these organisations. Additionally, a key aspect of my research was exploring HIV positive MSM experiences of accessing healthcare services and adhering to antiretroviral treatment, it was therefore essential to include these NGOs. These three organisations, HAI, PC, and ICARH provided access to the study population from which a sample was selected for the FGDs and interviews.

### **3.5.2 Obtaining Ethics Approval: Tensions and Reflections on the Process**

After the GOs had been secured, the next step was to obtain ethical approval to conduct my study. Although I had already received ethics approval from the University of Sheffield in the United Kingdom, prior to data collection, this is a necessary step before any health research can be conducted in Nigeria. The processes involved in obtaining ethical approval in Nigeria are not without its tensions and this phase of negotiating access posed the most challenges.

The two research governance bodies I sought ethical approval from were the Federal Capital Territory Health Research Ethics Committee (FCT-REC) and the Lagos State University Teaching Hospital Health Research and Ethics Committee (LASUTH-REC). Prior to going to the field, my contact at HAI sent me by email the documents outlining the processes and procedures required to gain ethical approval from FCT-REC. I was able to send the necessary documentation and with support from HAI secure ethical approval by the time I arrived in Nigeria for data collection. However, obtaining ethical approval from LASUTH-REC took longer than I had anticipated due to temporary setbacks in the system. As a result, modifications had to be made to the research protocol but eventually I received approval and the documentation for this can be found in Appendix 5c.

### **3.5.3 Recruitment of Study Participants**

The research protocol had to be modified again in the identifying the research participants. In Abuja, the three NGOs, HAI, PC and ICARH provided the sampling frame where participants were recruited from. The organisations were briefed and provided with information about the research and the inclusion criteria (see Table 3) providing the participant specification. In other to recruit participants for both FGDs and Nis, the GOs were asked to approach clients who met the person specifications and provide them with verbal and written research information.

For interviews, once the participants agreed, a date and time when the clients could meet for the interview was fixed. In the case of FGDs, the participants were approached on a day I was present at the facility, provided with the study information and left for a minimum of 24hours to decide whether or not they wanted to participate. If they agreed to participate, they were recruited until the desired amount of participants in each FGD was achieved. It is important to note that two Abuja participants who were approached by the gatekeeper organisation and who initially gave their consent later withdrew their consent to participate in the study. After conducting 13 in-depth interviews and 3 FGDs with 9 participants in the first, 5 participants in the second and 6 participants in the third in Abuja, no new information was being generated and recurring themes were arising, it was at this point data saturation was reached.

In Lagos, the GO approached clients during their support group meeting to recruit participants for both in-depth interviews and FGD. Just like in Abuja, they provided potential participants with verbal and written research information as well as a consent form to initial on if they decided to participate in the study. I was asked to conduct the FGD on the day of their next support group meeting as that would be the best way to get all participants in the same venue. All Lagos participants who were approached to participate in the study gave their consent. After conducting 8 in-depth interviews and 1 FGD in Lagos no new information was being obtained and recurring themes began to arise. It was at this point that data saturation was reached.



**Table 3: Inclusion and Exclusion Criteria**

Population	Inclusion Criteria	Exclusion Criteria
HIV positive Men who have Sex with Men (MSM)	<ul style="list-style-type: none"><li>• Biological male</li><li>• 18 years or older</li><li>• HIV positive on ARVs or has been prescribed ARVs</li><li>• Report anal or oral sex with another man in the past year (that is 12 months prior to the start of the study)</li><li>• Self identifies as homosexual, heterosexual, or bisexual</li></ul>	<ul style="list-style-type: none"><li>• Non biological male</li><li>• Younger than 18 years</li><li>• HIV negative</li><li>• Has never engaged in anal or oral sex</li></ul>

### 3.5.4 Participant Characteristics

The demographics of participants (pseudonyms) from both states are shown in Table 3.1 below:

**Table 3.1: Participants Characteristics**

FGD/Interview Participant	Age	Marital Status S/M/Se	Ethnicity Y/I/H/O	Religion C/M/T/F	Sexual Orientation HQ/HE/BI/O	Education <1 <sup>o</sup> /2 <sup>o</sup> /3 <sup>o</sup> >	Occupation/ Income per annum
<b>Abuja Participants</b>							
1. Lucus	27	S	I	C	Bi	3 <sup>o</sup>	Health Worker/ 250k
2. Jide	27	S	I	C	Ho	3 <sup>o</sup>	P.O/ <250k
3. Ibrahim	28	S	I	C	Ho	3 <sup>o</sup>	Legal Practitioner/ >500k
4. John	33	S	I	C	Ho	3 <sup>o</sup>	Social Health Worker/ 500k
5. Peter	33	S	I	F	Ho	3 <sup>o</sup>	Human Rights Activist/ >500k
6. Ferni	30	S	H	C	Bi	2 <sup>o</sup>	Social Worker/ 250k
7. Obinna	24	S	Other: Tiba	C	Ho	2 <sup>o</sup>	Outreach Coordinator/ 250k
8. Kola	24	S	H	C	Ho	2 <sup>o</sup>	School and Work/ <250k
9. Abu	30	M	H	M	-	2 <sup>o</sup>	Illegible/ <250k
10. Boye	34	S	I	C	Bi	2 <sup>o</sup>	HCT Officer/250-500k
11. Adamu	32	M	I	C	Bi	3 <sup>o</sup>	Catering Services/-
12. Akin	30	S	I	C	Ho	3 <sup>o</sup>	HCT Officer/ >500k
13. Sule	23	S	I	C	Bi	2 <sup>o</sup>	Health Worker/ 250-500k
14. Abu	24	S	I	F	Ho	2 <sup>o</sup>	Make-up Artist/ <250k
15. Eneka	33	S	I	C	Bi	3 <sup>o</sup>	Unemployed/ -
16. Chidi	22	S	I	C	Bi	3 <sup>o</sup>	Student/ <250k
17. Chris	28	S	I	C	Bi	3 <sup>o</sup>	Care and Support Officer/ <250k
18. Yemi	29	S	I	C	Ho	3 <sup>o</sup>	Aspiring Vocalist/ <250k
19. Kunle	26	S	H	C	Ho	3 <sup>o</sup>	Music Vocalist/ <250k
20. Koye	24	S	Other: Tiba	C	Ho	3 <sup>o</sup>	Outreach Coordinator/ <250k
21. Arinze	29	S	H	C	Ho	2 <sup>o</sup>	Unemployed and Sex Work/ <250k
22. Amaechi	26	S	H	C	Ho	3 <sup>o</sup>	Student/ Sex Work/ <250k
23. Ifechi	28	S	I	C	Ho	2 <sup>o</sup>	Unemployed/ <250k
<b>Lagos Participants</b>							
24. Joe	27	Single	O: Ibibio/Akwa Ibom	C	Bi	3 <sup>o</sup>	Key Opinion Leader and Healthcare Mobiliser/ 450k
25. Olu	22	S	Y	C	Ho	3 <sup>o</sup>	Student/ n/a
26. Tim	19	S	I	C	Ho	2 <sup>o</sup>	Hairstylist/ 180k
27. Wale	21	S	Y	C	O: Pansexual	3 <sup>o</sup>	Health Volunteer and Fashion Designer/ 624k
28. Mustapha Caramel	24	S	O: Isoko	C	Ho	3 <sup>o</sup>	Key Opinion Leader, Counselor Tester for MTV Shuga, Fashion Stylist/ 624k
29. Danjuma	22	S	I	C	Bi	2 <sup>o</sup>	Office Assistant/ <70k
30. Hasan	35	Se	O: Ibibio	C	Bi	3 <sup>o</sup>	Healthcare Worker/ 1.2m
31. Gaddo	52	M	I	C	Bi	3 <sup>o</sup>	Healthcare Worker/ 240k

### 3.6 Data Analysis

The data set consisted of verbatim transcribed interviews, field and observation notes and the researcher's reflection diary. The interviews were transcribed by the researcher. Interviews were initially transcribed in Microsoft Word and then moved to NVivo 10 for analysis. During transcription, careful attention was paid to features of talk including emphasis, speed, tone, timing and pauses. The transcripts were then analysed using thematic analysis and individual analysis. Individual analysis involved thoroughly reading through each transcript in its entirety, taking detailed notes and writing pen portraits or profiles of each participant. A few participants' pen portraits are available in the Appendix 6. Thematic analysis is a descriptive method of analysing qualitative data in which sections of the data are broken up and subsequently coded into themes (patterns). It has been defined by Braun and Clarke (2006, p. 6) as a "method for identifying, analysing and reporting patterns (themes) within the data".

This study employed data-driven thematic analysis, in which analysis is conducted without using pre-determined theoretical concepts to analyse qualitative data. Data-driven thematic analysis was employed because the focus of the proposed study was on the concerns and motivations of participants (Vaismoradi et al. 2013). Thematic analysis is also a flexible analysis tool, which provides rich and complex interpretation of the data (Braun and Clarke, 2006). Some themes (i.e. stigma, barriers and facilitators of antiretroviral adherence, barriers and facilitators of access to healthcare services), were derived from the literature. while others emerged from the data. Field notes were used in informing and guiding the analysis of the data. The theme Experiences of Stigma, for example, were already conceptualised forms of stigma (sexual, HIV, internalization, stigma by association and anticipated stigma). Whereas, the subtheme 'Kito' emerged from the data

The interview topic guide explored the following three broad areas, which guided the analysis of data:

1. The social context
2. Their understanding experiences of HIV diagnosis
3. Experiences of accessing healthcare services and adhering to antiretroviral treatment

The six basic phases to thematic analysis of qualitative data employed in this study are outlined and described in Table 3.2 below.

NVivo was used for data management and storage. Data collection and analysis were conducted simultaneously, using an inductive and comparative analysis strategy (Glaser 1965). Practically, this meant that as new themes emerged the data collection instruments were adjusted. For example, during the first few interviews, participants' understanding of homosexuality was unclear to me. Therefore, I added a question asking specifically to explain to me their understanding of homosexuality, bisexuality and heterosexuality. During the interview phase of the study, I analysed the previously collected interviews and wrote memos that I later included as a narrative in the final report. A technique called winnowing, whereby the relevant data are focused on while irrelevant data are disregarded was employed (Padgett 2012). Winnowing was used because of the dense and extremely rich data retrieved from this study. All participants initials were changed during analysis in order to protect anonymity.

**Table 3.2: Phases of Thematic Analysis**

<b>PHASES</b>	<b>WHAT WAS DONE</b>
FAMILIARIZATION	Verbatim transcripts were read carefully and actively twice to familiarize myself with the data. In addition to this, notes were taken and ideas marked for coding.
GENERATING INITIAL CODES	This phase began after careful reading and familiarization with the data as well as note taking. In this phase, initial codes were identified and data was categorized into coherent groups. Coding was done on the NVivo software program.
SEARCHING FOR THEMES	In this phase of the analysis, both predetermined themes (e.g. sexual stigma, anticipated stigma, stigma by association) as well as emerging themes (e.g. Kito) were identified and codes were sorted and collated into different themes. This phase was concluded with a collection of 'candidate' themes and sub-themes.
REVIEWING THEMES	During this phase, irrelevant 'candidate' themes and themes that could be joined together or separated became apparent. Two levels of reviewing and refining were necessary at this stage. The first involved systematically reading through the collated data extract for individual themes and ensuring that there was a logical flow. The second level involved examining the validity of the separate themes in comparison to the whole dataset.
DEFINING AND NAMING THEMES	In this phase, themes were clearly defined and refined and the data within them analysed. A detailed analysis was written up for each theme while drawing out the 'story' emerging from the data.
PRODUCING THE REPORT	In this final phase of the analysis, the data was written up in a concise coherent, logical and interesting manner that gave an account of the lived experiences of Nigerian HIV positive MSM in relation to their access to healthcare services and adherence to ART.

### 3.7 Reflexivity and the Researcher's Positionality

Reflexivity as defined by Payne & Payne (2004) is

“the practice of researchers being self-aware of their own beliefs, values and attitudes, and their personal effects on the setting they have studied, self-critical about their research methods and how they have been applied, so that the evaluation and understanding of their research findings, both by themselves and their audience, may be facilitated and enhanced” (p. 191).

This definition perhaps captures the essence of reflexivity in qualitative research whereby the awareness of self in the research is paramount (Bloor & Wood 2006).

The aim of reflexivity according to Bourdieu (2007) is not to “discourage scientific ambition but to help make it more realistic”. The qualitative researcher understands the effect of their presence on the research as well as the impossibility of remaining outside of the subject matter. They also know that their interpretation of the study is heavily influenced by their background together with their epistemological and ontological beliefs, which may bias their interpretation of the research findings; therefore they recognise the significance of reflexivity.

Reflexivity was established throughout the research process in the following ways:

- By keeping a detailed reflexive diary, which contained detailed entries about the research process. The reflexive diary provided detailed accounts of how I gained entry into the research setting, presented myself within the setting, the extent to which trust and rapport with the participants were attained and ‘mistakes, misconceptions and surprises’ encountered during the research process (Altheide and Johnson, 1994).
- By ensuring that the epistemological and ontological perspectives as well as methodology and research methods guiding the research were clear (Seale, 1999).
- By maintaining constant dialogue with my supervisory team during the data collection process as well as presenting data I had collected to them.
- By writing myself into the research as I am part of the research process. Doing this ensured validation and reduced researcher bias.
- By attempting to remain objective throughout the research process, while maintaining my positionality

As a young, female researcher from a relatively high socioeconomic background and studying at a British University, there was a possibility that my interest in studying the experiences of marginalized men, in a context heavily influenced by gender and power imbalances may have been met with resistance. This resistance was evident in gaining access to participants, especially elite participants. For instance, there was an initial suspicion of the motive for my research by one of the gatekeepers. It was not after I had explained to her the purpose of my research that she was convinced although she still did not permit access to the 'elite' MSM. According to her, the organisation had put in a lot of effort to secure the trust of these men and approaching them would have been a threat to their anonymity.

When conducting sensitive research, gaining access to the study population may come with its strains and it is imperative that methods of reaching the population that safeguard researcher safety are carefully considered. One way in which I was able to gain access was by affiliation to the gatekeeper organisations. My status as an 'outsider', that is an independent researcher could have had a potential negative impact and it was for this reason I had to affiliate myself with the gatekeeper organisations. Although a few participants were keen to share their experiences with me, a couple of them mentioned to me that they were sharing sensitive issues with me because they had assumed I was working with the organisation.

Trust and rapport were built through familiarisation visits before the study commenced. During these visits, I got a chance to personally discuss the study with potential participants, and explain the ways in which their confidentiality and anonymity will be guaranteed. These preliminary visits also provided me with an opportunity to interact with participants on a personal level and in a setting where they were free to express themselves. After debriefing at the end of each interview or discussion, I stayed back and talked to participants about their life experiences and issues separate from my research focus, thereby building a long-standing relationship. During the interviews and FGD, participants were required to give their narratives, perspectives and opinions and were not interrupted. By this, power differentials that occur between participants and researcher were eliminated and trust was built. Furthermore, going back to the gatekeeper, key informants and participants with my findings increased trust and facilitated the rapport building process by ensuring transparency of the research.

Being a Nigerian national had a positive impact on how I was perceived by participants'. They more readily opened up to me and during interviews it was generally assumed that I could understand and share in the "Nigerian struggle". For example, during an interview, one participant said to me "you know the mentality when it comes to money in Ibo side, they are mad at it, so even if it's killing the pikin dey do, follow am, anything wey he dey do to get the money, follow am, we need the money"<sup>17</sup>. Although I am from the Yoruba tribe, there was an assumption that because I am Nigerian, I had an understanding of other tribal traditions.

My interaction with the men through interviews, FGD and chit chats in between evoked a range of emotions, sometimes happiness, other times deep sadness and other times still, shame and disgust at the Nigerian society. During the interview sessions, participants' narratives about their experiences of extreme violence, stigma and discrimination were particularly distressing. An interview session that comes to mind was with a participant, who was so distressed we had to stop the interview and continue the next day. The FGD often got heated as there was a lot of interaction and eagerness to get their points across. For the most part, during the FGD, there was a lot of laughter. Compared to the interview sessions, it was less tense. Reflecting on my experience of conducting the FGD compared to interviews, I believe that even though some personal experiences were shared during the FGD, these experiences weren't as deeply personal as those shared during the interviews and this is why some interviews were particularly distressing. At the end of every day during data collection, I recorded my thoughts in a diary and spoke to a close friend about how I felt during the interviews and my disappointment in the Nigerian society. I sometimes recorded my thoughts in the audio recorder, this was for me, a form of therapy, which was very necessary as I found myself 'imploding' a lot of times.

### **3.8 Ensuring Rigor and Trustworthiness**

The traditions guiding qualitative research differ from those guiding quantitative research. Criteria such as validity and reliability are replaced by trustworthiness and authenticity (Lincoln & Guba 1985). In quantitative studies validity refers to the precision of the study instrument and reliability refers to reproducibility of the research results (Hammersley 1992; LoBiondo-Wood & Haber 2014). The quantitative traditions

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<sup>17</sup> This means that Igbos are enthusiastic about money and will do whatever it takes to make money, even if it means killing people.



presuppose a fixed, objective social reality that can be measured. This differs from qualitative which assumes a non-stagnant and non-uniform social reality and are concerned with the accuracy of the researcher's findings and consistency across different researchers and project approaches (Long & Johnson 2000).

A number of steps were taken to ensure trustworthiness, authenticity, credibility and rigor (Brink 1993). First, by being reflexive throughout the research process, validity was ensured (Delamont 2008). Second, by going back to the study participants with the research notes to clarify themes and other relevant issues rigor and trustworthiness were both ensured. Finally, triangulation<sup>18</sup> of findings from the different data collection methods (Denzin & Lincoln 2011) increased the trustworthiness of study findings. Table 3.3 below provides the details of the criteria which were employed in order to ensure trustworthiness of this research.

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<sup>18</sup> Triangulation here refers to comparing findings from different data collection methods used to evaluate consistency

**Table 3.3: Criteria for ensuring trustworthiness**

<b>Criteria</b>	<b>Explanation</b>	<b>Techniques that were used to meet criteria</b>
<b>Credibility</b>	This describes the accuracy of the study findings	Interview and focus group transcriptions were reviewed by my supervision team. Throughout the research process, constant communication was maintained with my supervision team and key informants to clarify research findings.
<b>Transferability</b>	This describes the degree to which study findings can be replicated in different contexts	Findings from initial interviews conducted were compared with subsequent interviews. Additionally interview and FGD findings from Lagos were tested against those from Abuja. I maintained constant reflexivity during the interviews.
<b>Dependability</b>	This describes consistency in findings if study is repeated	I kept a detailed written and audio reflexive diary.
<b>Confirmability</b>	This describes the degree to which findings are free of researcher bias or misconception	This was achieved through constant reflexivity and awareness of the possibility of bias as well as my influence on the researched. During the writing up phase, study findings were related to the findings from previous studies.

*Adapted from Lincoln and Guba (1985) cited in Bryman (2015)*

### 3.9 Chapter Summary

In this chapter, the methods employed in conducting this research were described. The researcher's philosophical positioning, interpretivist constructivism, which acknowledges a constantly changing reality which cannot be directly measured and can only be perceived by individuals whose realities are influenced by their perspective and experiences was discussed. Gaining access to vulnerable populations and conducting sensitive research such as was the case in this study is rarely ever without dilemmas.

Negotiating access and ethical approval were imperative in this study in order to successfully conduct the research. I also discussed the importance of conducting research of this nature through a gatekeeper organisation. The phases of thematic analysis as well as procedure of conducting individual analysis employed in this research were defined. Finally, I discussed the importance of maintaining reflexivity and trustworthiness throughout the research process and how I was able to achieve this. In the next chapter, I present empirical data from this research which provides contextual information on homosexuality and HIV in Nigeria, which is crucial to understanding the Nigerian context and interpreting findings from the other chapters to follow.

## **FINDINGS CHAPTERS**

The following findings chapters are divided into two parts and are organised into five sections. These chapters which are descriptive draw on both FGDs and semi-structured interviews with HIV positive MSM accessing healthcare services from three NGOs based in Abuja and Lagos. The chapters provide insight into the daily lived experiences of men who have sex with men (MSM) living in Nigeria as they negotiate access into and navigate the Nigerian healthcare system.

The first part has two chapters, Chapters 4 and 5, which provide a picture of the context and is important in order to gain a better understanding of the chapters in part 2. Chapter 4, gives a detailed description of how homosexuality and HIV are both negatively perceived in the Nigerian context and the social, legal and religious implications of being labelled as either and/or both HIV positive and MSM. It explains how participants form their sexual identity highlighting how they understand their sexual identities and that of others. It also reports on their sexual partnerships and behaviours, including their sexual debut and more general sexual experiences, sexual roles as well as networks and transacting sex. This chapter illuminates their sexual risk taking behaviours that put them at risk for HIV. It sets the stage for the finding chapter to follow, Chapter 5, by showing how stigma and discrimination can be propagated by an unfavourable societal, cultural, religious beliefs as well as the legal context. Chapter 5 details the various forms of stigma and discrimination participants experience as well as the private and public spaces they experience stigma and discrimination. It also provides a narrative of the ways in which the participants deal with the stigma and discrimination they experience. In this chapter a new form of stigma, which I conceptualise as “Kito” a form of intragroup stigma is introduced.

The second part has three chapters, which describe how participants self-manage their HIV, access HIV-related healthcare services and adhere to their antiretroviral treatment within their heteronormative social context. Chapter 6 details how participants experience their illness (HIV) including the ways in which they self-manage it. Crucially, it discusses how participants learn about HIV and their knowledge of HIV and its transmission. Chapter 7 provides insight into the barriers and facilitators of access to HIV-related services. In this chapter, MSM specific clinics, which provide tailored services to participants are discussed as the preferred option for the participants. However, these MSM specific clinics still have some problems that may deter them from providing optimal care to this population and these issues are addressed in this chapter. The concluding findings chapter, Chapter 8, details MSM specific challenges and facilitators to adhering to ART as well as strategies which participants have adapted to maintain optimal adherence to antiretroviral treatment.

## **CHAPTER 4: HOMOSEXUALITY AND HIV IN THE NIGERIAN CONTEXT**

### **4.1 Introduction and Chapter Structure**

In the previous chapter, the methods utilized in this research were detailed. Although this research is primarily concerned with investigating the lives of Nigerian HIV positive MSM in relation to how they access healthcare services and adhere to antiretroviral treatment, it is imperative to first obtain contextual understanding of their lives especially as it pertains to their homosexual practices, which distinguish them from other HIV positive populations as well as the social context in which they experience homosexuality and HIV. This understanding can shed light on what factors influence their access to HIV-related healthcare services and adherence to ART in the Nigerian context. Crucially, an understanding of their sexual partnerships is key to understanding how they acquire HIV, an important aspect of their stigmatized identities as HIV+MSM. Therefore, this chapter presents descriptive accounts of the lived experiences of HIV positive MSM living in Nigeria including their experiences as MSM, HIV positive and the interactions between the two. Section 4.2 discusses how the study participants come to the realization of their identity as men who have sex with other men. Section 4.3 examines how the study participants understand their own sexual identity as well as heterosexual and other non-heterosexual identities. Section 4.4 discusses MSM sexual partnerships, outlining their sexual experiences, roles in sexual intercourse, sexual networks and transacting sex. In Section 4.5, an attempt is made to define the Nigerian socio-cultural and legal milieu in which HIV positive MSM experience daily life. Section 4.6, summarizes the key message(s) of this chapter.

### **4.2 On Becoming MSM: Forming of Nigerian MSM Sexual Identities**

The majority of the participants in this study reported coming to the realization of their sexuality during their school-aged (childhood) years. For some participants, this realization was expedited when classmates and sometimes family members mocked them about their effeminate mannerisms and their proclivity towards objects and activities conventionally considered feminine. For example, speaking about the realization of their sexuality, these participants stated:

***ORIGINAL:** “...when I dey small I dey do all these woman woman woman thing, I dey tie wrapper, I dey wear my sister blouse...if I go school all my friends dem go dey curse*

*me, dey say I be woman wrapper, I no dey too waka with boys. Because all that time, all my friends na girls” (Arinze, self-identified homosexual man, Abuja Interview)<sup>19</sup>*

*“Ok, hmm, ok, when I was 10, 12, I used to move with group of friends, they used to tell me, ‘why are you soft like woman like this?’ ...I was like soft like woman? ... I said oh, this is how I’m born.” (Joe, self-identified homosexual man, Lagos Interview)*

*“...since from my childhood my mum used to tell me that I like girlish thing and when I grow up, in my primary school they used to call me ‘boy-girl’, ‘boy-girl’” (Amaechi, self-identified homosexual man, Abuja Interview)*

Some participants expressed that they felt like they were female and had always had attraction for the same sex and this provided confirmation about their sexuality. For some of these participants, the realization of their sexuality was prompted by physiological developments in the body resembling the female anatomy. This is evident in the case of Ifechi, who reported that when he was younger he experienced growths on his chest which resembled female breasts.

*“But that time, when I started growing up, there is something I noticed in my nipples here, it was like growing big and that time I have not started releasing what they call sperm, it was like much here (pointing to his chest).” (Ifechi, self-identified homosexual man, Abuja Interview)*

Participants’ responses also illustrated the significant role family and religion play in shaping aspects of social life, including sexual identity in the Nigerian society. In the quote below, one participant, Lucas, narrated the role his mother and religion played in shaping of his sexuality:

*“So I was so much into girls and my mum didn’t like that idea. You know I was brought up in a very good, rooted, deep Christian family... And my mum, she is this kind of holy*

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<sup>19</sup> **TRANSLATION:** *“...when I was small, I behaved like a woman, I tied wrapper, I wore my sister’s clothes...at school, my classmates insulted me, they would say I like walking with girls, I don’t walk with boys. All my friends were girls” (Arinze, self-identified homosexual man, Abuja Interview)*

*holy person, you being close to a girl is a sin...everything about girl is a sin, oh my goodness lord. So she did everything possible to keep me away from girls...For God sake I'm a child and growing into puberty age [...] And at that point the sexual urge becomes something else, you get? ...So I believe I was a victim of that circumstance, my mum even because of that made it possible that I must go to boy's school where I would not have any access to girls, so I would be off girls because girls are deadly, girls have all the diseases in the world, girls have everything, without even knowing that the boys are even the worse one, ignorance...I don't blame her but ignorantly she was pushing me into a different world that I never knew and I wouldn't have known if not for the push and everything. So I stayed off girls completely, and then I went to boarding school, the thing happened like joke, like joke, like joke in school, touching one another stuff like that" (Lucas, self-identified bisexual man, Abuja Interview)*

For some other participants, religion played a very different role in the process of realizing their sexuality. Ibrahim, whose quote is presented below, mentioned that during childhood he had strong sexual feelings for the same sex. However, his religious beliefs caused him to experience immense conflict with his sexuality:

*"When I got to secondary school I started going into all these religious things, trying to be very very religious, going to church, I didn't want to commit sin at all. I see any act of sex whether homosexuality or heterosexual sex relationship as sin...So I started being very religious and trying as much as possible to avoid any relationship with the female peers. But then, I kept having that feeling that I am sexually attracted to the same sex, though, I tried to suppress the feelings. Each time it comes on me, I keep praying oh blood of Jesus cover me...I don't like this" (Ibrahim, self-identified homosexual man, Abuja Interview)*

Like Ibrahim, a majority of the participants who questioned their sexuality, mentioned that it was largely because their religion preached against it. According to the participants, their religious precepts suggested that any sexual act whether heterosexual or homosexual is considered inherently iniquitous, therefore in order to remain in right standing with God they had to constantly suppress and refrain from acting on these feelings. However, those who mentioned that they prayed, fasted or observed any other form of religious rites in order to rid themselves of their non-normative sexuality, noted

that it had no impact on their sexual feelings, instead their sexual feelings only intensified.

Despite noticing being different from their male counterpart, most participants did not understand what their sexual feelings or engaging in these practices entailed till they were taught or had engaged in sex with another man. These sexual partnerships and roles played a very important role in the lives of HIV positive MSM living in Nigeria and detailed findings are presented below. As expressed by an older participant, “*most people that are MSM they don’t know what they are doing until they are already into it*” (Gaddo, self-identified bisexual man, Lagos Interview). This was also expressed by other participants as in the quotes below:

**ORIGINAL:** “*When I don dey grow, I know say I be, as in them born me into it, but that time I never know say man and man dey sleep with themselves. Then when I come dey grow, when I come get the experience, when somebody sleep with me, nah when I no say so nah wetin the life be, be that.*”

**TRANSLATION:** “*As I got older, I had the experience of sex with someone and that is when I knew that this is what homosexuality is*” (Arinze, self-identified homosexual man, Abuja Interview)

“*...I’ve always had attraction for guys. If I see maybe a cute guy then I would just admire the person, then I don’t know what that feeling was, I would just [think] oh this person is cute...I think it was through my cousin that is also an MSM because we were very very close, that I got to know that yes this is really who I am.*” (Sule, self-identified bisexual man, Abuja Interview)

In the section that follows, participants’ understanding of their sexual identity and other sexual identities are explored in more detail.

### **4.3 Nigerian MSM Understanding of Theirs and Other Sexual Identities**

Nigerian MSM appeared to understand theirs and other sexual identities but perform their sexuality in a way that complies with the prevailing norms in Nigeria. Although, there was a sense of ambivalence about theirs and other sexual identities, evident in most MSMs’ conceptualizations is the consideration of both emotional and sexual



attraction as well as sexual practices, both of which are necessary components of sexual identity. This section presents findings on how Nigerian men who have sex with men (MSM) construct meaning around and understand theirs and other male same sex sexual identities and practices.

Participants' understanding of homosexuality, bisexuality and heterosexuality appeared to be varied. Their understanding also appeared to be highly fluxional, especially when it related to heterosexuality. While some participants described these concepts in relation to sexual practices, others described them in relation to sexual identity. Although, participants' responses revealed a general understanding of homosexual as emotional and sexual attraction to the same sex as well as engaging in same sex sexual intercourse, some participants noted that merely engaging in same sex sexual intercourse was not a requirement for being defined as a homosexual. Rather, men could be motivated to engage in intercourse with the same sex by factors other than sexual desire. These factors included financial advancements, employment opportunities, favours and recreation. The concept of 'pure homosexuality' was introduced by some of the study participants. A 'pure homosexual' according to participants is one who is only interested and gets sexually aroused by the same sex and rejects the idea of any form of sexual relationship with females. In relation to bisexuality, the general understanding was that bisexuality requires either emotional or sexual attraction to both same and opposite sex as well as engaging in sexual intercourse with both sexes. Some participants' responses however revealed the complexity of bisexual identity in Nigeria. For example, Chris explained:

*"I have a boyfriend, he does girls, he's a bisexual, I cannot even call him a homosexual, talk of gay, he's not. I'm into him, I used to tell my friends. Although him, he's telling me it's play, it's joke but me I understand. I was the one that lured him into it, he's not into it and that he has done men once or two times doesn't make him a homosexual...On a good day like that, we had it, then now we are living together, he doesn't do it, he told me it irritates him, he's not in it...You can call him a bisexual because he still kisses me, he still sucks me and plays with me, he doesn't go to the strafing side of it, like fucking me. He says it irritates him, so you can't call that person a homosexual, he's a bisexual, he does girls more than even guys"* (Chris, self-identified bisexual man, Abuja)

The first point to be noted from the quote above is that once a man engages in sex with a woman he may be considered bisexual. It further illustrates some participants understanding that an individual may not be considered homosexual merely because he has sexual intercourse with another man. Additionally, like Chris, participants' reported that a man can be considered bisexual regardless of whether he enjoys sexual intercourse with other men or the extent of his sexual involvement with other men. The mere fact that he engages in a same sex sexual relationship is sufficient for him to be considered bisexual. This is in many ways similar to Akin who although attracted to women as well as men, considered himself homosexual because he had only engaged in sex with other men and never had the opportunity with women.

In relation to understanding of heterosexuality, the general consensus amongst participants was that for a man to be considered heterosexual he must not only be sexually and emotionally attracted to women but he must also be able have sexual intercourse with women. According to participants, a heterosexual man typically rejects the idea of homosexuality and is put off by it. Some participants however, mentioned that many Nigerian men who identify as heterosexual may actually engage in sex with other men either because they were lured into it or as a means of making money. According to participants, these heterosexual identifying men who are lured into homosexuality, engage in it for financial achievements or are the penetrative partner in sexual intercourse who may not necessarily consider themselves homosexual or bisexual. Participants also noted that heterosexual identifying men under certain circumstances, for instance, the influence of alcohol or drugs may engage in sex with other men and not consider themselves homosexual or bisexual. These men who secretly engage in sex with other men were referred to by participants as 'being in the closet' or 'down-low'.

The participants' understanding of the term MSM, like other sexual categories and identities also seemed to be fluid in practice. Participants generally considered MSM to be men who may have sex with men for reasons other than sexual or emotional attraction. According to participants, for such men, sexual behavior is not a part of their identity but just a 'game' and as such they can 'exit' whenever they have achieved their goal. Perhaps, this impermanence, that is the ability of an MSM to 'exit the game' at his convenience, is one of the reason why some participants particularly those who self-identified as homosexual did not describe themselves as being MSM. Some participants

stated that they understood being MSM and being gay to be different. For example, SO by differentiating MSM from gay men in his statement “*I’ve had sex with a lot of people, not even MSM alone, not even gay men alone...*” implies and in fact, acknowledges that these are two distinct categories. Furthermore, Chris’s statement, “*so being MSM in Nigeria...when you are talking about MSM oh Miss Bisola, it’s different from gay... because MSM is not really gay*” illustrates in a more direct way, his understanding of both concepts as distinct.

As the findings from Section 4.2 suggested, participants’ general understanding differed from what might be described as mainstream or even hegemonic heterosexual identities in Nigeria. A majority of the participants considered their sexuality to be an innate and natural part of them, given to them by God others considered it to be circumstantial. Importantly, those participants who understood their sexuality to be innate stressed that they were neither taught nor lured into engaging in homosexual practices:

**ORIGINAL:** “*To me ehn I think I was born being gay, so I found myself being gay, I found myself ok this is who I am...so this thing dey my blood, nobody teach me*”

**INTERPRETATION:** “*For me, I think I was born gay, so I found myself being gay, I found out that this is who I am...so being gay is in my blood, nobody taught me*”  
(Arinze, self-identified homosexual man, Abuja Interview)

“*Me, I see it as the way God created us because no one choose to be this...it is not an attitude, it is not a behaviour, it is natural...It is diversity in a human being, this is who we are, they should accept us, that would automatically reduce the prevalence of HIV in Nigeria, and that is it.*” (Olu, self-identified homosexual man, Lagos Interview)

The quotes above illustrate participants understanding of their sexuality as natural, innate or God-given. The emphasis on not being taught or lured into homosexuality served to further authenticate their claims of being ‘born this way’. In relation to the second quote, Olu went a step further in his interpretation of his sexuality as God-given, by affirming that the status of the HIV epidemic would be improved if only they were accepted by society. This understanding of his sexuality appears to underscore the fact that MSM are being marginalised based on an attribute which is out of their control. Additionally, Ifechi supports his point that he was born having homosexual tendencies

by mentioning that he had never had sex with a woman. Ibrahim, a self-described homosexual man, reported that although he had previously engaged in sexual intercourse with women, he still considered himself to be ‘homosexual’<sup>20</sup> because since he started developing sexual feelings towards others, they had never been towards women.

Participants who understood their sexuality to be circumstantial stressed that they were either ‘lured’ or sexually abused:

*“It was during my NYSC I was lured to it. Though it wasn’t easy but a friend of mine that we were in the same school...I don’t even know who he is. Unfortunately, they posted both of us to the same state and he has been coming closer, he has never talked to me, this is what I want, but before you know it as if a kind of...before you know it, it happened as if a kind of rape. I said ah, what is your problem? Are you alright? I was thinking that maybe he has a mental problem, but along the line he opened up to me (DEEP SIGH). I was pissed off as a human being and that created enmity between me and him for a very long, for about few months...So he came around on a very good day, I said ok, you have been disturbing me, what do you want? I was thinking that if I do that once that maybe he will leave me out and I’d just continue with my life. After then he keep on continuing...along the line, I danced to the tune (DEEP SIGH). So that is how I found myself into the game” (Emeka, self-identified bisexual man, Abuja Interview)*

*“but I look at myself apart from me being cajoled into this, my uncle apparently abused me sexually when I was younger, curiosity apparently pushed me out, despite the fact that I was girly, I wanted to try and understand, why is my uncle doing this? I wanted to understand why, but apparently he tried it for the first time, I enjoyed it and it was a huge turn around in my life I have no regrets ever” (Hasan, self-identified bisexual man, Lagos Interview)*

Participants who self-identified as bisexual were more likely than those who self-identified as homosexual to perceive their sexuality as circumstantial. These participants reported that they considered themselves to be bisexual because they were also emotionally and sexually attracted to women. Lucas, for example, reported that he

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<sup>20</sup> Homosexual here refers to sexual desire and not just sexual behaviour

understands himself to be bisexual because of his sexual attraction to females from childhood. This was regardless of the fact that at the time of the interview he mostly had sexual intercourse with other men.

*“...but I fall into the group of bisexual, because I remember when I was a child I was so much into girls, I like girls, I love girls. I remember things I did in the dark with girls when I was small... I never had any feeling for a guy, never had any feelings for a guy, never knew such thing existed, I never knew” (Lucas, self-identified bisexual man, Abuja Interview)*

Lucas particularly understood his practice of sex with men to be circumstantial and as a result of being sent to an all-boys boarding school where he was exposed to these practices. He also expressed his desire to stop engaging in sex with men but like other participants, he expressed that it was out of his control. He had also been involved in sexual relationships with females one of with whom he claimed he loved so much that “[he] forgot [he] was gay” (Lucas, self-identified bisexual man, Abuja Interview). He narrated that while he was in a relationship with this particular female, he had engaged in sexual intercourse with her male cousin and when she found out, she ended the relationship. However, if he met another female like her, he would forget he is gay. Like Chris, he expressed his desire to one day get married. However, while Lucas referred to himself as ‘homosexual’, Chris expressed that his desire to get married meant he did not consider himself to be ‘homosexual’. Furthermore, he was able to control his sexual practices with men and considered his practices to be a game.

*“Hmm like I said I am a bisexual because in no distant time I would get married... me I think, I am a (LAUGHS) bisexual anyway, even though it’s in me but I regulate<sup>21</sup> myself” (Chris, self-identified bisexual man, Abuja Interview)*

While most participants seemed to have a clear understanding of their sexuality, some participants’ responses revealed ambivalence about their sexuality as revealed in the excerpt below:

*“Akin: ...I know I have not had sex with women...I started with men and I’m still with men.*

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<sup>21</sup> Regulating himself is another way of saying he is able to control his sexual practices

*A.O.B: Ok, so you are attracted to women as well?*

*Akin: A lot, I am!*

*A: Ok so you consider yourself homosexual instead of bisexual?*

*Akin: Yes, I consider myself homosexual in the sense that I have never had sexual intercourse with a woman but I am attracted to women....*

*A: ... if you have the opportunity to have sexual intercourse with a woman, you will?*

*Akin: Yes, definitely I will.*

*A: So does that not make you bisexual?*

*Akin: (LAUGHS) I think bisexual is when you have both... when I hear of bisexual, what I believe is someone that has sex with both men and women. But me I've never tried women, so I keep saying I'm homosexual, I'm homosexual because I've never had that of a woman." (Akin, Self-Identified Homosexual Man, Abuja Interview)*

The excerpt above illustrates the case of a man who is sexually attracted to women but self-identifies as homosexual because although he is sexually attracted to women, he has never engaged in sexual intercourse with one. Here, we observe that his understanding of his sexual identity is based not merely on sexual attraction but on sexual practices. In other words, for a man to be considered bisexual he not only has to have sexual attraction to women but he has to have engaged in sexual intercourse with them.

Ambivalence and confusion about sexuality was expressed in a different way by another participant who self-identified as bisexual but expressed that he initially considered himself to be homosexual and had only recently developed attraction to females:

*Hasan: The first time I brought a girl home, my mum was like are you sure of what you want? I was like this is what I want, she was like are you sure? Because she knows that I am very effeminate and despite that, I transformed myself, it was this really huge transformation because I was really girly then but as I was growing up, I started mixing with other straight guys, who I could look at them and behave like them but deep down, I feel like I am a girl, clothed in a man's apparel but this who I am, I'm gay, I don't like girls. But growing up, I started liking girls a bit because I love big boobs, slim girls that have big boobs and have big ass*

*[BREAK]*

*Hasan: (LAUGHS) ...like I said in the beginning, I'm confused! If you remember, I said I am so confused [A: So you are bisexual?] bisexual and bisexual let me not forget, we have bisexual who love guys more and we bisexual who love girls more [A: oh ok, which one are you?] I love guys more, sweet Jesus, guys, just 2% of me loves girls, yah! (Hasan, self-identified bisexual man, Lagos Interview)*

The excerpt above illustrates how sexual identity may change over time. In this case, Hasan during his childhood was only attracted to the same sex but as he got older, he began keeping the company of heterosexual men. With time he began to develop their 'masculine' mannerisms, which are in line with the hegemonic social ideals of masculinity in the Nigerian society. He later developed attraction for females as well. He in particular stated that he was confused about his sexual identity, however, he can be categorised under bisexuals who prefer men over women. It should be noted that the general consensus among participants was that sexual attraction and sexual practices were both requisite for the conceptualization of bisexuality.

Some self-identifying homosexual and bisexual participants reported that they were expected to get married and have children in order to meet up to cultural expectations of the heteronormative Nigerian context. Some others just had the desire to either get married or have children as illustrated in the quotes below.

*"Hmm like I said I am a bisexual because in no distant time I would get married...it's the money that I'm looking for...I think I am matured, I am matured, one, I'm a man, I don't categorize myself as a, even though whether they straff me, I straff them, it's not my issue. [I am] the only son of my parents, so you should know what is boiling on my head, and [I am] a graduate too. So the issue there is that there's no money yet. Had it been that there's money if there are other places in the East they would force you to get married, your parents will pay the bride price, they would do everything for you to get married. But me, I don't like that perception, my parents to get a wife for me, no, no, fuck that. I need a woman of my choice, a woman that can understand me and I understand her" (Chris, self-identified bisexual man, Abuja)*

*"A: So you desire to have kids, you desire to get married? Akin: Even if I don't desire to get married, I desire to have kids. It's not a must I must get married to have kids [A:*

*YES, YES] it's not a must, I can have kids out of wedlock" (Akin, self-identified homosexual man, Abuja Interview)*

The quotes above illustrate why some participants desired to get married and have children. As the only son of his parents and also being a university graduate, Chris, like all other participants, is expected to get married and have children. This depicts the social and cultural expectation of Nigerian cultures that require a male child to get married once he is of age. Finally, one of the study participants understood himself to be transgender and not homosexual. According to him, this is because during sexual intercourse with a man he feels like he is a woman.

The findings presented in this section, illustrate how male same sex sexualities are conceptualized by Nigerian MSM. The participants highlighted ambivalence, fluidity, and the complexity of sexual identities and practices in the Nigerian social context. It is apparent that homosexuality refers to the practice of engaging in sex with other men and not necessarily sexual identity as may be implied elsewhere. The next section reports on MSM sexual partnerships, including their sexual experience, roles and networks as well as transacting sex, which are pertinent to their experiences as HIV positive MSM living in Nigeria.

#### **4.4 Nigerian MSM Sexual Partnerships**

##### **4.4.1 Sexual Experience**

Similar to when they came to the realization of their sexuality, participants reported that they had their first sexual encounter with another man in their adolescent to young adult years and in most cases in school settings. These sexual encounters were generally with older men some of whom they transacted sex with. As highlighted in the quote below:

*"... But I don't have the experience of the sex, it was when I was in JS3, in Command, so that was my first experience of having gay sex...That time when I was in secondary school, I know I have mature people that I do sneak in the night and meet them, but you know, they used to help me with money after we have sex." (Amaechi, self-identified homosexual man, Abuja Interview)*

This was the case for all but one participant who reported that his first sexual encounter was with a younger boy, who taught him all he knew about anal sex. This participant,



Lucas, who had previously been jilted by an older man, expressed his dislike for older men.

