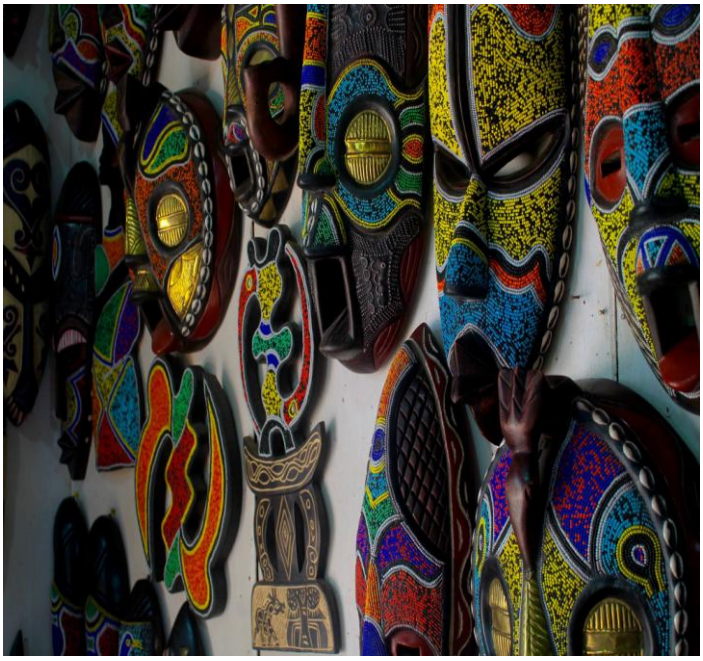


Understanding the Barriers and Facilitators across the HIV Continuum of Care Among Key Populations In Ghana.

REPORT

KEY POPULATION IMPLEMENTATION SCIENCE STUDY, GHANA, JULY 2017

NACP
NATIONAL AIDS CONTROL PROGRAMME

GHANA HEALTH SERVICE
Your Health · Our Concern

CDC

Table of Contents

Content Page

List of tables

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti- Retroviral Therapy
ARVs	Anti-Retrovirals
CCE	Community Capacity Enhancement
CDC	Centre for Disease Control and Prevention
CHRAJ	Commissioner for Human Right and Administrative Justice
DIC	Drop In Centre
DOVSU	Domestic violence Victim Support Unit
FGD	Focus Group Discussion
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GHS	Ghana Health Services
HEO	Health Education Officer
HIV	Human Imuno Deficiency Syndrome
HTC	HIV Testing and Counselling
IDI	In-Depth Interview
IBBSQ	Integrated Biological and Behavioral Surveillance Questionnaire
JHS	Junior High School
JSS	Junior Secondary School
MARPs	Most-At-Risk Populations
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NACP	National AIDS/STI Control Programme
NGO	Non- Governmental Organization
NHIS	National Health Insurance Scheme
NSP	National Strategic Plan
KII	Key Informant Interview
KPs	Key Populations
KPIS	Key Population Implementation Science
PA	Physician Assistant
PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
SOP	Standard Operating Procedure
SHS	Senior High School
SSS	Senior Secondary School
STI	Sexually Transmitted Infection
WAPCAS	West Africa Project to Combat AIDS and STI
WHO	World Health Organization

ACKNOWLEDGEMENTS

The National AIDS/STI Control Programme, Ghana Health Service wishes to thank all who in diverse ways made this possible. Special thanks goes to all respondents especial KPs, GHS staff and NGO staff without whose participation this would not have been possible. We are also highly indebted to all persons who were actively involved in data collection, cleaning, and analysis. Without the leadership of the respective facilities and institutions this exercise would not have been possible. We therefore commend them for their coordination and supervisory role.

The development partners such as the, CDC, GAC, UNAIDS deserve commendation for their technical assistance and coordination. The Director General of the Ghana Health Service, Ministry of Health and relevant divisions provided the needed leadership and support to the NACP staff for the timely execution of this very important assignment.

I wish to commend the following under-listed persons who formed the core team for the exercise.

Dr Ernest Kenu	Co-ordinator, University of Ghana, School of Public health
Margaretta Gloria Chandi	University of Ghana, School of Public Health
Mr. Daniel Kwablah	MICKDAK
Mrs. Comfort Asamoah	WAPCAS
Dr. Celia woodfill	CDC Ghana
Trista Bingham	CDC Alanta
Ijeoma Ugonna	CDC Alanta
Mr. Silas Quaye	CDC Ghana
Dr. Akosua Baddoo	National AIDS/STI Control Programme
Ms. Marijanatu Abdulai	National AIDS/STI Control Programme
Ms. Victoria Dafeamekpor	National AIDS/STI Control Programme
Mr. Francis Frimpong	CDC Ghana

Dr. Stephen Ayisi Addo
Programme Manager
National AIDS/STI Control Programme

Understanding the barriers and facilitators across the HIV continuum of care among Key Populations in Ghana.

Executive Summary

Background: Key Populations (KPs) face unique barriers in HIV diagnosis, linkage to and retention