Penetrative sexual intercourse occurred much later for most participants, instead they engaged in what they called ‘laps’ which is a form of mutual masturbation and other forms of non-penetrative sexual intercourse. As they advanced in age, however, participants reported that they began engaging in penetrative anal sex with partners with whom they were either in a relationship or transacted sex with. For example, participants when asked about their sexual experience stated:

*“...you know initially, this gay stuff, it’s in this recent time that people started this anal penetration. I think when we were like growing up, I don’t know what is anal penetration, I got to know that was in 2008, still in HND<sup>22</sup> or something...then when I was doing it, it’s laps we do, person would just insert the cock [between the laps] and after some minutes the person would cum, you would cum, nothing like this anal penetration [A: AND THEN YOU HAD THE ANAL PENETRATION IN 2008?] That is what I’m telling you now. That is when I got dis-virgined through the anus” (Chris, self-identified bisexual man, Abuja Interview)*

*“... practically I started having this when I graduated from secondary school, which was 2011, I was 16 years, that’s when I had my first sex, but I’ve been having like oral sex when I was in the secondary schools I attended and boarding school, which I had been having with one of my classmates then but there was nothing like penetration, the real gay sex then” (Olu, self-identified homosexual man, Lagos Interview)*

Many participants in the study who self-identified as either bisexual or homosexual mentioned that they had engaged in sexual intercourse with a female at some point in their lives. The majority of the homosexual identifying participants mentioned that they had only engaged in sex with a female once when they were younger but only because they were pressured to do it or did it for financial gains. At the time the study was conducted, the majority of the bisexual identifying participants mentioned that they were in concurrent sexual relationships with both males and females. Two of these

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<sup>22</sup> HND is Higher National Diploma

participants (Hassan and Gaddo) had been married in the past and both reported actively engaging in sexual intercourse with their wives and other men while they were married.

#### 4.4.2 Sexual Roles and Networks

Accounts of participants in this study appeared to suggest that sexual roles in MSM sexual partnerships are also fluid. Participants who weren't strictly 'top' or 'bottom' reported that depending on the situation, they could take on the 'insertive' ('top' role) or the 'receptive' ('bottom' role) or both roles in sexual intercourse. Participants referred to those MSM who take on both top and bottom roles as 'vers' meaning versatile.

While two participants stated that they were always exclusively top (Gaddo) or bottom (Olu) during sexual intercourse, others mentioned that they had either taken on the versatile role in the past or actively take on the versatile role. Participants who were the insertive partner but mentioned that they had on some occasions taken on the role of the receptive partner, did so in the context of a trusting relationship.

*“I am top, that doesn't mean I have not been fucked once. You get? Because when you are in a relationship and your boyfriend says ok I would like to know how it feels to fuck too, you can't deny it that because you are just top, I believe that is just being selfish because we are all gays, you get? So if he also enjoys fucking, why would you deny him that? Claiming you are the top so he must be the one to receive all the time, that's selfish, very selfish...So I don't really believe in this our thing, that there is anybody that is strictly top, there's no such thing...I don't enjoy the other part of being the bottom, I don't at all, as a matter of fact it is punishment, but sometimes you need to sacrifice some things for somebody you say you love...” (Lucas, self-identified bisexual man, Abuja Interview)*

Taking on the receptive role for an insertive partner as indicated in the quote above was done even when it wasn't necessarily enjoyable for the fostering of mutual trust and 'selflessness'.

Sexual preference, social media and transactional sex seemed to be key factors in shaping the Nigerian MSM's sexual network. Participants mentioned how the 'gay' community is well connected across the different states in Nigeria. Describing the extent of these connections, a participant said: *“You know in the gay community it's a place like they have channel of knowing people from different states, at least a friend*

*can give you a number to go and meet another person in a different state.”* Most participants stated that through social media, they have been able to connect with other men for sex in Nigeria. The quote below illustrates how these connections are made:

*“I went online, I started meeting people then we started chatting, then I hooked up with this guy that we dated for like some time... Then okay, prior to that time, I met his friend that we were in a bar together and his friend snapped my picture and sent my footage to a friend of theirs that was in Vietnam. So this guy was so attracted to me [LAUGHS] from a picture and I have not even talked to this guy. This guy left Vietnam down to Nigeria to see me.”* (Wale, self-identified pansexual man, Lagos Interview)

Although social media appears to be a valuable tool for the MSM in this study looking to form sexual partnerships, as would be revealed in the next chapter, it was also used to facilitate community based blackmail and discrimination, which the participants referred to as ‘Kito’.

#### **4.4.3 Transacting Sex**

Some participants in the study mentioned that at some point in their lives, most Nigerian MSM would have transacted sex and may still actively be transacting sex. One participant explained:

*“...nobody that is ‘TB’ would say that he has never done ‘runs’...it’s more like prostitution. Someone at the early stage you would now decide to be a prostitute, maybe you are doing it to help out in school or to help your family out at a time you feel that you’ve achieved your aim, you now decided to like quit”* (Akin, self-identified homosexual man, Abuja Interview)

In this study, the main motivation for transacting sex was financial sustenance. Most of the participants in this study were not gainfully employed and needed extra money. A benefit of transacting sex was attaining some form of financial freedom as they were able to make enough money to complete their education, rent their own accommodation and fend for themselves. Like the quote above suggests, MSM who transact sex may stop when they have achieved their goal, which for many was financial independence.

Transacting sex often meant that MSM had to travel to different states in the country to meet potential partners. Generally, participants mentioned that after they were initially diagnosed with HIV they stopped transacting sex. However, one participant explained that when he was diagnosed initially he still transacted sex and would pretend to be healthy to get customers:

*“...then in Abuja that time, we used to go to Millennium Park, up Ghana street, stay in the streets looking for customers to come, then! So I would pretend like I’m healthy and then you know, even now, maybe you are hungry, you are looking for 10000 naira and you meet somebody that will give you 30000 naira without using condom and you don’t have any other alternative than to do...” (Amaechi, self-identified homosexual man, Abuja Interview)*

Participants discussed that when transacting sex, their partners are willing to pay more for sex without condoms. Although most of the participants in this study mentioned that they always use condoms when they transact sex, Chris pointed out that because MSM are not empowered and are not gainfully employed, they may agree to transact sex without condoms:

*“...they (MSM) need little things to empower them...and by the time somebody is doing something...you would hardly fall into these HIV diseases and all that. Because most of the times, you try to see that what is happening to us is that when you go to all these runs, what if this person is paying 100,000 (naira) and he basically tells you that he’s not going to use condom, you have no option, maybe you have to give, because the money is too huge and you don’t have it, if you leave it and go home, you would go hunger [sic]” (Chris, self-identified bisexual man, Abuja Interview)*

Here the importance of financial independence is stressed. Equally stressed is the ease at which HIV can be spread through the transaction of sex and through MSM sexual networks. Participants mentioned that transaction of sex may occur in hotels, shared accommodation and is not necessarily limited to roadside. Participants reported that while most MSM have engaged in roadside ‘sex work’, transacting sex in their network is much more sophisticated and usually involves the development of long-term contacts. They further mentioned that transacting sex doesn’t always involve the exchange of money for sex; rather they may require their transportation fare be paid or a favor. This therefore distinguished transacting sex from mainstream prostitution. In this section,

findings on MSM sexual partnerships, and high risk behaviors such as UAI in sexual transactions, which may potentially encourage the spread of HIV within as well as outside of MSM networks. The next section reports on HIV positive MSM in the socio-cultural environment of Nigeria.

#### **4.5 HIV Positive MSM in the Socio-Cultural Environment in Nigeria**

This section defining the socio-cultural and –legal environment in which HIV+ MSM lives is organised into three sub-sections. The first sub-section is a discussion of the ways in which men who engage in homosexual practices are identified in Nigeria. The second sub-section is a discussion of societal perception of HIV as well as homosexuality and ‘homosexuals’. Finally, the third sub-section is a discussion of the social (cultural and religious) and legal consequences of engaging in homosexual practices in Nigeria as reported by the participants.

##### **4.5.1 Markers perceived to be associated with MSM**

In Nigeria, men who engage in homosexual practices are identified through a number of ways. One of the most significant ways reported by participants is through the presentation of effeminate mannerisms. Wale illustrates this point in the quote below:

*“I can remember vividly while growing up, I had this friend that was extremely feminine, then if we are going out I would tell him that okay, you know that I am not discriminative and you know I am not discriminative but just to save my own ass and your own ass, I would want you to please curtail the way at which you behave. But he knows, he understands and sometimes I am even scared for him, do you get? Because if you go out there’s no how he is gonna try to man up uhn, people would still tell him ‘god you’re gay’, ‘why you behaving like a female?’, ‘Why are you doing this, can’t you man up for a while?’, ‘That is why Sodom and Gomorrah was condemned’, and all of that, ‘ah you will rut in hell!’...” (Wale, self-identified pansexual<sup>23</sup> man, Lagos Interview)*

The above quote exemplifies how effeminacy is perceived in the Nigerian society as a marker of homosexuality and an attribute that many seek to conceal or distance themselves from in order to avoid being stigmatized and discriminated against. Participants suggested that the typical African man is quintessentially masculine, he

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<sup>23</sup> Pansexual here means gender blind

typically has a wife or girlfriend, may have children and he can be said to “walk like a man” or “talk like a man”. They further stated that in the Nigerian society, a man who goes against these expectations by presenting “feminine” characteristics would be looked upon with disdain, he would most likely be the topic of gossip and ridicule as in the quote above, he may face violence and he will automatically be labelled ‘homosexual’ even if he is not.

MSM in this study suggested that another way in which a man who engages in homosexual practices can be identified is if he is always seen with other men and never in the company of women. This is especially so in private spaces, like their homes and in hotels. As illustrated in the quote below:

*“...living here in Abuja, the place that I was staying, sometime people would be talking, my neighbors, area people, that this guy is gay, they’ve never seen him with a woman, it’s only guys guys that always visit him. You know people would be talking, even though they don’t have any evidence but because they feel that this is what you are supposed to do and you are not doing it, they would now tag you gay.” (Sule, self-identified bisexual man, Abuja Interview)*

Societal perceptions imply that a man who has only men visiting him regularly must be engaging in sexual intercourse with them as demonstrated in the quote. Otherwise, it serves as ‘confirmation’ to society that he engages in homosexual practices. As discussed in Chapter 2, it feeds into the dominant patriarchal narrative that suggests that a Nigerian man should have a ‘harem of women’ around him to prove his virility and his masculinity.

Although, this will be addressed in its own chapters to follow, it is necessary to make a point that stigmatization and discrimination as illustrated above are the direct result of these societal perceptions about homosexuality.

#### **4.5.2 Societal Perceptions of homosexuality and HIV in the Nigerian Context**

One of the prevailing perceptions of homosexuality in the Nigerian society according to participants is that homosexuality is against Nigerian culture. Participants expressed that

their homosexual practices were perceived to be a taboo, as illustrated in the quotes below:

*“...being MSM, most of us, we are on the streets, because we are MSM. We, MSM some of our family members have rejects us because you are MSM, they would say you are doing demonic things, it’s not our culture....” (Arinze, self-identified homosexual man, Abuja Interview)*

*“This is insanity, this is demon, you have been casted, this is a big spell on me, she sees it like a demon, that somebody in the family, you know Yoruba mentality now, ‘won they e’, they are doing you, they are following you...” (Olu, self-identified homosexual man, Lagos Interview)*

*“... the way the country perceives them (MSM) and the way people relate to them (MSM), like (they are) nobody, demons, possessed. So that would just make them (MSM) go into their shell” (Yemi, self-identified homosexual man, Abuja Interview)*

Participants described how homosexual practices are perceived as ‘demonic’ and against the Nigerian culture. These perceptions lead to family rejection and their inability to express themselves. Family rejection here is a form of social rejection, which is a consequence of societal perceptions that homosexuality runs counter to key hegemonic cultural values and mores<sup>24</sup>. Therefore, the narrative, as Arinze states above, suggests that men who engage in homosexual practices are demon possessed and should be excluded from all forms of social interaction. Rejection from the family could mean being evicted from their homes by family members or being disowned by parents as experienced by some of the participants. Additionally, the inability to express themselves means that as stated by Yemi, in his quote above, they are likely to retreat from social interaction and are driven ‘underground’ and away from necessary social and healthcare services.

Along the same lines of the practice of homosexuality being ‘un-Nigerian’ is the perception that it is a ‘borrowed’ lifestyle imported from the West as noted by one

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<sup>24</sup> Hegemonic cultural values and mores in the context of this research refer to values and mores which are highly patriarchal and heteronormative

participant. In the following quote, the tension between his understanding of homosexuality and societal perceptions of homosexuality is exemplified:

*“It’s not an easy thing for people to identify you as a gay in this community because it is highly against our moral standards as Nigerians....it is a belief that it is a [...] kind of borrowed lifestyle from the Western country and all that but not knowing that this thing can actually generate itself here.” (Kunle, self-identified homosexual man, Abuja Interview)*

Participants further mentioned that they were assumed to have the ability to make a choice or seek spiritual help to deter their homosexual desires and practices. As such members of the society including family members, healthcare workers and well-meaning members of society take it as their duty to ‘correct’ their sexual practices which they judged to be deviant:

*“...But I know that some people say it can be corrected, you go to the church, you pray, you fast, oh sweet Jesus, can you just shut up and just free yourself, I don’t think anybody can correct it, it comes from within...” (Hassan, self-identified bisexual man, Lagos Interview)*

Many participants, like Hassan spoke about how they were chastised by others such as healthcare workers because of their sexual practices and told to change their ways. Some participants stated that they went as far as preaching to them and telling them to stop attending the MSM friendly healthcare centers. One participant in particular stated that some healthcare workers at the MSM clinics became friendlier with them when they observed that they were ‘changing their ways’. Others reported that because of these perceptions they prayed, fasted and went for deliverance in order to stop their homosexual practices. This was the case particularly when they had internalized these perceptions.

It should be noted that there appears to be a distinction in how affluent and impoverished MSM are perceived in the Nigerian society and this highlights existing power dynamics in the Nigerian society. For instance, one participant reported,



*“If I am to be very wealthy now and they know me as a homosexual, they might not have maybe power to come to lynch me or something, they would all be assuming I am a ritualist I am using those people’s star to make money, I get close to any of those guys to use their star to enrich myself, that is their mentality towards it. But if you are poor, (they will assume) maybe you just committed abomination because they don’t know what you are using it for, what came over you to even do it. If you are rich they would say ok he’s a ritualist, it’s because of the money that you want to use it to make, because you are a ritualist you must have gone to babalawo<sup>25</sup> that would now say you should go and make love to a man but now you are poor what happened? That means you are just possessed by one demon to commit abomination either you should be lynched or you should be banned from the community, you understand?” (Peter, self-identified homosexual man, Abuja Interview)*

Affluence, in the Nigerian society, confers social power. The above quote illustrates how society regards men who they believe hold socio-economic and/or -political power. It further suggests that there is some sort of safeguard for the affluent man who indulges in homosexual practices so that even if he were to deviate from what is widely regarded as the cultural norm, no one has the power to do anything about it. He is either pardoned or labelled a ritualist<sup>26</sup> who uses the men or boys he engages in sex with for financial enrichment or he is able to bribe his way out. The reverse is the case for a poor man who engages in homosexual practices, he is seen to have committed an act with no valid basis for his actions and he is even more demonized and could be subjected to social rejection or even lynched. This is illustrated below in the dialogue between two Lagos FGD participants:

*“Mustapha: I even heard about one (case) in Ondo state, a politician and a man, a married man actually with two kids and a wife... Let me just cut the long story short, they caught them in the act and the politician was able to bail himself with some money...*

*Olu: No, he ran away, even till now they’ve not seen the man*

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<sup>25</sup> Babalawo in the Yoruba Nigerian culture is a traditional doctor/diviner who upon request has the power to tell people their futures and alter their future for better or worse. He is able to give wealth, health, long life or anything, good or bad a person pleases. People seek him for the provision of wealth, in most cases, they have to give something in return through rituals or sacrifice.

<sup>26</sup> Ritualist in this case is a person who uses black magic/spiritual powers to generate wealth

*Mustapha: Yes, but he paid some money...*

*Olu: ...The politician you mean?*

*Mustapha: Yes, the politician!*

*Olu: He's out of the country*

*Mustapha: He's out of the country, yes! but before they allowed him out that day, he paid some amount of money...*

*Olu: But he was able to bail himself out and the other guy was beaten...*

*Mustapha: Well not really bail himself, he dropped some money, then he ran but they are still looking for him according to what they said. Then they killed the other guy, they brutally beat him up and he died in the hospital, he's a man, a married man...if you say they are MSM, why would you take bribe from his hand? And also beat up that other one, you could have just leave the two of them and take bribe from one person that would settle the both of them but they were like no, he has to pay this amount, the politician was able to pay his own amount but the married man was unable to pay, so they now had to beat him up" (Lagos FGD)*

The use of money as currency for pardon is clear from the excerpt above. The situation is such that the wealthy can bribe their way out, leaving very little prospects for the impoverished. This concept of affluence as power and respect, is reflected in some of the responses to the FGD icebreaker question asking what participants would do if they won an unlimited amount of money through the lottery:

*"As for me, if I get that kind of money, you know I used to hide that I am a gay, so this time around I will announce not only in Nigeria but for the whole world to know that I am a gay because nobody will hold me again, my family will no longer reject me because already I am the bread winner" (Kola, Abuja FGD1)*

*"Well I don't do lottery but if per adventure I was to win that kind of money, first of all what I will do is to shut the mouth of all the straight guys in the street, with that money because money has power... I will make him shut up and respect anyone who is gay, bisexual, lesbian or transgender..." (Bode, Abuja FGD1)*

Generally, participants could not separate their experiences of being MSM in Nigeria from being HIV positive as these were often experienced simultaneously. Across the interviews and FGDs, participants stated that two dominant narratives persisted in

relation to HIV. The first is that HIV represents retribution from God for the ‘sinful’ behavior of men who engage in homosexual practices and the second is that men who engage in homosexual practices are ‘reservoirs’ of HIV. The quotes below exemplify these perceptions and the implications for men who engaged in homosexual practices:

*ORIGINAL: “Because sometimes now, people believe that, you don’t become HIV, nah the curse wey God curse you be that because of sin, una be gay, MSM.” (Ifechi, self-identified homosexual man, Abuja Interview)<sup>27</sup>*

*“...ok being HIV positive in Nigeria as a gay person is very bad, because they (society) feel MSM in general are the HIV carriers... it’s because of what you are doing, that’s why you are positive...So, if you want to be open, if you want to be a positive living person, you have to be straight, you have to be heterosexual, you cannot say you are gay and you are positive. That is it.” (Mustapha, self-identified homosexual man, Lagos Interview)*

The first quote illustrates the influence of religion on perceptions of HIV and homosexuality. In Nigeria, members of society view HIV as a punishment from God for homosexual practices, which is considered to be sexual sin. This narrative is particularly predominant amongst religious and cultural adherents in Nigeria. The second quote illustrates the perception of men who engage in homosexual practices as the reservoirs of the disease. Since it is widely assumed that HIV is primarily spread through sexual contact, given that the sexual practices among this group are considered ‘unnatural’, sinful and an abomination, it is perhaps unsurprising that MSM are perceived to be reservoirs of the virus.

According to some participants in this study, another widely held perception of HIV is that it is a ‘death sentence’. This perception was not necessarily related to only MSM but PLWHA in general. One participant in particular, TW, stated that when he disclosed his HIV positive status to his family members they started crying because they believed he will die very soon. Another participant stated, “...some people believe that once you have HIV, you are dead, it’s a death sentence” (Akin, self-identified homosexual man, Abuja Interview). The origin of the perception of HIV as a death sentence could

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<sup>27</sup> TRANSLATION: “Because now, people believe that you have become HIV positive and it is a curse from God for the sin of being gay, MSM” (CH, self-identified homosexual man, Abuja Interview)

possibly be traced back prior to the availability and accessibility of antiretroviral treatment and diagnostic tests, resulting in the deaths of infected individuals within days or weeks of diagnosis.

#### **4.5.3 Socio-legal and Religious Implications of Homosexuality and HIV in Nigeria**

Participants expressed fears and concern about their inability to express themselves in light of the ‘*Same Sex Marriage Prohibition Act*’ (SSMPA) otherwise known as the ‘anti-gay’ law. Similarly, another participant speaking about the implications of the law stated:

*“Being MSM in Nigeria is not easy because the country doesn’t want it; the country tags it as a crime, because they criminalise it, so to them it is a crime. If they find you doing this you go for jail, 14 years’ imprisonment so it’s not easy.” (Sule, self-identified bisexual man, Abuja Interview)*

In the dialogue below, Joe discusses the consequences of the punitive law on MSM in relation to their sexual partnerships:

*A: Ok so now I would ask you what it is like being an MSM in Nigeria?*

*Joe: Ok being an MSM in Nigeria, you know the law in this country, they said it’s 14 years once you are caught, so everybody is like hiding, everybody is looking for ways, how to have safe sex with his partner so that they would not get caught, so we are just hiding. So it has not been easy at all for we, MSM here in Nigeria. What you are enjoying that you are sneaking to eat, what you love to eat and you are hiding to eat... (Joe, self-identified bisexual man, Lagos Interview)*

In Nigeria, engaging in homosexual practices is not just considered socially and culturally unacceptable it is also criminal. Participants reported the fear of running into trouble with the law as the reason behind their inability to express themselves in public spaces. For example, according to Mustapha as a result of the law “*a man having sex with a man is...very scary [and] very secretive because you cannot express your feelings outwardly in the public*” (Mustapha, self-identified homosexual man, Lagos Interview). Some participants reported having to ‘man-do’ when they were out in

public. ‘Man-do’ here implies performance of masculinity, which for some participants did not come naturally. They further reported having to change their dressing and mannerisms in order to avoid running into trouble with the police or attracting societal scrutiny. Some reported that they were arbitrarily searched by police on the road and threatened to reveal their sexual partners under duress if they had any incriminating items in their possession.

Despite this disabling crimino-legal context, however, gay parties, marriages and event were still frequently held and this is evidenced in participants’ accounts:

*“...me in the East oh, I’ve done some of my gay parties, I did my graduation party, it was pure gay and ladies party, as in lesbian party, yes! ...I did the second one again, that was my birthday party...then I now did the last one, I had my engagement night, with my ex-boyfriend. Although it was in the night, engagement night...we printed 100 cards and it got finished, we shared it, to our friends that came for the engagement night and we had a wonderful party...I have also witnessed pure marriage in Nigeria, gay marriage, although they were in the night. All these things, it is happening but it is not really open. Like the one we did at um Oba in Anambra State...He did both white wedding and traditional wedding, and he dressed like pure woman and the guy wore suit, the wedding was talk of the town, I have never attended such gay wedding in Nigeria before. It still happens in Nigeria but those things are very very secret...So it’s quite alarming here, it is just that everybody should be very very careful” (Chris, self-identified bisexual man, Abuja Interview)*

*“Even Nigeria, when Jonathan signed the bill about MSM, it doesn’t stop, it continued, they will still sleep...every Friday there must be TB<sup>28</sup> party in Lagos state, they can’t do anything, even though now there’s a place they are doing TB party the man now would call the DPO, he would tell police to come and stay for the gate where they are doing the party, so you can’t stop it.” (Gaddo, self-identified bisexual man, Lagos Interview)*

It is clear that the anti-gay bill has not prevented MSM from socializing together. Participants revealed that they organized their events mostly at nighttime and were highly clandestine. For some participants, it appeared that they had come to accept that the task of creating an enabling environment where they are decriminalized would be a

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<sup>28</sup> TB literally means top/bottom and it is used to describe gay men and other MSM

difficult one. To some degree, they were ready to accept this fate and this was evident in their organizing parties, albeit covertly.

With respect to religion in Nigeria, participants mentioned how Islam and Christianity both forbid their homosexual practices. Participants also mentioned that pastors preach against it and label homosexuality as inherently sinful and those who indulge in these acts as profoundly evil. For instance, one of the participants said, “...being a homosexual doesn't feel right, if you look at the religion where we are coming from... something that all the religions are kicking against it, it doesn't feel right” (Kunle, self-identified homosexual man, Abuja Interview). It is clear that from a religious perspective homosexual practices are viewed as sinful and this perception of homosexuality as sinful is not only held by religious enthusiasts but also seems to be internalised by those participants who expressed that they perceived their sexual practices to be aberrant. Additionally, participants who were religious adherents had a stronger inclination to conceal these practices from their religious friends and family members to avoid being perceived as hypocrites:

*“Because of religious sake, you won't come out and say you are MSM, who would listen to you? In fact, knowing that they say, are you born again<sup>29</sup>? And the fact that I'd say I'm born again, hypocrite! ...Also because of the mantle, that I hold in church, because of the respect, that I hold in church, because of the role, we hold on to respectively, we wouldn't want this part of us to be out, because if they know, ah, like I said, they would stigmatize you, one. Two, it goes round that you are hypocrite, then you were never born again, so how can you now cope?” (Hassan, self-identified bisexual man, Lagos Interview)*

Like Hassan, participants who were religious adherents mentioned that they concealed their sexual practices in religious spaces because of the respect they held for the church. Additionally, some of them held highly respected leadership positions; as such, revelation of their sexual practices had the potential of jeopardizing the respect they held. Participants revealed that if their practices were to be revealed they may be denied membership rites and evicted from the church community.

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<sup>29</sup> Born again here refers to someone who is a genuine Christian

#### **4.6 Chapter Summary**

This chapter has explored homosexuality and HIV in the Nigerian context by discussing HIV positive MSM in the socio-cultural context of Nigeria as well as investigating how Nigerian MSM understand their sexuality and how they negotiate their sexual partnerships. It hinted at the different forms of stigma which appear to be inherent to the experience of being HIV positive and MSM in Nigeria and will be expatiated upon in the chapter that follows. It revealed clandestine MSM lexicon and argues that by keeping these secret codes within their community they are not only able to achieve solidarity but also protect themselves from their repressive society. This chapter also revealed societal perceptions of homosexuality and HIV which propagate the ill treatment of HIV positive MSM in Nigeria. Societal perceptions suggest that homosexuality is a borrowed lifestyle from the West, hence its practice has often been tagged ‘unNigerian’ and a colonial import. It was argued that societal perceptions of homosexuality as a demonic and taboo practice, is part reason for societal and family rejection as well as the inability to express themselves which the study participants experienced. As a result, MSM literally become an abject category in society, thereby making them vulnerable to stigmatization, discrimination, physical and psychological harm, including violence and diseases such as HIV which is discussed in Chapter 6.

Societal perceptions of HIV especially as it relates to MSM were also revealed. These included HIV as retribution from God for ‘sinful’ sexual practices, ‘gay men’ as reservoirs of HIV and HIV as a death sentence. These societal perceptions of HIV like those of homosexuality fuel stigma and discrimination of HIV positive individuals especially MSM. Since they have dual identities of being HIV positive and MSM they experience a layered and doubled effect of stigmatization and discrimination, which will be discussed in Chapter 6. It was also revealed that HIV positive MSM are confronted with a punitive and oppressive socio-legal context, which results in driving them underground and away from necessary healthcare services. Against this backdrop, Nigerian MSM must negotiate their sexual practices within these traditional and contemporary contexts.

This chapter provided a critical analysis of the various ways in which MSM conceptualized theirs and others sexualities and how their sexual practices may change over time. There was a general ambivalence and mixed responses in their conceptualizations of theirs and others sexual identity suggesting its fluid and situation-

specific nature. It was noted that merely engaging in sexual intercourse with the same sex is not a prerequisite to be considered 'homosexual' while homosexuality was generally understood to be emotional and sexual attraction as well as engaging in homosexual practices with the same sex. At the same time, this chapter depicted the importance of sexual roles, networks and the transaction of sex in defining MSM sexual partnerships. It was revealed that most MSM have at some point in their lives would have transacted sex. Employed or unemployed their purpose of transacting sex is as a means of financial support and after they have achieved financial freedom they may decide to stop. Important in the transaction of sex are age and status dynamics, as older MSM establish dominance by paying younger MSM for sex.

While most MSM have their first sexual experience in their adolescent to young adult years, they do not necessarily experience anal sex until they advance in age. Sexual experience is mostly with older men with whom they transact sex with. Although, MSM do not take on exclusively receptive or insertive roles in sexual intercourse, power and status negotiations have to be made in some cases that permit them to take on these roles exclusively. MSM are likely to take on versatile roles in the context of a trusting relationship where there is a need to foster trust and selflessness. An unexpected finding was that MSM do not reveal their HIV positive status even within these trusting relationships to avoid a form of stigma they referred to as 'Kito', which is elaborated on in the next chapter. Furthermore, societal perceptions of homosexuality as well as the crimino-legal context for MSM in Nigeria had several implications. It proliferated the stigma and discrimination experienced by MSM as is discussed in the chapter to follow.



## **CHAPTER 5: EXPERIENCES OF STIGMA AND DISCRIMINATION**

### **5.1 Introduction and Chapter Structure**

The previous chapters presented findings on HIV positive MSM experiences in the Nigeria including their sexual partnerships key to the acquisition of HIV as well as how they are perceived in society. The social and legal context both play a crucial role in the propagation of stigma and discrimination, a significant aspect of their lived experiences in Nigeria. Furthermore, stigma and subsequent discrimination stem from the widespread ignorance about HIV, its causes and modes of transmission as well as misconceptions about MSM. Participants experienced stigma in different forms presented below, some of which have previously been conceptualised in the literature. It is important to note that participants in this study were sampled and recruited from NGOs that cater to the specific health and psychosocial needs of MSM in Nigeria. Therefore, they appeared to be familiar with and use terms such as stigma by association, internalised homophobia, double stigma and discrimination during the interviews. Additionally, when they did not explicitly use these terms, scenarios which they described fit into these categories of stigma and discrimination.

In terms of the settings where stigma and discrimination were experienced, participants mentioned the general or public hospitals (when accessing healthcare), employment, places of worship, family units and in their wider societies or neighbourhoods. The focus of stigma and discrimination was generally towards the men because of their sexual practices or HIV status or towards their associates, that is, people who are connected or identified with them. These experiences of stigma impacted on how they perceived themselves and this was apparent in that a majority of them had internalised feelings of stigma as a result of either their sexual practices or HIV status or both. While, this was the case for most participants, there were a few participants who had developed ways of managing their identities so that they were able to avoid or reduce the effects of stigmatisation and discrimination.

Section 6.2 of this chapter explores the range of stigma experienced by HIV+MSM along with the societal, religious and cultural values their sexual practices and HIV status are generally assumed to undermine. This is followed by Section 6.3 which presents the concept of 'Kito', which encompasses stigma and discrimination instigated by other MSM in their immediate community. Section 6.4 describes discrimination as experienced by HIV positive MSM in this study. Section 6.5 discusses implications of

stigma and discrimination, while Section 6.6 discusses how HIV positive MSM are able to deal with the stigma and discrimination which they experience. Finally, Section 6.7 of the chapter concludes with a summary of the key messages.

## 5.2 Experiences of Stigma

Findings revealed that participants experienced stigma in six major forms: HIV stigma, sexual stigma, stigma of being both HIV positive and MSM, stigma by association, internalised HIV and sexual stigma and anticipated stigma. It should be noted that the participants experienced stigma related to their homosexual practices and their HIV status concurrently as double stigma.

### 5.2.1 Sexual Stigma

As revealed in Section 4.5.1, societal perception of MSM sexual practices as immoral and sinful propagated sexual stigma. They are often perceived to be possessed by evil spirits and are seen more as alien than human. One participant recounted an occasion when he accessed treatment at a general hospital, he said:

*“So the way you describe, dem go come ask you say ok how you take get am, you understand? So from there, nah from the talk, some of them, dey go just say God forbid, why you go dey sleep with man? E no good, this and that, it’s a demonic thing, God no go dey happy with you, this and that. Dey go come dey preach bible for you...I get rashes...so I come dey explain give the woman, the woman come dey ask me, how I take get am? I explain give the woman, I explain give the woman, the woman now come say ah it no good, she come begin dey read bible for me, dey preach for me. She come leave the problem wey carry me go... if any of her pikin dey do that, say she go kill the pikin, na so she come dey tell me. So as she come dey talk all this kind things, I no dey comfortable, I no dey comfortable, I no dey comfortable, I say me I come clinic for my own good, you you come dey talk bible, dey preach for me, dey talk another different different thing, so since then I no dey like go, anything wey dey concerning my sexual orientation, I no dey like. Now maybe I get maybe fever, na him I fit take it, may I manage go hospital say ah fever dey worry me oh, or malaria all these kind things, that one is a normal thing...”<sup>30</sup>(Arinze, self-identified homosexual man, Abuja Interview)*

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<sup>30</sup> (TRANSLATION) “So when you describe your ailment, they (the healthcare workers) would ask you how you got it. After you tell them, they would say, God forbid, why would you sleep with a man? It is not good, it is demonic, God will not be happy with you. They (the healthcare workers) will preach to you...I had rashes...I explained to the woman, she now asked me, how did I get it? I explained how I got it to her, she now said, it is not good, she started quoting scriptures, preaching to me. She left the issue I brought to her...she said if any of her children does what I did (engage in homosexual practices), she will kill the child, that’s what she told me. So as she was saying all that, I

Inherent in Arinze's quote above, is stigmatisation as a result of his homosexual practice being perceived by the health worker as sinful and immoral. Healthcare workers according to participants, resort to preaching to them when they become aware of their homosexual practices. As a result of the strongly held belief of homosexual practices as sinful and immoral, healthcare workers can go as far as threatening to kill anyone they know who engages in homosexual practices, including their children, as illustrated in the case above. Further analysis of the interviews revealed that the participants' sexual practices may have been viewed as sinful and immoral because these practices do not conform to the heteronormative norms and expectations of the Nigerian society. This point is also demonstrated in the quote below about experiences accessing healthcare or treatment from general/public hospitals:

*“As an MSM I can't go to a public hospital to receive treatment, number one, it is very notable that a doctor would ask you how come? What is your sexual orientation? They would want to know how come you contracted this virus, how you come in contact with this virus, do I just go there and tell them I am an HRM? I mean MSM? That I'm being penetrated through the ass, you know, I'm going to hide a lot of things. It's not even HIV alone that kills, we have other infections in the body that we can't even declare, but what if I go there disguising to the woman, the nurse, which I was to be treated for anal warts and other things, because as an HIV positive person you are prone to a lot of diseases in the body but as a minority population, someone that can't declare himself, how would you tell them, divulge a lot of things like that?” (Olu, self-identified homosexual man, Lagos Interview)*

Heteronormative expectations are generally understood to mean that a man should have sexual intercourse with a woman and not with another man. As stated above in the quote and as would be seen in the Chapter 7, HIV positive MSM in Nigeria encounter difficulty accessing care and treatment through public/general hospitals because of the stigmatisation they experience from healthcare workers when they disclose their sexual practices. This has the implication of MSM concealing their sexual practices and subsequently getting the wrong treatment for their ailments. In addition, not only are

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wasn't comfortable, I wasn't comfortable, I wasn't comfortable. I said to myself, I came to the hospital for my own benefit, she was now preaching to me, talking about something different. So since that experience I don't go to the hospital for any issue concerning my sexual orientation. If I have a fever, I can go, I can manage and go if I have a fever or malaria, those are normal issues...” (Arinze, self-identified homosexual man, Abuja Interview)

homosexual practices perceived as sinful and immoral, but there is the belief that those who engage in such practices could potentially corrupt the morals of younger boys in the society. For example, one participant stated, “... *(the district head would say) that you being there is a threat to them, your lifestyle is immoral and you might end up corrupting the rest of the boys in the community*” (Ibrahim, self-identified homosexual man, Abuja Interview)

Also, participants mentioned that they were stigmatised when their behaviour was believed to deviate from normative expression of masculinity expected from them as men living in the Nigerian society. For instance, Ibrahim stated,

*“But then as an MSM the only fear, not only fear, because there are a lot of fears, a lot of fears that keep hunting us personally as an MSM, the only thing I could say is that I don’t act girly, I am not feminine, **but for those that are feminine, they are the ones that are most at risk, because you find out that even in the area you are living you will not be free, in that particular locality you are staying, if you are feminine, you will not be free, you can’t come and sit down where other guys are seated, drinking or smoking because you will find yourself being inadequate, they might not even welcome you when you come and whenever you pass you will hear side talks.**”* (Ibrahim, self-identified homosexual man, Abuja Interview)

Ibrahim’s declaration that he isn’t feminine shows the potential risk to a man’s social identity if he does not conform to widespread masculine conventions of the society. Here, stigma is experienced by Nigerian MSM who possess feminine characteristics through social exclusion coupled with an inability to express themselves or fit into their wider communities. This finding was corroborated in the FGD held in Lagos, when one participant stated:

*“...Secondly, if you are a person that is feminine, they would start pointing fingers that ok you’re gay, your sexuality then would be questioned, do you get? Now, Nigeria has not gotten to that stage whereby we can accept people regardless of their sexuality, their religion, their beliefs...”* (Wale, Lagos FGD)

An interview participant expressed the difficulty he faced relating with his colleagues at his former place of work because of what was perceived to be ‘effeminate’ behaviour.

He reported, “...*the place I was working before, because being MSM people used to say why are you going out with this gay that used to behave like a woman, I don't find it easy.*” Another participant mentioned that MSM who are described as displaying ‘feminine’ mannerisms are socially isolated because of these mannerisms:

*“...Like, if you identify yourself to be a gay person in Nigeria or an MSM really, the way people tend to look at you, the way people tend to talk to you, people would even detach themselves from you... Because if you go out there's no how he is gonna try to man up huh, people would still tell him ‘god you're gay’, ‘why you behaving like a female?’, ‘Why are you doing this, can't you man up for a while?’, ‘That is why Sodom and Gomorrah was condemned’, and all of that, ‘ah you will rut in hell, you will do this and do that’ oh my god.” (Wale, self-identified pansexual man, Lagos Interview)*

A participant who identified as an active choir member at his church stated that if his sexual practices were to be revealed to members of his church, it could mean he would be judged as a hypocrite and never really been ‘born again<sup>31</sup>’:

*“...because of the role, we hold on to respectively, we wouldn't want this part of us to be out, because if they know, ah, like I said, they would stigmatise you, one. Two, it goes round that you are hypocrite, then you were never born again, so how can you now cope?” (Hassan, self-identified bisexual man, Lagos Interview)*

As the preceding quote implies, MSM are stigmatised because their homosexual practices contradict and challenge established heteronormative beliefs and expectations of not only culture and society but religion. These men are therefore not only seen as hypocrites but also as frauds. Participants also recounted their experiences of stigma related to their homosexual practices within their more familiar family unit.

*“Talking about disclosure, Jesus Christ ah oh no. Number one thing is that consider our family, I'd die before you can just say you want to disclose anything to them. When they knew about my sexual orientation, oh God! I wanted to kill myself because it wasn't easy... After then, I was inside using my grandmas phone to chat, my sister just barged in, carried my phone, ehn! You are on gay site again? She just went to my grandma and said, “When everybody are (sic) bringing girls and wives to their house,*

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<sup>31</sup> Born again here refers to someone who is a genuine Christian

*your child would bring husband”, in the presence of everybody, my cousins, it was during a festival. I was like Jesus Christ, I felt ashamed...they were trying to frustrate me so I could just repent from that way... again they called a family meeting, that ah (says name) is this, he’s having sex with fellow guys, so they were like ok, if you can’t stop this, get out of the house, they ejected me out” (Olu, Lagos FGD)*

HIV positive MSM experiences of stigma from family members and generally was closely linked to disclosure, intentional or unintentional like in the case above. This was to the extent that those who disclosed their homosexual practices to their family members were more likely to be stigmatised by them. In most cases, like Olu in the quote above, participants reported that they did not intentionally or willingly disclose their homosexual practice to any of their family members.

### **5.2.2 HIV stigma**

For most of the participants, stigma stemming from being HIV positive was all too familiar. Some participants stated that they had been stigmatised because of the unknown means of how they had contracted HIV. For instance, one participant said:

*“...Hmm, being HIV in Nigeria is something else, I said it nobody can come out today or can go to radio or television and announce, ok I’m HIV positive and if anybody, **even in the church, even in the church.** You can only hear somebody come out and give a testimony, I was HIV, but by the time that person is battling with that this thing, he cannot disclose it. So it’s not an easy thing, because you know once you disclose that you are HIV positive, **even your family members** they would stigmatise you, they would discriminate you. Any little things...**if you do anything wrong, they would say, ah do we know how you take carry AIDS.** So it’s something that we find it difficult and even in the midst of your friends you cannot tell them that this is my status, if you do that you will **lost (lose) so many of your friends**, nobody would come to you.” (Kunle, self-identified homosexual man, Abuja Interview)*

This quote highlights spaces where stigma related to being HIV positive is experienced. Specifically, it shows the social bonds that are threatened when an individual’s HIV positive status becomes known. Here, Kunle’s emphasis on the breakdown of relationship with his church, family and friends if they become aware of his HIV status reveals how greatly he values these relationships and the fear he has of losing these

relationships. Furthermore, his statement “if you do anything wrong, they would say, ah do we know how you take carry AIDS” highlights the perception of HIV as a sort of mysterious disease and how individuals are likely to stigmatise others when the source of a disease is unknown to them. This ‘mysteriousness’ and poor understanding of the source of HIV and the resulting fear was an issue that participants in this study mentioned as a cause of the stigma they occasionally encountered. A FGD participant narrated his experience of growing up in the village where HIV was still very mysterious, he recounted:

*“Those days in our village when we were still small...When we were small, if you were sick a bit tiny, what they do is that they take you, everybody with stick, you are moving, nobody is touching you, you move on your own until you get to that place. You are staying there, if you like you make your camp on your own, you stay there, you won’t be allowed to associate with anybody, they are keeping you in that place on your own, you are on your own. So you stay there, until you die, then when you die, life goes on, everybody forgets about you. Once you are there you are not a human being anymore, so that was when I got to make sense out of it. We were doing it out of ignorance” (Chidi, Abuja FGD3)*

This issue is also apparent in Ifechi’s quote about his concerns with disclosing his HIV status to his mother, he said:

*“I now said ok, anyway my mum she knows that I am an MSM, the only thing she normally tells me is that always use condom, but she doesn’t know that I’m positive, till now I have not told her I am a positive because I know how they would react. I remember when my, one of my uncles he stays in Gabon and he have an (was) HIV positive, I remember the way they treated him in the village...**everybody was scared of him, the way they were throwing food**<sup>32</sup>. So I now remembered, I say ah if I told my mum this is what I am, the stigma and the discrimination will still be there” (Ifechi, self-identified homosexual man, Abuja Interview)*

Again, like in the case of stigma related to homosexual practices, disclosure is used as a tool in which participants in this study have deployed in order to avoid stigma and subsequent discrimination (which will be discussed in Section 6.3). Aside from

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<sup>32</sup> throwing food here is perceived to be disrespectful as you only throw food to dogs or animals.

participants being stigmatised because of poor understanding of the source of the disease, participants stated that they were also stigmatised because of poor understanding of how the disease can be transmitted:

*“I regretted telling them that I am positive. It was when I told them that I am positive, my brother started acting funny and he started doing ahan, my brother that he can even wear my clothes, he can even eat, he uses my [tooth] brush most times...he can just keep his [tooth] brush here and he would forget and he would leave it outside and in the morning he’s going to work, he would start looking for his [tooth] brush, he won’t see it, he would just pick any [tooth] brush and use. So that one is not good to share [tooth] brush with someone that is positive, I know, but spoon? That one won’t affect you...So he would start telling me about spoon, that it’s his spoon, I shouldn’t use spoon, I should have my own spoon. But spoon won’t infect you, so I had to move [out]” (Joe, self-identified bisexual man, Lagos Interview)*

Another participant reported that a friend of his after watching his brother suffer rejection and isolation castrated himself because he believed it was because of his penis that his brother had contracted HIV and died from it:

*“I was chatting with my friend, then he said that before now he has a senior brother, he died about 10 years ago, before then if the senior brother ate something and he wants to give him, he will not collect it, then one of his mind would tell him collect it now, he’s your brother, he will say, no, I don’t want to die with him, to the extent that, that boy is not a gay, to the extent that he take a knife and cut his penis, because penis is the one that caused him to have HIV...” (Kola, Abuja FGD1)*

He further narrated,

*“...when I was in the village there was a house close to my family...that guy has been sick for very long time, so they discovered that it’s HIV, he is not a gay. So when he come to the family to greet them, he sat down on the stone like this, immediately he stand up they now bring fire and burn the stone, that they want to burn the germs, so the guy just go far a little bit and turned back and saw them burning the stone. Even when he was going they were taking broom to sweep the till they reach roadside and the guy*



*started crying. For some time during the one month and he died, and before then he was not taking drugs” (Kola, Abuja FGD1)*

As illustrated in the quotes above, poor knowledge or understanding about the modes of transmission of HIV can lead to an infected individual being stigmatised even by his family members. Participants were possibly stigmatised because of the fear that HIV could be transmitted through casual contact like sharing clothes, spoons and association with HIV infected individuals as evidenced in FGD participants statement “*you won’t drink with the same cup [John: THEY WILL BUY SPECIAL CUP FOR YOU] they will not allow you to eat with them, how dare you, they will buy a special plate” (Abuja FGD1)*. Interestingly, this poor understanding is not only limited to family and societal spaces but also medical spaces, where one may expect health care professionals to have a better understanding of these issues. Some participants mentioned that in the past whenever a person was diagnosed with HIV, they were injected and killed, so that they did not spread the virus. This of course has implications for how participants accessed healthcare services as will be discussed in Chapter 7. Participants spoke about the sectioning and labelling of HIV wards and overly cautious manner in which health care workers related with them. Akin, for instance, expressed his anger about the stigmatising treatment he experienced in a ward sectioned for HIV infected individuals in a general hospital:

*“... like as of the time I was going to general hospital, you go to general hospital, being that they have a ‘Heart to Heart’<sup>33</sup> centre there, they are the ones that are meant to even make you feel among, make you feel that HIV is not a death sentence, but then the health workers there would even make you see yourself as a dead person already. They want to touch you as I am now, I am HIV positive, is there anything wrong with my skin? If you want to touch my skin now you have to wear a, to even check your temperature, your BP, they would have to wear a glove, wear a nose mask. You mistakenly cough maybe something hang on your throat not just a normal cough, you just cough, they would be very very angry with you. At a time, they would tell us that if you are coming for your appointment, you have to come with a white handkerchief a new one, if you want to cough or if you want to talk, you have to cover your mouth and*

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<sup>33</sup> Heart to Heart centre is a clinic that provides comprehensive HIV services including ART and is located in government-run hospitals.

*all that so that you won't pass the disease to them" (Akin, self-identified homosexual man, Abuja Interview)*

HIV was also generally associated with death and according to one participant while having a conversation about someone who was known to be HIV positive, the woman exclaimed "*they are still alive talking about this?!"*. According to this participant, "*she thought that anybody that catches HIV should just die immediately"* (Peter, Abuja FGD1).

Despite the general understanding that HIV stigma is prevalent in Nigeria and the overt stigmatisation participants experienced, some participants felt that over the years the overall level of HIV stigma in Nigeria had reduced and those who still stigmatise have poor knowledge about HIV. When asked about what it is like being HIV positive in Nigeria, Chris stated that:

*"nobody wants to hear it...Nigeria no wan hear am (Nigeria doesn't want to hear it), though now knowledge has come in, the stigma then is not now again" (Chris, self-identified bisexual man, Abuja Interview)*

### **5.2.3 The double stigma of being both HIV positive and MSM**

For participants, the intersection of being MSM and at the same time HIV positive compounded the stigma which they experienced living in Nigeria. When an HIV infected individual also identifies as MSM, he is likely to face what participants reported to be 'double stigma'. This experience of double stigma is what some participants mentioned led them often to contemplate suicide. One participant, Peter, during the FGD expressed this when he stated, "*...narrow it down to being MSM too again, now you are having double stigma attached to you. Most of the time you might even result to suicide because ok I've not accepted my sexuality again my status again, then life doesn't worth living!" (Peter, Abuja FGD1)*. Another participant in the same FGD adding to Peter's comment expatiated:

*"...it's double stigma, being HIV positive, being gay in Nigeria, it's double stigma. Double stigma in the sense that if your family perceive, or the society or the community you live perceive that you are, gay, they will not only gossip [about] you, but one day somehow you must hear it somehow, because they will definitely like you to hear to see*

*your reaction. Now, coupled with [becoming] HIV positive, that thing, it can be so so traumatised (sic), when you see people, they are homeless, they are HIV positive, and they are thinking about their status, how do they start their lifestyle...it is very very difficult” (Femi, FGD1)*

Evident in the quotes and the participants’ general experience of double stigma was that it was experienced when society became aware of their sexual practices and HIV status. This double stigma left them feeling hopeless and traumatised, like they had nothing to live for. HIV in Nigeria has been constructed as a disease of moral pestilence and promiscuity. As a result, men who are identified or suspected to engage in homosexual sexual intercourse are more likely to experience overt stigmatisation compared to their heterosexual identifying counterparts:

*“...in Nigeria...if you are positive and you are not MSM, they might accept you a bit, take care of you a bit because they think maybe ok fine it was a mistake, they treat the straight people more closer than the MSM people or the gay people rather... if they now say that they had sex with a man before, they would be like ok, you see what we are saying, that it was a man that gave you this thing and may it might not be the man that gave that person, the infection, it may be another form, maybe through sharing of sharp objects and the rest, maybe unscreened blood transfusion and the rest, so that’s all I can say” (Mustapha, Abuja FGD)*

In the wider society, HIV positive heterosexual-identifying individuals are assumed to have made a mistake, which caused them to acquire the HIV infection, while men who engage in anal sex are perceived to have brought the HIV infection upon themselves because they knowingly engaged in ‘risky’, ‘forbidden’ sex. They are ‘blamed’ for being HIV positive. This is despite the fact that they may have gotten infected through non-sexual means such as blood transfusion or sharing of sharp objects. As discussed in Chapter 4, HIV is believed to be punishment for their sexual orientation and referred to as ‘gay sickness...gay disease’. According to the men, when an MSM was found to be positive Nigerians “*will conclude that finally God has visited him with his sins, he is now facing the repercussions for what he’s doing*” (Ibrahim, Abuja FGD1). Therefore, HIV positive heterosexual-identifying individuals are more likely to be treated sympathetically than their HIV positive male counterparts who engage in anal sex with other men.

#### 5.2.4 Internalisation of HIV and Sexual Stigma

Although not as common as other forms of stigma experienced, some participants in this study internalised feelings of stigma as a result of their HIV positive status. One FGD participant speaking about internalised HIV stigma aptly described, “...*once you undergo test and you notice that you are HIV positive, you are the first person that will stigmatise yourself, before any other person*” (Emeka, Abuja FGD3). When asked if they harboured feelings of blame, condemnation, hate or remorse towards themselves as a result of their HIV status, participants answered in the affirmative and provided instances of their experiences. Furthermore, participants reported that they harboured these feeling because of a combination of hopelessness since HIV has no cure, fear of people finding out about their HIV positive status and a feeling of regret that they were HIV positive. In response to the question about his experience of internalised HIV stigma, one study participant stated that:

*“... Yeah, firstly because I see myself as **I am not a proper person, I am not normal, I don't see myself like a normal being, how can I be living in a drugs?** Human beings don't live that way, I see myself as if I'm a freak of nature. I'm not some kind of (sic) some fun birds that you get to put chemicals to make them... that's where the self-discrimination comes in. If I can turn it around, I would just want to be me, I would want to be (says name), HIV negative.” (Kunle, self-identified homosexual man, Abuja Interview)*

Like the participant in the quote above, other participants during their interviews shared similar feelings that can be described as immense regrets about being HIV positive. For some, it was the fear that they would not be able to get married and have children. For others, it was their discomfort with the fact that their HIV status meant they would have to keep taking medication every day for the rest of their lives. For one participant in particular, his concerns were his uncertainty about death and that if death did come as a result of his status, his family will find out what he had been concealing from them and know that HIV was the cause of his death. He said:

*“I don't think that any human being that God created who has found himself or herself in this situation will never for the first time feel self-stigma...This thing that has no cure,*

*am I going to die of it? ...what if by today anybody knows it, how would they feel? Or maybe I die today, they find out that it is HIV that killed me...I condemn myself...”*  
(Emeka, self-identified bisexual man, Abuja Interview)

Words participants used revealed their personal struggles with self-blame, self-hate, self-condemnation and depression, all indicating that they had internalised stigma. Some participants reported that whenever they remembered that they were HIV positive, thoughts about the reactions of others if they were to find out and feelings of not being human made them contemplate suicide. There was therefore immense pressure to conceal their HIV status from others.

Although internalized HIV stigma was experienced by most participants, it is important to note that some claimed that they experienced this to a lesser degree and some others, not at all. Those participants who claimed not to internalise HIV stigma attributed their ability to do so to having extensive knowledge about HIV and how to manage it. One participant stated, “...before I found out my HIV status, I was already a graduate, so I already had a lot of knowledge about HIV” (Akin, self-identified homosexual man, Abuja Interview). This same participant expressed that because he experiences positive effects of the ART and looks healthier than before he was infected he did not see a reason to internalize stigma. The success of the ART was therefore a protective factor against internalised stigma for participants.

Unlike internalised HIV stigma, what I categorised as internalised sexual stigma was one of the recurring themes across the interviews. Perhaps the reason this theme was more apparent in the one-on-one interviews than the FGDs was because it was more personal and some feared that subscribing to societal and religious beliefs about homosexual practices was a sign of disloyalty to their MSM peers. One of the reasons participants mentioned that they struggled with accepting their sexual practices was because religion and society were generally unaccepting and were even disturbed by their sexual practices. For instance, Lucas spoke about the conflict he faces within himself as a result of his sexual practices:

*“...And of course in our church the pastor preaches against it and says all sorts of things, its demonic, it's that, it's this, it's that and I didn't like myself anymore. I wanted to stop, I did everything to stop, I went for deliverance, I fasted, I prayed, the*

*more I go for deliverance, the more the urge comes, the more I prayed, the more the thing comes, it can stop for a while but it would come back. I've tried everything humanly possible but I couldn't. if I had my way I would have...just like I said the other day during the discussion, some of us might think, I am gay but I don't like the fact that I am gay, that's the truth, I don't, truth be told, I don't and if God could do a miracle today I stop I would be so grateful, I would be so grateful. Yeah it's sexuality, it's a way of life, people are born that way, yeah they say all that, I know it's true, it could be true, because science has proven it to be true, that some people are born that way, hormones and everything all of that, I accept, but then I know myself, I wasn't into boys when I was younger, I wasn't into boys when I was younger, I was so much into girls.” (Lucas, self-identified bisexual man, Abuja)*

Lucas later mentioned that he was brought up in a Christian home where the religious precepts and the bible had been deeply instilled in him. In the same way, some participants internalised feelings of stigma because they believed that their homosexual practice was not ideal. The interviews quickly revealed how easily participants internalised these perceptions and how they influenced their self-perception negatively. For instance, one participant stated, “...man is meant to be with a woman, not man and man, it's demonic...Biblically, it's demonic [and] that was why God spoiled Sodom and Gomorrah, because of the homosexuality and lesbianism”. (Chris, self-identified homosexual man, Lagos Interview)

For some other participants, what appeared to be an internal conflict about their sexuality was as a result of their inability to find their place in their heteronormative society. A study participant voiced his distress concerning his inability to maintain a serious relationship with females. He stated:

*“Initially...I had self-homophobia...I was asking myself, why am I like this? Why me? I see everybody carrying women...I never even feel that way... So if we go out there to pick, as in normal guys, let's go out to look for girls, but I'm never serious with mine but they are always serious with theirs, some of them now they have ended up in marriage...So I was still asking myself, why me? You know? Why me? Why am I like this? ...Initially, if I am undergoing any hardship in life, I would feel it's because I am doing this that is why I am suffering and all of that, maybe because I'm doing, I*

*always feel I'm different, I'm not doing the normal thing so my life would always be in shambles" (Peter, self-identified homosexual man, Abuja Interview)*

Here, the conflict participants face between their homosexuality and societal expectations of heteronormativity is evident. From the quote above, also evident is this participant's internalised feelings of stigma because of their feeling of inadequacy at matching with heteronormative expectations. The constant questioning 'why me', emphasises this feeling of inadequacy further. Additionally, the use of the term 'normal' in the case above, suggests feelings of inadequacy which may result from deviations from normative praxis, which in this case is forming and maintaining heterosexual relationships. Internalised sexual stigma in this study was also a result of the participants' perception of homosexuality as an illicit act. For instance, when asked about feelings of internalised homophobia, Emeka's response showed his discomfort with his sexual practices and the extent to which he viewed his sexual practices as criminal. He said,

*"...Um well I know this is a lifestyle, even the worst criminal today, it's the lifestyle that the person chooses to live and it may be because of the condition or one thing or the other, the person like doing it. There's no how the worst criminal cannot even think ahan, why do I kill? Killing is not good because at least even though the person is not a Christian neither a Muslim he must have that self-conscience within himself that shedding another human's blood is not good. So sometimes this is a something that most of the time, why am I doing this? Why do I find myself in this kind situation? And what if my people know it now, how would they feel? What would they say? So I think if others do not have that feeling, me, most of the time, I do have it, I have it, kind of like, why do I find myself in this?" (Emeka, self-identified bisexual man, Abuja Interview)*

Emeka's comparison of homosexuality to murder illustrates clearly the extent of the immorality to which he sees his homosexual practice. Like most other participants, he constantly struggled internally with his homosexual practice as well as the fear of what may happen if it was revealed to his family. Although, he initially mentioned that this practice was for him just a lifestyle, simply a game. Suggesting that for him, his homosexual practice was a choice, this was in stark contrast to others who believed that their sexual practices were an innate part of them. Finally, participants internalised

sexual stigma because they believed it was through these practices they had become infected with HIV. In one of the interviews, one participant painfully said, *“I’m not comfortable, sometimes I feel like to commit suicide because I was like is it because I am MSM that I contact this HIV?”* (Ifechi, self-identified homosexual man, Abuja Interview)

Despite most participants harbouring these feelings of stigma, a few mentioned that never experienced these feelings of internalised sexual stigma:

*“...Being MSM, the stigma, I have never. Actually I love having sex with men, yeah, I love having sex with men...So I see myself as MSM, although I have not tried that part of a woman to know the one to choose from, but the one I’m into now, I love doing it so I don’t stigmatise or regret doing it.”* (Akin, self-identified bisexual man, Abuja Interview)

Participants who claimed never to have felt internalised sexual stigma seemed to enjoy and were comfortable with their sexuality. As will be discussed further in the chapter, participants used this as a tactic to rationalise and deal with stigma, internalised or experienced.

### **5.2.5 Stigma by Association**

Participants mentioned that when their homosexual practice and/or HIV status was known, family members and members of the society also get stigmatised as a result of their association with them. In this research, this was categorised as stigma by association, what Goffman (1963) in his classic work referred to as courtesy stigma. They further mentioned that in order to avoid sharing in their stigma and assumptions that they too were like them, family members and members of the society avoided interactions with them. The quote below illustrates:

*“And once they hear you have someone being HIV in a family, they’ve tagged the whole of the family being HIV positive”* (Akin, self-identified homosexual man, Abuja Interview)

This quote above provides an indication of how society perceives associates of HIV infected people, specifically their family. Participants expressed general assumptions



that because they were HIV positive their family members were as well. This perception of ‘what the priest is like, so is the church’ was one that affected not just the infected person but their families as well. It was for this reason that one of the participants stated,

*“...if you die of AIDS they might not relate it to people that he died of AIDS; they would say that they were unable to detect what was wrong with him because of the stigma. The stigma will go down to be affecting the family, look at the guy, no be AIDS kill your brother? (Is it not AIDS that killed your brother?)” (Peter, self-identified homosexual man, Abuja Interview)*

Stigma by association resulting from the participant’s sexual practices was also expressed and experienced in a slightly different way. Participants’ mentioned that because they successfully concealed their sexual practices from others, they were able to protect their family members and associates from being victims of stigmatisation. They were however able to provide experiences of others who had not been so successful in concealing their sexual practice. Olu, for example mentioned:

*“There’s this guy in my school, we shared the same hall but I know the guy very well that he is an MSM, there was a day he was inside the school, he was talking to me, he used to stay inside the hostel, what I saw was that a guy just came, fag, gay look at you, is he the one fucking you? I was like guy come back here, are you ok? Because he’s gay, he can’t even stand and talk to anybody again?” (Olu, self-identified homosexual man, Lagos Interview)*

Another participant reported that by concealing his sexual practices he is able to prevent people verbally and physically attacking his family members. Though he had not experienced this personally, he was able to provide instances from other MSM who had not been as successful in concealing their homosexual practice. He reported,

*“...when the father is trying to chip in something, they would say shut up, do you even have a son? Is that what you call a son? And the whole thing is affecting...you know the moment it affects...it’s about you and then it affects your father. There are some instances that the father supposed to go for this chieftaincy title that they normally give in the East and all that, they refused him that because of the son...Because of that*

*reason, although he finished his secondary school in his father's house before the father now sent him away from the house, you can see that it's bad. From the family, they get so uncomfortable with you they can actually send you away" (Kunle, self-identified homosexual man, Abuja)*

The quote above illustrates stigma by association, in other words, the sharing in the stigma by association with the stigmatised as a result of his stigmatised identity. The father sharing in his son's stigma meant that he could not speak among other men at village council meetings. He was even refused a chieftaincy title, which is a very prestigious and honourable title to have not only in the East as mentioned above but in other regions across Nigeria.

Experiences of stigma by association were not just limited to family members and associates but also within MSMs themselves. As one participant stated,

*"...if I discover a person that is too bitchy, I always tell the person, you see as we dey waka, you dey front or me I go dey front, you dey back...so we walk like that most times. They can't manage and walk as a man, so he walks like a woman...because in my area there, we have this attitude of um like believing that MSM are vampires, so they like beating them, they beat them, get their money" (Joe, Lagos FGD)*

In the quote above, the participant expresses that in order not to be associated with MSM perceived to be feminine or MSM in general, he literally keeps his distance from those who act feminine when in outside spaces. This is because if he is associated with them and identified as MSM he could be subjected to violence.

#### **5.2.6 Anticipated or Fear of Stigma**

Participants used disclosure of HIV status or sexual orientation to avoid being stigmatised against. In other words, by controlling who they revealed their HIV positive status or homosexual practices to, participants were able to control whether or not they were stigmatised. When probed further, participants revealed that they did this because of the fear of being stigmatised. Some participants even revealed that they would watch how their family members or associates reacted when they discussed about HIV

infected individuals. They then decided whether or not to disclose their HIV status based on their reaction:

*“...there’s this movie that I have, you know I work with um MTV Shuga as a counsellor/tester there. So they gave us a CD, MTV Shuga Season 4 to always play for our peers and maybe just show people around. Then I played that movie in my house, my mum was there...there’s a guy there, he’s name is Femi in the movie, he’s positive but his girlfriend is negative...she now saw how they are behaving, she was like, “ehn! No no no! This cannot happen in my house, how can this girl be so stupid to get married to him” [Tim: DID YOU FEEL BAD?] Me? I did not feel bad oh, I was like it doesn’t mean anything now, shebi there’s ARV, he’s taking his ARV and very soon before they get married or when they are married they can be discordant couples and she can always be taking a drug that would prevent her from being positive and she can be negative and her child can be negative. So when I explained to her she was like, “ehen, so it’s like that?” I said yes, that’s how it is now in Nigeria and all over the world, it’s more like malaria, HIV doesn’t kill anyone, it’s just the thinking that kills and if you don’t take care of yourself, that’s when you will now fall sick. She understood it and I’m sure if I want to disclose to her that I am positive, I am sure she’d be able to take it, but not now” (Lagos FGD)*

Participants reported that they sometimes falsified their symptoms and illness because of the fear of being stigmatised by healthcare professionals:

*“...and when you go for HIV screening, the first question they would ask you is about your sexual orientation and that is when they get your history, you try to falsify some history about you, when you have other things, they would diagnose something else for you because you can’t say what exactly is wrong with you” (Olu, Lagos FGD)*

Even when these services were provided free as in the case of MSM friendly clinics, participants mentioned that some MSM would not access services. This was because they feared that they will be stigmatised.

Participants’ responses depicted how the fear of stigma can jeopardise ART adherence, for example:

*“...I live with a brother who is also positive, before he came to stay with me, he was living alone, so he keeps telling me that he doesn't know how to take his drugs because he was not alone at that time. He has his friends that have been staying with him, so he misses his drugs almost every day and he will call me on phone and be like “I didn't take my drugs” I will say why? He will say “this person was around, I couldn't take my drugs, this person was around, I couldn't take my drugs, I was shy of taking my drugs”. There was a time he told me that one of his friend's girlfriend entered and she saw him and she was like “ah this one no be HIV drugs?” and he didn't know what he tell her”*  
*(Koye, Abuja FGD3)*

The following section presents findings on a unique form of stigma that has not been previously conceptualised in the literature.

### 5.3 'KITO' Intragroup Stigma

According to study participants, 'Kito' is a Nigerian slang word used within the MSM community to describe when an MSM is stigmatised, discriminated against, extorted from or blackmailed by a fellow MSM (s). Kito was a highly recurring theme and one that I did not expect and as such is deserving of its own section. One of the participants in describing the motive for 'Kito' stated *"because the country doesn't want you, they criminalise the activities. So people now use it (Kito) as an advantage to even blackmail, extort and do all sorts of crime...Yes it is Kito! That is what we call Kito"* (Sule, self-identified bisexual man, Abuja Interview). Another participant, Ibrahim stated further, *"...some of the MSMs within themselves also use the law as an avenue to blackmail and extort things from people"* (Ibrahim, self-identified homosexual man, Abuja Interview). Participants reported that MSM may be motivated to blackmail and extort money and other valuables from their peers for other reasons. Among the motivators was financial gain, according to one participant, *"some gay guys that are into money and they like setting people up just for them to get what they want"* (Chris, Abuja interview). A lack of employment opportunities for MSM and those who are HIV positive may push them to blackmail and extort from their peers.

The majority of the interview participants expressed that they had at some point experienced Kito. For example, in the following quote, Joe narrates his ordeal with a fellow gay man he had invited to the MSM clinic, he said:

*"...it was a shocking one; they call it 'Kito', yeah. So I had this MSM, one guy like that, I brought him to this clinic, he's a friend, he always wanted me to...like because he is the bottom, he always wanted me to like have sex with him and I don't like him...So I now invited him down here, so he came, I paid for his T fare (transport fare)...Ok and there was one particular phone I borrowed him... So I now told him that it's time for me to collect this phone, that where is this phone...He said they've stolen his phone and I saw this phone with him like not long ago...So me too, I wanted to drag, there was one phone he had in his hand, I wanted to collect that one, so he was now started screaming...because he is a feminine person, when you even see him you would notice he is a gay person, so one guy now came, he now called one of the touts in the area where he stays...he was now telling the guy what happened, so he had to lie to the guy that I was toasting him and he refused, I was so shocked, like ahan this is not what happened and the guy refused to even listen to me, so all of a sudden, I said listen to me*

*first, he said listen to what? The guy just gave me a dirty slap on my face, me I don't like fighting, I hate where they are fighting...I don't want it to even extend, I don't want people to even come again, I was so ashamed of myself, I had to like leave that place immediately (LAUGHS SHEEPISHLY), I had to like look for a way to leave place” (Joe, self-identified bisexual man, Lagos)*

Like the quote above illustrates, one way in which Kito was perpetuated was through backbiting and blackmail. The result of this was that it prevented them from forming relationships with other MSM and they were afraid to take their medication or access MSM friendly healthcare services when they knew other MSM would be present to avoid being stigmatised. For instance, the quote is a conversation between participants in FGD1 held in Abuja, Kola mentions the reason he finds it difficult to take his medication:

*“Kola: ...like um like, for me, in my house, I just did it yesterday, I want to take my drugs and I know that there are friends within (sic-with) me, they came to see me, I would just say ah, what would I do oh... I said how will I take it now, because I'm living in a one room, I say ok if I take it now, maybe they will see and they are gay like me and they have HIV too.*

*[Bode: But they are living in denial]*

*Kola: NO! they are even taking drugs but if they just see you with the bottle of the drugs or the container they will just go out and start telling people...*

*[John: And they won't talk about their own selves! It boils down to community based stigma and discrimination, at the community level]*

*Kola: ...look at him, look at how he's behaving, someone that will soon die.” (Abuja FGD1)*

Kito as seen in the quote above, has implications for ART adherence and accessing healthcare services. Kito was also perpetuated through extortion of money, phones, laptops and other valuables by fellow MSM who they had invited to their homes for sex or to shelter. Social media platforms appeared to be a key facilitator for the perpetuation of 'Kito'. This usually led to brutal gang rapes or 'set-ups'. The two quotes below illustrate:

*“...it was true a social media where MSM meet each other. So the person contacted me there and asked for my pin, I gave out my pin but he has been trying to invite me for a very long time, I keep turning him down, I don’t know what happened that day, I think because of what (LAUGHS)...I was financially broke, so he was like when you come I’d give you back your T-fare blah blah blah. So I said let me just go, so I went. Getting there, it was set-up and they took my phone, after taking my phone, they took money from me, instead of them to allow me go, they still had sex with me and they were like four of them and they had sex with me without condom. I had condoms in my bag, I was trying to bring out the condom, I think it was because of the place we were, it’s not like a house, it was like an uncompleted building, I think even the one that used the condom because of the force and everything, the condom got busted...after everything, they just left me there, I had to find my way back. I begged somebody to take me home from the bus stop, I just lied that I was robbed, the person now took me to my house. So I went to my house that day, I was unable to go to the hospital because I didn’t know this place and the only place I know is general hospital but I don’t want to tell them when I get there like I cannot go and start telling them that I was raped, how can a man be raped? ...then the law was out, the 14 years’ imprisonment, I say ah if I now go and tell them now, I’m sure they won’t even attend to me, they would just call the police” (Mustapha, self-identified homosexual man, Lagos Interview)*

*“...You meet someone on social media, Facebook, Baddo, their like ok come to my house, you go to this place, like I told them here, I went to Ibadan to meet someone, so getting to Ibadan, Challenge, we now met, took me to a house, small hall, there’s a bed, a lamp and toilet here. So I didn’t know that they had like six extra boys in that bathroom waiting. So me and the guy started making out, I was even enjoying it, and the funniest thing...He said ok I’m coming let me go and pee and immediately he disappeared he came back, there was no light because they offed the light. The way this person fucks differs from the way the other person fucks but because I was carried away oh this sweet guy... it was about the fourth time when the other person left and came, I was like this person is not as big as the other person, I now tried to on the light, the next thing I saw was a punch in my face, gboah, they all beat me, they dragged me, I ran they chased me with stone, with stick, planked my head, I ran naked, I didn’t wear anything, I ran, I was bleeding and when I saw this police station here, I had to run again” (Hasan, self-identified bisexual man, Lagos Interview)*

As reported earlier in this section, this process of ‘Kitorising’ as one of the participants put it, was facilitated by repressive criminal laws. In both cases above, the men had the possibility of either going to the police (as in the second quote) or the hospital to seek treatment (as in the first quote) but they were unable to because of fear of persecution. Despite participants affirming their wariness towards MSM, the general consensus was that not all MSM were bad. One participant said, *“it’s very very few of us that would, we are like brothers, like brother’s keeper”*.

#### **5.4 Experiences of Discrimination**

As has been shown throughout the findings chapters, participants in this study possess dual discrediting identities in the Nigerian social context as a result of their non-normative sexual practices and HIV positive status. Like their experience of stigma, they experienced compounded discrimination due to the intersections of being MSM and at the same time HIV positive. Discrimination experienced was a direct consequence of the stigma attached to HIV positive MSM. Some participants spoke of these experiences in relation to their homosexual practices while others spoke in relation to their HIV positive status and others in relation to both. The five major forms of discrimination participants reported experiencing were: denial of access to fundamental necessities of life, withdrawal of support, arbitrary police arrests, blackmail and violence and finally homophobia and are discussed in greater detail below.

##### **5.4.1 Denial of access to fundamental necessities of life**

In terms of discrimination experienced through the denial of access to fundamental necessities of life, participants were directly and indirectly deprived of employment opportunities and access to healthcare services. Participants’ experience of employment discrimination was in terms of the relative ease or difficulty in securing jobs, earning a living and practicing as a professional. One participant, who was unemployed at the time the interviews were conducted, stated:

*“...when you are HIV positive and you go where you want to go and work, they might go for screening or blood test and because they know that you test HIV positive, you would lose that job...when you don do like this for office {when you do like this for office} (demonstrating feminine mannerisms), dem go dismiss you {they would dismiss you} and you don’t know when you would now do it because the thing is in you. They*



*would believe it's because of your sexual orientation and say ah I dey suspect this guy oh, e be like say this guy nah gay nah MSM, abeg make we push am commot for this place {They would believe it's because of your sexual orientation, they would say, 'ah! I am suspecting this guy oh, it is like this guy is an MSM, please let's get rid of him}' (Ifechi, self-identified homosexual man, Abuja)*

The quote presented above describes an overlap of or layered discrimination, so to speak. The first being on the basis of HIV positive status and the second, on the basis of sexual practices. The medical diagnosis of HIV as a determinant of eligibility for a job position was reported across FGDs and interviews and is used as a tool to discriminate against HIV positive individuals seeking employment as they immediately become ineligible for the position once their positive status is revealed to prospective employers. The men reported having difficulty securing employment even when there was considerably low risk of HIV transmission:

*"...in this Abuja I was denied a job opportunity in [X Bank] because I'm positive, you understand what I'm saying. So, most job opportunities in Abuja here, they do not, before they employ you, they will screen you very well to see if you are clean, if you are positive or not, ok so, most like banking sectors and other sectors they don't accept, they don't employ people that are positive" (Bode, Abuja FGD1)*

These men have a reduced chance of securing employment in a context where securing steady job opportunities are already challenging. While some of the participants mentioned that they were out-right denied job opportunities, the alternate narrative was that like Ifechi in the quote above, they avoided applying for jobs that require them to be tested for HIV in order to avoid being discriminated against. In these cases, avoidance was used as a strategy to deal with discrimination. The 'thing' which Ifechi states in the quote above refers to feminine mannerisms, which as revealed in Section 4.5.2 was often used to identify men who are homosexual or engage in homosexual practices. This finding also shows that MSM who possess feminine characteristics are more likely than those who do not or are able to pass as heterosexual to lose their jobs or to be denied job opportunities because of their effeminate disposition.

While the majority of the participants agreed that they had experienced discrimination when seeking employment, a few others contradicted this. For example, Gaddo, who at

the time of the interview was a member of one of the largest CSOs for People Living with HIV/AIDS in Nigeria (PLWHAs) stated:

*“...even now there’s a law that we are preparing now, Lagos State has passed a bill [in the past] but the bill is not working, we have went back, I’m among [the] people that went back, we amended it, we changed things, then we put pictures so that people who cannot read can see the pictures and picture can interpret to them what the law says about this. So before, anybody that is working under somebody, find out that he is HIV positive is sacked, he’s thrown out of that place. But now it has been reduced, it’s no more there, like that. It’s not that it’s all oh, there are people doing it but the rate has dropped” (Gaddo, self-identified bisexual man, Lagos)*

Gaddo’s claim about the reduced rate of employment discrimination experienced by HIV positive individuals who securing a job may be influenced by his position on the Lagos State Board as a representative of the People Living with HIV/AIDS in Nigeria. The Network of People Living with HIV/AIDS in Nigeria is an organisation for people affected by HIV/AIDS and aims to provide care and support to them while giving them a voice. As a representative of the organisation, one of Gaddo’s roles is influencing policies like the anti-discrimination law. His role in amending the policy could be the reason he believes that the law has been changed in favour of those who are discriminated against. Despite these claims of amending the discrimination policies in favour of HIV positive individuals, the majority of the participants interviewed had still experienced discrimination when seeking employment on the basis of their HIV positive status. In respect to their HIV status, some participants were uncertain about whether there were HIV anti-discrimination laws protecting them and what exactly they stipulated. In one of the FGDs in Abuja the discussion below ensued:

*“Femi: “Now, taking it from the government, the government itself is not helping matters. There’s no even, I am not sure, the lawyer is here and can say if I am not getting it right. I am not sure if there’s any law that clearly states that people living with HIV have the right to be given job or if someone insults somebody, or accuse somebody of being HIV positive or stigmatise somebody for being HIV positive, there is clear law that says “hold this person”, so so so years imprisonment, just like they say same sex practice, 10 years! In prison, I’m not sure, even if there is the law has not been active,*

*it's just there. Most times our government plays (sic) lip services on so many issues when it comes to homosexuality and HIV positive persons in Nigeria”*

*LP: “...already there are laws that are anti-discriminatory, there are laws that stipulate that nobody should be discriminated on the basis of his being HIV positive but the issue and the problem we have in Nigeria is the enforcement or the implementation of those laws, putting them into action. These laws are there but it seems they are lying dormant because the employer himself will not come openly and say I have denied you this job because you are positive neither would he say I am sacking you because you are positive, he would look for something else” (Abuja FGD1)”*

Participants generally felt disappointed with the Nigerian government and felt that the anti-discrimination laws were just for publicity and not active. Some felt that even though they were discriminated against, it would be impossible to go to court because they would be unable to point out how they had been discriminated against. In respect to their homosexual practices, there were no existing anti-discrimination laws, therefore participants did not discuss this during the interviews.

Another necessity of life that participants mentioned was that they were denied access to was healthcare services (this will be addressed in more detail in chapter 7). Participants generally spoke about how they were discouraged from seeking HIV related healthcare services or healthcare services that required them to reveal their sexual practices from government run hospitals and hospitals that did not cater to their specific healthcare needs (this was similar to participants' experiences of stigma). Additionally, the 'overly cautious' practice of the nurses or healthcare workers of wearing gloves and nose masks when treating HIV infected patients was perceived as discriminatory (as well as stigmatising) by participants. Participants further expressed that healthcare provider attitudes were directly discriminatory and discouraging and this prevented them from seeking care and treatment from these hospitals:

*“...immediately she found out that I engage in anal sex, that's the public health, immediately she found out that I engage in anal intercourse she said there's nothing she can do about it, she discharged me, she said I need to go find whatever. I felt so bad, because that means she was telling me there's no hope...” (Peter, self-identified homosexual man, Abuja Interview)*

This experience was not unique to Peter. Other participants reported this feeling of hopelessness resulting from the discrimination they encountered whenever they went to the public hospital for treatment. Participants mentioned that they had also been denied housing or told to evacuate their homes because of their sexual practice and/or HIV status.

#### **5.4.2 Withdrawal of Support**

Some participants expressed that educational and general support was withdrawn from them when their sexual practices were revealed and until they renounced these practices. Mustapha in particular talked about how his father stopped paying for his education and stopped giving him his feeding allowance. Other participants amid distress narrated their experiences of being rejected by their family members because of their sexual practices:

*“...my immediate elder brother got home and saw a condom in my room. Due to he has not seen me with a girl but he has been seeing my male friends coming around, he now concluded...So my immediate elder brother had to like break my wardrobe, saw some lubes and condoms, so he had to take it to like our eldest brother and tell him that this is what he saw in my room, that he believes that I am gay. So they called me and asked me, I told them yes I am, which resulted to a serious issue, actually I was sent out of the house for being gay. I was staying with my family in Lagos, that’s how I came to stay in Abuja. I was sent out of my house for being gay so I had to relocate to Abuja to stay...The experience is not something like I just share like that because it really hurts for somebody that for your family to just reject you because of your sexuality...” (Akin, self-identified homosexual man, Abuja Interview)*

Kunle gave an example of a friend of his whose father disowned and threw him out of the house when his sexuality began affecting the family’s image:

*“...it’s about you and then it affects your father, there are some instances that the father supposed to go for this chieftaincy title that they normally give in the East and all that, they refused him that because of the son. So you can see that it has gone far, if it happens that way, you the individual, how would you feel? Because of that reason, although he finished his secondary school in his father’s house before the father now*

*sent him away from the house, you can see that it's bad. From the family, they get so uncomfortable with you they can actually send you away” (Kunle, self-identified homosexual man, Abuja Interview)*

### **5.4.3 Arbitrary Police Arrests**

In terms of arbitrary searching and the consequent arrests and extortion of money by police, one participant said, *“we've been having cases of police extorting from you, we've been having cases that police will search and if they see pornography or see your chat, God...you'll be in the cell and they might even beat you, tell you that you should take them to your gay clients under duress [then] battery and assault comes in” (Wale, self-identified pansexual man, Lagos Interview)*. Participants believed that this intrusion and arrests were an act of discrimination because of their homosexual practices. Participants also mentioned that the police on finding incriminating evidence in their possession lock them up in jail and would require that they bail themselves with huge amount of money:

*“You would be walking on the street and a policeman would stop you, ‘hello can I see your phone?’ All he does is just get your phone, intrude your privacy, go through your Facebook, try to check the applications you have on your phone, then when he sees anything suspicious, all he needs to do is take you to the station, arrest you, you have to use a huge amount of money to bail yourself” (Ola, self-identified homosexual man, Lagos Interview)*

### **5.4.4 Blackmail and Extreme Violence**

The form of blackmail most described by the interview participants was getting ‘set up’. ‘Set up’ here involved tricking or deceiving someone suspected to be homosexual with the intention of incriminating them through various means. Unlike the ‘set-up’ described in Kito, this was between non-MSM and MSM. Chris for example reported about an experience where he was set up by people who suspected him to be gay:

*“I've gotten many setups, I was hit, I was brutalised...Let me just give you an instance, when I was still in school, we stayed on one street like that, so not knowing they've already told him, people perceived I'm that kind of person, so they now told him, he was now tracing on how to get me close. So we will talk on phone, love, love, love, romancing. So at a point one day, I'd just dressed up, because I sing, I am a vocalist, so*

*I was to go to church, he now called me, I should come to his house, so I went, not having anything in mind, because I have already dressed. He said I should pull my clothes, let's have fun...his dick got stood, within few minutes' guys bogged (sic: barged) into the house, they beat me, they naked me" (Chris, self-identified bisexual man, Abuja Interview)*

Here, setting Chris up resulted in violence and humiliation. Men who identify as heterosexual disguise as men seeking to have sex with men after which they use the opportunity to extort money from them, physically abuse them and in some cases rape them. This is especially when they are already suspected to be 'homosexual'. For participants living with family members, a strategy for blackmail and subsequent extortion of money was to threaten to reveal their sexual practices to their family members. For example, one study participant narrated his experience where he was in a room in his house and the MSM in the other room asked him to join them, unknowingly to him there was a straight guy among them, who alerted his friends outside about activities going on in the house:

*"...they wanted to raise alarm in the compound, we were pleading. I was like ok what do you want? They said at this point they are going to collect like 50 thousand naira from each of us, we pleaded and pleaded until it got to 20, that if we don't bring it, between now till the next 24 hours, our parents would know about it and they took pictures of us though, that our parents would know about it and all that. So we had to get the money and pay them off, that's how we settled the case" (Tim, self-identified bisexual man, Lagos Interview)*

#### **5.4.5 Homophobia**

During the interviews, all participants attested to the fact that Nigeria is a homophobic country and talked about the extremely high prevalence of homophobia in Nigeria. Homophobia, which has been defined to be 'a pervasive, irrational fear of homosexuality' (Weinberg, 1972) was experienced by majority of the participants interviewed in almost every facet of their lives from accessing health care to taking a walk in their neighbourhood. For example, in accessing healthcare one participant stated that:

*“...as an MSM I can’t go to a public hospital to receive treatment, number one, it is very notable that a doctor would ask you how come? What is your sexual orientation? They would want to know how come you contracted this virus, how you come in contact with this virus, do I just go there and tell them I am an HRM? I mean MSM? That I’m being penetrated through the ass, you know, I’m going to hide a lot of things.” (Olu, self-identified homosexual man, Lagos Interview)*

Here, there is a recurring theme of concealment as HIV positive MSM like Olu, do not reveal their sexual orientation to healthcare workers. This could be due to the experience and anticipation of homophobia. Either way, it may result in poor health seeking behaviour of HIV positive MSM or healthcare workers treating them for the wrong disease. For some others, homophobia was experienced in their communities. For example, when asked about his experience of homophobia, one participant who had been suspended from his church because of his sexual practices had this to say:

*“...I have experienced it in many ways, in my family I didn’t experience it but in my church, workplace, I experienced it...I’m going on the road I see two small boys, they saw them playing and doing like this (DEMONSTRATING FEMININE BEHAVIOUR) and they started beating them, I intervened, I intervened and I stopped them beating them, they said, why should I stop them? I said don’t touch them, if you want go and call police and take them to police station, you don’t have right, did you catch them, the law says caught [sic]t them red handed where they are doing it, you don’t caught (sic) them, many people can do that way does not mean they are MSM...So I took them, they said they would not stay in their street and enter motor (car), I took them, trekked to another area and they entered motor and then I went back to my house. So it’s part of homophobia, there are many ways, they don’t want to hear that name MSM, they don’t want to hear that name that he’s a gay but you can’t stop it.” (Gaddo, self-identified bisexual man, Lagos Interview)*

The quote above is a clear illustration of homophobia experienced as a result of suspicions that people are engaged in homosexual practices. It is clear that homophobia can lead to extreme violence and humiliation. The intensity of homophobia in Nigeria is emphasized clearly by Peter’s statement that, *“it’s so so so terrible that if you are caught one, you can be lynched before the police comes or you can even be banned*

*from the community for committing abomination”* (Peter, self-identified homosexual man, Abuja Interview).

### **5.5 Dealing with Stigma and Discrimination**

In order to address the stigma and discrimination they experienced, participants developed strategies which they used in dealing or coping with their identities. These strategies included concealing their stigmatised identity, avoiding situations where they had to reveal their sexuality, searching for a cure for their stigmatised attributes through prayer sessions, deliverance and fasting, rationalising their stigmatised identity and finally, attempting to stop homosexual practices.

One of the recurrent themes across participants was the concealment of either HIV status and/or sexual practices. Participants narrated different ways they attempted to conceal their sexual practices including, leading a double life and joining gyms. Leading a double life meant having girlfriends and/or wives, who were not aware of their homosexual practices. While some participants had to make an effort to conceal their homosexual practices, some others were able to do it easily. For Joe and some others, it was because they were more masculine. Other participants mentioned that they prayed, fasted and went for deliverance hoping that they will be ‘cured’ of their stigmatised identities. In relation to homosexual practices, one participant said,

*“...I didn’t like myself anymore. I wanted to stop, I did everything to stop, I went for deliverance, I fasted, I prayed, the more I go for deliverance, the more the urge comes, the more I prayed, the more the thing comes, it can stop for a while but it would come back”* (Lucas, self-identified bisexual man, Abuja Interview)

In relation to HIV, another participant said,

*“It’s always a wish that you go to the church you pray every day...it’s always there as long as the wish is not to be HIV positive, it’s there. Nobody wants to be HIV positive, there’s nobody that wants to. You just accept it because you want to be free from the burden, from the pains in your heart”* (Kunle, self-identified homosexual man, Abuja Interview)

Although many of the participants reported praying, fasting, seeking deliverance or miracles, there were a few that were sceptical about the possibility of being ‘cured’



from either HIV or their sexual practices. Two participants mentioned how they enjoyed having sex with men, used an acceptance tactic, for example:

*“Being MSM, the stigma, I have never. Actually I love having sex with men, yeah, I love having sex with men... So I see myself as MSM, although I have not tried that part of a woman to know the one to choose from, but the one I’m into now, I love doing it so I don’t stigmatise or regret doing it” (Kunle, self-identified homosexual man, Abuja)*

As the participant in the quote illustrates, accepting their homosexual practices and perhaps normalising it can be used as a protective factor against stigma, enacted, experienced, or anticipated.

## **5.6 Chapter Summary**

This chapter explored MSM experiences of stigma and discrimination. It was revealed that stigma and subsequent discrimination of MSM mainly stem from cultural and religious beliefs about homosexual practices as deviant, against the Nigerian culture and a western import as well as the crimino-legal context. Stigma and discrimination of HIV positive individuals on the other hand, is primarily perpetuated by misconceptions about HIV and its transmission through casual contact. HIV positive MSM who possessed both socially discrediting attributes therefore experienced a layered or double stigma and discrimination. This played out in their need to conceal both attributes from society hence having to maintain a double life by having sexual relationships with females.

A novel finding, was the mention and recurrence of ‘Kito’ a slang used by MSM that encompasses stigma and discrimination and is instigated by other members of their marginalised group. The criminalisation of homosexuality in Nigeria spurred MSM to blackmail their peers and as a result, MSM kept their HIV status concealed from other MSM. HIV positive MSM in this study employed some strategies to deal with the stigma and discrimination they encountered. These included concealing their stigmatised attributes, avoiding situations where they were required to reveal their stigmatised attributes, searching for a cure for their stigmatised attributes, rationalising their stigmatised attributes and in relation to their sexual practices, attempting to stop. By concealment and avoidance they were able to pass as ‘HIV negative heterosexual men’ in their society. In the next chapter, the means through which HIV positive MSM negotiate access to HIV-related healthcare services are discussed.



## **FINDINGS PART TWO**

## **CHAPTER 6: EXPERIENCES, UNDERSTANDING AND THE SELF-MANAGEMENT OF HIV AMONG HIV POSITIVE MSM IN NIGERIA**

### **6.1 Introduction and Chapter Structure**

The previous chapter explored homosexuality and HIV in the Nigerian context as experienced by HIV positive MSM, highlighting the stigma and discrimination they encounter. This chapter focuses on how HIV positive MSM construct understanding around their illness and their experiences of ill health, including how they are able to manage their ill health and what treatment options they opt for. Crucially, this chapter reports on the missing narrative of HIV transmission as it relates to the role of anal sex. An understanding of this is imperative as it provides insight and queries how HIV positive MSM experience, understand and manage their illness.

Section 6.2 describes participants' experiences of HIV in terms of the health challenges they initially encounter and motivations to get tested for HIV. It also provides a critical analysis of the different phases MSM go through immediately post HIV diagnosis. Section 6.3, explores participants understanding of HIV, including how they developed the understanding, the different misconceptions they harboured concerning HIV and how they learned about managing their illness. Section 6.4 explores the different ways the men self-manage their HIV and the treatment options they opt for, whether orthodox or traditional. The chapter concludes with a summary of key research findings.

### **6.2 Experiences of HIV**

In this section, the range of experiences which participants encounter regarding their health from challenges they faced with their health, to the testing experience to HIV diagnosis are introduced and discussed.

#### **6.2.1 Experiencing Health Challenges**

Experiencing challenges with their health prompted participants to consider getting tested for HIV. In most cases, these illnesses ranged from as serious as drastic weight loss and fainting spells to the less severe but equally worrying recurrent fevers, catarrh and rash breakouts. Participants reported that when these symptoms became visible to family members and friends they were encouraged or prompted to seek HIV testing services:

*“I was having rashes like black black spots on my skin, so people were advising my family to take me to hospital to run a HIV test that since I had blood transfusion that it*

*could be something else or my blood didn't match that of the blood that was given to me.” (Akin, self-identified homosexual man, Abuja Interview)*

*“I was feeling ill, I had to come down here to take some measurements and then to go on some observation and have my test done because I had been feeling the symptoms.” (Olu, self-identified homosexual man, Lagos Interview)*

The serious health issues participants encountered during this time meant that they were away from their jobs for long periods and as a result, they were made redundant. As explained in the quote below:

*“Then it now became the issue of, because I lost my job as a result of the sickness ...the sickness was taking months...because if to say it lasts for 3 days, one week...but this one I month, 2 months, they have to relieve me of my job. When I now got better, I didn't have any more job to be doing, because I have taken up to 1 year, you understand, that was now what brought me down to Abuja” (Peter, self-identified homosexual man, Abuja Interview)*

The course of HIV illness experienced by participant took up to a year in some cases; this meant that like Peter, participants who were employed had to take time off work. Ill health had a negative impact on their jobs, shelter and important relationships. All of which had a dramatic negative impact on the overall quality of life of the participants.

### **6.2.2 Post HIV Diagnosis Phases**

The phases participants went through when they got diagnosed with HIV were varied. Generally, participants in this study went through three different phases: denial or rejection phase, devastation or depression phase and finally, acceptance phase. The pathway in which participants progressed through these phases wasn't always linear. Some participants progressed through the phases in order, while others jumped to the second or third phase and some others straight to the acceptance phase. All participants seemed to eventually end at the acceptance phase with no indication that they relapsed to earlier stages. These phases are elaborated upon in Section 6.2.2.1-3.

### **6.2.2.1 Devastation or Depression Phase**

Participants expressed that they were inconsolable and often broke down after getting their HIV diagnosis. This phase was characterised by a deep feeling of anger, shame and hopelessness. They often felt like their world had come to an end and quit their jobs. For example, Lucas stated,

*“So I tested three years ago, when that happened it was like the world had come to an end for me...I don't know how this happened, but when I went for test...and I was very confident that I would be negative because when they asked me to go and test, I was like ah no problem let's go, because I was very healthy, I had no issues. But then the moment I tested, I thought he was joking when he told me the result and I found out he was serious, I broke down, I didn't care who was around, who see me, I just broke down... I was working in a hotel, I just went to work the next day and resigned, I said I am not working again...” (Lucas, self-identified bisexual man, Abuja Interview)*

*“I was tested and I found out I am positive. I felt bad in the first place because (LAUGHS), well, I am knowledgeable about this virus very well, I was once a peer educator and I have learnt a lot about it. But I felt ashamed that a whole me, being a peer educator...I used to pass information about it, how they spread the virus, (INAUDIBLE) in other people I have been peer educating, I felt bad in that way and I felt bad again because I was like D, I'm just like a mentor to some other people, how would I cope with this?” (Olu, self-identified homosexual man, Lagos Interview)*

From the above quotes, the various ways in which participants experienced this devastation or depression phase can be observed. While some participants, like Lucas quit their jobs, others like Olu in the quote above, expressed a deep sense of disappointment and shame because they were in the position as peer educators, well knowledgeable about HIV to have known better.

### **6.2.2.2 Denial or Rejection Phase**

Some participants' described an initial period of being in denial about their HIV diagnosis. Participants narrations seemed to indicate that their denial was as a result of poor knowledge and disbelief that HIV could be transmitted through anal sex, beliefs that they had used condoms consistently during sexual intercourse and so they couldn't possibly be HIV positive and thoughts about what people would think about them if

they found out they were HIV positive. During this phase, participants expressed a range of emotion which included disbelief, shock, anxiety, anger, discouragement and hopelessness. As a result of being in denial and the non-acceptance of their HIV status, they went elsewhere to get retested or sought spiritual help from the church through fasting and prayer.

*“Ok so when I did my HIV test and I tested positive, I did not accept the result, I said I can't be positive, it's a lie, I'm not sure that person can get HIV through maybe homosexual you can only find it in maybe female but not for maybe gay person...from the beginning I wanted not to go for the drugs. From the beginning I was like ok, maybe I would go through fasting and prayer, maybe God would heal me, I'm not having it” (Arinze, self-identified homosexual man, Abuja Interview)*

*“...the information wasn't, what word would I use? It wasn't really strong...We didn't understand it properly, let me say, yeah. HIV, yeah you will die after certain time. He (healthcare provider) now spoke to me in a different way and I understood that, I could live for a longer time if I abstained from this particular behaviour, I was also advised to commence ARV but I was still adamant, no I have to go to church, I have to go and pray over this.”(Hassan, self-identified bisexual man, Lagos Interview)*

Participants during the denial/rejection phase questioned the professional knowledge of the HIV testers, which led to their going elsewhere to confirm the test results, sometimes far away from where they lived to avoid seeing familiar faces. They also tended to refuse starting ARVs because they didn't believe they were HIV positive and taking the medication meant that they had to accept their HIV status as positive. A lot of times, they had to contend with their newly diagnosed HIV status as well as their other stigmatised identity as men who engage in homosexual sexual intercourse. Some participants mentioned that they even contemplated suicide because they felt that life no longer had meaning and they were unable to figure out where to start.

### **6.2.2.3 Acceptance and Action Phase**

Although all participants eventually ended up accepting their HIV status and taking action, a few went straight to this phases as exemplified in the quote below:

*“So when I was told you are positive, I wasn’t shocked that much, I didn’t feel bad, I was not depressed because I already had a lot of knowledge about HIV/AIDS transmission, the management that they have and the rest, ARV drugs. So a lot of campaigns going on in the social media, in the newspapers, in the radio, telling you that if you have HIV doesn’t mean death sentence, it’s not the end of your life, all these things. So that already give me the courage...since I know that there is a treatment for it, even though you will not be totally cured, but at least you will still live your life like any other person” (Ibrahim, self-identified homosexual man, Abuja Interview)*

For the participant in the quote above, he was able to move straight to the acceptance and action phases because of prior understanding and knowledge about HIV. This was despite his partner infecting him with HIV and not informing him of his status. Other participants who eventually got to this stage were able to because of the support they received from family, friends, healthcare workers and from MSM support groups they had joined:

*“My status? I feel okay, I feel good, I feel alright with it but from the beginning I did not find it easy. So time going on, going to the support groups, we used to share experience, we used to talk all those kind of things so it encouraged me, so I think I feel alright.” (Arinze, self-identified homosexual man, Abuja Interview)*

For participants in this study, a strong support system seemed to be instrumental to the acceptance of their HIV positive status. Encouragement from family and friends was important after diagnosis as these provided coping tools that helped them deal better with their status overall and in terms of accessing the required HIV-related healthcare services adhering to their treatment as would be seen in Chapter 7. Moreover, participants mentioned that they were able to gather strength and hope from their shared experiences of not just being ‘homosexual<sup>34</sup>’ men but also being HIV positive when they attended the support groups. As has been revealed in this section, MSM were able to cope better with their HIV diagnosis when they had prior knowledge about HIV. The means by which participants obtained HIV knowledge and dominant narratives about HIV and its transmission are explore in the following section.

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<sup>34</sup> Homosexual here is used very loosely but is important as the MSM interviewed in this study sometimes used this term to identify themselves



## 6.3 Management of HIV

### 6.3.1 Learning about the management of HIV

Participants' accounts about how and when they started learning about the management of HIV were varied in terms of whether they had learned prior to and after HIV diagnosis. Most participants mentioned that they had learned how to manage HIV from healthcare workers and peer-educator training at the MSM friendly health facilities, others mentioned that they had also learned from their schools, friends, the internet and by reading books and HIV journals.

During the interviews, the concept of '*positive living*' was mentioned by nearly all participants. Positive living according to participants entailed maintaining a balanced nutritious diet which included fruits, vegetables and clean drinking water, avoiding alcohol and narcotics, taking their ARVs consistently and using condoms consistently and correctly so as to prevent re-infecting themselves with a different strain of HIV. Consider the quote below which illustrates this:

*"After the counselling and everything from the counsellors in the clinic, that I can still live a normal life as an HIV positive person, they gave me dos and don'ts like, taking fruits and vegetables, living a healthy life, taking enough water, adhere to my medications and having protected sex, so the fact that I am positive doesn't mean that I'd spread the virus, I would still have protected sex, I can still get married, like one year after my medication, I can come back and be tested and the virus will suppress, the medication would suppress the virus"* (Tim, self-identified bisexual man, Lagos Interview)

Additionally, in terms of interpreting health vital results such as their viral load and CD4 counts, participants mentioned that they were trained to do so at the community centres they attended. Importantly, when participants learned how to manage their illness, most of their misconceptions about HIV and ART were corrected and participants became so grounded in this knowledge that they could take on roles as peer educators in their communities.

Positive living in respect to management of their sexual health meant that when participants engaged in sexual intercourse they had to ensure that it was protected by correctly using condoms. One participant explained:

*“even during sex, you make sure that you have protected sex because sometimes people forget...like I said earlier sometimes I even forget that I’m HIV positive, so sometimes I might want to have sex and remember that I don’t have protection like condoms and I’m like ah I can’t and my partner would be like ah why didn’t you want to have sex without condom, it’s not a big deal, I’d be like no, I have to...even if I’m not protecting him, I have to protect myself to avoid re-infecting myself because that’s most of the things some people don’t know. You think being HIV positive, once you have unprotected sex, you would keep sharing it to people but forgetting that you re-infecting yourself, you are being at risk too. So I make sure that I take care of myself by making sure that if I want to have sex, I make sure I use protection” (Akin, self-described homosexual man, Abuja Interview)*

### **6.3.2 Self-Management of HIV**

Treatment options explored in this study included, orthodox, traditional and self-treatment. In this study, all participants reported using antiretroviral treatment (ART) to manage their illness. In addition to ART, participants reported that apart from maintaining a healthy and balanced diet as reported above, they enhanced their diets with dietary supplements and immune boosters like, Immunace, blood tonic and multivitamins. One participant even mentioned that he could not take his ARV without accompanying it with blood tonic. The reason he gave for doing this was his belief that his ARVs ‘dry the blood’ and without using these supplements he would look lean and his status as HIV positive would become evident to all. For other participants who couldn’t afford to buy fruits and vegetables, they substituted with cheaper sources of nutrients like beans or fruit and vegetable supplements.

While all participants mentioned that they currently used ART, some of them recalled times when they had stopped for various reasons reported in Chapter 8. In terms of seeking non-orthodox treatment options such as traditional and herbal treatments, participants mentioned that they had been advised by healthcare workers not to use these options. One participant expressed:

*“I don’t believe in traditional medicine; I don’t believe in all these people would say ah ok let me go to a native doctor or maybe they would cure it. Sometimes God used to, like in church now, I used to hear people, they used to say ok now I’m healed from HIV,*

*to me I'm not too sure of that, I'm not too sure, to my own understanding, I'm not too sure...you go to meet a man of God and a man of God pray for you and you went for a clinic and the nurses there tell you that there is no HIV, the virus is also living there. And to me I don't believe in all these traditional medicine, agbo all these things, I don't believe in that. I also believe in the maybe Oyinbo treatment<sup>35</sup>; it works for me very well” (Arinze, self-identified homosexual man, Abuja)*

Apart from the bitter taste of these herbal medicines, which some participants reported they disliked, they mentioned that there was no way to measure the amount that was required for each dose of the herbal medicine. Additionally, herbal medicines are sometimes mixed with spirits (dry gin), which they had been discouraged to take by their healthcare providers. Furthermore, participants who were highly educated stated that with their level of education and exposure, they preferred to stick to orthodox treatment options. However, there were some participants who meddled with traditional treatments. One such participant shared:

*“it's one of my friends told me that there's one man that used to cure people in Jos and it's just water, that he will pray and he would do some incantations and he will give you, you will stop taking your drugs and you will be free from HIV and AIDS. And we went there, that time that I told you...we went there, we did that and ah so we are wasting time taking drugs? It's just 15000 naira, you will go and put hand and they'd pray for you and they would bring the water inside the calabash you will drink and they would tell you that you are free. So after I do that and they said you should have faith that you are going to be healed...so if you go and test, maybe you don't have faith, you want to test God. So since from then I said oh now I'm HIV free, I didn't go for test, I didn't mind but I would tell you most of my friends, three of us would say that now we are now free from HIV, we don't have HIV. Not knowing that still the virus is still inside us. That's why we left our drugs for more than like my friend that I lost, left his own more than 6 months before he died. I left my own for more than 3 months before it weighed me down” (Amaechi, self-identified homosexual man, Abuja Interview)*

In terms of self-medication, participants' responses were varied, while some said they do not self-medicate because they were advised by healthcare workers not to, majority stated that they had self-medicated at some point. This was not necessarily for their HIV

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<sup>35</sup> Oyinbo treatment means Western treatment

but for other ailments, like malaria, typhoid and headaches as reported by a participant who said, *“Self-medication is that at least if I have fever now or headache, I know if I take Paracetamol or Panadol now it can cure it, at least it might happen in the night, while waiting to go to the hospital, you rush to the chemist or pharmacy, you take it. Because you know that at least with this, it will calm it but if it persists”* (Emeka, self-identified bisexual man, Abuja Interview). When asked about whether he self-medicates, one participant reported:

*“Yes, there has been a point, before I got a job here. If I have malaria, I do self-medicate because...I have this particular drug that if I have malaria, once I take it, the malaria goes or if I have typhoid, once I take it, the typhoid goes, so once I feel like ah I’m having malaria symptoms or I’m having typhoid symptoms, I’d just take those drugs, I was doing this till I started working here. So I see it as there’s no need of me self-medicating when I have nurses and doctors that can actually talk to, they would even give me free drugs and all that...”* (Akin, self-identified homosexual man, Abuja Interview)

Participants self-medicated primarily because of its convenience and ease, but when they had free access to medication, they felt they had no need to. Participants who did not self-medicate mentioned that they reported any unfamiliar physiological changes to the healthcare practitioners and this was one of the ways they managed their illness:

*“And every month I come here to Population Council, anything I found strange in my body, just call my doctor, call other people that I can call, hello this is what I’m seeing in my body, because I don’t want to die young... see what I’ve been noticing in my health, whenever I cough I feel like this, I just complain a lot, even the doctors know much about me...Is it normal for me to feel like this?...That is how I get to manage my health”* (Olu, self-identified homosexual man, Lagos Interview)

Participants gave varied responses in terms of their drug and alcohol use. While majority of participants mentioned that they had never taken drugs, alcohol or smoked, some mentioned that they drank alcohol and smoked cigarettes only occasionally. Other participants mentioned that they smoked marijuana and used drugs like tramadol. For example, Joe, who mentioned that he drank alcohol whenever he went on peer HIV awareness outreaches in order to gain access to his other MSM. Also, Peter and Hasan,

who mentioned that they took drugs like Tramadol and SK. There were however, a small proportion of participants who reported that they were IDUs. Participants who were IDUs or took hard drugs reported that they stopped this immediately they learned they were HIV positive. One participant reported that he had used sexual performance enhancement drugs in the past but discontinued it because it did not work for him.

#### **6.4 Obtaining Knowledge on HIV and its Transmission: Dominant narratives associated with HIV and its Transmission**

Participants offered mixed responses about where and how they had obtained information about HIV. Majority of the participants in both interviews and FGDs reported that they were first acquainted with information about HIV either during their primary, secondary or tertiary education or in their villages when they were younger. Other participants mentioned that they got their HIV knowledge from mainstream media including, TV, radio, billboards and social media. This mode of HIV information dissemination was the second most frequent after MSM community centres and health clinics. For example, in the excerpt below, one participant from the Northern part of Nigeria narrated how he initially heard about HIV while in the village and how his understanding of HIV changed from watching television programs:

*“I know of HIV when I was a child, I knew that it always existed, through some people who go out to do this so called thing, hustling (referring to prostitution) and they come back being sick. And then in the community where I stayed they have a name which they call it, it’s a Hausa name so they call it ‘Chiwon Zamani’, they say ah she went and came back with ‘Chiwon Zamani’, that she came back with a modern illness and it has no cure. I know about HIV right when I was a child, would I say 12 or 13 years” (Kunle, self-identified homosexual man, Abuja Interview)*

When probed further about where he had gotten his knowledge as a child, the participant responded:

*“...from people talking about it. It’s just that the proper awareness came when I was in my ss3. Proper was when I got the full awareness through the television program, sometimes it’s a reality program, HIV patients and all that, they get to say their mind, to express what is to be HIV positive” (Kunle, self-identified homosexual man, Abuja Interview)*

Two other participants mentioned that they had also first heard about HIV from their villages. One of the participants when asked reported:

*“In my village they call it ‘ORIOBIRINAJOCHA’, that means sickness than ends with death. ‘ORIOBIRINAJOCHA’, that is that red sand they use to dig out from the grave, that is ‘ORIOBIRINAJOCHA’, that’s where it ends. So anybody that’s sick that time, they call, ‘ORIOBIRINAJOCHA’, it’s HIV. If you are very slim, even one of my cousin’s sister died of it, but she never wanted to tell anybody. I don’t think the drugs were rampant that time and she’s a nurse, she was a nurse. She was just like a stick, she died” (Chris, self-identified bisexual man, Abuja Interview)*

HIV information gotten from the village was often laden with misconceptions. This was to the extent that anybody who was skinny even prior to being diagnosed would be assumed to be HIV positive. The narrative of HIV being a disease of cities, which only ‘city’ female prostitutes contracted, was also rampant. As evidenced in Kunle’s quote about prostitutes returning from the cities with *Chiwon Zamani, a foreign, modern disease*. Additionally, the association of HIV with death is apparent in these conceptions. Oriobirinajocha, as explained by Chris literally means red sand from the grave. His association of HIV with death may be attributed to the sparse availability of ARVs especially in the village, which meant that anybody who contracted HIV died almost immediately. Language here played an important role in the understanding of HIV as a disease associated with promiscuity and death.

Other sources of HIV information reported were internet search engines like Google. Participants mentioned that it was convenient to get information on the internet especially since the world had gone technological. Participants also noted that they sometimes used internet search engines to verify the HIV information they have received from other sources. Furthermore, they preferred getting information from the internet to avoid questioning from inquisitive people. In other words, it’s used to deflect stigma or discrimination that may occur if either HIV status were to be known or suspected as revealed in the quote below:

*“...the world is now going digital now so I tend to get my information, if I don’t want to start being inquisitive or asking people and people would be like ‘okay what is he doing*

*with this information'...so I would go on Internet now, Google will give me right answers sometimes and I would make use of it.” (Wale, self-identified pansexual man, Lagos Interview)*

For some participants, information about HIV information had been part of their school curriculum and sometimes healthcare workers were invited to educate them. Although HIV information obtained from schools provided the main routes of HIV transmission, it failed to mention unprotected anal sex and was often tailored to the heterosexual majority. This is illustrated in the quote below:

*“Before now in school we always discuss about HIV, it’s a human immune virus which can be contracted through sharing of sharp objects, unprotected sex and all that” (Tim, self-identified bisexual man, Lagos Interview)*

As reported in the FGDs and some interviews, the HIV information participants got from all mainstream sources was also tailored to the heterosexual majority. However, among all the sources of HIV information participants reported, the only sources they got information about HIV transmission through unprotected anal sex were facilities that provided MSM friendly services. At the MSM friendly clinics, most of them reported that they took on roles as peer educators and underwent mandatory peer educator training. These participants further stated that it was during these peer educator training that they became well acquainted with knowledge about HIV and their misconceptions about HIV were debunked. This was in addition to the support group meetings, which they attended and also in their conversations with healthcare workers at the MSM friendly clinics. The dialogue below from a FGD conducted in Abuja illustrates:

*“Peter: But there is one thing they take away from us, all the jingles that you say, the adverts, nobody talks about anal sex, unprotected anal sex as another means of transmission of HIV. I do do anal sex so whenever they talk about HIV, I just say what is my business after all, I don’t do women...”*

*John: this community centre and few other community centres that we have in this country, that we know, it’s the only place that community will go and then they have that first-hand information that talks about anal sex. Imagine if we have, in our whole*

*intervention, putting this information that there is high possibility of HIV transmission through unprotected anal sex with an infected partner...this will go a long way. I think he hit one point that I like when he said, even the male and female that do have anal sex can infect their partners, infection can happen, if one is positive. So if you pass this message, even if you don't want to say man and man, say anal sex whether with man and woman or woman and man...why we are having this issue is because of the highest stigmatisation, or the societal stigma against the community, from the religion, the cultural aspect of it and even the law itself, is not helping matters” (FGD1 Abuja)*

This finding is of great significance for HIV transmission in MSM populations as one participant attested, *“if I was informed I can never be positive!” (Peter, self-identified homosexual man, Abuja Interview)*

## **6.5 Chapter Summary**

This chapter explored how HIV positive MSM experience, understand and manage their illness. It revealed the processes HIV positive MSM go through from recurrence of ill health to HIV diagnosis. It provided a critical description of the stages participants go through when they are diagnosed with HIV. The processes by which MSM in this study gained knowledge about HIV as well as learned about the management of HIV were also uncovered.

In many cases experience of ill health prompted MSM to get tested for HIV. However, since ill health especially when it is related to HIV persists over a long period of time, they have to take a significant time off work, which eventually leads to their being made redundant. Ill health as experienced by the MSM therefore has an overall negative impact on their daily life and quality of life.

MSM go through three distinct phases post HIV diagnosis and passage through these phases is not always linear. It was determined however that all MSM in this study eventually arrived at the final phase, which was the acceptance phase. It was when they got to this phase that they decided to take positive action towards their illness including starting ART. Good understanding of HIV and its modes of transmission as well as social support were imperative in getting to and expediting progress to this phase.



The many sources where MSM obtained HIV information were revealed in this chapter. However, these various sources of HIV information were saturated with the dominant heterosexual narrative, which suggests only penile-vaginal HIV transmission. As a result of core discourses around the transmission of HIV in Nigeria being centred on heterosexual transmission, a majority of the MSM are unaware of the high risk of HIV transmission from engaging in unprotected anal sex. The Nigerian society is permeated with misconceptions about HIV, which MSM have to filter through in learning about HIV and its management. The next chapter discusses participants' lived experiences of accessing healthcare services in Nigeria.

## **CHAPTER 7: ACCESSING HIV-RELATED HEALTHCARE SERVICES AND ART IN NIGERIA**

### **7.1 Introduction and Chapter Structure**

In the previous chapter, the experiences of stigma and discrimination by HIV positive MSM living in Nigeria were examined. It was argued that HIV positive MSM have double stigmatised identities and as a result experience discrimination in many forms and spaces. One of the spaces in which stigma and discrimination was reported to be enacted and experienced was through accessing of HIV-related healthcare services.

This chapter presents findings on how HIV positive MSM navigate the healthcare system and negotiate access to HIV-related healthcare services and antiretroviral treatment in Nigeria. It answers the research question that sought to explore the experiences of HIV positive MSM in accessing HIV-related healthcare services in Nigeria. Section 7.2 presents findings on the range of experiences HIV+ MSM encounter as they access HIV-related healthcare services and ART, specifically describing the barriers encountered when accessing care and treatment from general healthcare facilities in Nigeria. Section 7.3 discusses the influence of MSM social class on access to healthcare services. Section 7.4 describes particular interventions that MSM specific clinics have that enable access to healthcare services. Section 7.5 is a discussion of issues that potentially make accessing healthcare from MSM specific clinics challenging. The chapter concludes with Section 7.6, which provides the chapter summary. For the purpose of this study, MSM specific clinics refer to those clinics that provide MSM specific and friendly services while general healthcare facilities refer to all other health facilities that do not provide these services. It is important to note that these MSM specific clinics were run by international NGOs (Heartland Alliance and Population Council) and local NGOs (ICARH).

### **7.2. Experiences accessing HIV-related healthcare services and ART**

The key findings in this section are categorised into five broad categories: experiences relating to healthcare provider attitudes, those relating to point of service delivery, those relating to the legal system, those relating to financing and finally, those relating to societal perceptions and the environment. Experiences relating to healthcare provider (HCP) attitudes were the most recurrent barriers to accessing care and treatment and included lack of confidentiality, stigmatising and discriminatory HCP attitudes and

unqualified HCP. This was followed by barriers relating to point of services delivery. Finally, those relating to the individual and financing were the least recurrent barriers. These barriers are elaborated upon in the sections below.

## **7.2.1. Health Care Provider Attitudes**

### **7.2.1.1. Lack of Confidentiality**

The majority of MSM mentioned that they preferred not to access healthcare and treatment from general healthcare facilities because of the lack of confidentiality. Participants reported major concerns about healthcare workers disclosing their HIV positive status. For example, nurses often shouted out their names and personal information in crowded waiting areas, which meant that their HIV status was revealed to people present in the clinic and even those passing by the clinic. This is illustrated by two MSM in the quotes below:

*“I’m not comfortable going to maybe a general hospital, I think to me, I prefer coming to this place, which is ICARH<sup>36</sup> because if I should go to a general hospital now, maybe the way they would just carry the ARV now, maybe they should carry my folder now, they would say ok number 1, ok take your ARV. The way they would just expose it, I’m not comfortable with it, you understand? ...everybody would know that this person has gone to go and carry the HIV drugs.” (Arinze, self-identified homosexual man, Abuja Interview)*

*“So when they go to the public place (general healthcare facilities) for them to go and take their ARV drugs, the way they are calling the name, everybody would know that this person is HIV positive (describes how HCP calls names out), “Vivian!” In the public you understand? Everybody would know that this person is positive...” (Ifechi, self-identified homosexual man, Abuja Interview)*

Another concern related to confidentiality, which was reported during one of the FGDs conducted in Abuja, was about healthcare providers “gossiping” about their clients and sharing personal information with family members and friends. In some cases, this ‘gossip’ had become known by the client, and not surprisingly, it reduced their trust in

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<sup>36</sup> ICARH is an NGO that provides healthcare services and treatment as well as psychosocial and legal support to MSM living in Nigeria

the healthcare provider and healthcare facility and prevented them from returning to access services in the general health facilities, as exemplified in the case below:

*“You go to hospital, there is nothing like confidential, as far as that person is closer to someone [else]. A friend of mine told me that...he came to access...[after] he left, the person that was attending to him now said “eh guys I don tell you people be very careful use condom oh, if you see wetin I see today”. Not knowing that the information he passed to that person would get back [him]...So the next time you would try to advice that person to go for HIV test that person would not come, he would not like to come.” (Emeka, self-identified bisexual man, Abuja FGD3)*

According to the interviewees, healthcare workers at general healthcare facilities were negligent with this information and this discouraged them from accessing healthcare services and ART. Three interviewees, (Boye, Emeka, Gaddo) however, reported that when the healthcare workers at the general healthcare facilities diagnosed them with HIV, they did so in a confidential manner and in a closed door environment with no one else around. They nevertheless acknowledged that confidentiality was indeed a cause for concern when accessing healthcare and treatment from general healthcare facilities.

One FGD participant proposed that the implementation of strict monitoring teams at these healthcare facilities will ensure that healthcare providers are more careful with client’s personal information. He further stated that these monitoring teams would be responsible for penalising healthcare providers who breach patient confidentiality and any healthcare provider found breaking confidentiality would lose their job. There was a general agreement among MSM in one of the FGDs in Abuja that in addition to the monitoring teams, NGOs should employ females who were trusted instead of MSMs as this may improve confidentiality. This was because they felt that females had little interest in them and were unlikely to gossip about or spread information about them especially since they weren’t part of their community.

#### **7.2.1.2. Stigmatising and Discriminatory Healthcare Provider Attitudes**

MSM reported that at general healthcare facilities, healthcare providers’ attitude towards them was highly stigmatising and discriminatory especially when they learned of their homosexual practices. The fear of healthcare provider stigma and discrimination

was reported by MSM as one of the reasons why they are uncomfortable sharing any health issues related to healthcare providers. MSM recounted instances when they had been insulted, judged and preached at to desist from their transgressive practices when they sought treatment for anal warts and other anal STIs. Others mentioned that healthcare providers at these facilities were likely to be homophobic and could be irritated by their sexual practices. For this reason, most of the MSM reported that they could only access general healthcare services for issues that were unrelated to their sexual practices.

*“...the experience that I have is that there’s a time that I’ve never done my HIV test and I went to a general hospital. I think that year, I was having STI, when I go to a hospital in Maitama, when I discuss to the lady, she was saying God forbid bad thing, ahan are you a gay? She was shouting Jesus! All these kind of things, so since then I don’t feel going to the hospital, that’s it. I can go to hospital maybe for another treatment, maybe malaria...anything that has to do with my sexual orientation, I don’t need to go to the general hospital, that’s it.” (Arinze, self-identified homosexual man, Abuja Interview)*

*“...Because of that, I’m scared to go to the clinic to tell them that I have issues in my anus and by the time they say ok, turn let us see and you turn and they see, ah! You are gay and they start shouting, you now run most people end up killing themselves, committing suicide because of these reasons of coming out or who to meet...” (Hasan, self-identified bisexual man, Lagos Interview)*

*“...but what I go to do is just for normal typhoid, malaria treatment and all that but anything about HIV, chlamydia test, anal warts, I have not gone there before because of the fear of being asked some kind of questions.” (Tim, self-identified bisexual man, Lagos Interview)*

*“As an MSM I can’t go to a public hospital to receive treatment, number one, it is very notable that a doctor would ask you how come? What is your sexual orientation? They would want to know how come you contracted this virus... do I just go there and tell them I am an HRM? I mean MSM? That I’m being penetrated through the ass, you know, I’m going to hide a lot of things. It’s not even HIV alone that kills, we have other infections in the body that we can’t even declare, but what if I go there disguising to the woman, the nurse, which I was to be treated for anal warts and other things? because*

*as an HIV positive person you are prone to a lot of diseases in the body but as a minority population, someone that can't declare himself, how would you tell them...? It is very absurd for a straight doctor to hear that you are gay" (Olu, self-identified homosexual man, Lagos Interview)*

As highlighted in the quote above both interview and FGD participants reported that in order to avoid stigma, discrimination or jail, they concealed their ailments such as anal warts and falsified their symptoms. The consequence of this was misdiagnosis and prescription of wrong treatment. In addition to this, MSM also reported that in some cases they were out-rightly refused treatment. For instance, an Abuja FGD participant mentioned how a friend of his had been denied treatment because he had anal warts and the healthcare providers had concluded that for him to have anal warts it means he engages in homosexual practices. The refusal of treatment based on a health professionals' knowledge of sexual practices was one of the tools<sup>37</sup> used to discriminate against MSM. However, as discussed in previous chapters because of the criminalising laws in the country, MSM felt that they were unable to report to the police as doing so would prove futile and furthermore, going to court meant that a case would have to be opened and their sexual practices would be publicly revealed.

As presented earlier in Chapter 6, participants also described 'overcautious' practices on the part of some healthcare workers, for example, wearing gloves and face masks before attending to clients. This was, not surprisingly, perceived as not only discriminatory but also stigmatising. One FGD participants, referred to this practice as a "*'HIV phobic' [because] before they attend to you, they would have to cover their face, they would advise you that on the day of your appointment, you have to come with handkerchief, if you want to cough, you cover your nose so that you won't pass it to them. They would have to cover their face, wear gloves*" (Akin, Abuja FGD2)

### **7.2.1.3. Unqualified and Unfriendly Healthcare Providers**

Furthermore, MSM in this study reported that there was a lack of specialist skills amongst the healthcare workforce to address MSM needs. As explained in the quote below:

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<sup>37</sup> Other tools are outlined and discussed in the discrimination chapter

*“...when I went for the anal warts treatment in a public hospital...they kept giving me that Augmentin and it is not working. So when I came back, the health care provider was like, do you do anal sex? I said yes, I answered in the affirmative, I said yes, that was the end of my case. She said I should go and take care of myself there’s nothing she can do about it.” (Peter, self-identified homosexual man, Abuja)*

Interviewees stated that because they were HIV positive, most of them were prone to developing anogenital warts, known as condylomata and as such medical services geared towards treating this was a necessity. However, healthcare workers in general healthcare facilities didn’t have the capacity or the knowledge to deal with their specific healthcare needs and were inadequately trained and therefore unable to cater to these needs.

In addition to the lack of specialist competence, MSM revealed that healthcare providers were also unfriendly and unwelcoming and often humiliated, mocked, insulted them especially those who portrayed stereotypical feminine characteristics. One FGD participant narrated how one nurse had said to an HIV positive client who wasn’t happy with the service he was provided, *“am I the person that give you HIV?” (John, Abuja FGD1)* This same participant recounted an instance when an MSM-related study was being conducted and clients were told they could either access their healthcare services from the NGO or from a general healthcare facility. Most of them chose to access care from a general healthcare facility because they assumed it would reduce their likelihood of being stigmatised or discriminated against. However, contrary to what they expected, the healthcare providers were unfriendly and unwelcoming and they eventually had to return to the NGO. Another participant during the discussion pointed out that this unfriendliness was only directed to clients from lower socioeconomic backgrounds as healthcare providers were friendly to prominent individuals who were able to bribe them with gifts and money. He stated, *“...if you are their person, they come, they would leave the other person that has been there for long and start attending to the people, like I call them prominent people, most of them come with their cars and buy them gifts. We that can’t afford to give them money or tip them or even buy them gifts, they would just leave us behind and attend to other ones. So I see that as a challenge too” (Akin, Abuja FGD2).* Participants were discouraged from accessing healthcare services as a result of the preferential treatment afforded to clients whom the healthcare providers knew.

## 7.2.2. Point of Service Delivery Issues

### 7.2.2.1. Overcrowding, Long Queues and Long Waiting Times

Interviewees expressed their unhappiness about having to stand in long queues and overcrowded waiting rooms which resulted in longer waiting times at the general healthcare facilities. Speaking about challenges of accessing general healthcare facilities prior to transferring to a facility which provides MSM specific services, one interviewee stated:

*“The only challenges I had was [the] issue of population, whereby you go in the morning before you reach house it would be that kind afternoon, evening. So if your appointment today is for collection of drugs, you should only know that it must be today only...today you are doing nothing else apart from collection of drugs and if you are working...you would be taking permission once in a month for drugs collection, what would you be telling them? These are the challenge we are having, that’s in public hospitals.” (Peter, self-identified homosexual man, Abuja Interview)*

As explained in the quote above, participants encountered long queues and crowded waiting rooms when accessing care at general healthcare facilities. This resulted in longer waiting time and in most cases meant the whole day had to be dedicated to accessing healthcare services and treatment. One FGD participant mentioned that he would have to get to the clinic as early as 5:30am and on a good day, he would be lucky to leave by 2pm, by which time he would be exhausted. This was a problem for participants who were employed as they had to make up excuses to get a day off from work in order to avoid disclosing their HIV status to employers. This experience was in marked contrast to that of accessing treatment from facilities that provided MSM specific services. Participants mentioned that they rarely experienced long waiting times or delays in getting their treatments and were attended to expediently as healthcare providers were conscious of their jobs and other commitments. This point is evident in a statement made by the same participant from the quote above during the FGD:

*“But when I started my treatment with ICARH, I haven’t had any challenges like that, I just come, maybe if I come early in the morning like 8, I take my drugs before 8:30, I’m off and they would understand this person is working let’s service him fast fast fast, so he would go, the highest you would spend here is one hour, you would leave the*



*facility...I wish it could be like this forever ...here I collect my drugs like a prince, like a princess (ALL LAUGH). That is the only difference. Anywhere I am I don't think I can ever ever ever, if it is going to public hospital I would stop. It is that bad!" (Peter, self-identified homosexual man, Abuja FGD)*

Interviewees reported other concerns about having to stand in a long queue. These increased the likelihood of seeing familiar faces and the inconvenience of standing for long hours in the queue especially if it is out in the sun.

*"You see a lot people queuing under the sun, how many people could have this mind of staying under the sun? Look at the health, consider the health first. With that, I have friends that work over there also, I can't just got there now and see me under there, things like that." (Olu, self-identified homosexual man, Lagos FGD)*

Because HIV is highly stigmatised in Nigeria, MSM did not want to be categorised as being 'HIV positive' and this meant avoiding places like the HIV clinics where they could be identified as such.

#### **7.2.2.2. Separating and Labelling of HIV wards**

General (public) healthcare facilities in Nigeria typically organise special clinics, such as 'Heart to Heart' clinics or might label the clinics 'HIV clinic'. These clinics are usually in separate areas of these general healthcare facilities, isolated from the rest of the facility. FGD participants expressed their discomfort in accessing healthcare services from these facilities. Reasons given were the high probability of seeing a familiar face and that anyone seen going into the clinic was automatically identified as being HIV positive. For these men, the fear of being seen at a clinic tagged 'HIV clinic' and the resultant gossip prevented them from accessing healthcare services, whether general or MSM specific as expressed in the quote below:

*"...And then tagging a special ward, 'HIV clinic', in a very big hospital where people will go, it is not as if there is a hidden entrance gate. All the roads that lead to that place from the major clinic is [sic] just accessible, so it means even if you come to see somebody or even if you come to see one of the clinicians, maybe you are sitting down,*

*somebody that knows you would just see you and say ah, so even you?” (John, Abuja FGD1)*

This concern about lack of privacy so to speak was echoed across all FGDs. The MSM community is very tightly connected and interwoven and as such personal information about MSM can spread easily through gossip. Another MSM shared his experience of accessing treatment from a military hospital<sup>38</sup> where a lot of HIV positive individuals access HIV care and treatment. He recounted a particular time he had gone to access his treatment and seen his HIV outreach coordinator who unknown to him was also HIV positive and also receiving treatment. Although he eventually went into the clinic, he mentioned that he initially felt reluctant going into the clinic as it meant the possibility of unintentionally disclosing his HIV status. There was some debate about the issue of privacy and the fear of seeing familiar faces, and one MSM in the group made a point not to obscure the two. For him, accessing HIV related care and treatment is made easier once there is a realisation that every other person at the HIV clinic is there for the same reason. The sectioning and labelling of HIV wards at these hospitals was perceived by interviewees to not only be discriminatory but also stigmatising.

### **7.2.2.3. Distance of Healthcare Facilities**

This sub-theme yielded mixed responses, while distance of the healthcare facilities was a concern for some interviewees, other interviewees found accessing healthcare facilities close to where they lived or were employed as challenging. One participant discussed the challenges he encountered accessing treatment from a general facility in his home town. When asked what made the process of accessing healthcare easier, he stated:

*“I would say it’s the organisation (MSM specific clinic) because if there is no organisation, it would be very hard for me...when I was in Port Harcourt when I tested positive, the hospital where I tested positive, going there self is very difficult for me self because it is not far from where I live and sometimes you are scared of who you would see there...I would have to call the nurse [...]to find out how the queue there is and all that. But with ICARH here, has made it easier for me and other MSMs living with HIV*

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<sup>38</sup> See Introduction for Military hospital role

*to freely come out and access healthcare.” (Sule, self-identified bisexual man, Abuja FGD)*

General healthcare facilities are open to everyone and so the likelihood of seeing someone familiar is a significant factor. It is for this reason participants in this study stated that prior to ‘discovering’ these MSM specific clinics, they would travel far distances and sometimes as far as neighbouring town to access services and treatment.

### **7.2.3. Barriers pertaining to the Legal System- Criminalisation of Homosexuality**

Some MSM reported that they feared incrimination especially after the passing of the Same Sex Marriage Prohibition Act (SSMPA) and for this reason they avoided accessing healthcare and treatment from general healthcare facilities even when they were in desperate need. As illustrated in the quote below, the SSMPA which criminalises men who engage in sex with other men has had far-reaching implications for how MSM negotiate access to healthcare services:

*“I begged somebody to take me home from the bus stop, I just lied that I was robbed, the person now took me to my house. So I went to my house that day, I was unable to go to the hospital because I didn’t know this place (referring to MSM friendly clinic) and the only place I know is general hospital but I don’t want to tell them when I get there. Like I cannot go and start telling them that I was raped, how can a man be raped? All these things, then the law was out, the 14 years’ imprisonment, I say ah if I now go and tell them now, I’m sure they won’t even attend to me, they would just call the police and who knows maybe I would still be there till now. So that was how I just kept quiet and I didn’t know about this place then.” (Mustapha, self-identified homosexual man, Lagos Interview)*

In the quote presented above, Mustapha narrated how after a brutal rape incident<sup>39</sup>, he was unable to access health services from the general hospital for a number of reasons. First, he did not know how to explain that he had been raped and not only had he been raped but by men. Second, he feared imprisonment in light of the recent criminalisation law that had just been passed. This inhibited him from seeking necessary post-exposure prophylaxis (PEP), which could have been prevented him from becoming HIV positive.

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<sup>39</sup> See pen portraits in appendices for CO’s story

Unfortunately, it was shortly after this incident that Mustapha retested for HIV and was diagnosed HIV positive.

#### **7.2.4. Financial Issues and Access to Antiretroviral Treatment (ART) and Other Healthcare Services**

Antiretroviral treatment (ART) is currently provided free of charge in Nigeria, however some general healthcare facilities still charged fees for ART, as expressed in the quote below:

*“...when you go to general hospitals, federal hospitals, when you go there, you can only get your ARV, mostly you get your ARV with pay, without paying they would say [A: WITHOUT PAYING?] without paying you won't be able to access it...” (Olu, self-identified homosexual man, Lagos FGD)*

Not only were ART provided at a cost to MSM, they also reported that at general healthcare facilities they have to pay for other services including routine and diagnostic tests and treatment for opportunistic infections. These additional costs of diagnostic and routine tests, transport to and from the healthcare facilities, treatment of opportunistic infections and other ailments incurred by MSM were considered to be expensive and in their eyes posed a barrier to their access. One participant reported that at general healthcare facilities payment had to be made in order to be attended to by a healthcare provider. He stated, *“...you will come for an emergency, instead of a doctor to treat you first before talking about the payment, he will first of all want you to pay completely... before they commence treatment” (Akin, self-identified homosexual man, Abuja Interview)*. MSM who were unemployed or in temporary employment expressed that paying these costs was difficult and represented an additional burden giving their other non-health related financial commitments.

For some of the men, paying for healthcare services and treatment wasn't as much of a difficulty as the payment process was, as explained in the quote below:

*“... [the] main challenge for me, I don't have any challenge...[but] when in NIMR<sup>40</sup> we have challenge. You pay money for your drugs, you pay money for your chemistry lab, you pay money for everything you are doing there...before you pay money you would go to bank, go and pay, bring teller, and many a' times you would come you don't have drugs and your appointment is today... then the bank tells you there is no network, you came(sic) back, they tell you they would not give you drugs, you would go to 3,4, 5 banks, there would be no network, it means that you can stay without drugs so it's a challenge” (Gaddo, self-identified bisexual man, Lagos Interview)*

Although the interviewee in the quote above did not face any major challenges accessing treatment he reported that the process of making payments for healthcare services was often tedious and time consuming. The quote reveals two issues: first, the lack of interest in those that set up the payment process in the experiences of the clients and other users of the services and second, the breakdown not only of the general healthcare system in Nigeria but of other infrastructure and the effect on access to healthcare services. It depicts how a malfunction of infrastructure in one sector, in this case the banking sector, can result in the inability of an HIV positive individual to get his treatment. This has major implications for adherence, as would be discussed in detail in the next chapter. The participant in the above quote reported that although this tedious and time consuming process of making payments for healthcare services was the case in healthcare facilities run by the federal government, it was not the case in those run by the state government, like where he volunteered as a health worker.

#### **7.2.5. Societal Perceptions of HIV Services**

The general perception of MSM is that anyone seen attending HIV clinics must be HIV positive and this is one of the reasons to why MSM do not seek healthcare services. This perception was mentioned across all FGD and is evidenced in the quote below from the discussion held in Lagos:

*“...like this hospital now, they offer free healthcare services and most people don't like accessing it, they always give flimsy excuses like, ah they don't like coming here, they don't want people to know, their friends, what they do come here for. A friend of mine*

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<sup>40</sup> NIMR stands for The Nigerian Institute for Medical Research and is a medical research institute situated in Lagos, Nigeria. Its main focus is HIV research, however, other HIV related services e.g. HIV testing and treatment are also provided.

*was like, ah you are going to Yaba, “you self you don carry HIV abi<sup>41</sup>?” That it’s only those that have the virus that come to this place.” (Tim, self-identified bisexual man, Lagos FGD)*

For another participant, it was the general environment of the HIV clinics, both private and public, that was a deterrent to access. This participant further stated that what he would consider a positive change was if private services could be provided, which could easily be accessed for example, from the comfort of his home.

Other barriers to access to healthcare services and ART that MSM in this study mentioned were fear of ARV side effects, comorbidities and inconvenient appointment times. One participant expressed that he has not been able to access ART because of his comorbidity (hepatitis B), which has caused his liver to be compromised. He mentioned that until he was able to receive a positive liver function test result, he would be unable to access ART

### **7.3 The Influence of MSM Social Class on Access to Healthcare Services**

An important and interesting finding about how MSM in different social classes access healthcare services was brought up during FGD1 in Abuja. High social status seemed to ameliorate many of the barriers to accessing healthcare services. Interviewees discussed specifically their conceptualisation of social class as a stratification between ‘low class’ and ‘high class’ MSM, ‘mature’ and ‘young’ MSM and ‘employed’ and ‘unemployed’ MSM. According to interviewees, these differences in social class were particularly salient as it meant that some MSM who felt they were above a certain class or could not be seen in the company of those in that class. MSM considered being from low or low-middle class were more likely to access MSM friendly services and as such MSM who were considered to be ‘higher class’ did not access healthcare services through these facilities. These prominent ‘high class’ MSM were able to access healthcare services in the comfort of their homes, from general healthcare facilities or travel out of the country.

During the discussion, there was some misunderstanding among FGD participants about the distinction between social class and sexual preferences. However, the group came to

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<sup>41</sup> ‘you don carry’ is MSM lingo for you are HIV positive

a general agreement that social class and sexual preferences were in some way related but they have different implications and MSM from the different social classes had their unique sexual preferences. One MSM in the group who mentioned that his sexual preference was for mature men, reported that the mature men he engaged in sexual intercourse with always wanted the commodities like condoms and lubricants. He further stated that these men would never come to get them from the clinic where he gets them. Participants mentioned that the reason these men may not access healthcare services from these clinics despite the fact that they are geared towards their population is because they believe it is only meant for young MSM and accessing these services would be going below their 'level' or in other words, social status.

According to participants, these higher status individuals could access care wherever they wanted to in the world but more importantly there were 'VIP' services tailored for this group and available at the general healthcare facilities. Participants discussed how a high status MSM could get to the healthcare facility at any time he wanted, even right before closing and still be catered to in a very friendly manner by nurses who are fully aware of his sexual practices. It was even mentioned during the discussion that 'home service', whereby this elite group are provided with healthcare services and treatment from the comfort of their homes was readily available at their request. A related point that was brought up by another MSM during the discussion was that MSM from lower socioeconomic backgrounds faced these challenges gaining access to care at general healthcare facilities was because of a lack of social and financial capital. According to him, having influence, wealth and power made all the challenges they encountered secondary because with these tools at their disposal they could not be maltreated, stigmatised or discriminated against by the healthcare providers.

*"We have said it all, I think we have said it all, because if you have money, if you have money, some of these things, so many things we say here are secondary, that people say you are gay, they bitch at you, they say this, they say this, if you have money. Talk about politicians we know, high class politicians we know that people talk about them, that they are gay and then they still access care and the nurse that bitches at us in the hospital will still go to them and do home service. So it also boils down to what is your level, what is your class." (Femi, self-identified bisexual man, Abuja FGD1)*

There is a clear difference in how MSM from different social classes negotiate access into the healthcare system. From reports of the interviewees, this difference lies in the tools, influence, wealth and power, which 'high class' MSM have at their disposal.



#### **7.4. Specific Interventions to facilitate and address challenges to accessing HIV-related healthcare services and ARV**

Many of the barriers identified at the general healthcare facilities were generally absent at MSM specific clinics. Interviews and FGD findings referred to a number of interventions developed by MSM specific health facilities to facilitate and address challenges MSM encounter when accessing HIV-related healthcare services and ARV. These interventions included provision of comprehensive and tailored HIV-related healthcare services, organising innovative methods of healthcare delivery, peer educators, test and treat initiative and finally, following up on clients and way-billing ARV. MSM reported that these interventions made accessing healthcare services at their specialised clinics easier and more convenient.

##### **7.4.1. Provision of Free Comprehensive and Specialised HIV-related Healthcare Services**

MSM noted that access to HIV-related healthcare services and ART was greatly facilitated by MSM friendly clinics because they were provided with comprehensive and tailored healthcare services which included ART, STI treatment, diagnostic and routine tests at no cost to them. The NGOs were able to provide these services free because they receive funding for HIV programs and intervention from international donors. Given that most interviewees were either unemployed or their wages could not cover the costs, free provision of these healthcare services and treatment enabled their access to healthcare.

*“...thank God for all these NGOs because the NGOs are actually supporting the MSM in Nigeria, in that...support in terms of providing them with free medical treatment and other preventive measures like distribution of condoms and lubricants...So there is no difficulty in accessing the drugs and then the healthcare because I later had some other STI after I tested positive... So I came immediately and complained and I was treated immediately, I was given injection and some pills to take. So when I took it, everything went off, so I felt okay, I felt normal” (Ibrahim, self-identified homosexual man, Abuja interview)*

Interviewees also stated that they were able to express their sexual health issues and symptoms such as anal lesions or discharge freely with healthcare providers as well as

receive necessary treatment in a professional, judgement free and friendly environment without fears of stigma, discrimination or being reported to the police (FGD2, 3). Interviewees in the Lagos FGD stated that whenever they had any health concerns, there was a hotline they could call to speak to a healthcare provider who advised on their issue. As CO mentioned, *“Whenever I want to complain about something, I always call the hotline here and whatever time I call them, I always have answers and anytime I am here for services they always attend to me on time.”* (Mustapha, Lagos FGD).

According to interviewees, the Nigerian government did not fund HIV programs and interventions especially for these NGOs and most funding for the HIV programming came from international donors e.g. DFID, USAID and PEPFAR. This is discussed in further detail in Section 7.5.2.

Overall, interviewees felt that because healthcare providers at most of the NGO clinics were extensively trained to cater to the needs of key populations including MSMs, they were able to deliver friendlier services. The men also mentioned that at these NGO clinics, they were valued, respected, given the necessary support and treated with care regardless of their sexual identity and practices or HIV status, as reported by one of the participants in the Abuja FGD, *“if you go to hospitals like this, like NGO and all that, they will treat you with care, you know, they will give you that support, they value you, they respect you for who you are, irrespective of you being gay or HIV positive”* (Jide, FGD1).

#### **7.4.2. Organising Innovative Methods of Accessing Healthcare Services**

When it was impossible to seek healthcare services from formal health facilities, participants with the available and necessary resources could seek these services in the comfort of their homes. One interviewee whose sister is a nurse mentioned that he goes to his sister for advice or treatment for any health issue pertaining to his sexual practice:

*“...when I want to talk about it, I go to my sister and I tell her this is what I’m feeling, this is what I’m feeling. She prescribes for me, if she has to prescribe. If she has to ask, she will go and ask and the next day she comes back with a solution, go and get so so drugs, so so treatment. If it is drip, I have to take the drip, I would hang my leg on top of the chair, she will be giving me in the house. That’s how it has been. If it’s this she*

*buys them herself and comes back home.” (Chidi, self-identified bisexual man, Abuja Interview)*

Another interview participant who is a health volunteer narrated how he was able to provide more accessible and less stigmatising healthcare services for MSM by organising HIV testing and counselling (HCT) at his home. He stated,

*“In my compound where I’m living now...the landlord came and said that they called them on the phone and told them that I am an MSM and that MSM people are coming to my house, I said, “yes they are coming to my house, I treat them, I’m a health worker, a social health worker, so I treat them and that’s the way I get the money I use to pay your house rent”. He said, “no oh! what you do, we don’t want you to pack out, but don’t bring them here, get an office”, (I said,) “oga I work in an hospital but they came to my house for treatment too, and the one that I work in the hospital is different from the one I work at home and I get money” ...I still bring them, what I do, I changed the situation, I organised open space and started doing general population test, so MSM would come, people outside the street would come [A: In your house?] Yes, in my house. So when the outside people, general population comes, they would do test and anybody that comes, they see everybody now as their general population, ah you dey live for that area, ok you dey do test there, that’s true, that man said nah test dem dey do” (Gaddo, self-identified bisexual man, Lagos Interview)*

The excerpt above shows how Gaddo was able to provide healthcare services for MSM who otherwise would not have felt comfortable accessing these services from general healthcare facilities. Although he was personally subjected to discrimination because of the sexual practices of some of the men he was providing services to, he was able to extend these services to the general population as a camouflage. By making HIV testing open to the whole community, it was nearly impossible to point out who was and was not MSM.

Other innovative methods organised to facilitate access to healthcare mentioned by interviewees included organising HIV testing at hotels where MSM are known to congregate and organising ‘open house’ at MSM clinics where MSM are invited for infotainment, free healthcare services and treatment.

### **7.4.3. Way-billing of ARVs and Client Follow-up**

Another intervention which MSM specific clinic deployed to facilitate access to ARVs was by way-billing the ARVs to their clients if they were not able to collect it. Interviewees reported that as long as they informed the clinics that they would be unable to pick up their treatment, by paying a small fee for shipping they could get their ARVs sent to them no matter where they are in the world. An alternative form of way-billing which interviewees reported was that their ARVs could be sealed securely and dropped off at bus parks to be taken to a destination closer to them where they could pick it up. This was very convenient for those who either resided or went school in a state where these clinics were unavailable, for example, Enugu, which is in the Eastern part of Nigeria.

One FGD participant mentioned follow up of clients as one way MSM specific clinics facilitate access to care and treatment. He mentioned that even when clients test negative for HIV, they are immediately booked for a follow up appointment and called to ensure they return for a test three months after. Those who test positive are monitored to ensure that they are adhering to their treatment and they attend their appointments. He explained, “...here when we say lost to follow up, everybody would team up and say how can we get these people, how can we get these people and we device means of reaching out to these people” (Femi, self-identified bisexual man, Abuja FGD1). In response to this, another FGD participant stated that when he accessed care from a general healthcare facility, he was always followed up. However, the program that provided them with ART was a PEPFAR funded program.

### **7.4.4 Other Strategies**

Other strategies discussed during the interviews and FGDs include the mobilisation of peer educators to spread HIV awareness and the provision of extra month's supply of ARVs. These are described briefly below:

#### **i. Peer Educators**

In the context of this research, peer educators are MSM who are employed by the NGOs to spread awareness about HIV and services provided by the NGOs in their various communities. These peer educators are crucial to the dissemination of HIV information

to the most hidden populations especially since they have knowledge about their communities. The mobilization of these peer educators to spread awareness was discussed as one feature of NGO run clinics that increased its accessibility. According to the MSM in one of the FGD, these peer educators were strategically placed in districts where MSM are known to reside. These peer educators are given the duty of spreading correct and complete HIV information to their peers and also inform them about the availability of a MSM friendly services tailored to meet the specific needs of MSM at the NGO run clinics. The excerpt below from a FGD in Abuja depicts this point:

*“Ibrahim: Well, for me the experience I have is only NGO, NGOs make it easier in that they have peer educators that go to the field, you know you are a gay person and you are living in a particular district, they will make you a peer educator to be reaching out to your friends who are also gays, so when you reach out to them you pass all these health messages to them and encourage them to go for HCT. When you refer them for HIV counselling and testing and they are usually being refereed to those NGOs clinic. So when they are being tested, if they tested, if they are reactive, the next thing is that they will place them on drugs*

*John: Yes, that’s one channel that makes it easier for people to access care*

*Ibrahim: ...so peer educators actually help a great deal.” (FGDI Abuja)*

## **ii. Provision of Extra Month’s Supply of ARVs**

Participants also mentioned that when they accessed ART from MSM friendly clinics they were first given about a month’s supply of ART and monitored. If the ART worked well for them, they were subsequently given two to three months’ supply of ART:

*“Yes, I am on ARV right now, I’m taking the pills, I’m taking the ARVs and for the access, yeah I always have access to it because whenever because the bookings or would I say the arrangement they made is that you come, you take your drugs, and one bottle lasts for a month. So the first time they gave me one bottle for a month, the second time, they gave me two bottles, for two months and this third time, this is my third time of coming to access the drugs, I actually accessed the drugs yesterday and I was given three bottles, which would last for three months.” (Ibrahim, self-identified homosexual man, Abuja Interview)*

Provision of extra month's supply of ARVs facilitated access to ART as MSM reported that they didn't have to return to the facility and incur additional expenses till their ARV supply was used up.

## 7.5 Issues for Consideration with MSM Specific Clinics

### 7.5.1. Unequal Distribution of MSM Specific Clinics across Nigeria

While MSM specific clinics offered services tailored to the specific health needs of MSM, there was concern among MSM about the limited availability and accessibility of these services across Nigeria. Interviewees mentioned that these facilities were not available in every state in Nigeria, especially in the Eastern parts of the country. Although the NGOs have attempted to enable access to healthcare for these marginalised population by establishing these MSM specific clinics, MSM felt that others in the different parts of the countries were not benefitting and may still be subjected to inequitable access to healthcare services and treatment. They stated that there was a need for more even distribution of these facilities in the country as well as more healthcare staff in these facilities. The quotes below are taken from focus group discussions conducted in Lagos and Abuja.

*“Imagine, like me now, when I was schooling in Ibadan, I would need to leave Ibadan down to Lagos to pick up my drugs, because I can’t just go to any hospital, I can’t barge into any hospital...we all agree that this is the only place where MSM get to take their drugs in the whole of Nigeria...I said, “I stay in Ibadan, I normally come to Lagos”, he was like, he has a lot of people that come from Port Harcourt, Edo, those far places to Lagos to pick up drugs like that. All because of two months drugs! It’s very very vital in that case but there should be other means that we can also get that<sup>42</sup> ...” (Olu, self-identified homosexual man, Lagos FGD)<sup>43</sup>*

*“...in the East, he said that guys are dying like mad in Enugu, Anambra<sup>44</sup> state, in all those areas. They don’t access these health facilities we access, I am telling you the gospel truth, they are dying every day and it is HIV” (Chris, self-identified bisexual man, Abuja FGD3)*

*“I am coming from the Eastern part of the country... I was feeling so bad that they have a lot of people dying on daily basis because they have not been able to access medical treatment, we don’t have any of these kind of thing in the Eastern part of Nigeria, I*

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<sup>42</sup> referring to ARV drugs

<sup>43</sup> Olu, a Lagos FGD participant narrates his conversation with the doctor at the MSM specific clinic he attends in Lagos

<sup>44</sup> Enugu and Anambra are both states in the Eastern part of Nigeria

*don't really know if they have, I don't think so.” (Yemi, self-identified homosexual man, Abuja FGD3)*

Other participants felt that the few MSM specific clinics that were available couldn't sustain the high numbers of MSM accessing care and treatment. As a result, there was concern that these facilities may start getting just as crowded as general healthcare facilities. One MSM called for an increase in capacity building and human resources:

*“...because of the large amount of persons that come to access these things and there are not much helping hands around, staff are limited, most times, we need more hands, we need more outlets... Like community centres should be created, that one can go and apparently be yourself [sic] and access facilities there. I mean a more enabling environment should be created for us” (Hassan, self-identified bisexual man, Lagos Interview)*

### **7.5.2. Donor Funds**

Another recurring issue was about the uncertainty of donor funding. As stated above, funding for HIV programs and interventions especially those geared towards key populations come from international donors with little financial contribution from the government. Participants expressed concern over the likelihood of foreign donor funds being stopped at any time without warning or any alternative. Speaking about the accessibility of healthcare services, Wale voiced,

*“For this place it is accessible but I wonder what happen when funds stop coming in, people would die and I need to leave this country by then [BOTH LAUGH]” (Wale, self-identified pansexual man, Lagos Interview)*

Another participant spoke more generally regarding his fear of donor funding being discontinued:

*“...it is not easy because who cares about you? Nigerian government doesn't care about you, do they? All the funding about HIV, is it not foreign funding? Nigeria does not fund anything about HIV, so should American government say no we don't want to fund Nigeria again about HIV, what would happen to (HIV) positives in Nigeria? What*



*would happen to them? It's very bad, and we just keep praying that American funding continues, but it won't last forever, it won't last forever, and I don't know what Nigerian government would do or are doing to see that they take charge of the healthcare of its citizens, I don't know what they are doing about it.” (Lucas, self-identified bisexual man, Abuja Interview)*

### **7.5.3. Homophobic Healthcare Workers at MSM specific clinics**

One interview participant reported that accessing healthcare services from MSM friendly clinics didn't always guarantee that they were served by health workers who were all accepting of their sexual practices. He recounted how a couple of homophobic health workers were asked to step down from their positions after preaching to some of the clients to desist from their homosexual practice. According to the participants, the lucrativeness of a job position as a health worker in an NGO means that a lot of people can easily pretend to get these jobs. Notwithstanding, participants reported that they were able to access all necessary healthcare services at these MSM friendly clinics and as such there was no need to access healthcare services elsewhere.

## **7.6 Chapter Summary**

In this chapter, the ways in which HIV positive MSM negotiate access into the Nigerian healthcare system have been discussed. Based on the study findings, it was understood that the majority of the MSM have experienced accessing both HIV related healthcare services and ART either through general (public, private and/or military hospitals) healthcare facilities or MSM specific clinics. As a result, participants tended to juxtapose their experiences of accessing HIV-related healthcare services and ART between general healthcare facilities and MSM specific clinics in terms of the relative ease or difficulty of accessing care and treatment. Most of the difficulty MSM encountered was at the general healthcare facilities, where they were confronted with a disabling, stigmatising and discriminatory healthcare environment.

Class differences influenced access to life changing HIV healthcare services. MSM specific clinics tend to provide a more enabling environment where MSM can freely access healthcare services, however, they were not without their shortcomings. These MSM clinics are unequally distributed across the country, with more in the urban cities than rural areas. Additionally, since most of the HIV interventions and programs offered

at these clinics are being funded through international donors, there is great concern about these funds ceasing. Finally and surprisingly, was the mention of homophobic healthcare workers at these MSM clinics. In the next chapter, participants understanding and response to the medical expectation that they maintain optimal ART adherence is explored.

## **CHAPTER 8: ADHERENCE TO ART**

### **8.1 Introduction and Chapter Structure**

In the previous chapter, the various ways in which HIV positive MSM negotiate access to HIV-related healthcare services including ART in Nigeria were explored. It was argued that HIV positive MSM as a result of their dual stigmatised status in the Nigerian society encounter several barriers to accessing healthcare services and ARVs particularly from general healthcare facilities. As a result, MSM in this study preferred accessing healthcare services through MSM specific clinics where they encountered significantly fewer barriers.

In this chapter, adherence to ART among HIV positive MSM in Nigeria is explored in detail. This chapter answers the research question of how HIV positive MSM in Nigeria understand and respond to the medical expectations that they adhere to their antiretroviral treatment. Section 8.2 investigates MSM understanding of antiretroviral treatment and what it means for them to adhere to their treatment. Section 8.3 describes the processes of starting and using ART. Section 8.4 outlines benefits of and motivations to adhere to ART. Sections 8.5 and 8.6 both analyse and discuss challenges and facilitators of ART adherence as reported by the men. Section 8.7 describes specific strategies MSM deploy in maintaining optimal adherence to their ART. The chapter concludes with a section outlining the key messages.

### **8.2 Understanding of ART and adherence to ART**

Participants in this study generally understood antiretroviral therapy (ART) to be treatment used to suppress an infected individual's HIV viral load. One participant described ART as treatment necessary to ward off infections. He explained:

*“...one thing I know about HIV is that HIV destroys the immune system to fight against infections, the immune system fights against infections that are coming in like the dust all those things, if you don't take your ARVs the HIV would destroy your immune system and even though you just inhale small dust you would fall sick. So, I see it as infection that destroys immune system, so if you don't take your medicine, the infection would destroy your immune system and you would start having malaria” (Mustapha, self-identified homosexual man, Lagos Interview)*

Although participants understood what maintaining optimal entailed they gave mixed responses to the question asking about this understanding. What this indicated was that they placed higher value on certain aspects of adherence for instance, time keeping, maintaining a balanced diet, and avoidance of alcohol, than others. One participant reported that he was told by healthcare providers that when an infected individual adheres to ART, the virus leaves the blood and goes to the bones and HIV loses its power to infect.

### **8.3 Initiating ART**

As reported in Chapter 5, all MSM in this study used ARVs to manage their HIV. The majority of them reported that they did not start using ART immediately they were diagnosed with HIV and in some cases, they didn't actually start until years after diagnosis, when they became seriously ill and were experiencing symptoms of HIV/AIDS or their CD4 count had dropped drastically.

*“Then they told me I wouldn't be placed on drugs yet because my CD4 is still very much high, I was like ok, but I should be taking fruits and I should get Septrin...Then after like a month,...I think I fell sick, I think, yes, I think I had fever, typhoid and malaria. Then after the typhoid and malaria, I lost some weight, then I was like ok ah, I have to just pick up courage and start taking this medication if not I would start falling ill, what I've been hiding, I don't want anybody to know, to later find out because in our community, whenever somebody is falling sick regularly, regularly, they just conclude, ah he has HIV. So I was like ok I'm ready” (Mustapha, self-identified homosexual man, Lagos Interview)*

The above quote highlights the stages an individual goes through before eventually deciding to start using ART. The Nigerian government had recently adopted the WHO 'test and treat' policy which recommended an initiation of therapy for all HIV infected individuals irrespective of CD4 count in 2010. This meant that MSM who had CD4 counts greater than 350 cells/mm<sup>3</sup> were not prescribed ART. Instead they were counselled on how to maintain good health through diet and if necessary prescribed Septrin, which they said was used in treating bacterial infections. An HIV infected individual was usually not prescribed ARTs until they began to fall sick consistently.

In terms of the treatment regimen, the majority of the interviewees in this study stated that they took their ART once per day and it was usually at night time. However, two interviewees reported that they took theirs twice a day because they were on second line treatment regimen. One of the interviewees, who was initially prescribed first-line ART reported that he was placed on second line treatment regimen when he stopped responding to treatment. He stated:

*“When I started...there’s this one I take, two in the morning, two in the night, that’s how I used to take it but after some, like a year, they said that, I did my CD4 and my viral load...the viral load was increasing, something that supposed to be decreasing because I’ve been taking drugs, it was increasing...It’s either I’m not taking it well or the drug is not working for me, they now had to place me on the second regimen which is the one I’m taking now. And that one is even more stressful, the drugs are very big and you have to take it three in the morning, two in the night with Septrin again making it three in the morning, three in the night...from what they told me, this second line is my last opportunity because it fails, the third regimen is not in Nigeria, it’s either I have to go to abroad and maybe start taking the other one or I’d be ready to die, which I am not ready” (Sule, self-identified bisexual man, Abuja)*

In the case above, the amount of drugs to be taken daily was an issue and may have caused the participant to stop taking it consistently which led to the increase in his viral load (VL). He also stated that using second line treatment was even more difficult as there was an even higher pill burden and bigger pills he had to swallow. The difficulties MSM encounter using and eventually adhering to ART are discussed in more detail in the next section.

Once participants gained entry into the healthcare system, the next step was to access ART treatment. Participants expressed that they were reluctant to start using ART for a number of reasons, which included, misconceptions about the treatment and its side effects, fear of others becoming aware of their HIV status and cohabiting with other MSMs and non-MSM friends or with family. In order to understand the importance of maintaining optimal adherence, participants reported that they had to undergo two to three weeks’ mandatory adherence counselling. Study participants revealed that this mandatory adherence counselling was mainly provided at MSM friendly clinics.

Participants reported that during adherence counselling, they were counselled on the basic mechanisms of ART and how to manage their illness with ART. In terms of maintaining good health, participants mentioned that they were advised by the healthcare providers to avoid drinking alcohol, smoking and using illicit drugs to use condoms even if their partner is HIV positive as well, to maintain a healthy diet by eating foods high in protein and drinking plenty water and finally to avoid stress. In terms of the treatment, participants reported that they were advised that in order to maintain optimal adherence to ART, they had to take their pills at about the same time every day and try not to miss doses. They mentioned that they were informed about possible side effects associated with ART and to expect encountering these side effects till they get used to taking the treatment. After adherence counselling, participants were prescribed ART which they used in managing their HIV.

#### **8.4 Benefits of and Motivations for Using and Adhering to ART**

The general consensus amongst participants was that consistent use of ART offered an abundance of health benefits. All MSM reported that they experienced an overall improvement in their health and wellbeing as well as their CD4 count and viral load within a few months of starting their treatment. Some stated that they felt they looked healthier than even those that weren't HIV positive and attributed this to the potency of the treatment.

Feeling and looking healthier as a result of adherence to ART allowed MSM to deal better with stigma. One participant mentioned how he never experienced any stigma towards himself because there was no physical evidence that he had HIV as a result of using his ART. Common to all MSM in this study was the confidence that they could live longer and normal lives because they were using ART. Participants' responses revealed a high level of self-efficacy and responsibility for their lives and their health and this was one of their motivations for adhering.

Additionally, the need to conceal their HIV positive status from others was one of their major motivations for using and adhering to ART. On one hand, without treatment participants experienced some of the visible side effects of HIV such as drastic weight loss, fever and rashes and there was a possibility of rapid decline to full blown AIDS, which made it impossible to conceal their HIV status. On the other hand, these side effects were also experienced in the initial stages of initiating ART. As a result,

participants found it difficult to conceal their HIV positive status from inquisitive family members and friends who often probed into the cause of the side effects. As would be discussed in the following sections, this had a negative impact on adherence. The next section presents findings on challenges to ART adherence as expressed by the participants in this study.

## **8.5 Challenges to ART Adherence**

Participants in this study reported various challenges of adhering to ART that they encountered. The challenges to ART adherence fell under three major interlinked categories namely: patient-related challenges, nature of the ART and social/structural barriers. It is important to note that MSM in this study sometimes experienced these factors at the same time.

### **8.5.1 Patient-related Challenges**

#### **8.5.1.1 Inability to Keep to Time**

Although also reported during some interviews, the inconvenience of timing was reported mainly during FGDs as a challenge to using and adhering to treatment. A particular issue that was raised was the difficulty of taking their ARVs at a set time every day for the rest of their lives. Participants also reported that they were unable to take their ART at times when they had engagements or daily activities, which conflicted with the timing of their ART. They also reported that they often missed their ART when they were in the presence of family and friends, including other MSM. Their inability to keep to the allotted time was enhanced by their high mobility. One FGD participant (Olu), expressed to the group that his personal opinion was that the timing made adhering to ART difficult and even impossible:

*“...Adherence, number one is time taking. You know when you are given the drugs they would tell you that once you start taking it by 9 o’clock, throughout, till you die, till you stop taking it, you must keep taking it at 9 o’clock but I know it’s very very hard for us to just get adhere to that kind of thing...I don’t think that one is possible getting adhere to time” (Olu, Lagos FGD)*

In response to Olu’s statement about sticking to a particular time, two FGD participants reported that they were advised by the healthcare workers that once they got accustomed to taking their ART, they could allow more flexibility in the timing. In

other words, they could take their ART within a one or two-hour time frame but not after midnight.

### 8.5.1.2 Forgetfulness

Though forgetfulness was reported mostly during the interviews, both interview and FGD participants reported it as a challenge to taking ART. Forgetting to take ART was experienced by the MSM in the many different forms presented below:

*“I think I forgot, I slept off, one of the reason was that I slept off. Like I told you once it 9 o’clock I always feel, naturally once it’s 9 o’clock, I always feel like I’m going to sleep as long as I’m not going for a party, I’m not talking or watching anything, so that was the first one. The second one was that I forgot, I was going for a party, it was actually in my pocket, I forgot to take it until when it was 2 o’clock at night, I now remembered that, ah I didn’t take this thing. Then the third one was like it was 11:30, I did not take it, I thought maybe once it has passed 10 o’clock I cannot take it again.”* (Mustapha, self-identified homosexual man, Lagos Interview)

*“Challenges is just taking the drugs sometimes, sometimes you forget, you are a human being now, sometimes you forget. Sometimes the drug could be there (points to the table) you are here, to get up and pick it up will be a problem (LAUGHS). Later sha, you will go and pick it sha, but then sometimes you will just forget completely and before you remember time has gone, far gone for you to take it. So those are the challenges we face...”* (Lucas, self-identified bisexual man, Abuja Interview)

*“Taking the drug has not been easy, the first time I started, I know I used to miss a lot, sometimes I would forget that I even have something like that to even take...that’s just it, sometimes you forget about the drug as in you forget that you have not taken it. Sometimes self you would even take, you won’t remember that you’ve taken it, you will still go and take it again, so it’s still a challenge, it’s just forgetfulness.”* (Sule, self-identified bisexual man, Abuja Interview)

*“...taking in the morning maybe you can forget the evening own, if you take it in the evening you can forget the morning own. So that is another one again, those are the challenges”* (Boye, Abuja FGD2)



The quotes above illustrate the major forms of forgetfulness participants reported. Participants attributed forgetfulness to human nature. As shown above, they reported forgetting to take it at the scheduled time, forgetting that they had taking it and then double dosing and forgetting they had ART to take.

### **8.5.1.3 MSM lifestyle**

MSM lifestyle in this context describes MSM sexual partnerships and networks as well as their high mobility which potentially pose a challenge to their maintaining optimal ART adherence. Several aspects of the ‘MSM lifestyle’ impacted on participants’ ability to adhere to ART, these included and are described below:

#### **i. Clubbing and Drinking**

One challenge related to the ‘MSM lifestyle’ reported by participants was having busy schedules or conflicting activities. Some participants reported that they sometimes had jobs and/or engagements that kept them out till late and they were therefore unable to take their ART. Others reported that the ‘MSM lifestyle’, which often involved clubbing and drinking interfered with their ability to take their ART. For these participants they were unable to take their ART because they had been advised by healthcare workers not to drink alcohol when taking ART.

*“... I think some of us take alcohol and we are advised that you don’t take your drugs when you are drunk, so I think that one is also an issue. Because you won’t say that because of the drugs you won’t drink or you just want to stop drinking, so sometimes we get ourselves drunk and we just leave the drugs because you won’t know the implication of it” (Koye, Abuja FGD3)*

*“Adhering god, adhering is crazy...Now MSM world, adhering is crazy because sometimes you might be out somewhere and you know its lovely, you’re seeing a late night movie and you are supposed to take your drugs at 10 o’clock and [LAUGHS] imagine you taking your drugs and your drugs is going to shoot you out of the sky, you’re not going to concentrate and your friends would be asking you that ‘what is happening?’”. (Wale, self-identified pansexual man, Lagos Interview)*

## **ii. Inconvenience of Carrying Pills**

Another challenge related to participants' high mobility' which was discussed in both interviews and FGDs was the inconvenience of carrying pills around, this was because participants found the pill bottles to be bulky and noisy. Participants mentioned that because they were very mobile it was inconvenient carrying the pills around with them and as a result they sometimes missed their doses. For example:

*“But another challenge is carrying it around [A: Carrying it around in what sense? Can you talk more?] As tomorrow is Friday now, I would feel like I want to go to my friend's place for weekend [A: And where is this your friend?] Akin: Maybe Kubwa or.... [A: But not outside Abuja?] Akin: No, it's in Abuja. I find it difficult to carry the container around and all that” (Akin, Abuja FGD2).*

One interviewee reported *“Sometimes if you want to go to somewhere, I can't go with the container, I have to pour it in that sachet...that's what I used to put it” (Arinze, self-identified homosexual man, Abuja Interview).* The general unwillingness to carry the pill bottles around could be attributed to the aesthetic characteristics of the bottle; this is discussed in more detail below. Majority of the MSM also reported that the pill bottle was too noisy and attracted attention whenever they carried it in their bags. Despite most participants being dissatisfied with the inconvenience of carrying their pills about, one participant reported that he did not find the pill bottle noisy and hence, it was not an issue for him.

## **iii. Interference with Sexual Partnerships**

Participants reported that they were unable to take their ART when they were with sexual partners because they feared that their partners would stigmatise them if they found out they were HIV positive. Although this was generally the case, there were a few cases when participants had overcome this fear. Participants who were in a trusting relationship reported that they informed their partners that they were HIV positive and on ART. Additionally, one participant who seemed to be open about his HIV status reported that he always revealed his HIV status to his partners.

#### **8.5.1.4 Lifetime Drug/ Drug Fatigue**

Additionally, participants reported that they found it hard adjusting to taking the drugs daily. This experience of drug fatigue was expressed clearly by one participant:

*“Taking the drug has not been easy...Sometimes I would feel like I don’t want to take this thing again. So I keep doing that, I take sometimes, sometimes I would forget, sometimes again you will remember oh God how long will I continue taking this?”*  
(Sule, self-identified bisexual man, Abuja Interview)

Sometimes it was the experience of side effects of the ART, which made participants tired of taking them:

*“...the first day I take my drugs, immediately I just took it I didn’t even know where is my door. I was searching the wall as if somebody blocked my eyes, my head turned off as if I take cocaine, I don’t even know how to go out. I was now like ah, am I going to be taking this thing forever?”* (Kola, Abuja FGD1)

From the above quotes, it is evident that the lifelong commitment of taking ART has potential negative impact and can easily discourage MSM from maintaining optimal ART adherence.

### **8.5.2 Nature of ART**

Nature of ART describes the aesthetic characteristics and palatability of ART. Participants mentioned that the pill bottle, pill size and taste of the pill made it difficult to adhere at times. As stated above, some MSM mentioned that the pill bottle inhibits their movement, which made adhering difficult especially because MSM in this context are generally highly mobile. Participants described various strategies they adopted to ameliorate this problem, which are discussed in Section 8.7 below.

#### **8.5.2.1 Side Effects**

A majority of the interviewees reported that they experienced side effects taking the ART, most especially during the initial weeks and months of commencing treatment. Most recurrent side effects reported were skin rashes, scars, drunken feeling, dizziness,

unusual or bad dreams, hot flushes and fever. One participant mentioned that he experienced visible side effects of using the ART and this caused his family members to question him about it:

*“So when I start the drugs, I did not find it very very easy...I have...very terrible wound on my mouth and my eye was like red, I can't see. That is the reaction of the ARV, so my family was like asking me, ah what is the problem? What is the problem?” (Arinze, self-identified homosexual man, Abuja interview)*

MSM were reluctant to adhere to their ART because of the visible side effects that developed in the initial stages of taking the treatment. These visible side effects such as mouth sores, fat redistribution and rashes could not be easily hidden from family members and associates, who questioned them about it. As was discussed in Chapter 6, there was a concern that revealing that they were HIV positive and taking ARVs could lead to rejection, stigmatisation and discrimination. Participants who had been on ART for a longer period of time reported that they became used to these side effects with time and only occasionally experienced the side effects of the treatment. When asked about his experience of side effects, Olu reported:

*“... that happened in the first stage, let's say like the first 6, 7 months of taking it...but I don't even feel it anymore, I think I am now used to the drugs. But some hours later, 2 hours later, I still feel dizzy, like I'm drunk, feel hot or so, feel dizzy, like tipsy, you grab? I still feel like that” (Olu, self-identified homosexual man, Lagos Interview).*

At the time of the interviews, one participant, Joe, reported that he had not been using ART for almost a year because of serious side effects he experienced after he had changed to a different brand. Joe was told to stop using his ART until he had undergone liver function tests by healthcare workers because he developed hepatitis and experienced severe health issues such as liver damage, weight loss, vomiting and jaundice. He desperately wanted to get back on his treatment as he was uncertain about how long he had to live if he did not. Based on his experience of using ART, he narrated:

*“The ARV I was taking they had to change it, I think according to our doctor they said, the people that was supplying it,... they demand a bigger money before they can be*

*releasing the ARV...So I now started taking the drugs, I have not started taking one pack that lasts for a month before it now affected my liver... I started feeling sick, then after running some tests they couldn't discover anything, they asked me to stop my drugs... It was affecting me real bad, anytime I took the drugs, I would vomit it immediately, I would vomit all the food, so I had to stop. Immediately I stopped, I started eating well, so that's it... For now, I'm living with HIV, without my ARVs for over 7 months now and I don't know what...because according to my doctors, they say if I stop for a day, I would die. But I'm not happy not taking my ARV, but I don't know what might happen tomorrow.” (Joe, self-identified bisexual man, Lagos Interviews)*

Although an inclusion criterion was that participants had to have been prescribed and actively using ART at the time of the interviews, I found Joe's case to be an excellent case in point of how side effects can impair one's ability to adhere (See Joe's pen portraits in the appendices). This is the case even when an individual is willing to maintain optimal adherence.

#### **8.5.2.2 Pill Bottle**

An extremely salient challenge to adherence among study participants was what one participant referred to as “lousy” pill bottle. As stated in the section above on MSM lifestyle, participants generally agreed that the noise the pill bottle made drew attention to them and increased the likelihood of them being asked about the ART. This was also the case for the labelling on the pill bottles.

*“I think information should get to the manufacturers of that drug about the packaging of the drugs, because that thing is so lousy. There was a day I almost got myself disgraced (ALL LAUGH) I was just coming from the clinic and I had this bag with me on my hand and I was in a cab. Whenever the cab entered, all the potholes on the road the thing will just be (making the sounds) and people would just be looking at me (LAUGHS) and I was like which kind wahala come be this one again” (Koye, Abuja FGD3)*

*“P: ...yes! the bottle is so loud! Another P: Even as it is in your bag and you are carrying it in your bag, it will be shaking, I think it is that white thing inside that is making that noise...” (Dialogue between 2Ps in Abuja FGD1)*

### 8.5.2.3 Pill Taste and Size

One interviewee reported that the sour taste of the ART posed a challenge to taking it:

*“...and though I grew up taking drugs, that particular drug you are not used to, it’s kind of straining. I am always used to Panadol extra, Paracetamol, injections and now I’m actually taking one pill everyday every day all my life, with that sour taste inside you know” (Chidi, self-identified bisexual man, Abuja Interview)*

For other participants, it was the size of the pill that was a challenge:

*“... Eh it’s not easy but it has been part of me. You know swearing every day, when you are taking drugs you are swearing because every day you would put hand up swallow, sometimes it would pain you, you know sometimes the smallest drug you can swallow it, it would be as if you swallow stone, talk of that size of ARV that every day, since 2001, you have been on it every day you must take it, every day you must take it, so it’s a very big challenge” (Gaddo, self-identified bisexual man, Lagos Interview).*

### 8.5.3 Social/Structural Level Challenges

Social/Structural level challenges refer to those challenges related to participants’ social circumstances including their financial capability to maintain ART adherence, cohabiting and their beliefs about causes and cures for HIV.

#### 8.5.3.1 Lack of Financial Capital and Sustenance

A participant in the study mentioned that his partner was initially reluctant to start taking ART because they lacked sufficient funds for food and at the time he did not have a job.

*“...he was complaining no no no, I wouldn’t want to take the drugs, we don’t have money now, because as at that time I wasn’t working, it’s still that volunteer work that I was doing that we were using to feed and the money is still too little so we cannot afford three square meals. So he was telling me that he heard that once you start taking these drugs you need to eat very well and you know we don’t have money so how can we eat very well and be taking these drugs? You know there’s no money at hand” (Ibrahim, self-identified homosexual man, Abuja Interview).*

Lack of financial capital and sustenance was a salient challenge to adhering to ART among participants in this study. Majority of the participants in this study were of low or middle socioeconomic backgrounds and due to discrimination they were unable to secure employment or their income was insufficient to sustain them. The implication of this was that they could barely afford to feed themselves. Furthermore, their interpretation on the guidance provided by healthcare providers was that adhering to ART requires a healthy balanced diet and they believed that they could not commence ART if they could not afford to maintain a balanced diet.

### **8.5.3.2 Cohabiting and Lack of Privacy**

A social level challenge to adhering to ART which was also salient especially in FGDs was living with family, non-MSM friends and even other MSM or just having them present. According to one of the FGD participants, *“most of the MSMs are cohabiting... so it makes them miss their drugs often”* and *“disclosure is a very big deal in this community. All of you might be on the same issue, but you will not know that you are dealing with the same issue, you don’t even talk about it”* (Peter, Abuja FGD1). It was surprising that MSM who were themselves HIV positive could not only hide it from others but also stigmatise other MSM who were HIV positive. This challenged the idea of being a close knit community, discussed in the Chapter 4. Participants were generally uncomfortable and in some cases would not take their ART when there were others around as expressed in the quotes below:

*“So when they told me I’m HIV positive, it’s not immediately I started taking the drugs, why? Because, one, I’m not alone, how can I keep the drugs? That’s the first challenge that I have... So I was afraid to start the drugs, I stayed almost 1 to 2 years before I started taking drugs”* (Amaechi, self-identified homosexual man, Abuja Interview)

*“...then whenever I have visitors in my place, in my room, I would have to do it stealthy, that is trying to take it without being noticed, that is the only barrier.”* (Ibrahim, self-identified homosexual man, Abuja Interview)

In addition to this, one FGD participants in particular mentioned that it was particularly difficult to take ART for those who traded sex, he stated:

*“Me, the only big challenge of that adherence that you said, is that issue of eh cohabiting, not wanting the person close to you to know that you are taking the drugs... Yeah, you know that would make you miss your drug one day. I know that if you have ‘market’ and that ‘market’ now would now come around at 8 or after 8 and your drug time is 9 o’clock, you understand. You will be trying and say make e no see me carry that bottle” (Peter, Abuja FGD1)*

Market in the quote above refers to transacting sex. During the interviews, majority of the MSM reported that they transacted sex. Having their clients around when it was time to take their treatment was a challenge, because a lot of them had not disclosed their HIV status to their clients for fear of being identified as HIV positive which resulted in stigmatisation and ultimately losing them.

### **8.5.3.3 Beliefs About Causes of and Cures for HIV**

Some participants, however, mentioned that there were times when they stopped the treatment temporarily either because they had been taken to spiritual houses to cure what they assumed was poisoning<sup>45</sup> or to were told to stop using it so they could get cured of HIV. As narrated in the quote below:

*“...and at that point I also stopped taking the drugs because you can’t mix ARV with herbal drugs, so I was on herbal drugs then, I stopped taking the drugs. So after a month plus I was there with the ailment, so when that one was cured, I came back to Abuja, when I came back I went to the clinic again and told the nurse what happened to me and she said “ah, I should have come oh that this is a bistle star and blah blah blah”, I said well, I didn’t know, they said it was poison, so I had to follow what the people said, but thank God I survived. They asked me about my drugs, I said I stopped that nobody called, they said they were calling, I said they told me not to pick any number I don’t know because you know when you are poisoned you don’t know who is who, so that was their thought...ignorance!” (Lucas, self-identified bisexual man, Abuja)*

This quote exemplifies how beliefs about HIV can negatively influence ART adherence. As revealed in the quote the perception about HIV of most individuals living in rural

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<sup>45</sup> HIV and its symptoms were sometimes attributed to poisoning or witchcraft and required the healing of native healers



areas and who have poor knowledge about HIV is that it is caused by either witchcraft or poisoning. In this case, their understanding was that Lucas had been poisoned and so they took him to a spiritual house to get cured. During this time Lucas had to stop using his treatment because he has been advised by healthcare providers not to mix ART with herbal medicine. The quote below exemplifies the negative influence of false beliefs about cures for HIV on maintaining optimal adherence to ART:

*“...the second experience that I told you that I left my drugs, it’s one of my friends [sic]told me that there’s one man that used to cure people in Jos and it’s just water, that he will pray and he would do some incantations and he will give you. You will stop taking your drugs and you will be free from HIV and AIDS. And we went there, that time that I told you...we went there, we did that and ah so we are wasting time taking drugs? It’s just 15000 naira, you will go and put hand and they’d pray for you and they would bring the water inside the calabash you will drink and they would tell you that you are free. So after I do that and they said you should have faith that you are going to be healed...so if you go and test, maybe you don’t have faith, you want to test God. So since from then I said oh now I’m HIV free, I didn’t go for test, I didn’t mind but I would tell you most of my friends, three of us would say that now we are now free from HIV, we don’t have HIV. Not knowing that still the virus is still inside us. That’s why we left our drugs...like my friend that I lost, left his own more than 6 months before he died. I left my own for more than 3 months before it weighed me down” (Amaechi, self-identified homosexual man, Abuja)*

The next section discusses facilitators of ART adherence as reported by the study participants.

## **8.6 Facilitators of ART Adherence**

Generally, participants in this study acknowledged the fact that adhering to treatment is not always an easy task for them. Careful analysis of the data revealed different facilitators, which enabled maintenance of optimal adherence to their treatment. These facilitators included having a supportive healthcare environment and adherence support messages, fear of death, living alone and provision of ART at no cost and are discussed below.

### 8.6.1 Supportive Healthcare Environment and Adherence Support Messages

Participants mentioned that the supportive environment created at the MSM specific clinics through encouragement from healthcare providers facilitated adherence to their ART. One of the participants mentioned that he usually received text messages from the MSM friendly clinic which gave him tips on maintaining optimal adherence to his treatment. Another participant reported that whenever the healthcare providers observed an improvement in the CD4 count, they were given incentives to keep it up and this motivated them to maintain optimal adherence:

*“Oh, like I said, the encouragement you get from service providers here, the advice they give to you, they try to follow up from time to time. They send you health tips to your SMS, create a channel for you to even call in case anything goes wrong with you, also call you reminder, ah this is this, this is what you would face but do not worry after this phase it would change it would stop and like I said they are like family they show concern, it makes it much easier because you know you have a backup plan, someone who is there, like a companion, someone who is there to accompany you through that journey your passing or you are going through and it’s been really useful” (Hassan, self-identified bisexual man, Lagos Interview)*

*“...so with that and with this Population Council, a lot of lives have been saved from here, I can proudly say yes, I am positive and I have been able to adhere to my drugs and I’m doing very fine for the past 2 years now and I have never fallen ill or sick or had any issue” (Mustapha, Lagos FGD)*

*“...and you know the way they are doing it to us here at least if your CD4 count is high they used to do something that would motivate you, next month you will at least take good care of yourself, so that your CD4 count will be high again.” (Amaechi, self-identified homosexual man, Abuja Interview)*

This form of support from the health facility encouraged participants to adhere to their treatment, thereby highlighting the significance of providing support for adherence.

### 8.6.2 Fear of Death

Some participants’ motivation came from their need to stay alive. They understood that in order to do so, it was imperative to not miss any doses of their ART:

*“You know, what motivates me, whenever I feel like not taking it, I always remember what the nurse told me the day I wanted to start my drugs, she said, do you still want to live? You are responsible for your life, HIV doesn’t kill until you don’t take good care of yourself, that word alone motivated me, ah D you want to die? No no no, you need to take it, you still have a lot of things to do, you want to be in the best place of the world, you still want to help your family, you still have a lot of missions, you want to build the community members, no no no, you don’t need to die now, take your drugs, that’s what motivates me, that’s what he told me the first time, the very first time I was to take the drug, motivates me a lot. And a lot of people I’ve been hearing about, that they died of it, I’m like no no no, I don’t want to die young, I’m still a kid, I still have a lot of things to do” (Olu, self-identified homosexual man, Lagos Interview)*

*“A: Ok and what motivates you to take your treatment regularly?”*

*Lucas: Because I want to live, I want to be strong, I cannot die young” (Lucas, self-identified homosexual man, Abuja Interview)*

The men were highly motivated to live long and healthy lives. Majority of the participants were also relatively young and between the ages of 19 and 34 and as such they felt that they had a lot to achieve in life. According to them, they had to stay alive for their families, friends and to fulfil their aspirations. They recognised that their only way they could achieve all these was by adhering to their ART.

### **8.6.3 Living Alone Vs. Cohabiting**

As was discussed in the previous section, cohabiting has a contradictory effect, as both a challenge and a facilitator to ART adherence. Although some participants complained that cohabiting with family or friends posed a barrier to adhering to their treatment, others felt that it was in actuality a facilitator. Participants who felt cohabiting was a facilitator, cohabited with trusted lovers or friends, who were in some cases HIV positive as well and who could remind them when it was time to take their treatment.

On the other hand, participants who did not cohabit mentioned that they were disinhibited and could take their ART freely. One participant talking about what makes taking ART easier for him concluded:

*“...I stay alone, I don’t really have people that would poke nose and say why am I taking this thing and all that, so it is very free for me” (Kunle, self-identified homosexual man, Abuja Interview).*

Leaving alone meant that participants were able to conceal their HIV status and control who they disclosed this personal information to. This reduced participants’ vulnerability to stigmatisation.

#### **8.6.4 Provision of Free ART**

The fact that ART is provided free of charge was a facilitator for participants as exemplified below:

*“So, if I cannot use knife and chook myself and kill myself, I don’t think I can say ok I’m not taking the drugs again, while the government and donor have made it possible and give this thing free of charge, I’m not paying the money for it, then why should I not take it?” (Emeka, self-identified bisexual man, Abuja Interview)*

*“...when I want to take my drugs, I take it at the right time then I would sleep and since we are getting it for free, I was getting it always, there has not been a day that I would say ah, I don’t have money to buy drugs. So I get my drugs anytime I’m supposed to get it, I get it.” (Joe, self-identified bisexual man, Lagos Interview)*

The next section presents strategies deployed by participants to maintain optimal ART adherence.

#### **8.7 Strategies for Maintaining Optimal ART Adherence**

Analysis of the data revealed different strategies the participants had adopted in order to maintain optimal adherence to their ART. In some cases, participants adopted more than one strategy to adhere to their treatment. The main strategies deployed were, concealment of ART by repackaging, breaking pills into smaller sizes or using non-traditional adjuvants, taking the pills before bedtime, carrying the pills about with them and taking the pills stealthily.

### **8.7.1 Setting Alarms**

Majority of the MSM in this study set alarms on their phones to remind them when it was time to take their ART. This was necessary otherwise they could easily forget to take it at the appropriate time due to their high mobility or conflicting activities.

*“...it was not easy because of the commitment here and there, you would easily forget and the alarm thing to helps. The setting, using your phone to set an alarm or something it does help to overcome this challenge” (Yemi, self-identified homosexual man, Abuja Interview)*

Other participants reported that in addition to setting alarms they made taking ART part of their daily routine and this facilitated their adherence to ART:

*“And then what I do is I always set the alarm to wake me up on time. Jump up to the bathroom and brush my teeth and then I make sure that I grab at least a cup of tea, just take it and then I zoom off to where I’m going. Likewise, when I come back, I make sure that I keep everything...” (Kunle, self-identified homosexual man, Abuja Interview)*

For one participant, although he set alarms as a reminder, he had made taking ARVs so much a part of him that regardless of whether he was prompted by the alarm, he took his treatment. He stated, *“it’s part of my life. I set my alarm till today but whether my alarm rings or it didn’t ring, if I am sleeping I don’t know what would wake me up by that time, I take it...it has been part of me” (Gaddo, Lagos Interview).*

### **8.7.2 Disclosing HIV Status**

Participants also disclosed their HIV status to trusted family and friends in order to enable adherence to their ART. As highlighted in the quotes below, by disclosing to close family or friends, participants were able to secure support in many different forms: an individual who could remind them when it was time to take their treatment, provide encouragement and financial assistance.

*“Even as at the time when I was placed on ART, I still called that my sister and told her that ah, I am on ART now. [she asked] ‘what time do you take it?’ I told her it is only at*

*night it's by 9pm. Sometimes she would even call me, if she don't call me, she would flash me to remind me to take your drugs" (Akin, self-identified homosexual man, Abuja Interview)*

*"She was now encouraging me, say if I can go home to take my drugs, she will buy me this, she would buy me that, she was the one making sure that I try to, she was giving instance that there was one lady in her church, if you see her now she's very big now, there were rumours that she had HIV but when she started the drugs she changed automatically, she doesn't like the way I am looking, I should go and start these drugs, anything I want her to do for me, if I start, she would do it. She started encouraging me..." (Peter, self-identified bisexual man, Abuja Interview)*

### **8.7.3 Concealment of ART**

Concealment of ART was a strategy used by participants to adhere to their treatment. Concealment was achieved by repackaging the pills or peeling off the label from the pill bottle. This was done so that others would be unable to know what the pills were for. One participant reported how he does this:

*"You know when people see you with that, it sends a kind of wrong impression, they are like ahan you are using this thing? People start looking at you, they start stigmatising against you or basically you just pour it into something else and you use or you find a way to repackage it, what would I say, you can put it in an envelope or you can apparently, one for me, like you saw I had to throw it into another can" (Hassan, self-identified bisexual man, Lagos Interview)*

Aside from repackaging the ART to conceal it from others, participants mentioned that they repackaged the ART because the pill bottle was too bulky and inconvenient to carry about. The excerpt below illustrates this point:

*"Danjuma: But I do take it out of the main container to another one, because there's one she got for me, it's like toothpaste, close-up cover, just open it and then you insert like four into it. So I just put it in my bag but it's not with me here, I would have shown it to you*

*A: Ok, so she did that for you to make it easier. And is there any other reason why?*

*Danjuma: No, instead of me carrying the whole bottle.” (Danjuma, self-identified bisexual man, Lagos Interview)*

#### **8.7.4 Taking ART at Bedtime**

Participants mentioned that taking ART could be difficult because of some of its side effects such as drowsiness and weakness. To ameliorate these side effects of ART, participants stated that they took the ART right before they went to sleep:

*“And two I wouldn’t like to take it because it makes someone to be drowsy, you will need to sleep. So when you are in club even if you take it the thing would make you feel weak that you want to sleep. So that’s why my own drugs, I always take it at bedtime” (Peter, self-identified homosexual man, Abuja Interview)*

*“...I would just go out, carry one like this, put am for hand, go to toilet, backyard, swallow am, come inside back, come bed, come sleep because if I didn’t sleep that moment, I might be saying rubbish, tipsy that kind of thing” (Olu, self-identified homosexual man, Lagos Interview).*

#### **8.7.5 Carrying ART about**

MSM in this study reported that in order to take their ART at the scheduled time, they usually carried it out with them especially when they were not going back home. One of the participants mentioned that he avoided going out or meeting with friends when he didn’t have his drugs with him so as not to miss the time for his ART. Participants also reported that when they had visitors in their homes or around them they had to take the medication stealthily so that no one saw them.

*“...before I leave the house every day because as an MSM you cannot predict the kind of movement, you might say you are coming to Yaba today, from Yaba, O we are going to Morrison’s house, let’s go now (EVEYRBODY LAUGHS), if you are not with your life medicine, life saver, if you are not with it, and if you say you are not going, it would look somehow, so what I do is that if I come and I’m not with mine, I always go to the*

*doctor here, I'd say please just borrow me one for today, he would insult me, why didn't you...I'd say I didn't know I was not going to go back home today and this place I'm going to is very far, he would say oya take, but next time do this and do that. So he gives me this sachet, so anytime I'm going out even though I'm not planning to go out from there, I take like 5 in my pocket, as I just carry the bag and I have some few clothes in it, so in case I come here and we are going somewhere, no problem let's go, I know I have my medication with me. But if I want to take it, once I know it's late because I'm now used to it, so I don't really take it like 9 o'clock, so I take it like 8:30, 9, 10 o'clock, so when I know it's about time, we will be talking I'd just chook my hand inside my pocket, open it, take one and be discussing, ehen I'm even thirsty please get me water, so once the person goes and gets me water, (DEMONSTRATES) what's up now abeg give me water, that's it. Nobody can ever see me when I'm taking my drugs!"*  
(Mustapha, Lagos FGD)

*"...but then whenever I have visitors in my place, in my room, I would have to do it stealthy, that is trying to take it without being noticed" (Ibrahim, self-identified homosexual man, Abuja Interview)*

Other strategies used for maintaining optimal adherence included breaking the pills into smaller pieces, mashing the pills or swallowing it with eba<sup>46</sup> so that it was easier to swallow. According to one participant:

*"I do get afraid because the drug itself is very big but now I do break it into two, then I throw the two into my mouth at once" (Danjuma, self-identified bisexual man, Lagos Interview)*

The participant who reported that he swallowed his pills with eba mentioned that he was advised by the healthcare provider not to do this as it may reduce the efficacy or speed at which the pill works. This section has outlined the different strategies, which have been deployed by MSM in this study to facilitate ART adherence.

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<sup>46</sup> Eba is a Yoruba delicacy made with cassava and eaten with local soups. It is similar in appearance to a ball of dough. Participants mentioned that they fold the ART pills into it and swallow it.



## **8.8 Chapter Summary**

This chapter explored the experiences of HIV positive MSM living in Nigeria in relation to adhering to their antiretroviral treatment. More generally, it discussed the processes of initiating ART, challenges and facilitators of ART adherence as well as strategies deployed to maintain optimal ART adherence. It was revealed that participants understood medical expectations of maintaining optimal adherence, which arguably depicts the various aspects of adherence they valued. In terms of their response to these expectations, they adapted various strategies that made adhering to ART easier.

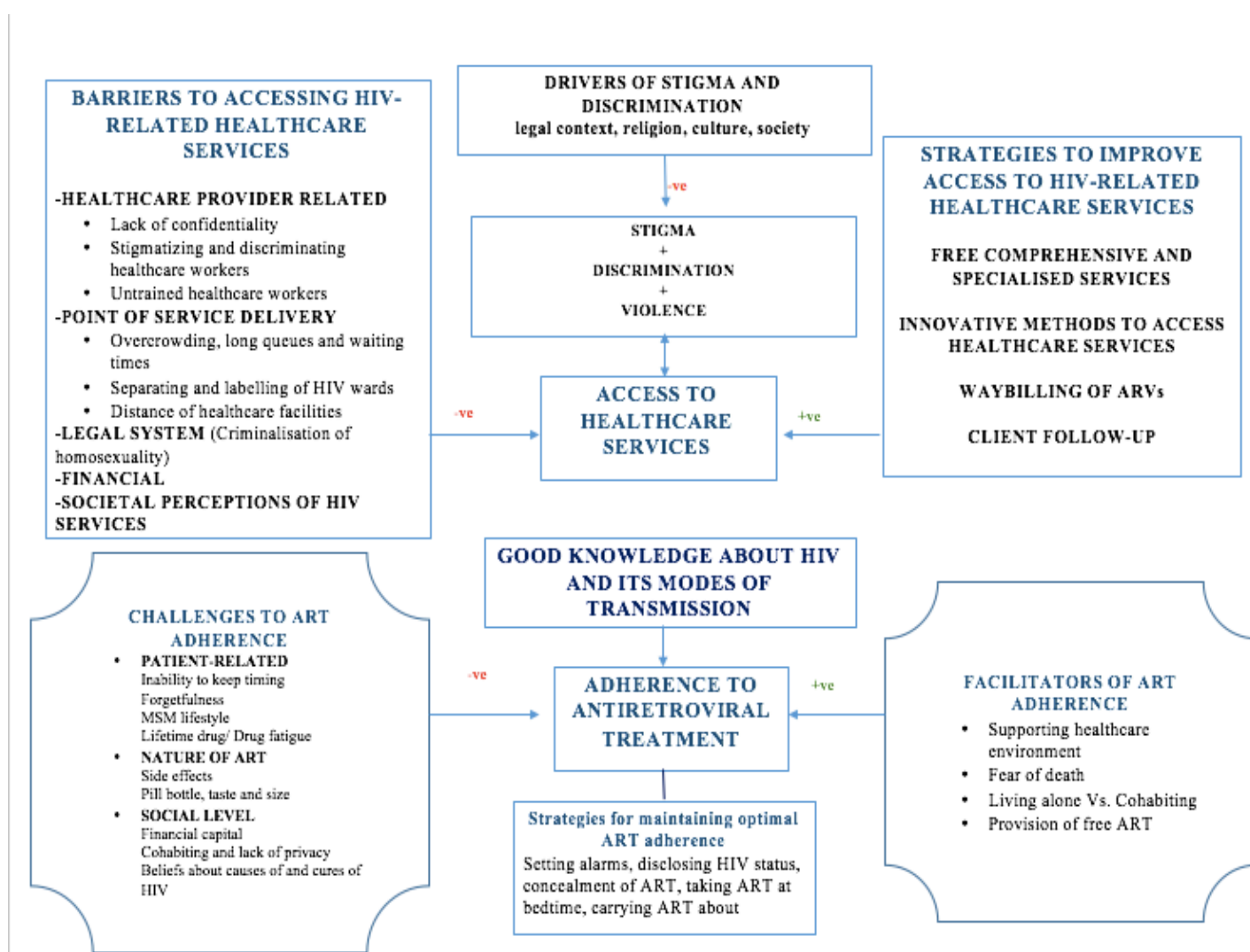
Adhering to ART was not without its challenges which fell into three groups: patient-related, nature of ART and social/structural level. These challenges were revealed to be very much reticulate and were sometimes experienced as an overlap. Patient related challenges included aspects of the MSM lifestyle and other individual level challenges such as forgetfulness and inability to keep to timing that made it difficult for participants to adhere to treatment. Nature of ART referred to those challenges related to the aesthetics and palatability of ART that made it difficult to adhere. Finally, social/structural level challenges referred to challenges in participants' social circumstances such as finances and cohabiting that made maintaining optimal ART adherence difficult.

Facilitators of ART adherence which included a supportive healthcare environment, living alone and provision of free ART were also revealed. Some of these these facilitators which enabled ART adherence: provision of free ART and supportive healthcare environment and adherence messages were provided by MSM friendly clinics and not government healthcare facilities. Finally, strategies which MSM employ to maintain optimal ART adherence were revealed.

The next chapter brings all the findings chapters together and discusses the main findings in light of the existing literature.

## SUMMARY OF FINDINGS CHAPTERS

**FIGURE 8: DIAGRAM DEPICTING FINDINGS AND HOW THEY ARE RELATED**



The findings chapters have provided a detailed overview of the experiences of HIV positive MSM particularly in relation to how they access healthcare services and adhere to their antiretroviral treatment within the criminalised and heteronormative context of Nigeria. The data have provided evidence of the immense stigma, discrimination and extreme violence experienced in virtually every aspect of the lives of HIV positive MSM. Figure 8 above is a diagrammatic representation that pulls together all the findings explained below and depicts how they are connected.

As depicted in Figure 8 above, in Nigeria, the drivers of stigma and discrimination include the legal context, religion, culture and society. Participants reported that societal perception of homosexuality as ‘unAfrican’, demonic, inherently sinful, a choice and a borrowed lifestyle from the West promoted the ill-treatment they received. According to participants, HIV in Nigeria, is also perceived negatively and when an MSM is HIV positive, he is either perceived to be suffering retribution from God for his sinful sexual practices or to be a reservoir of HIV. Participants also reported that to some in the

society, HIV is still perceived as a death sentence. Death sentence, according to participants was the societal perception that the HIV positive individual would die shortly after diagnosis. One of the key issues which concerned participants was the legal context, which criminalises same sex activities thereby making it difficult for MSM to gain access to healthcare. Participants revealed that criminal laws also inhibited their free self-expression, in relation to how they preferred to dress as well as their mannerisms (which were considered feminine). Despite these criminal laws, they still managed to organise parties and have sex with other men albeit clandestinely. However, as many of the narratives from the participants, these clandestine practices put them at a greater risk of getting arrested by the police.

The data from this study indicated that MSM experienced considerable stigma, discrimination and extreme violence from the general/public hospitals, in their workplace, places of worship, within their family units and in their wider societies. The forms of stigma they experienced included sexual stigma, HIV stigma, double stigma, stigma by association, anticipated stigma and internalised stigma. They also experienced discrimination such as denial of access to fundamental necessities of life (e.g. healthcare, education and employment), withdrawal of support from family members, arbitrary police arrests, blackmail, extreme violence and homophobia from societal members and other MSM. One of the novel features of this study was, the experience of 'kito', whereby MSM within their communities stigmatise, discriminate, extort from and blackmail other MSM at some point in their lives. Social media seemed to play a central role in the propagation of 'kito' and was used frequently in enacting kito. Participants discussed wealth as an important mediator of stigma, discrimination and extreme violence. Participants felt that when an MSM was either highly educated or wealthy, they were able to cope better than others with the stressors of stigma, discrimination and violence and also had different experiences.

As we saw from the data in Section 6.3, MSM learn about the management of HIV from a range of sources including healthcare workers, peer educator training, schools (mostly secondary and tertiary), the internet, mainstream media (TV, radio, billboards) friends and books. These sources of information were often filled with misconceptions about HIV and its transmission. The majority of the participants mentioned that up until accessing healthcare services from facilities providing MSM specific services they were not aware that HIV could be transmitted through anal sex and engaged in it frequently. This poor knowledge of HIV transmission can be attributed to the largely heterosexual focus of HIV awareness campaigns and intervention in Nigeria, a major finding of this study. As depicted in Figure 8 above, having knowledge about HIV and its modes of transmission largely influences the extent to which individuals are able to adhere to antiretroviral treatment.

Importantly, HIV positive MSM in this study preferred to access HIV-related healthcare services from facilities which provide MSM specific services. This is largely due to factors such as experienced or anticipated stigma, discrimination and violence which they encountered. They also encountered a number of barriers and facilitators that shaped how they were able to negotiate access into and navigate the healthcare system. These barriers categorised into five broad categories include those relating to healthcare provider attitudes, those relating to point of service delivery, those relating to the legal system, those relating to financing and finally, those relating to societal perceptions and the environment. These barriers negatively influenced the participants' access to healthcare services (see Figure 8 above). The most recurrent barriers were those relating to healthcare provider attitudes and included lack of confidentiality, stigmatising and

discriminating attitudes, unqualified and unfriendly healthcare workers. This was not surprising as the men sought to keep their personal details private and placed a high value on confidentiality.

Other barriers that were important but were not necessarily MSM specific were those relating to point of service delivery included overcrowding, long queues and waiting times, separating and labelling HIV wards, distance to healthcare facilities. Important to note is that all the barriers reported were related to MSM experience of accessing healthcare services from general/public hospitals. Frequently mentioned strategies which facilitated their access included the provision of free comprehensive and specialised HIV-related care, organising innovative ways of accessing healthcare services, way-billing ARVs and client follow-up, peer education, provision of an extra month's supply of ARV. Despite the efficiency of facilities which provide tailored healthcare services for MSM, a number of pressing issues for consideration were discussed. According to participants, the unequal distribution of these specialised clinics in Nigeria meant that not every MSM could access healthcare services, especially those in remote parts of the country. Furthermore, most of the funding for HIV initiatives especially for this key population comes from international donors. Participants expressed concern over the funds being stopped anytime without warning or an alternative.

While adherence to ART was generally understood by participants, they reported that they sometimes faced challenges that inhibited them from maintaining optimal levels of adherence. These challenges, shown in Fig. 8 above, were patient-related, nature of ART and social or structural level challenges. The MSM lifestyle of clubbing and partying as well as their high mobility and transacting sex were among the factors that amplified these challenges. In order to overcome these challenges, participants described adapting strategies (shown in Fig. 8 above) such as setting alarms, disclosing their HIV status to trusted associates, concealment of ART, carrying their ART about, repackaging their ART and taking ART during bedtime.

## **CHAPTER 9: DISCUSSION AND CONCLUSION**

### **9.1 Introduction and Chapter Structure**

As stated in Chapter One, the aim of this study was to explore and provide a thick description of the lived experiences of HIV positive MSM living in Nigeria with particular reference to how they navigate and negotiate access to the Nigerian healthcare system and adhere to antiretroviral treatment (ART) (Geertz 1973). Given both the criminalised and heteronormative context relating to same sex activities in Nigeria, a key aspect of this work has centred on how stigma and discrimination shape access to healthcare and adherence to ART. To achieve this aim, FGDs as well as an adopted form of narrative interviews were conducted. Given the paucity of qualitative research on this salient topic, this research contributes not only empirical evidence regarding the experiences of HIV positive MSM in terms of their access to healthcare services and adherence to ART but also participants' broader lived experiences, specifically as it relates to being homosexual and HIV positive in Nigeria.

The most important findings have been selected for discussion in this chapter. These findings are organised into themes around experiences of homosexuality and HIV in Nigeria, specifically highlighting the experiences of stigma and discrimination, the experiences of accessing healthcare services and finally, the experiences of adhering to antiretroviral treatment. There is evidence which suggests that MSM living in Nigeria or the 77 other countries which have criminal laws against same sex sexual partnerships have different experiences from those living in less stigmatising contexts especially as it pertains to health-seeking practices (Arreola et al. 2015). Therefore, in discussing the experiences of participants in this study, comparison has focused on similar criminalised or repressive settings.

A key factor that the study highlighted was the profound experience of stigma and discrimination which were a pervasive aspect of everyday life for this group of participants. These appeared to not only affect their access to healthcare services and adherence to ART but also permeated their daily social interactions including employment, family life, places of worship, the wider society and surprisingly to the author, within their immediate MSM communities. Participants in this study experienced what is described here as multiple levels of stigma (and discrimination) resulting, primarily, from the intersection of their identity as men living with HIV and

engaging in sex with other men, two extremely stigmatised attributes in the Nigerian context. This study also revealed the ways in which same sex activities are constructed in public discourse in Nigeria. Specifically, the very profoundly ‘noisy’ discourse around what is considered to be the appropriate use of male and female bodies and sexuality. This public discourse, as this study revealed, largely shaped the quality of knowledge and awareness about HIV risks and transmission that the participants’ received. Surprisingly, participants also experienced what they referred to as ‘Kito’, a form of stigma which encompasses stigma, discrimination and blackmail enacted by fellow MSM. In this study, the concealment of their stigmatised identities was deployed by participants to varying degrees and was described as a strategy used in combatting the stigma and discrimination they experienced. This concealment of stigmatised identities had several implications for participants and significantly impacted on their access to healthcare services and adherence to ART as will be discussed further below.

The following section highlights issues regarding participants experience of stigma and discrimination and its impact on their daily lives especially in light of the criminalised context of same sex practices in Nigeria. It discusses the findings in relation to existing literature. In Section 9.2, I discuss the role of the legal context, religion and patriarchal and heteronormative societal structures characteristic of the Nigerian society in the propagation of stigma and discrimination. In Section 9.3, a form of stigma, referred to as Kito, is introduced and discussed. There are no other studies which have referred to this type of stigma. Section 9.6 is a brief discussion of the use of concealment as a tactic for dealing with stigma and discrimination. In section 9.4, I discuss how knowledge and awareness of HIV and its transmission patterns amongst this group of participants are shaped by dominant heteronormative discourses in the Nigerian society. Section 9.5 is a discussion of MSM experiences of accessing HIV-related healthcare services in Nigeria including key barriers as well as specific interventions which facilitate access to healthcare services. Section 9.6 is a discussion of issues regarding maintaining optimal adherence to ARVs specifically in relation to MSM specific challenges and facilitators. The chapter closes with a section highlighting the limitations of the research as well as its implications for policy, practice and future research and, finally the conclusion to the thesis.

## **9.2 Drivers of Stigma and Discrimination: role of the legal context, religion and patriarchal and heteronormative societal structure**

Findings in this study reveal three main drivers of stigma and discrimination which work in tandem in the Nigerian society to keep HIV positive MSM subjugated. They include, the legal context, religious structures and finally patriarchal and heteronormative social structures and are discussed in detail in the following sections.

### **9.2.1 The role of the legal context**

Despite the UK abolishing its laws criminalising homosexuality, a majority of its previous colonies still retain these laws (Altman et al. 2012). As revealed in the literature review, Nigeria is among these former colonies, where like much of the African continent, engaging in homosexual practices is not only considered socially and culturally unacceptable it is also criminal. The title of the law which criminalizes homosexuality, ‘SSMPA’ is in itself problematic as it suggests the criminalisation of same-sex marriage but in practice goes beyond to criminalise same-sex sexual behaviour and same-sex sexual identity. Moreover, the ‘quiet’ signing of the SSMPA law has previously been referred to by critics as a political distraction, which former President Goodluck Jonathan deployed to win the favour of voters for his re-run in the 2015 Presidential Elections and also shift attention from the country’s many troubles, including ethnic-religious clashes, militancy in South-South Nigeria, corruption, lack of electricity and substandard education and healthcare (AP 2014). It has also been suggested that this law was signed as a response to Western pressures to decriminalise homosexuality (AP 2014). Similar to findings of the study reported here, the literature abound with evidence, which suggest that stigma and discrimination are proliferated in criminalised and legally repressive contexts (Arreola et al. 2015; Sekoni et al. 2016).

As reported in this study by participants since the signing of the law, stigma, discrimination and extreme violence against MSM have dramatically increased and have been perpetuated by members of the society, law enforcement officials, the media and even their peers in the MSM community. In Section 5.4, participants recounted experiences of being denied access to fundamental necessities of life such as healthcare, education, employment and housing as well as withdrawal of financial support from family members, arbitrary police arrest, blackmail, extortion and extreme violence. One of the negative implications was that even when they were denied for example, employment on the basis of their sexuality or HIV status, they could not take action or sue the organisations as they would have no basis. As one participant noted this was because “...*the employer himself will not come openly and say I have denied you this*

*job because you are positive... he would look for something else” (Ibrahim, Abuja FGD1).* In a country where the rights and access to essential social services for the common citizen are not guaranteed and are exacerbated by political corruption, these punitive draconian law makes the daily realities of MSM especially those who are HIV positive even more dire.

Across Nigeria, popular media houses continue to publish sensationalised stories of the arrests of ‘homosexual’ men. Most recently was a story first published by Punch Newspaper reporting the arrest of 42 homosexual men who were allegedly “caught in the act” in a hotel in North Lagos on the 30<sup>th</sup> of July 2017 (Hanafi 2017). These men were accessing HIV testing services from this hotel when they were rounded up by police men for allegedly getting caught having sex. This was followed with articles by other media houses notably ‘The Sun’ (2017) which published an article titled ‘HIV epidemic looming’ and reported the names of the 42 previously arrested homosexuals (Igbokwe 2017). This tactic of using media to spread hate and shame sexual minorities has been used across Africa, Uganda being an example. In 2011, Ugandan gay rights activist David Kato, was beaten to death, after winning a lawsuit against a newspaper that had published his name and picture identifying him as homosexual and calling for him to be hanged (Gettleman 2011).

Similarly, law enforcement agents use the anti-gay law as a means of extortion through the arbitrary searching and arrests of suspected ‘gay’ men. Some participants in this study reported that when they were stopped by police on the road and threatened to reveal their partners or present their phones under duress, they were arrested if they had any incriminating items in their possession. In the jail cells which were usually in extremely poor and unhygienic conditions, they were beaten till they revealed their partners and only released after they could pay bail, which in most cases they could not afford as reported by Wale on page 146. The arrest of these men, it should be said, had severe implications for optimal adherence to ART as in many cases they were not allowed to take their medication and were told that they deserved to have HIV because of their sexual practices. Police were also reported to invade the homes of suspected MSM during parties and not only arrest them but also publicly humiliated them by putting up naked pictures of them in local newspapers. To a Western audience, this is an extreme form of stigma, discrimination and humiliation and underlines the appalling conditions that many MSM with HIV continue to experience in parts of Nigeria. It is



difficult to convey the desperation and despair of many of the participants, but these extreme stories have given some indication of this. Perhaps not surprisingly, in terms of thinking about the management of risk, for example, in relation to taking HIV medication, these issues of basic human safety and dignity and the avoidance of extreme violence set a powerful context for understanding why individuals might have problems foregrounding their use of ARVs.

Similar to other countries where same sex activities are criminalised in Africa, the criminalisation of homosexuality also meant that there was a rise in what participants referred to as jungle justice and mob attacks. This was also noted in Altman et al. (2012) paper on stigma and discrimination of men who have sex with men globally. Jungle justice refers to the lynching, sometimes burning alive of suspected MSM by community members who have taken the law into their own hands. This horrendous behaviour appears to be a result of the criminalised context for homosexual practices in Nigeria, plus the endemic and casual experience of violence within the country generally. As a result, participants sought to ‘man-do’ or pass as heterosexual in public spaces. ‘Man-do’ here implies that they had to perform a version of heteronormative masculinity, which for some participants did not come easily. As reported by participants on page 113, most of these men had to change the way they dressed, talked and walked in order to conform to societal expectations of a male and so that they did not run into trouble with the police or attract societal scrutiny. The implication of the criminal context for MSM was an increased risk of contracting and transmitting HIV because of their engagement in clandestine sex, violent rape and also as a result of their being driven underground and away from required healthcare services.

In this study, many of the participants feared the legal repercussions and that they would have violence meted out on them if their homosexual practices were revealed and as a result engaged in them clandestinely. Moreover, when they were blackmailed, extorted from, stigmatised or discriminated against as a result of their homosexual practices, they were unable to turn to the law because of fear of persecution. The repressive legal climate also had several hugely negative impacts most especially for their healthcare seeking behaviour. As revealed in the findings, many participants avoided accessing healthcare services from government hospitals for fear that they would be arrested. In section 5.3, for example, Mustapha reported how he had been gang raped by four men

he had met on a social media platform and Hasan who had a similar experience but had to conceal this and were both too scared to go to the police or seek medical attention.

Similar findings from a study conducted by Schwartz et al (2015) stress the consequences of criminalising sexual practices on the proliferation of stigma and discrimination and reduction in the access to healthcare services. Schwartz et al. (2015) in their study reported an increase in the experience of stigma and discrimination, fear of seeking healthcare and avoidance of healthcare among gay men and MSM in Abuja in the period immediately after the signing of the law. In contexts which criminalise homosexuality, a higher likelihood of HIV infection in the MSM population has been reported (Millett et al. 2012). Additionally, countries which have criminal laws against MSM are less likely to fund and allocate resources toward HIV programmes and interventions for this population (Santos et al. 2013). As reported in the Telegraph (2014), this is the case in Nigeria where many donor organisations have either stopped completely or threaten to stop donor funds.

### **9.2.2 The role of religion**

Participants' reports, for example, Hasan and Kunle in Section 4.5.3 reveal the major role religion plays not just in the shaping of societal perceptions about homosexuality and HIV but also in the propagation of stigma and discrimination in the Nigerian society. Like in most other sub-Saharan African countries, many people in Nigeria are adherents of Christianity, Islam or traditional religions (Mbonu et al. 2009; Monjok et al. 2010; Olaore & Olaore 2014). In the Nigerian society, religious beliefs heavily influence both the social and legal framework of the country (Olatunde 2016). These religious beliefs, according to Aguwa (2010) have hindered the uptake of HIV services and also resulted in poor knowledge and information about HIV and sexual issues. Religious beliefs have also been linked to discriminatory behaviours from healthcare workers as observed in this study when healthcare workers responded negatively to MSM sexual orientation and their health issues (Amosu et al. 2011). Moreover, as revealed by Ibrahim during a FGD (see Section 5.2.3) religious doctrines have encouraged and created the perception that those who are infected with HIV are being punished for their sinful practices (Singh, 2001). This is similar to findings in this study which show that MSM who were HIV positive were often blamed by healthcare workers and society members for bringing the disease upon themselves and as a result avoided seeking healthcare services. Sexual activity does not only challenge strong

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public and private cultural and political values but also religious values (Otolok-Tanga et al. 2007) it therefore appears to be in the best interest for religious leaders to maintain a hold on these values by creating an environment where stigma can flourish. Campbell et al. (2005) in their study of stigma and HIV/AIDS management in a South African community note that a strategy used by churches to maintain moral authority is to link sexual vices and HIV with sin and immorality.

The majority of the participants in this study identified as Christian. It was noted that key religious perceptions of both homosexuality and HIV propagated the stigma and discrimination experienced by HIV positive MSM. Again, in relation to homosexuality, these perceptions were: homosexuality was considered to be demonic, sinful, an abomination and unnatural. This sentiment was shared by Arinze, Olu and Yemi on page 105. In relation to the disease, HIV positive MSM were perceived to have been punished for their iniquitous sexual practices. Faith leaders were profoundly against homosexual practices and often preached against it because homosexuality is perceived by religious leaders and some MSM as immoral and inherently sinful. Some participants, especially those who were religious, appeared to have internalised these teachings and expressed discomfort regarding their same sex practices. For example, Kunle on page 112, reported that he did not feel right having sex with men because his religion is against it. A majority of the religious participants reported that in their churches where they held influential positions as ministers, they had to conceal their HIV status and sexual practices in order to avoid being stigmatised or discriminated against. Concealment, which will be discussed later, was therefore a technique to shield the self from stigma and discrimination, but it was only partially successful because of its impact on the emotional state of participants.

According to participants, the church for them was meant to be a place of refuge but instead if an individual was found to be HIV positive, they would be relieved of their ministerial posts, isolated and avoided as recounted by Hasan on page 115. Hasan and other participants in this study also mentioned that in relation to homosexual practices, if it was found that an individual was engaging in those practices, he would be labelled as a hypocrite, relieved of his position in the church and may be excommunicated.

### **9.2.3 The role of patriarchal and heteronormative societal structures**

In the African context, culture has been said to play an important role in the way in which HIV/AIDS and sexuality are both perceived (Airhihenbuwa & Webster 2004). Cultural beliefs and values about the how sexual orientation should be defined in the context of HIV/AIDS are among factors that have been identified to influence the various ways that HIV/AIDS impact the African populace (Niang et al. 2003). The importance of cultural context in the HIV/AIDS epidemic cannot be ignored and is relevant to completely examine stigma that occurs in these contexts.

In this study, participants reported that they were stigmatised and discriminated more as a result of their homosexual practices which were deemed to contradict prevailing cultural norms. These cultural norms are not only heteronormative but are also patriarchal. They privilege heterosexuality over homosexuality and the hegemonic masculine male dominates not only over women but on other men who do not conform to the hegemonic expression of masculinity. Rather, the societal perception is of homosexual practices being a Western colonial import. This is despite the plethora of evidence recording same-sex sexual practices within various African cultures dating before colonial era. A key aspect of Nigerian social interactions is reproduction and development of heterosexual friendships and courtships (Teunis 2001; Allman et al. 2007).

In terms of HIV/AIDS, infected individuals are often isolated from their family, friends and community when they are found to be HIV positive (Rankin et al. 2005). As participants in this study reported, when HIV infected individuals die, family members do not report the cause of death as HIV instead they hide it so as to reduce the stigma. As like most collective societies, in Nigeria, individuals and family lives tend to be closely intertwined and so if it is reported that one of the family members died of HIV then the whole family may also be perceived to be HIV positive.

### **9.3 A special type of stigma- ‘Kito’**

This study reported a special form of stigma identified within the HIV+ MSM cohort. This form of stigma to the best of my knowledge has never been reported in any previous research on this population. This form of stigma, referred to as ‘Kito’ by participants was found to be widely present and to have significant impact on the

HIV+MSM population in Nigeria and may be present in other settings. Kito, which I refer to as intragroup stigma, has multiple dimensions which include blackmail, extortion, rape, violence, stigma and discrimination. It was enacted by other MSM in their immediate communities, when either the knowledge about the homosexual practice of another MSM or HIV status was acquired. Knowledge of group members' homosexual practices was used to blackmail, extort, rape or perpetuate violence, stigma and discrimination. In the case of the participants' HIV status, knowledge about this was used to stigmatise and discriminate against HIV+MSM.

Kito appeared to account for at least part of the study participants' distrust and hesitation in accessing MSM friendly healthcare services and taking ART in the presence of other MSM or healthcare workers who were MSM. As reported in Section 6.3, participants were reluctant to access healthcare services, including support group from facilities that provided tailored services for MSM, in order to avoid the possibility of being blackmailed. Additionally, participants often got their personal items and money stolen by MSM who they had invited to their homes for sex. Kito affected MSM sexual partnerships negatively as a result of habitual gossiping and backbiting reported to be common among MSM community. Once their HIV status became known, there was a likelihood that this information would get back to their sex partners, who then stigmatised and avoided them. Although this was the case, participants reported that they consistently used condoms with their partners and because of this, did not feel the relevance of disclosing their HIV status to their sex partners. MSM living arrangements also contributed to the ease at which Kito could be and was enacted. As many as 10 MSM could be living together in a room and because of this MSM were hesitant to take their ART as taking it signalled to others that they were HIV positive. Even in situations where pill containers for other medication were found by other MSM, there was the assumption that they contained treatment for HIV. According to participants, this was because of the high prevalence of HIV in the MSM population, which resulted in the assumption that whatever medication was being taken had to be for HIV. This had implications for adhering to ART, which will be discussed in more detail in Section 9.5.

The drivers of Kito in Nigeria include the criminalisation of homosexuality, poverty, social media, religion and norms of the society. The law and social norm increase the risk of disclosure for the victim while poverty and opportunity to make quick financial gains increases the reward for the beneficiary of Kito. This finding suggests that Kito

may also be observed in contexts where sexual minorities are disempowered and existing laws criminalise their sexual behaviour.

In this study, social media played a crucial role in the enactment of Kito as it was used to 'set-up' and in some cases, gang rape unsuspecting MSM as seen in the cases of Mustapha and Hasan on page 141. This typically occurred when either MSM or heterosexual men contacted participants on dating platforms for MSM. After agreeing to meet with them, these men were either raped or brutally beaten before being extorted from and blackmailed. In these cases, participants were unable to report these violent events to the police or in some cases, to even seek medical attention for fear of persecution. In many cases, participants' inability to seek help from the law or healthcare, resulted in their becoming HIV positive or going underground and into isolation. Ironically, as was discovered in the study and reported in the supplementary section (see Appendix 8), the MSM community is a close-knit community which has a strong bond and provides a support system for MSM. It is therefore difficult to understand exactly why 'Kito' could flourish within this community. The only possible explanation was the repressive legal climate coupled with the disempowerment of MSM in Nigeria.

An online search of intragroup stigma among MSM yielded only one result of a study conducted in the US (Goldenberg et al. 2016). In the study, intragroup stigma was defined as stigma within the MSM community perpetuated by others who share the same sexual practices and in some cases HIV status. This study examined intragroup stigma among MSM seeking sex on Craigslist, and the findings revealed a motivation for intragroup stigma that differed from what participants in my study referred to as 'Kito'. In this study, MSM were reported to stigmatise or choose their partners based on their health status, in other words, the presence or absence of disease and what the authors referred to as "feminine" gender expression. The repercussion of intragroup stigma was just sexual partner discrimination, unlike my study, where participants reported blackmail, extortion, rape and violence. A differentiating factor between the US study and this study may be the unfavourable legal, social, religious and political context in Nigeria. This finding specifically highlights the mechanisms by which criminal laws which are unfavourable towards already marginalised populations may foster discord among close knit groups.

#### **9.4 Dealing with Stigma and Discrimination through Concealment**

In order to manage the stigma and discrimination experienced as a result of their HIV status or sexual practices, participants often sought to conceal these aspects of their lives. Where they could, they concealed these from their faith communities, members of the society, healthcare workers, families and other MSM. In some cases, participants concealed their stigmatising attributes in order to protect their family members and associates from stigma by association. This was vital for the protection of the family name as Kunle reported on page 135. Indeed, concealment of practices and identities was, perhaps not surprisingly, one of the key findings from this study. The concealment of their homosexual practices from healthcare workers often led to incorrect diagnoses and treatment. This was reported by Olu on page 170 who revealed that because he was unsure of how to respond to the doctor's questions about his ailment, he rather hide his symptoms. The use of concealment was also noted in a study conducted by Judgeo and Moalusi (2014) in the Western Cape province of South Africa as a tactic devalued individuals used in managing information about their HIV status. This study conducted by Judgeo and Moalusi (2014), reported that participants selectively disclosed information about their HIV status and only disclosed to healthcare workers when absolutely necessary. One of the reasons was to avoid stigmatisation from their communities. Similar findings were reported in a study by Allman et al (2007) which revealed that participants concealed their sexual identity and led double lives, often appearing heterosexual in public while engaging in homosexual practices in their private lives.

#### **9.5 Knowledge on HIV and its Transmission and HIV Prevention**

One of the most shocking and heart-breaking findings of this study, is that participants were not aware that HIV could be transmitted via anal sex. Indeed, as reported by Peter on page 165, participants believed that anal sex actually offered protection from HIV transmission and therefore there was no need to observe any of the protective measures promoted widely for vaginal intercourse (e.g. use of condoms). Not surprisingly, these participants frequently engaged in unprotected anal sex leading to HIV infection. In this study, participants lack of knowledge about the role of anal sex in HIV transmission could be attributed to two major factors. First, the dominant discourse relating to the sexual transmission of HIV focuses only on heterosexual modes of transmission. Second, and perhaps more pertinent, HIV education and awareness in Nigeria is tailored to the heterosexual majority. Hence, it is not so much that there is an absence of

knowledge about HIV transmission as it is that a different knowledge, which contradicts what is generally known about HIV transmission within the medical community is not included in preventive messages in Nigeria. The second factor can be said to be a direct result of the first

In Nigeria, there is a general silence about issues pertaining to sexuality and its expression (Ikpe 2004; Izugbara 2004; Onwuliri & Jolayemi 2006). When these discussions occur they are usually framed within the socially acceptable expression of sexuality, which is heterosexuality (Ikpe 2004). Although the extent may differ across cultures, discussing these issues is generally restricted to the confines of the bedroom between two married heterosexual adults (Ikpe 2004; Izugbara 2004). This silence extends to the practice of anal sex, which is considered culturally taboo in the Nigerian society (Onwuliri & Jolayemi 2006). This silence persists despite the high biological risk of HIV transmission through anal intercourse when compared to other forms of intercourse as well as the epidemiological evidence indicating that receptive and insertive anal sex is a common practice among African MSM (Wade et al. 2005; Baral et al. 2009b; Smith et al. 2009; Merrigan et al. 2010; Beyrer et al. 2012; Vu, Adebajo, et al. 2013; Muraguri et al. 2015).

Additionally, although having recently been challenged by some researchers, like Oshi and colleagues (2005) as well as Samuelsen et al. (2012), in Nigeria, like much of sub-Saharan Africa transmission of HIV has often been ascribed to either heterosexual or mother-to-child transmission (Nasidi & Harry 2006; Bashorun et al. 2014). As mentioned in the literature review, it was not until 2007 that the first IBBSS which monitors the HIV epidemic in Nigeria's MARPs began to collect data on high-risk sexual behaviours that propagate the spread of HIV. This survey revealed the not only high but rising HIV prevalence in the Nigerian MSM population. Prior to the IBBSS, the HIV epidemic in Nigeria was monitored by the ANC Sentinel Survey and National HIV/AIDS and Reproductive Health Survey (NARHS) both of which measure the HIV burden among pregnant women and the general populace. One of the consequences of this was it created a picture of an HIV epidemic primarily driven by women and heterosexual intercourse.

In this study, the majority of participants reported four main channels through which they obtained HIV information: mainstream media such as TV, radio and billboards,



their villages, their schools and healthcare facilities. These channels of HIV information exclude anal sex as a route of transmission, even when practiced among heterosexual couples for the reasons discussed previously. Rather, they are heavily focused on penile-vaginal transmission of HIV as the only form of sexual transmission of HIV.

In Nigeria, as with many countries, awareness about HIV/AIDS is mainly raised through mainstream media, as it is one of the most effective channels to effectively reach the general populace (Oketunji 2016). However, the accuracy of the content of mass media awareness campaigns have not been assessed but in any case, the silence around anal sex and homosexuality means that mainstream media will still push the one-sided heteronormative HIV messages as findings from this study have suggested. The result of these one-sided discourses is that HIV positive MSM especially those in rural areas do not receive adequate knowledge about HIV transmission and are less able to make positive health choices like using condoms during anal intercourse. This is responsible for majority of the HIV transmission reported by participants in this study.

HIV awareness campaign videos promoting the use of condoms and produced by the Society for Family Health (SFH), one of Nigeria's leading NGOs, with the aim of empowering Nigerian to lead healthier lives revealed the heteronormative narrative that suggests purely heterosexual transmission of HIV. All the videos portrayed heterosexual couples who either chose to use condoms or failed to do so with the consequence of failing to do so being acquiring HIV. This leaves no room for other forms of sexual transmission like homosexual transmission. As was reported on page 163, this heterosexual focus is apparent in radio, billboard and television adverts as well. There have been recent encouraging developments in challenging the narrative that excludes anal sex from mainstream conversations. For example, in 2017, popular music channel MTV Base, released its latest series of its HIV edutainment show, *Shuga Down South*. This series aimed at spreading awareness about HIV depicts a school-aged boy who is sexually attracted to other men. His character expresses great concern about his non-conformist sexual attractions as well as distress about disclosing his sexuality to his family members and friend. Portrayal of this character on the show is a crucial step to creating dialogues on non-heterosexual transmission of HIV and challenging the single narrative of HIV being solely heterosexually transmitted. By creating opportunities such as this for discourse on these issues, opportunities for a diversion from dominant

heteronormative portrayals of HIV transmission can be successfully created as long as these representations are non-stigmatising.

Most participants in this study reported that their first contact with HIV information was at school. The National Family Life and HIV Education (FLHE) Curriculum developed by the Nigerian Educational Research and Development Council (NERDC) in collaboration with the Universal Basic Education, Federal Ministry of Education and Action Health Incorporated provides comprehensive sexuality education (CSE) in primary and secondary schools in Nigeria (NERDC/FMoE 2003). The FLHE is defined as a “planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and values as well as development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human living” (NERDC/FMoE 2003). The FLHE, which is a component of secondary school curriculum in Nigeria provides HIV prevention and sexual health education and has a strong heterosexual focus. It was reviewed and re-designated as FLHE in order to vigorously mainstream HIV/AIDS prevention in schools. Contextually, strong religious and traditional norms restrict open discussion about sex in the Nigerian society (Izugbara 2004). Children are not supposed to ask parents questions about sex and sexuality. So also, teachers are not expected to teach sex education to their students (Ikpe 2004). Other sexual health and HIV curriculum in primary and secondary schools focus majorly on and push abstinence only (Fawole et al. 1999; Oladepo & Fayemi 2011). The heterosexual focus and emphasis on abstinence of the Nigerian health education excludes non-heterosexual identifying individuals. Because the focus is on abstinence, this means that less emphasis is put on the sexual routes of HIV transmission especially transmission through anal sex.

Participants’ responses indicated that prior to accessing healthcare services from MSM friendly clinics, their knowledge, attitudes and prevention practices of HIV was very poor. For these participants, the MSM friendly clinics were their first point of contact with valid information about HIV. As an example, most participants like Peter only learned that HIV could be transmitted and contracted through anal sex after they began accessing healthcare services from MSM friendly clinics. Participants were infuriated and expressed their anger about finding out that HIV was not a disease that affected only those that engaged in vaginal intercourse.

As evidenced in Section 5.3, a result of this lack of knowledge was the consideration of sex with other men as a protective behaviour against contracting HIV. Findings from the current study are corroborated by a study conducted in Kenya by Geibel et al. (2008). This study revealed that participants believed that anal sex posed no risk for HIV transmission and actively sought anal sex. This understanding was attributed to two reasons: first anal sex was understood to be a dry environment which the virus could not live in and second, and perhaps most relevant, was that the Kenyan media campaigns or health authorities never mentioned it. Like the Nigerian context, in the Kenyan and most African context, HIV intervention programs assume that vaginal sex is the only mode of sexual transmission of HIV. Other studies conducted in Nigeria revealed a lack of knowledge about the role of anal sex in HIV transmission among both university and secondary school students (Ola & Oludare 2008; Oketunji 2016). A study conducted in Ethiopia also reported that MSM believed that HIV/AIDS could be transmitted only through heterosexual sex (Tadele 2010).

Oketunji (2016) conducted a study among University students and reported that the participants stated that the HIV virus could be found in blood, semen, vaginal fluids and breast milk of infected individuals, however, the presence of the HIV virus in rectal fluids was omitted. Ola and Oludare (2008)'s study conducted among secondary school students in South West, Nigeria, found that the students obtained HIV information from television, radio, family and friends and the internet. However, there was poor knowledge about the high risk of transmission of HIV through anal sex, with just over 38% answering yes to the question, "can HIV be contracted through anal sex?". This compares to approximately 90% who thought it could be contracted through having multiple partners or through the non-use of condoms (Ola and Oludare, 2008). These findings strengthen the claim that there is general silence about transmission of HIV through anal sex and also that although there is a general awareness of risk factors for HIV transmission being disseminated through the awareness campaigns; there remains a lack of adequate knowledge about the role of anal sex in HIV transmission. On the contrary, a study conducted by Oshi and colleagues (2005) on secondary school teachers and HIV/AIDS sex education in Nigeria, reported high level of knowledge about the role of vaginal and anal intercourse in HIV transmission among teachers.

## 9.6 Accessing HIV-related Healthcare Services

Narratives from MSM in this study are concurrent with the literature which suggests that MSM have decreased access to healthcare services. There is evidence that less than 10% of MSM in the globe have access to healthcare services at an individual level (Beyrer, 2010). Specifically, in Nigeria, access to healthcare services for the general public is limited as a result of the weak healthcare system. However, as revealed in the literature review, it is even more restricted for the MSM population who have added barriers to access as a result of repressive and oppressive society which they experience their daily lives in (Allman et al, 2007; Okanlawon et al, 2013; Sekoni et al, 2015). The literature also reports that African MSM have reduced access to healthcare services despite their significantly higher burden of HIV when compared to their counterparts in the general population (Niang et al, 2003; Wolf et al, 2013; Hunet et al, 2017). It is for this reason that identifying and understanding specific barriers that impede access to healthcare services for MSM is imperative. Similar to the findings of Holland et al (2015) study, this study found that participants preferred to access healthcare services from facilities that provided specialised and friendly services to MSM rather than from general healthcare facilities. Therefore, most of the barriers reported were associated with their experiences of accessing healthcare services from general healthcare facilities. Participants expressed more concern about issues pertaining to negative and discriminatory healthcare provider attitudes and responses but also mentioned financial barriers to accessing healthcare services. Examples of MSM specific barriers to accessing healthcare services at these general healthcare facilities included the healthcare providers who were deemed to be stigmatising, discriminatory, unprofessional in their conduct and who also lacked specialist competence and would be discussed in detail below. Underpinning these discriminatory practices was the legal context, specifically the criminalisation of same sex practices as reported in Section 7.2.3. General barriers to accessing healthcare services will be discussed first.

This study identified barriers which were not specific to MSM populations and could be extended to the general population. These barriers consisted of point of service delivery issues, such as overcrowding, long queues, long waiting times, sectioning and labelling of HIV wards, distance to healthcare facilities as well as financial issues. Although these were non-MSM specific barriers, they still have implications for this population in relation to accessing healthcare services. Participants in Rispel and colleagues (2011)

study also reported long queues and waiting times as structural barriers to accessing healthcare services. In this study, participants were particularly displeased with the overcrowding, long queues and waiting times for a number of reasons. First, for those who were employed, spending the whole day accessing healthcare services meant they had to take the day off work. Being HIV positive requires active engagement with healthcare, including regular check-ups and drug pick-ups. The result of taking too much time off work was a loss in income and more drastic loss of employment as reported by Peter on page 173. As reported by some participants, when MSM are not gainfully employed and have no source of income they are likely to engage in blackmail and extortion as well as engage in risky sexual practices including transacting sex without a condom. Second, overcrowding increased the chances that they would see a familiar face. As has been reiterated throughout this thesis, there was a need for participants to conceal their sexual orientation and HIV status in order to deflect stigma and discrimination. Finally, the delay accessing healthcare meant that by the time they left, which in most cases was at the end of the day, they were exhausted.

Anxiety about the almost overwhelming lack of confidentiality experienced when accessing general healthcare facilities was a recurring theme in this study. Indeed, one of the ways in which MSM in this study sought to maintain control over their health and illness (HIV) was through concealment of their HIV status or concealment of their use of ART. It was therefore not only important but necessary to the participants that confidentiality was maintained about the release of personal information and in particular, their HIV status, since not doing so increased their vulnerability to stigma and discrimination. Studies reviewed demonstrated the link between disclosure of sexual practices and identity and stigma and discrimination (Park et al, 2013; Risher et al, 2013; Wanyenze et al, 2016, Hunt et al, 2017). However, at the general hospitals where participants in this study accessed healthcare services, the general consensus was that healthcare providers did not respect their confidentiality and often gossiped and shared personal information about them (see Section 7.2.1.1). Healthcare workers also actively sought to stigmatize and discriminate against MSM, sometimes to the extent of refusing them treatment. Similar to findings from Wolf and colleagues (2013) study, the implication of this was that participants did not disclose sexual health issues with healthcare providers which in many cases led to misdiagnosis and prescribing incorrect treatment. Finally, healthcare services were reported to be heteronormative with a lack of specialist competence to address the specific healthcare needs of MSM. Services

targeted only at heterosexual individuals was reported as barrier to access for MSM receiving care in Malawi, Namibia and Botswana (Fay et al, 201). In addition to their lack of specialist competence, they were reported to be unfriendly and unwelcoming to MSM clients, especially those who portrayed stereotypical feminine characteristics. The outcome of poor healthcare provider attitudes was distrust in the general healthcare system which prevented MSM from accessing HIV-related healthcare services. Distrust and non-utilisation of healthcare staff has also been reported in studies conducted in the United States (Wilson and Yoshikawa, 2007; McKirnan et al, 2013). However, it appeared that prominent MSM who were able to bribe or give gifts to healthcare workers were treated better. This is a possible reflection of the corrupt healthcare system with inadequate checks and balances (Obansa & Orimisan 2013).

Similar findings relating to poor healthcare provider attitudes towards MSM have been reported in studies across Africa and the US (Merrigan et al. 2010; Rispel et al. 2011; Kennedy et al. 2013; Park et al. 2013; Wolf et al. 2013; Magesa et al. 2014; Underhill et al, 2014; Hunt et al. 2017). In these studies, lack of confidentiality and privacy as well as poor practices and negative healthcare provider attitudes have been cited as factors contributing to poor access to healthcare services amongst MSM. One study which used a mystery client survey methodology was conducted in 12 Nigerian states to assess the 'friendliness' of healthcare services provided in healthcare facilities (Ifekandu et al. 2014). The use of this methodology was important in ensuring that a non-biased assessment of healthcare provider attitudes could be obtained. The majority of the participants in the study reported that the services offered were non-inclusive or targeted to meet the needs of MSM. Furthermore, confirming findings from my research, healthcare providers were reported to have judgmental attitude towards MSM (Ifekandu et al. 2014).

The impact of legally repressive environments on access to healthcare services is well documented in both developing and developed contexts (Millett et al. 2012; Kennedy et al. 2013; Wirtz et al. 2014; Arreola et al. 2015; Schwartz et al. 2015). It was therefore not surprising then that there was a strong tendency for MSM to poorly engage with healthcare services as reported by participants in this study. As discussed in the literature review, the Same Sex Marriage Prohibition Act (SSMPA) stipulates a jail sentence of 14 years for those caught engaging in same sex practices. It also states that those who do not report same sex practices will be sentenced to 10 year's imprisonment.

Although, it does not explicitly state that healthcare providers cannot provide services to MSM, healthcare providers often assume this and this has negative implications for the health and general welfare of MSM who have an increasing need to access healthcare services (Sekoni et al. 2016). As revealed in Section 7.2.3 participants reported a fear of seeking healthcare services especially because of the criminalisation of same sex practices. As one of the interview participants mentioned, “if I now go and tell them now, I’m sure they won’t even attend to me, they would just call the police and who knows maybe I would still be there till now” (Mustapha, self-identified homosexual man, Lagos Interview). This was the case even when they had been violently raped as reported by Mustapha on page 88. Of course, these experiences of rape in many cases resulted in their contracting HIV. Not only was the fear of seeking healthcare apparent but so also is the fear that one can be imprisoned, highlighting clearly the connection between fear of seeking healthcare services and repressive punitive laws. This finding is consistent with those from other research on MSM living in similar legally repressive contexts as Nigeria. These studies report the exclusion of sexual minorities from healthcare services as a result of criminal laws or fear of repercussions (Beyrer et al. 2012; Mason et al. 2015). Beyrer and colleagues (2012) in their call to action, specifically emphasised the need for MSM to be able to access basic HIV services and technologies especially in light of the advances in HIV treatment and care. They noted however, that the criminalised nature of same sex practices is a major structural level impediment to accessing healthcare services, which will have to be addressed if universal access were to be achieved.

Another issue that emerged from this analysis was the dearth of appropriate and accessible MSM-specific healthcare service options in Nigeria. Currently, only five CBOs: Heartland Alliance International Nigeria, Population Council, International Centre for the Advocacy for Rights to Health (ICARH), The Initiative for Equal Rights (TIERS) and Society for Family Health (SFH) offer HIV-related healthcare services to MSM and other key populations for HIV. These services, specifically those provided by HAI, PC and ICARH where I collected data from were reported by participants to provide comprehensive and tailored HIV-related healthcare services including innovative methods of healthcare delivery as reported by participants in Section 7.4. Participants reported that these services were not readily available in many parts of the country resulting in the death of many of their peers who could not access healthcare (see Section 7.5.1). Even when these were available, participants expressed concern

about whether available services could sustain the high and growing numbers of MSM accessing care and treatment. As illustrated in the quotes in Section 7.5.1, MSM residing in parts of the country where these services were unavailable were left with two options, either to travel extremely long distances to access their treatment and services or to not access healthcare services at all. To put in context, the distance travelled to get to these healthcare facilities would be 260km, approximately twice the distance from Sheffield to Birmingham by road. Due to the poor conditions of the roads and depending on the day of the week, the journey to these healthcare facilities could be up to 10 hours or more. Accessing these facilities, therefore meant, clearing one's schedule for up to three days, two of which may be spent in transit. Participants in the study expressed concern about the fate of HIV positive MSM if these services were discontinued. The Nigerian government currently contributes very little funding to HIV interventions and nothing for MSM populations because of the legal context (Schwartz et al. 2015). The implication of this is the extremely high and increasing HIV prevalence in MSM populations.



## **9.7 Adhering to Antiretroviral Treatment (ART)**

Maintaining optimal adherence to ART is imperative for HIV positive individuals as it has been shown to result in achieving viral suppression, reduced chance of developing drug resistance and transmitting the virus to others and halting disease progression and death (Chesney 2003; Nachega & Mills 2007; Glass & Cavassini 2014b). As reported in the literature review, an adherence level of >95% has been recommended for the management of HIV and in order to achieve viral suppression (Paterson et al. 2000; Orrell et al. 2003; Uzochukwu et al. 2009). There is evidence demonstrating the effect of ART in stopping sexual transmission of HIV by halting replication of the virus in genital fluid (Cohen & Gay 2010; Cohen et al. 2011; Fidler et al. 2014; Rodger et al. 2016). There is a dearth of research on the experiences of ART adherence in African MSM population, and this study provides some qualitative data with respect to this issue, although it needs to be acknowledged that the study did not attempt to measure or assess adherence levels through more quantitative measures. An understanding of HIV positive MSM experiences in terms of their ability to maintain optimal adherence to ART is vital for the development of public health interventions with the aim of increasing adherence to antiretroviral therapy. In this study, key challenges and facilitators to maintenance of optimal adherence among Nigerian MSM were explored and accounts about these issues were reported by participants. This study went a step further by identifying strategies which enabled MSM to maintain or approach optimal adherence to ART.

In this study, participants reported their understanding of ART to mean treatment in order to suppress HIV viral load in an HIV infected individual an example of which was reported by Mustapha for example, on page 192. However, as revealed in Section 8.2, their understanding of maintaining optimal adherence showed that participants placed varying emphasis on different aspects of adherence, such as time keeping, or maintaining a balanced diet over others. In terms of benefits and motivators for adhering, this study found that participants were generally motivated by the many benefits maintenance of optimal adherence offered. As a result of consistent use of ART, participants experienced an improvement in their health and well-being and also looked healthier, thereby helping to easily conceal their HIV status and deflect stigma (see Section 8.4). The knowledge that maintaining optimal adherence to ART meant that they could live longer was also reported as a motivator. Quick progression of HIV to AIDS can lead to death and participants appeared to understand that if they did not

adhere to their treatment, they could die as reported by Olu and Lucas on page 206. Moreover, since the majority of the participants were young, they believed they still had a lot to offer their societies and families. Similar to the study reported here, participants in a study conducted in Zimbabwe reported experiencing an improvement in their health and the prospects of living longer as facilitators to ART adherence (Sanjobo et al 2008). Whilst the fear of dying was a motivator for maintaining optimal adherence in this study, a study conducted in South Africa by Peltzer and colleagues in 2010 found a lower association between fear of death and maintaining optimal adherence. They suggested that the reason for this negative association was that participants in their study might have had a lower perception of their need for ART when compared to other participants (Peltzer et al 2010).

For MSM living in Nigeria, this study revealed the many challenges encountered in maintaining optimal adherence. These challenges are reported under three broad categories: patient related, nature of ART and social/structural challenges. Among patient-related factors, participants cited the ‘MSM lifestyle’, forgetfulness and drug fatigue. What participants referred to as the ‘MSM lifestyle’ entailed a life of clubbing, drinking, often times smoking and taking illicit drugs as well as transacting sex. This is the first study reporting ‘MSM lifestyle’ as a barrier to adherence. As shown in Section 8.5.3.2 MSM who traded sex found it difficult to take their medication in front of clients. Because they usually did not disclose their HIV status to their clients, there was the fear that they would lose their clientele and subsequently their source of income if they were found out to be HIV positive. Participants reported that during adherence counseling they were advised by healthcare workers to avoid alcohol, smoking and taking illicit drugs when taking ART. Other studies have also reported patient related factors that shape the extent to which individuals are able to adhere to ART (van Servellen et al. 2002; Mills et al. 2006; Uzochukwu et al. 2009). Among these factors are forgetfulness, busy work schedule, financial barriers, mental health, having a strong support system (Sanjobo et al. 2008; Merten et al, 2010; Portelli et al. 2012; Musumari et al. 2013; Bezahbe et al. 2014). Because this thesis explored MSM specific barriers to adherence, it adds ‘MSM lifestyle’. An aspect of MSM lifestyle is excessive alcohol use, which has previously been cited among factors for sub-optimal adherence to ART in a study conducted in sub-Saharan Africa (Mills et al. 2006). Furthermore, Chander et al. (2006) in their study provided evidence establishing the deleterious effects of alcohol on both viral suppression and immunological functioning. Alcohol use was also found

to be among the main determinants of non-adherence to ART in a review conducted by Heestermans and colleagues (2016).

In terms of the nature of ART, this study found that MSM generally reported that they found the aesthetics, characteristics of the pill and its packaging as well as side effects of the pills problematic. The aesthetics and characteristics of the pills and its packaging refer to the pill size, taste and bottle. In the same way as reported in Section 8.5.2.1 the side effects of the ART, which included skin rashes, scars, dizziness, unusual or bad dreams, hot flushes and fever made it challenging for participants to adhere to their treatment. The side effects which were visible were advised by healthcare workers to be only temporary but because they occurred in the initial stages of starting ART, they had the potential to result in sub-optimal adherence. Interestingly, not taking ART at all also resulted in visible side effects as their condition worsened. This meant that they had to commence ART as soon as possible. It was vitally important that this group of men do not get any visible side effect as it hinders their ability to conceal their HIV status leading to people discovering. These findings are similar to findings in the literature pertaining to aspects of the nature of the drugs being a barrier to optimal adherence (Mills et al. 2006; Merten et al. 2010; Bezabhe et al. 2014). Similarly, participants in a study on patient-reported barriers in sub-Saharan Africa revealed adverse reactions as a barrier to ART adherence (Merten et al. 2010). Side effects were also reported as being responsible for suboptimal adherence to ART in a study conducted in Botswana (Weiser et al. 2003). Additionally, other medication related challenges including the pill burden, aesthetics, that is pill size, taste and overall palatability, which were also reported in my study were reported to cause suboptimal adherence among PLWHA (Weiser et al. 2003).

Finally, social and structural level challenges were also found to pose a barrier. These included: a lack of financial resources, cohabiting and lack of privacy, beliefs about causes and cures for HIV. A majority of the study participants found it difficult to adhere to their ART because they had no steady employment and therefore no income. It was important that these participants had a steady source of income as it provided the sustenance required for them to take their medication. Based on both WHO and healthcare worker recommendations, participants were expected to maintain a healthy balanced diet to boost their immune system. Financial issues as well as patients' beliefs that ART had to be taken with food have been reported as factors leading to suboptimal

adherence in SSA (Nachege et al. 2006; Ramadhani et al. 2007; Rachlis et al. 2011). Studies in similar African contexts have found food insecurity to be a major barrier to adherence (Weiser et al, 2010; Groh et al, 2011; Musumari et al, 2014). Specifically, participants in Uganda reported that ARVs increased their appetite and lack of food exacerbated hunger, side effects of ARVs were exacerbated in the absence of food, they had been counselled on the importance of having a balanced diet when taking ARVs and competing priorities made them unable to purchase or even use their ART consistently (Weiser et al, 2010).

In this study, participants who had not disclosed their HIV positive status found it particularly challenging maintaining optimal adherence, this was exacerbated by cohabitation. The majority of the participants who lived with either family or peers were unable to take their ART stealthily because they had not disclosed their HIV status. Additionally, some of these participants reported that their family members and friends sometimes stole their ART because especially when they thought it was a drug used for 'getting high'. Participants reported that MSM have a tendency to cohabit, in some cases with as much as 5-10 men living in a room at a time. Their living arrangement made it difficult for them to take their ART at the scheduled time, thereby compromising adherence according to the study participants. Conversely, some participants reported that when they lived alone, they were free to take their ART when they needed to take it. Therefore, cohabiting especially with trusted lovers, family or friends, provided participants with the support they needed especially because they could be reminded when it was time to take their ART. As demonstrated by the findings, living arrangement particularly cohabiting and living alone can be both a deterrent and a facilitator to optimal adherence. Sanjobo and colleagues (2008) reported 'living alone' as a barrier to ART adherence.

In this study, key facilitators of adherence to ART were identified. They included having a supportive healthcare environment and the use of adherence support messages, the fear of death, living alone, and provision of ART at no cost to participants. A number of NGOs that cater to MSM also provide them with HIV services including ART. As reported in Section 7.2.1, most MSM access these facilities for HIV treatment as well as general healthcare services. These healthcare facilities tend to be more receptive to key populations including MSM populations because healthcare providers go through training and sensitization so that they are better able to meet the specific

healthcare needs of MSM. Participants reported that these facilities provided innovative services such as frequent text messages on tips on maintaining optimal adherence and safer sex as well as incentivizing progress in CD4 counts keeps MSM motivated. These findings are consistent with those of Bezabhe and colleagues, who found that receiving messages, education and counseling on maintaining optimal adherence was a facilitator to ART adherence.

The provision of ART free-of-charge as reported in Section 8.6.4 was also a facilitator of adherence to ART. Most participants were unemployed or did not have a consistent source of income, but still had the financial responsibility of providing sustenance and transportation to the health centers. Therefore, having their ART provided at no cost to them reduced this financial burden. Provision of ART at no cost to HIV infected individuals has been shown to enable adherence in a number of studies.

This study went a step further to explore the strategies which these men adopt to enable adherence. Currently, no other study in sub-Saharan Africa has explored these strategies. These strategies reported in Section 8.7 included, setting alarms, disclosing HIV status to close trusted individuals, concealment of ART, taking their ART at bedtime and carrying a pill bottle around. Studies reporting strategies for enabling optimal adherence in the general population report pill repackaging, educational interventions and cell phone message reminders (Simoni et al. 2008; Reda and Biadgilign 2012). These strategies are crucial for understanding the MSM specific dynamics of maintaining optimal adherence to ART which may be different from other HIV positive individuals given their homosexual practices. Additionally, it is important for tailoring MSM specific interventions that could be valuable in increasing adherence levels in the MSM population.

Having discussed the findings of this research, the following sections present recommendations for policy, practice and future research. This is followed by some final reflections, limitations of this study and a conclusion of the thesis.

## **9.8 Recommendations and Implications for Policy, Research and Practice**

This research has significant implications for public health including policy, research and practice. The following section is grouped under three major sub-headings: recommendations for small-scale changes, recommendations for large scale changes and recommendations for further research. These are listed and discussed in detail below.

### **9.8.1 Recommendations for Small-Scale Changes**

The small-scale recommendations listed below are changes that are more easily achievable short-term if taken into consideration. These recommendations have the potential of setting the agenda for the large-scale changes and are likely to make the large-scale changes more achievable if considered and implemented.

#### **1. Awareness Raising and Sensitising Society by NGOs and other organisations working with MSM**

It has been observed that in contexts like Nigeria's, merely decriminalising same sex laws will not necessary make a more enabling environment for sexual minorities (Beyrer & Baral 2011; Drame et al. 2013). Examples being South Africa and Guinea-Bissau, countries which have decriminalised homosexuality but still report high rates of stigma, discrimination, corrective rape and murder of sexual minorities (Beyrer & Baral 2011; Drame et al. 2013). It is also imperative that programs with the mandate of raising awareness and sensitising the public about issues pertaining to HIV and MSM with an emphasis placed on respecting the human rights of this population are put in place.

#### **2. Provide comprehensive HIV and sexual health education curriculum in Nigerian schools**

A fundamentally important finding in this thesis was that MSM lacked basic levels of awareness of the role of anal sex in the transmission of HIV. Indeed, some participants perceived anal sex to be a protective factor against HIV, they engaged in it and avoided females who they thought were HIV positive. This misconception was as a result of the missing narrative of the role of anal sex in HIV transmission. In this study, three major reasons were attributed to the propagation of this discourse; these were, the general silence about sexual issues, the dominant narrative suggesting that the HIV epidemic is driven primarily by heterosexual contacts and the lack of attention given to anal sex in

HIV awareness and education nationally. Currently, the only available HIV and STI prevention guide book (see picture Appendix 8) with a focus on MSM is produced by the Population Council's under the Men's Health Network project. It is therefore recommended that HIV awareness campaigns as well as education have a focus on all modes of sexual transmission of HIV including anal sex. Sexual education in Nigeria which mostly has an 'Abstinence only' focus has been shown to be ineffective because it is not acceptable to all adolescents (Inyang & Inyang 2013). Therefore, a focus on the other two components, 'Be faithful' and 'Condom use' is necessary. However, the difficulty of achieving this in Nigeria must be acknowledged given it criminalises same sex activities and depending on the success of the recommendation on decriminalisation.

### **3. Provision of training to increase competence and sensitise healthcare workers**

This research found that MSM are not able to comfortably share their sexual health issues especially those relating to their sexual practices such as anal warts and other anogenital STIs with healthcare workers. This was because of the fear of being stigmatised or discriminated against and healthcare providers' lack of specialist competence to deal with these issues. The study also found that medical school curriculum on sexual health did not provide training on issues related to the non-heterosexual form of sex. Consequently, when participants approached healthcare providers with their sexual health issues, they were unable to provide any medical help. Therefore, it is recommended that healthcare workers in general healthcare facilities are not only sensitised but also trained so that they are able to offer specialist care. This training should also have a focus on improving healthcare provider attitudes towards MSM clients.

### **4. Provision of opportunities for skills acquisition, empowerment and housing**

As a result of the discrimination HIV positive MSM in Nigeria face, a majority especially those whose HIV status or sexual practices are publicly known are not able to secure gainful employment. As reported in the thesis, this has the implication of them resorting to transacting sex in order to make enough for their upkeep. Also, in the process of transacting sex, they engage in risky sex by not using condoms because of the higher pay it attracts. In order to curb this, it is recommended that MSM especially those living with HIV are empowered by providing opportunities for skills acquisition.

Also opportunities for capacity and self-esteem building as well as condom use negotiation should be provided to HIV positive MSM. It is also important to provide shelter management for those who have been displaced.

### **5. Sensitisation of religious leaders**

Nigeria is a highly religious country, and clergymen wield huge influence. It is therefore important that faith leaders and religious bodies are not only sensitised but educated about issues pertaining to HIV as well as those pertaining to non-heterosexual men. They should also be encouraged to preach non-stigmatising sermons and encourage their followers to be more tolerant towards the plight of those affected by HIV.

### **6. Improving waiting times at HIV clinics**

Apart from having to arrive at the healthcare facilities very early in the morning, long queues and overcrowded waiting rooms produce longer waiting times. For MSM who were employed, this meant that they frequently missed work and risked being identified by family and friends. Setting up administrative policies and targets for healthcare professionals at general hospital, which ensure that they are attended to quickly should be a priority if waiting times are to be improved. Waiting rooms can be expanded to accommodate the large influx of clients that access healthcare services from these hospitals. Participants in this study reported the ease with which they accessed healthcare services and treatment at MSM friendly clinics. Lessons can be learned from the manner in which these clinics are organized.

#### 9.8.2 Recommendations for Large-Scale Changes

These large-scale changes listed below are more challenging legal and socio-cultural level changes to enact and may be long-term and difficult to achieve. Despite these challenges, if enacted, they could potentially improve the situation for key populations for HIV particularly men who have sex with men (MSM) living in Nigeria.

#### **1. Decriminalisation of same sex relationships**

This study provided evidence of how laws criminalising same sex relationships are counterproductive to HIV prevention and control efforts and could potentially reverse the gains recorded in the fight against HIV in Nigeria. These repressive and punitive laws not only drive MSM underground but drive them away from lifesaving HIV



services. Additionally, the laws propagate stigma, discrimination as well as extreme violence, which have the implications of denial of access to fundamental necessities of life, withdrawal of financial and emotional support, arbitrary police arrests, loss of valuables through blackmail and extortion and in extreme cases loss of life. In light of this, a recommendation to policy makers, the Nigerian government and all relevant stakeholders is to repeal the criminal law against 'homosexuality'. By so doing a more enabling environment, where MSM have equal access to healthcare services without fear of being stigmatised, discriminated or harmed will be created. In order to achieve this, policy makers must be sensitised and educated on issues pertaining to MSM and HIV. It should be noted, however, that decriminalisation may not necessarily yield the enabling environment required for MSM to enjoy universal health coverage and access rights (Drame et al. 2013). Rather, a more enabling change in cultural, societal and political perspectives is what is needed (Beyrer & Baral 2011). This may be achieved through open dialogue on the nature of MSM and implications of criminalisation on health outcomes including HIV at the individual and population levels. There is a need to conduct and disseminate evidence based research to policy makers and influencers. A dialogue between policy makers as well as relevant stakeholders which include the public and religious leaders and researchers should be created, so that they are made aware of the urgency of the need to not only decriminalise homosexuality in Nigeria but the importance of MSM especially as a bridge population in the Nigerian HIV epidemic.

## **2. Government funding of HIV interventions and initiatives**

Participants in this study reported that funding for HIV interventions and initiatives are mostly provided by international bodies such as PEPFAR, DFID. Little funding is received from the government especially for key populations. Given that Nigeria is among the top three countries with the highest HIV burden globally and second only to South Africa in SSA, it is imperative that the government makes funding HIV interventions, initiatives and research efforts priority. Targeting HIV initiatives at most-at-risk-populations (MARPs) may ensure that the Nigerian HIV/AIDS epidemic is effectively managed. This is even more important in light of the temporality of international funding and changing US political climate, where a large proportion of the HIV funding is received.

### **3. Registering of Support Group for HIV positive MSM**

Participants reported the positive effects support groups had on their overall health and wellbeing including their ability to cope immediately post diagnosis. Apart from providing an opportunity for HIV positive MSM to share experiences in a trusted environment, these support groups also provided a means of keeping MSM clients in the system so that they were not lost to follow up and their adherence was continuously monitored. Unfortunately, as a result of budget cuts, the support groups have had to be cancelled. Therefore, it is recommended that support groups are funded and an MSM specific support group is registered under the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) as they would have their unique health problems.

### **4. Inclusion of MSM into HIV National Frameworks and Strategic Plans**

As a result of the restrictive legal and social climate for MSM in Nigeria, they are not acknowledged or included in Nigerian HIV National Frameworks or strategic plans. This is despite their salient role in relation to the Nigerian HIV epidemic. There is evidence that MSM are a bridge population because of their bisexual behaviour. In order not to reverse the gains already recorded in the reduction of the prevalence of HIV in Nigeria, it is important that MSM and other key populations are acknowledged and policy is implemented to address the epidemics in their sub populations.

### **5. Provision of accessible and appropriate MARPs friendly healthcare services**

In relation to accessing healthcare services, it was reported in this study that MSM preferred to access healthcare services from NGO run facilities that provided MSM specific healthcare services. However, these facilities are not sufficient and evenly distributed in the country. This means that the majority of the MSM population needing healthcare services are unable to have access. It is recommended that capacity is increased for MARPs friendly services and these services are created not just in the urban areas but also in rural areas where MSM may not access healthcare services. It is imperative that the services provided at the MARPs friendly healthcare centres are not only culturally sensitive but also appropriate.

### **9.8.1 Recommendations for Further Research**

Much of the research conducted on African MSM is quantitative in nature, while this is necessary because it provides numerical estimates of the magnitude of the issue, it is not sufficient. There is a need for qualitative research which provides in-depth evidence-based insights into the experiences of MSM in a way in which quantitative research is unable to capture. Furthermore, qualitative research can be useful for explaining quantitative research findings. There is a need to conduct participatory research where MSM can be actively involved in the planning, investigating and implementing stages of the research process. Although this study provided detailed insight into the lived experiences of MSM, it raised pertinent research questions necessitating further research. Participatory research could be employed in answering some of the questions below.

- a. Can a set of interventions be built to address barriers to access to healthcare and adherence to ART? Which interventions work and how?
- b. How does legislation evolve in the Nigerian setting in terms of the criminalisation of same sex marriage? Who are the key actors involved?
- c. What informs religious positions of religious leaders? What are the opportunities for open dialogue with these key actors on related issues?
- d. How do MSM from higher social classes access health care services?

### **9.9 Study Limitations**

The limitations in this study, which were mainly methodological are presented below.

First, in terms of recruitment, although efforts were made to collect data on participants' previous experiences of accessing healthcare services from general healthcare facilities, participants in this study accessed healthcare services from NGOs providing comprehensive tailored HIV services including ART to MSM. The implication was that the experiences of those who were actively accessing healthcare services from general health facilities at the time of the interview could not be collected.

Second, the study population consisted mainly of MSM who were of low-middle income level. Therefore, direct accounts of how the relatively well-off MSM access healthcare service was missing. Efforts were also made to achieve a heterogeneous sample; however, most participants recruited were below 35 and single. Therefore, study participants may not have been representative of the actual MSM population in

Nigeria and therefore findings may not be generalizable to the MSM population who represent all age groups and income levels.

Finally, this study relied on the use of participants' self-report to explore issues including sexuality, sexual practices and health seeking behaviour, which may be regarded as sensitive. Although attempt was made to limit bias by building rapport and trust with the study participants, the reliance on self-reporting meant that reporting bias may not have been eliminated. Reporting bias here refers to the need to present one-self as a 'good' patient, thereby withholding useful and important information. This along with recall bias, are common limitations of participant self-report studies (Chenail 2011).

## **9.10 Conclusion**

In this thesis, I have attempted to provide ‘thick description’ of the lived experiences of HIV positive MSM as they relate to the accessing of healthcare services and adhering to antiretroviral treatment. In exploring this, I have highlighted HIV positive MSM experiences of stigma and discrimination, which appeared to permeate all aspects of their lives. The study contributes insights on how stigma and discrimination shape access to healthcare services and adherence to antiretroviral treatment as well as their knowledge about HIV transmission in a criminalized and heteronormative setting. The key findings from each of the chapters are listed and summarized below.

### **Chapter 4: Homosexuality and HIV in the Nigerian Context**

This chapter showed how in Nigerian society, stigma and discrimination permeate all aspects of HIV positive MSMs lives. Stigma and discrimination were found to be propagated and maintained by societal and religious perceptions of homosexuality and HIV coupled with a legal climate where homosexuality is criminalized. HIV+ MSM therefore become an abject category, driven to the margins of society and away from life-saving healthcare services.

### **Chapter 5: Experiences of Stigma and Discrimination**

In this chapter, the different forms of stigma: sexual, HIV, stigma by association, anticipated stigma and discrimination: denial of access to fundamental necessities, withdrawal of support, arbitrary police arrests, blackmail and extreme violence and homophobia. In this chapter, a new form of stigma, Kito, was conceptualized. This adds a new category to stigma, a form of intragroup stigma. The main way through which participants managed their stigmatized identities, concealment, was also identified.

### **Chapter 6: Experiences, Understanding and the Self-Management of HIV**

In this chapter, I described how HIV positive MSM experience, understand and self-manage their illness. The general consensus among participants was that healthcare services and ART were accessed through the MSM friendly clinics or hospitals as opposed to traditional hospitals, because participants were sampled from NGOs providing MSM friendly healthcare. Although there were reports of self-medication, participants generally avoided this and only self-medicated for minor ailments, such as headaches, cold and malaria, not related to their HIV. A key finding in this chapter was the lack of knowledge of the role of unprotected anal sex in the transmission of HIV.

This lack of knowledge was attributed to dominant heteronormative discourses in the Nigerian society.

### **Chapter 7: Accessing HIV-related Healthcare Services and ART**

This chapter provided a description of the way in which HIV positive MSM negotiate access to the Nigerian healthcare system while managing their stigmatized identities. In this chapter it was established that HIV+MSM preferred accessing healthcare services through facilities which provided MSM friendly services rather than public or private healthcare facilities. This was because of their negative experiences when accessing healthcare services including negative healthcare providers' attitudes, lack of specialist skills and competencies, stigma and discrimination, overcrowding and fear of arrests. These barriers were more pronounced for the majority of the participants in this study who had relatively low income. Although MSM specific clinics provided a more enabling environment where MSM could freely access healthcare services and treatment, they were reported not be readily available in all the states in Nigeria and only available in urban cities. Concern was also raised about the sustainability of donor funded HIV interventions and programs provided at the MSM friendly clinics, especially as the political climate in the United States, the main funder is changing.

### **Chapter 8: Adherence to ART**

This chapter provided a description of the processes of initiating ART, challenges and facilitators of ART adherence as well as strategies deployed by the HIV positive MSM to maintain optimal ART adherence. In addition, key barriers and facilitators of adherence to ART were reported in this study. Barriers included those pertaining to the individual, including the inability to keep to time, forgetfulness and the MSM lifestyle; the nature of ART, which included side effects, aesthetics and characteristics of the AR, social/structural level challenges such as cohabiting, and lack of financial capital. Facilitators included the supportive healthcare environment characteristic of the MSM friendly facilities, the fear of death and the provision of ART at no cost to MSM. Provision of ART at no cost to the MSM was crucial as it meant they had fewer financial responsibilities. A useful finding was the strategies which were employed by HIV+MSM to maintain optimal ART adherence, which included setting alarms, taking ART at bedtime, concealment of ART and because of their high mobility, carrying ART about.

In conclusion, findings from this research could provide policy makers and key stakeholders with evidence to inform public health interventions geared at enabling access to healthcare services and adherence to treatment for at-risk populations.

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## APPENDICES

### Appendix 1: Adapted Narrative Interview Topic Guide

#### Part 1

##### Topics to be covered

- Understanding experiences HIV diagnosis and living with HIV and how they manage it (do they seek treatment, what types of treatment do they seek i.e. self-medicate, traditional healers or formal health services)
- Experiences of access, utilization and adherence to antiretroviral (barriers and facilitators)
- Social context (experiences of stigma, discrimination, social exclusion related to HIV and/or being a MSM)

##### Topics that interest me

- Health seeking behaviour: traditional and modern
- Access to ART
- Adherence challenges
- Adherence facilitators
- Knowledge about ART
- Knowledge about ART adherence
- Experience of living with HIV: disclosure, discrimination experiences, internalised and felt stigma
- Risk perception
- Who they have disclosed to

##### Introduction

- Brief introduction to the interview (i.e., state your name, affiliated institution).
- Check that informants understand the purpose of the research and they consent to study.
- Remind informants that they are free to withdraw from study at any time and reassure informants of confidentiality and anonymity and their right to stop the interview at any time they feel uncomfortable answering a question.
- Let informants know you will be taking down notes, which you may need if points they have made needs to be clarified later on or to inform follow up questions.
- Also inform the informants that you will be recording the interview and if they are uncomfortable with that they should let you know.
- Briefly go through the process of what a narrative is and what will be expected from the informants during the process (Reminder to self: the narrative follows 4 main stages initiation, main narration, questioning and concluding talk).
- Do you have any questions for me before I begin the interview?
- Thank informants for participating.

##### Begin Interview

As you know I am researching if and how HIV positive MSM access, use and take their HIV treatment. So could you please tell me about your life, in respect to your health/illness; I am interested in your experiences and events that have been especially important to you with relation to your illness. I will not interrupt you while you are talking, please take your time and begin when you are ready.

[PAUSE] how you have managed your condition since your diagnosis/ Can you tell me about your experience of being diagnosed with HIV...and what happened after that? [ask this as follow up if it is not brought up in initial narrative].

[PAUSE] could you please talk about your experience being a Nigerian MSM...

**In narrative interviews there are no pre-determined follow up questions, questions are asked based on the response of the prior questions, assisting the respondent in giving narratives of events previously mentioned. Follow up questions are usually selected based on the guidelines listed below:**

- Ask follow-up based on the first and last event in the respondent's narrative
- Ask follow-up questions about events in order in which they were presented in the narrative
- Ask follow-up questions that are salient to respondent
- Ask follow-up questions about events that are related to the research questions.

##### Possible Follow-Up Questions

Below are hypothetical follow up questions

- You mentioned that you stopped going to health centres for your HIV treatment. Could you please talk a little more about that? (How did you manage your HIV during that time?)
- You mentioned that when you were staying in your family house, your sister who you had not disclosed (sexual orientation or HIV status) to, caught you taking your medication. Could you tell me how you were able to manage that situation?
- You mentioned that a time when you were thrown out of your house, could you please talk more about the events that led to that happening?
- You said there was a time when you felt lonely and frustrated; could you speak a little more on that?

#### Part 2

## SEMI-STRUCTURED INTERVIEW TOPIC GUIDE

### SOCIAL CONTEXT

1. What is your understanding of homosexuality, bisexuality, straight? Which do you identify with? What is your reason?
2. What is it like being a man who has sex with men in Nigeria?
3. Narrate when you first realized your sexual orientation? Sexual debut (age, where, when)?
4. Who did you disclose to? What was the reason behind you disclosing to this person?
5. Awareness of healthcare provider of your sexual orientation?
6. Has this awareness among health workers affected the access, quality of HIV care and support you have received?
7. What are your experiences with homophobia? Stigma? Discrimination? (family, healthcare workers, society? Self?) (In what ways have you been treated differently as a result of your sexual orientation?)
8. How have you coped with stigma and discrimination?

### UNDERSTANDING EXPERIENCES OF HIV DIAGNOSIS

9. How did you come to know about your HIV status? What was the testing experience like? Walk me through it from screening to the testing process (was there pre-test, post-test counselling? Confidentiality of the process?).
10. Who did you disclose to? What was the reason behind you disclosing to this person?
11. How do you get your knowledge about HIV? (TV? radio? newspaper?)
12. What is it like being HIV positive in Nigeria?
13. How have you coped with your status? What strategies have you used?
14. When you have sexual intercourse do you disclose to your partner your status?
15. How much of a risk do you think you pose to yourself and your partners?
16. What is your view on condom use?
17. What counselling have you received on precautions? Which precautions do you take and what is the reason for this?

### EXPERIENCES OF ACCESS, UTILISATION AND ADHERENCE TO ARV

18. Do you use any treatment to manage your illness? What treatment options do you use? (traditional, orthodox, living positively, antiretroviral treatment, adherence counselling, experience with ART treatment, coping mechanism)
  19. How do you navigate healthcare in Nigeria?
  20. What challenges have you faced accessing, utilizing and adhering to your treatment? What makes the process easier? (noisiness of the pill bottle, travel?)
  21. What do you do to adhere better to treatment? What do you do when you miss a dose? What motivates you to take your treatment regularly?
  22. In what way does the stigma, discrimination you face affect how you access and utilise ART?
  23. What do you understand by ART? Adherence?
- (if more time explore mobility of MSM, position (bottom or top), occupation (sex work?))

## Appendix 2: FGD Topic Guide

### WELCOME

Thank you for agreeing to take part in this focus group. I appreciate your willingness to participate.

### INTRODUCTION

My name is Abisola Balogun. I am a PhD Student at the University of Sheffield and I will be moderating this focus group. Here with me is [insert name] and he will be the assistant moderator and would be taking down notes and operating the recorder.

### PURPOSE OF THE FOCUS GROUP

The reason we are having this focus group today is to get an understanding of your opinions, experiences and concerns about accessing and utilising health care services and specifically accessing, utilising and adhering to treatment. Your input is very important and as such I would want you to share your honest and open thoughts during this focus group.

### GROUND RULES

1. You have your numbered identification for anonymity. If I call you or need to clarify, I would refer to this number.
2. I want you to do all the talking! Everyone has to participate and if I don't hear from you in a while, I may call on you.
3. It is important that we talk one after the other, so no talking over each other.
4. Remember that there are no right or wrong answers, every persons experiences and opinions are important and please speak up whether you agree and disagree, because it is important I get a wide range of opinions.
5. What is said in this room stays in this room! I want you to feel as comfortable as possible when discussing or sharing issues which may be sensitive. You will not be identifiable in any report.
6. [insert name here] will be recording this group discussion because we want to capture everything you say, again remember to talk one after the other so its audible on the recorder.

### ICEBREAKER QUESTION

We will start with an icebreaker question. So imagine that you won the lottery today, and this lottery has a limitless budget, so you can take as much out as you want at anytime. What will you do with the money?

### QUESTIONS

1. What is it like being HIV positive in Nigeria? (experiences, stigma and discrimination)
2. How do you get your knowledge about HIV? (TV? radio? newspaper?)
3. Do you use any treatment to manage your illness? What treatment options do you use?
4. How do you navigate healthcare in Nigeria?
5. What challenges have you faced accessing your treatment? (what makes it easier?)
6. What barriers do you face utilising your treatment? (what makes it easier?)
7. What challenges do you face adhering to medication? (what makes it easier?)
8. Tell me what it is like being a man who has sex with men in Nigeria?

## Appendix 3: Information Sheet for MSM Interviews

1. **Research Project Title**  
HIV Positive Nigerian Men who have sex with Men: Access, Utilisation and Adherence to Antiretroviral Treatment
2. **Invitation paragraph**  
You are being invited to take part in this study. Before you decide, it is important for you to understand why the study is being conducted and what it will entail. Please take time to read the information carefully and thoroughly. You may discuss it with others if you wish. Please direct any questions or concerns or requests for more information to the Principal Investigator, Abisola Balogun (details provided below). Take time to decide whether or not you wish to take part in this study. Thank you for reading this.
3. **What is the project's purpose?**  
The purpose of this interview is to explore and gain an in-depth understanding of your life as an HIV positive MSM living in the Nigerian social context and how it shapes the degree to which your HIV health seeking behaviour. Additionally, what treatment options you opt for in managing your illness and how you navigate the healthcare system. The duration of the entire project is 6 months, during which you will be interviewed once and only called back if there is a need for a repeat interview.
4. **Why have I been chosen?**  
You have been chosen because you use services provided by Heartland Alliance International and you meet the inclusion criteria of the study, which is aged 18 years and above, MSM, HIV positive and on HIV treatment.
5. **Do I have to take part?**  
Taking part in this study is entirely voluntary, and it is up to you to decide whether or not you will like to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). If after consenting to this study or at any point during the study you change your mind you are free to withdraw (you do not have to give a reason) and you will not be penalised in any way.
6. **What will happen to me if I take part?**  
When written consent has been obtained from you, you will be interviewed once and may be called back for a repeat if necessary (this will to clarify on any point you had made in the first interview that was unclear and to also explore any themes that were not covered during the first interview. Please note that it is entirely up to you to take part in the second interview). The first interview would be a narrative interview, which will last an hour and a half (1.5 hours/90min) to two hours (2 hours) and will be held in a space provided by the organization or any location convenient for you. The second interview (if necessary) would be a semi-structured interview, which will last an hour and will also be held in a space provided by the organization or any location convenient for you. During the interview(s) you will be asked questions based on the research topic, your experiences of being HIV positive and MSM in Nigeria, how you have managed your illness and how you access, utilise and adhere to HIV treatment.
7. **What are the possible disadvantages and risks of taking part?**  
There are no known discomforts, disadvantages and risks of participating in this study. However, due to the sensitivity of this issue in our community adequate measures will be taken to ensure your safety, anonymity and confidentiality. This will be done by conducting the study either in a space provided by Heartland Alliance or a secure location of your choice, ensuring your anonymity and that your name is not linked to any data from this study and that all data gotten from the study are stored in a password protected computer only accessible by the Principal Investigator and the research team. Due to highly sensitive topics covered during the interview, if requested, Heartland Alliance will provide you with counselling and psychosocial support.
8. **What are the possible benefits of taking part?**  
Although there are no immediate benefits for participants of the study, it is hoped that this study will inform HIV programmers to tailor HIV prevention, treatment and care services to meet your specific needs in a friendly environment.
9. **Will I be recorded, and how will the recorded media be used?**  
Yes, you will be recorded during the interview. All audio recordings of the interviews conducted during this research will be completely destroyed after they have been transcribed, analysed and written up as this is the University of Sheffield policy. They will not be used for anything else without your written permission, and no one outside the research team will have access to the original recordings.
10. **What happens if the research study stops earlier than expected?**  
It is anticipated that this study will be completed, however, if for any reason the study has to be halted or stopped completely the information gotten thus far will be retained for analysis and completely destroyed immediately after it has been analysed and written up.
11. **What if something goes wrong?**  
If you encounter any issues or need to complain, you may email the Research Supervisor, Professor Paul Bissell at [p.bissell@sheffield.ac.uk](mailto:p.bissell@sheffield.ac.uk). Should you feel that your concern has not been dealt with adequately you may contact Professor Jon Nicholl, Dean of the School of Health and Related Research directly at [j.nicholl@sheffield.ac.uk](mailto:j.nicholl@sheffield.ac.uk) or through his P.A. Kathryn Rooney at [k.rooney@sheffield.ac.uk](mailto:k.rooney@sheffield.ac.uk)
12. **Will my taking part in this project be kept confidential?**  
All the information collected about you during the course of this study will be kept strictly confidential and anonymous, unless it is thought that there is a risk of harm to myself or others, in which case this information may need to be shared with the research supervisor and the Dean of the School of Health and Related Research. You will not be identifiable in any reports or publications. All information obtained from you will be stored securely on a password protected computer only accessible to the Principal Investigator and Research Supervision Team and will be completely destroyed after it has been analysed and written up.
13. **What will happen to the results of the research project?**  
The findings from this study will be disseminated to the participants, Heartland Alliance, government and public health officials, international and local NGOs, academics and the MSM community. It will be published in academic peer-reviewed journals (you will be given further details of where to obtain a copy when it has been published). Again, you will not be identifiable in any report or publication.
14. **Who is organising and funding the research?**  
This study is not funded by any organisation or company.
15. **Who has ethically reviewed the project?**  
This study has received ethical approval through the School of Health and Related Research's ethical review board and also the Lagos/Abuja State Institutional Review Board (IRB).
16. **Contact for further information**  
If you have any questions, please direct them to the address below:  
**Abisola Balogun**  
Email: [aobalogun2@sheffield.ac.uk](mailto:aobalogun2@sheffield.ac.uk)  
**OR**  
**Paul Bissell**  
The University of Sheffield  
Regent Court, 30 Regent Street  
Sheffield, S14DA  
United Kingdom  
Email: [p.bissell@sheffield.ac.uk](mailto:p.bissell@sheffield.ac.uk)  
Fax : +44 114 272 4095

You will be given a copy of the information sheet and a signed copy of the consent form to keep. Thank you for taking part in this study.

**Date:**  
**Applicant Pseudonym:**

1

## Appendix 4: Information Sheet for MSM FGDs

1. **Research Project Title**  
HIV Positive Nigerian Men who have sex with Men: Access, Utilisation and Adherence to Antiretroviral Treatment
2. **Invitation paragraph**  
You are being invited to take part in this study. Before you decide, it is important for you to understand why the study is being conducted and what it will entail. Please take time to read the information carefully and thoroughly. You may discuss it with others if you wish. Please direct any questions or concerns or requests for more information to the Principal Investigator, Abisola Balogun (details provided below). Take time to decide whether or not you wish to take part in this study. Thank you for reading this.
3. **What is the project's purpose?**  
The purpose of the focus group discussion is to get collective and different perspectives on your experiences, opinions, needs and concerns about your access and utilisation of health care services including HIV treatment services. The duration of the entire project is 6 months, during which a focus group discussion will be held, and another one if necessary.
4. **Why have I been chosen?**  
You have been chosen because you use services provided by Heartland Alliance International and you meet the inclusion criteria of the study, which is aged 18 years and above, MSM, HIV positive and on HIV treatment. There will be 5 or 6 additional participants in this study.
5. **Do I have to take part?**  
Taking part in this study is entirely voluntary, and it is up to you to decide whether or not you will like to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). If after consenting to this study or at any point during the study you change your mind you are free to withdraw (you do not have to give a reason) and you will not be penalised in any way.
6. **What will happen to me if I take part?**  
When written consent has been obtained from you, you will be invited to a focus group discussion along with 5 or 6 other participants. Each focus group discussion would last 2 hours long and will be held in a secure space provided by the organization. During the discussion you will be expected to discuss among yourselves the research topic, experiences of being HIV positive and MSM in Nigeria, how you have managed your illness and how you access, utilise and adhere to HIV treatment.
7. **What are the possible disadvantages and risks of taking part?**  
There are no known discomforts, disadvantages and risks of participating in this study. However, due to the sensitivity of this issue in our community adequate measures will be taken to ensure your safety, anonymity and confidentiality. This will be done by conducting the study either in a space provided by Heartland Alliance or a secure location of your choice, ensuring your anonymity and that your name is not linked to any data from this study and that all data gotten from the study are stored in a password protected computer only accessible by the Principal Investigator and the research team. Due to highly sensitive topics covered during the interview, if requested, Heartland Alliance will provide you with counselling and psychosocial support.
8. **What are the possible benefits of taking part?**  
Although there are no immediate benefits for participants of the study, it is hoped that this study will inform HIV programmers to tailor HIV prevention, treatment and care services to meet your specific needs in a friendly environment.
9. **Will I be recorded, and how will the recorded media be used?**  
Yes, you will be recorded during the interview. All audio recordings of the interviews conducted during this research will be completely destroyed after they have been transcribed, analysed and written up as this is the University of Sheffield policy. They will not be used for anything else without your written permission, and no one outside the research team will have access to the original recordings.
10. **What happens if the research study stops earlier than expected?**  
It is anticipated that this study will be completed, however, if for any reason the study has to be halted or stopped completely the information gotten thus far will be retained for analysis and completely destroyed immediately after it has been analysed and written up.
11. **What if something goes wrong?**  
If you encounter any issues or need to complain, you may email the Research Supervisor, Professor Paul Bissell at [p.bissell@sheffield.ac.uk](mailto:p.bissell@sheffield.ac.uk). Should you feel that your concern has not been dealt with adequately you may contact Professor Jon Nicholl, Dean of the School of Health and Related Research directly at [jnicholl@sheffield.ac.uk](mailto:jnicholl@sheffield.ac.uk) or through his P.A. Kathryn Rooney at [k.rooney@sheffield.ac.uk](mailto:k.rooney@sheffield.ac.uk)
12. **Will my taking part in this project be kept confidential?**  
All the information collected about you during the course of this study will be kept strictly confidential and anonymous, unless it is thought that there is a risk of harm to myself or others, in which case this information may need to be shared with the research supervisor and the Dean of the School of Health and Related Research. You will not be identifiable in any reports or publications. All information obtained from you will be stored securely on a password protected computer only accessible to the Principal Investigator and Research Supervision Team and will be completely destroyed after it has been analysed and written up.
13. **What will happen to the results of the research project?**  
The findings from this study will be disseminated to the participants, Heartland Alliance, government and public health officials, international and local NGOs, academics and the MSM community. It will be published in academic peer-reviewed journals (you will be given further details of where to obtain a copy when it has been published). Again, you will not be identifiable in any report or publication.
14. **Who is organising and funding the research?**  
This study is not funded by any organisation or company.
15. **Who has ethically reviewed the project?**  
This study has received ethical approval through the School of Health and Related Research's ethical review board and also the Lagos/Abuja State Institutional Review Board (IRB).
16. **Contact for further information**  
If you have any questions, please direct them to the address below:  
Abisola Balogun  
Email: [aobalogun2@sheffield.ac.uk](mailto:aobalogun2@sheffield.ac.uk)  
OR  
Paul Bissell  
The University of Sheffield  
Regent Court, 30 Regent Street  
Sheffield, S14DA  
United Kingdom  
Email: [p.bissell@sheffield.ac.uk](mailto:p.bissell@sheffield.ac.uk)  
Fax: +44 114 272 4095

You will be given a copy of the information sheet and a signed copy of the consent form to keep. Thank you for taking part in this study.

**Date:**  
**Name of Applicant:**

1

## Appendix 5: Informed Consent

University of Sheffield

### INFORMED CONSENT FORM

**Title of Research Project:** HIV Positive men who have sex with men: access, utilization and adherence to antiretroviral treatment in Nigeria

**Name of Researcher:** Abisola Balogun

**Participant Identification Number for this project:**

**FCT HREC Approval Number-** FHREC/2015/01/84/29-12-15

#### Please initial box

1. I confirm that I have read and understand the information sheet/letter explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
3. I give permission to be audio recorded during the interviews and that the recording will be kept until the interviews have been transcribed.
4. I understand that the information from my interview will be pooled with other participants' responses, anonymised, and may be published.
5. I understand that my responses will be kept strictly confidential.  
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
6. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case this information may need to be shared with my supervisors.
7. I agree for the data collected from me to be used in future research, and the University of Sheffield can keep transcripts of the interview for 10 years after the study has finished.

\_\_\_\_\_  
Participant's Initial

\_\_\_\_\_  
Date

\_\_\_\_\_  
Lead Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

#### **Lead researcher contact details**

Email Address: [abalogun2@sheffield.ac.uk](mailto:abalogun2@sheffield.ac.uk)

**Thank you for your participation**

## Appendix 6a: Ethics Approval, University of Sheffield



Downloaded: 28/09/2017  
Approved: 06/01/2016

Abisola Balogun  
Registration number: 140132674  
School of Health and Related Research  
Programme: HARR41 Health and Related Research

Dear Abisola

**PROJECT TITLE:** HIV Positive Nigerian Men who have sex with men: Access, Utilisation and Adherence to Antiretroviral Treatment

**APPLICATION:** Reference Number 006330

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 06/01/2016 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 006330 (dated 18/12/2015).
- Participant information sheet 1013055 version 3 (18/12/2015).
- Participant information sheet 1013054 version 3 (18/12/2015).
- Participant information sheet 1013053 version 3 (18/12/2015).
- Participant information sheet 1013962 version 1 (03/12/2015).
- Participant information sheet 1013961 version 1 (03/12/2015).
- Participant information sheet 1013960 version 1 (03/12/2015).
- Participant consent form 1013056 version 2 (16/11/2015).
- Participant consent form 1013963 version 1 (03/12/2015).
- Participant consent form 1013955 version 2 (18/12/2015).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

Jennifer Burr  
Ethics Administrator  
School of Health and Related Research



## Appendix 6b: Ethics Approval, FCT HREC



### FEDERAL CAPITAL TERRITORY HEALTH RESEARCH ETHICS COMMITTEE

Research Unit, Room 10, Block A Annex, HHSS  
FCT Secretariat No. 1 Kapital Street Area II, Garki, Abuja - Nigeria

Name of Principal Investigator      Balogun O. Abisola  
Address of Principal Investigator:    Apt 7, 185 Upper Allen Street, Sheffield, United Kingdom, S3 7GT.  
Date of receipt of valid application: 17/12/2015

#### Notice of Research Approval

Protocol Approval Number: FHREC/2015/01/84/29-12-15

**Study Title: HIV Positive Men Who Have Sex with Men: Access, Utilization and Adherence to Antiretroviral Treatment in Nigeria.**

This is to certify that the FCT Health Research Ethics Committee (FCT HREC) has fully approved the research described in the above stated protocol.

**Approval Date:**            -            29/12/2015  
**Expiration Date:**         -            28/12/2016

Note that no activity related to this research may be conducted outside of these dates. Only the FCT HREC approved informed consent forms may be used when written informed consent is required. They must carry FCT HREC assigned protocol approval number and duration of approval of the study.

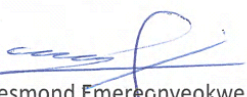
The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, and with the tenets of the code. The FCT HREC reserves the right to conduct compliance visit to your research site without prior notification.

**Modifications:** Subsequent changes are not permitted in this research without prior approval by the FCT HREC.

**Problems:** All adverse events or unexpected side effects arising from this project must be reported promptly to FCT HREC.

**Renewal:** This approval is valid until the expiration date. If you are continuing your project beyond the expiration date, endeavor to submit your annual report to FCT HREC early, and request for renewal of your approval to avoid disruption of your project.

**Closure of Study:** At the end of the project, a copy of the final report of the research should be forwarded to FCT HREC for record purposes, and to enable us close the project.

  
Desmond Emereonyeokwe  
For: Secretary, FCT HREC  
December 29, 2015

## Appendix 6c: Ethics Approval, LASUTH HREC



LAGOS STATE GOVERNMENT



LAGOS STATE  
UNIVERSITY TEACHING HOSPITAL,  
IKEJA

### HEALTH RESEARCH AND ETHICS COMMITTEE

REG.NO. NHREC04/04/2008

(www.nhrec.net)

PROJECT TITLE: HIV POSITIVE MEN WHO HAVE SEX WITH MEN: ACCESS,  
UTILISATION AND ADHERENCE TO ANTIRETROVIRAL TREATMENT IN NIGERIA  
REF. NO.: LREC/10/06/639

PRINCIPAL INVESTIGATOR: ABISOLA OLATOKUNBO BALOGUN

ADDRESS: SCHOOL OF HEALTH AND RELATED RESEARCH, UNIVERSITY OF  
SHEFFIELD, UK

DATE OF RECEIPT OF VALID APPLICATION: 12/01/16

DATE OF APPROVAL: 09/02/2016

**PROF. D. A. A. OKE**  
B.Sc. (Hon.), MBBS, FMCP  
Chief Medical Director  
08023137352, 08058995250,  
+2347032959145

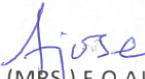
This is to inform you that the research described here in the submitted protocol, the consent forms, advertisements and other participant information materials have been reviewed and given full approval by the Health Research and Ethics Committee of LASUTH. (LREC)

This approval dates from 09/02/2016 to 02/08/2016. If there is any delay in starting the Research, Please inform the HREC LASUTH so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC LASUTH assigned number and duration of HREC approval. In a multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

**DR. A. ADEDOKUN**  
MD, FMCGP  
CMAC / Director Of Clinical Services  
and Training  
08086748003, 08033277108

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**DR. F. O. AJOSE**  
MRCP (UK) FRCP (Lond)  
Chairman LASUTH Research  
Ethics Committee  
08038559066  
E-mail: ethics@lasuth.org

  
DR. (MRS.) F.O AJOSE  
CHAIRMAN

**DIRECTORATE OF CLINICAL SERVICES AND TRAINING / HOSPITAL RESEARCH ETHICS COMMITTEE**

1-5, OBA AKINJOBI ROAD, IKEJA, LAGOS. P.M.B. 21005, TEL:01-4710670  
www.lasuth.org. E-mail:dcst@lasuth.org

## **Appendix 7: Literature Review Search Strategy**

The following databases were searched in the different combinations of keywords below.

**Databases Searched:** Scopus, PubMed, Embase, PsycInfo, CINAHL including Citation searching of included papers and hand searching of journals

### **Keywords for MSM papers**

1. “MSM” OR “men who have sex with men” OR “gay” OR “homosexual” OR “bisexual” OR “bi-sexual” OR “homo-sexual”
2. “HIV” OR “AIDS”
3. “Africa” OR “sub-Saharan Africa” OR “SSA” OR “West Africa” OR “North Africa” OR “South Africa” OR “East Africa” OR “Nigeria”
4. Benin OR Botswana OR “Burkina Faso” OR Cameroon OR Congo OR Ethiopia OR Ghana OR Guinea OR “Ivory Coast” OR “Cote d’Ivoire” OR Kenya OR Lesotho OR Malawi OR Madagascar OR Mauritius OR Mozambique OR Namibia OR Niger OR Rwanda OR Senegal OR “Sierra Leone” OR “Cape Town” OR Johannesburg OR “Pretoria” OR “South Africa” OR Swaziland OR Tanzania OR Togo OR Uganda OR Zambia
5. “Access” OR “Utilisation”
6. “Healthcare services”
7. “Adherence” OR “Compliance”
8. “Antiretroviral” OR “ARV” OR “ART” OR “HAART”

## Appendix 8: Pen Portraits

### OLU

Olu is a 21-year-old, single man who self identifies as homosexual. He reported that being both MSM and HIV positive in Nigeria is terrible because the society and family perceive HIV to be more severe than it actually is. Personally, he reported that being HIV positive has not been easy for him. He tested positive in July of 2014, 4 days before his birthday after he began experiencing HIV symptoms. According to him, he initially felt bad and ashamed about his status because of the knowledge he had from being a peer educator. He had all the knowledge of how HIV can be transmitted and did not expect his test result to return HIV positive. A lot of thoughts including how he was going to disclose to his family who already knew he was gay and how long he would have to take ARVs kept running through his mind.

Although Olu had started having feelings for men since he came to the realisation that he was physically a man and when he was younger, he narrated that he started having gay sex when he graduated from secondary school. Olu mentioned that he experienced a lot of discrimination and homophobia from his family. He narrated how his family found out about his sexuality. His aunt who lived in the United States wanted to adopt him and bring him to the United States to live with her and so she applied for a visa for him. He carelessly used the same email for his Facebook, for the visa application process and so when the embassy sent him an email to him, his aunt who had access to his email discovered offline messages his lover had sent him. She was very upset about this discovery and told his family in Nigeria.

His mum and grandmother were equally upset and took him to church for deliverance. After this they decided he would not go to the university instead he would learn a craft so that he could be near home. He wanted to learn how to be a hairdresser but his family considered hairdressing feminine and so he was taken to a printing press to begin work. He was made to dispose of his feminine clothes and his phone was seized from him. For two years he had no contact with his gay network. When the situation had died down, he took his grandmother's phone and was browsing on gay sites. His sister caught him and reported him to his grandmother. Shortly after, his family called a meeting and decided to send him out of the house till he repented. Olu reported that it was at the time the research was taking place that he had been accepted back into the house.

According to him, society sees MSMs as demon possessed and bewitched and as people who do not deserve to live and as such they are neglected and their human rights are seriously infringed. Going to access treatment in a public hospital, an MSM would be met with discrimination and stigmatisation which prevents him from opening up and telling the health professional about his problems. As an MSM living with HIV in Nigeria, Olu said what is most needed is acceptance because no parent wants to hear their child is gay, the community doesn't want to hear and religion and the law are against it.

### LUCAS

Lucas is a 27-year-old single man, who self identifies as bisexual. He tested positive for HIV in 2013. He reported being shocked and devastated by his positive test result because he had always been healthy. To him being HIV positive was a death sentence and so he quit his job at a hotel so he could prepare to die. He reported that whenever he talked to any of the health counsellors about his status he would immediately breakdown and cry. It wasn't until one of the counsellors who was just a few years older than him encouraged him by telling him how he was also living with HIV and was still healthy despite not being on treatment that he regained confidence in himself.

According to him, he was placed on ARV immediately and shortly after starting ARV, he began to experience terrible side effects. His family assumed he had been poisoned and decided to take him to the village to a traditional healer where he stayed till the reactions went away. While he was at his hometown receiving traditional treatment, he stopped taking his ARVs completely. On getting back to Abuja, he was told that the side effects were as a result of the ARV drugs and not poisoning. He was placed back on ARVs and started eating healthy and taking better care of himself. He reported that he still experienced side effects although they were not as severe as the first time. Since he started taking the drugs he has been very healthy and hasn't been to the hospital except for a surgery, which was unrelated to his HIV infection.

He narrated that he sometimes got tired of taking his treatment due to drug fatigue but whenever he got tired he would remind himself that as long as he eats and drinks water everyday he should be able to take his medication everyday to stay alive. Growing up, Lucas had a strict Christian mother who made him stay away from females and even sent him to an all boys' boarding school. It was at the boarding school he developed an attraction for the same sex. He tried to curtail his attractions and even went for deliverance but the more he prayed and fasted, the greater his attraction for the same sex got. Even though he wished to one day be 'delivered' of his sexuality, which he saw as deviant, he eventually came to terms with it.

Because he lives a very discreet life, Lucas reported that he hadn't experienced stigma, discrimination or homophobia. He recalled an occasion when he first moved to the city. He was walking on the road when a car pulled up to him and an older man asked him to get in. He got into the car and was carried away by the air conditioning, the smell of the man's perfume and the several promises the man made to him. After a night out and drinking for the first time, the man took him home and had sex with him. All Lucas could remember was the pain he felt when he woke up.

According to Lucas, being MSM in Nigeria is not easy because they have to live a completely discreet life and change their dressing, which for him is a major form of expression. He reported that as an MSM in Nigeria he has to be very careful to avoid embarrassment because if anyone finds out about his sexuality, stigma, discrimination and homophobia would follow, no one would want to remain friends with you and even his MSM brothers would want to stay away from him. According to him, the Nigerian government doesn't care about HIV positive people and most of the funding for HIV comes from the US government. Life is especially difficult for MSM who are HIV positive, especially if they don't have a job or they have been sent out of the house by their parents. Even when they have been placed on ARVs they still struggle because they have no place to sleep at night. Lucas reported that he uses ARVs to manage his illness and doesn't take herbs or recreational drugs. In terms of access to treatment, he reported that although he has constant access to HIV treatment at ICARH, sometimes there are no treatments for comorbidities and other opportunistic infections readily available. In terms of utilising his treatment, he mentioned that sometimes he forgets to take his ARVs but eventually when he remembers he takes it and if he misses the time, he just takes it the following day. He mentioned that the support group that helped him get through his sad phase when he was newly diagnosed was stopped due to lack of funds, but should be restarted because it was a place people like him could draw hope and encouragement from.

## HASAN

Hasan is a 35-year-old, separated man who self identifies as bisexual. At the age of 5, Hasan was raped by his mother's brother. He was quite effeminate when he was younger and often wondered if this was why his uncle took advantage of him. After the horrible rape incident, his curiosity grew and he began to explore this part of his sexuality.

He first fell ill when he went home to visit his family. He initially thought it was malaria or the change of environment but when he got back home he got tested and was confirmed positive for HIV. When he was told his result he pretended to have accepted it until he got home, where he reported that he broke down and cried. He was utterly devastated because he believed he was going to die since he was infected with HIV. He took his children to get tested and was relieved to find out that they weren't HIV positive.

Hasan had children out of wedlock with his girlfriend who he loved; however, his parents did not permit him to marry her because of cultural and family issues. He ended up getting married to a woman from his tribe who he was unable to have children with. She later left him because she could not have children with him and could not stand the fact that he was on ARVs. According to him, his one regret in life is becoming HIV positive and he often wishes he could change his status.

He feels alright about his sexuality although he has to hide it from his church members. He tries as much as possible to hang around his heterosexual friends in order to mask his sexuality. He narrated that his greatest fear is that one day as he is ministering on stage someone from his past would point him out to be homosexual. According to him, life as an MSM in Nigeria is taxing. This is because MSMs are often brutalised, lose their friends, isolated from society, family and lose their job because of their sexuality. He stated that being HIV positive in Nigeria makes it difficult to get someone to marry especially if the person is not HIV positive as well. In addition to this, HIV positive individuals face discrimination at health centres and are treated poorly.

He commenced ARVs in 2015 because his CD4 count had decreased and he had developed liver problems. According to Hasan, major issues MSMs face include coming out of the closet and identifying themselves as gay as well as discrimination and stigma which often lead to psychosocial and psychological trauma, mental illness and STIs. He stated that MSM want to be accepted in their country so they can come out of the closet without fear and without feeling threatened about their future, welfare or wellbeing.

He recounted an incident when he was arrested because he was blackmailed by a fellow MSM. He had to bail himself out and relocate to a place where no one knew him because of the shame and embarrassment he encountered. Although Hasan engaged in transactional sex in the past but no longer engages in it, his motto remains "no condom, no sex".

He uses ARVs and Septrin to manage his HIV and does not use traditional treatment. He referred to himself as sexually hyperactive and as such doesn't need or use performance enhancement. He formerly injected drugs and often smokes marijuana to escape from his reality. He occasionally smokes cannabis and cigarettes and takes codeine but keeps it to a minimum to stay healthy for his children and boyfriend.

At the time of the interview, Hasan accessed his treatment from Population Council (PC), although he stated that he initially accessed treatment at Mushin General Hospital, a government run hospital. His challenges accessing drugs include timing and distance to the health facility. In terms of using treatments, he mentioned that the first time he took the treatment he felt very weak, he also felt like he would pass out and he developed rashes on his body. He was encouraged by health workers at PC and told that the side effects were normal. In order to adhere better to his ARVs and also prevent stigmatisation, he repackages his ARVs.

## ARINZE

Arinze is a 29-year-old, single self-identified homosexual man of Hausa descent. At the time of the interview, he was unemployed and engaged in transactional sex in order to sustain himself. Arinze described his sexuality as an innate part of himself and as being incessant in his blood. Growing up and till date, Arinze had always been drawn to activities considered 'feminine' for example, he enjoyed dressing his mum and sister up and sometimes even dressing up in their clothes. Although his family had always noticed these effeminate characteristics, his older sister, who he reported was his confidant was the only family member that he disclosed his sexuality and HIV status to. His other family members found out because he would always bring his gay friends home and some of them were effeminate.

Arinze, was one of the participants who did not know that HIV could be contracted through anal sex, he believed it could only be contracted through sex with a female and so when he tested positive, he refused to believe the result. He retested several times but was in denial and even when his friend who was also HIV positive told him to start antiretroviral treatment (ART), he refused because he did not believe he was HIV positive. When he eventually considered starting ART, he was worried about how he would keep his drugs safe as he lived with his mother at the time. He believed he did not have enough privacy in his home because of his brother, who he described as being inquisitive.

Not long after Arinze started experiencing the symptoms of HIV in the form of rashes, headaches and discharge from his body. It was not until his HIV had developed into AIDS that he made the decision to start treatment. He went to ICARH, where he was counselled about starting ART including the management of his diet. He was also advised to quit smoking and drinking on order to improve the efficacy of the treatment. He reported that he found the initial stages of his treatment regimen difficult and experienced visible side effects that caused his family members to ask questions about his health. He was unable to disclose his HIV status to them because he feared that they would be unhappy and may throw him out of the house.

## JOE

Joe is a 27 year old, single man of Ibibio descent who self identifies as bisexual. He tested HIV positive in 2014 and was placed on ART after counselling and running several tests on him. When he tested HIV positive he was in denial and tried to commit suicide. He was adhering to his treatment and his CD4 count was increasing while his viral load was decreasing until one day the organisation was unable to continue supplying him with the drugs and had to change to a cheaper brand. He reported that he stopped tolerating the new drugs and it affected his liver, soon he started falling ill and had to stop the drugs completely. Joe reported that he now has to live without being on the drugs and fears for his life. He desperately wants to be placed back on his life saving treatment as soon as possible.

For Joe, being MSM in Nigeria is not fun because of the punitive laws and because MSM often have to live a stealth life and in fear. He recounted an experience of intragroup stigma or Kito as he called it, where a feminine gay man he had brought to the clinic took his phone and did not want to return it. The man then raised alarm and told people in the area that Joe wanted to have sex with him and he refused. People in the area then gathered and began beating him up, ashamed of the situation he had to leave the place immediately. He reported that whenever he goes to church and hears the sermon, he feels self stigma but then reminds himself that he works in an organisation that serves people like him who are innocent and not causing any harm.

Because he is not feminine, he is able to cover and pass as heterosexual and so he is able to hide his sexuality. But when he wants to start afresh, he usually relocates to somewhere he is not known. He tries to keep his distance from his feminine friends when they are out so that they don't give his identity away.

He disclosed his HIV status to his family, so that they would protect themselves but his brother started acting funny towards him. Frustrated about this he packed his bags and moved out of the house and till date he hasn't gone back. He expressed that he felt that because of the government and the disparity in education levels in Nigeria, the more educated people tend to understand the plight of HIV positive people in their community, while the less educated ones don't want to draw close to anyone who is HIV positive.

When he was younger his friends always taunted him for being soft like a woman. When he finished secondary school he started working with a man who would later become his lover. The man liked him so much he asked his mum to permit him to live with him and his wife. The first time Joe moved in, his boss came into his room and started touching him, confused at what was happening he asked him to stop. It was his boss who explained to him what being gay entailed and soon after the love triangle between Joe, his boss and his boss' wife began. With this new knowledge and experience, Joe started meeting other gay men. Till now he has only disclosed his sexuality to his sister, girlfriend and the healthcare workers at Population Council (PC).

Joe uses ARV and Septrin to manage his illness and does not take herbs because it is not good for patients with hepatitis and he doesn't like it. He drinks alcohol occasionally and especially when he is on the field recruiting clients. He also smokes marijuana and cigarettes. He accesses his treatment from PC which is much easier for him and doesn't go to the general hospital because of the discrimination, long waiting times and the amount of people at the hospital. The only challenges he faces accessing treatment is his comorbidity, hepatitis that stops him from resuming ARVs. He has no challenges using his ARVs, which are provided free of charge. However, his challenges adhering to the drugs are the size of the pill and the few side effects he has at the beginning. Joe plays the top (insertive) role in sexual intercourse and refrains from the bottom (receptive) role because of the pain.



## Appendix 9: Supplementary Section

### MSM Codes

MSM in this study had formed a brotherhood, a sort of support system. Together they were a group of men with similar interests and among whom they could be completely free to express themselves. Across the FGDs and interviews, majority mentioned that they had found solace in the company of these men who like themselves are marginalized from society. There was a sense of community so strong, that upon entering their space and interacting with them it could immediately be felt. The men had formed family units in their various communities and had older MSM who they referred to as ‘mothers’ and these mothers in turn referred to them as ‘daughters’. In the Lagos FGD, I was introduced to ‘Iya Bariga<sup>47</sup>’ who was an older MSM that was responsible for the welfare of her daughters, the MSM who were FGD participants. During the discussion, they often used feminine pronouns when speaking about themselves or referring to others.

Among themselves, they had developed coded lingo, which was known and understood only by members of their ‘community’. Keeping these codes confidential was particularly important to the men because it meant that they were able to discuss issues about their personal lives in the presence of outsiders without risking disclosure. Keeping these codes confined to their circles was so important to them that when I inquired about some of these codes and their meanings one FGD responded, “*That is our own language, we don’t bring it out*” (Boye, Abuja FGD2). It wasn’t until I started mentioning some of the codes I had picked up while building rapport with participants that they began to divulge these codes/slangs.

One of the popular slangs which has been used throughout the findings chapters, is ‘TB’. ‘TB’ literally means ‘top/bottom’ and is used to identify MSM in general. Another popularly used slang for MSM is ‘Sagba’ and although the origin of this slang was unclear among participants, it was generally understood to be used everywhere in Nigeria. Adamu stated that “*when you are in public, you say gay, people will understand what you are saying but when you say sagba or TB, it is between us...even if an outsider is there he will not understand what we mean by TB or sagba*” (Adamu, Abuja FGD2). Another participant mentioned that MSM that reside in the part of the

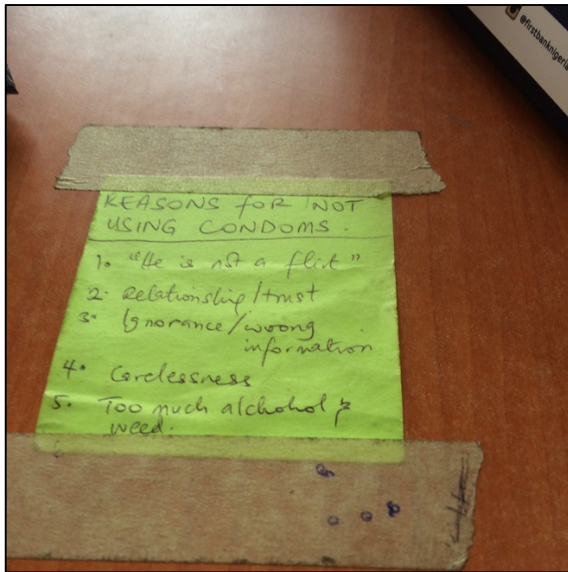
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<sup>47</sup> Iya Oshodi is Yoruba and translates loosely to ‘Mother of Oshodi’.

country he is from did not use 'TB' because it was already widely known and as a result, were at risk of being blackmailed. Rather than 'TB', 'Langwa' was used when talking in public. Other slangs mentioned by participants were 'throw your weave-on' and 'shele', which were both used to describe men who behaved in what was considered to be conventionally feminine; 'market', 'oja' and 'runs', were used to describe transacting sex; 'pasero', was used to describe older prominent men who sought sex with them; and 'shenke', was used to describe their boyfriends'. Generally, these codes were not restricted to a geographical space in Nigeria but were used in different states as long as MSMs were present.

There were also slangs for those who had gotten infected with HIV. One which participants mentioned was 'balance and take'. According to one participant, "*when you just mention 'balance and take' they (the MSM) will just understand ...you will just say, 'ah, he don get balance and take', instead of to call the name because of the straight people there, they would not even understand*".

## Appendix 10: Awareness Materials



(Left-Right) The picture on the left is a list of reasons clients had given the doctor for not using condoms. The picture on the right is an HIV and STI prevention brochure developed by the Population Council; it is geared towards MSM populations but cannot be found outside of their premises.

## **Appendix 11: Conference Attendance and Publications**

### **CONFERENCES**

- ScHARR PGR Conference June 2015
- ScHARR PGR Conference May 2016
- 1<sup>st</sup> ScHARR Global Health Forum  
2015 November
- Qualitative Health Research Conference, Quebec City, Canada  
2017 October
- ICASA 2017, Cote d'Ivoire  
2017 December

### **PUBLICATION**

- Queer in Africa Book Chapter Contribution

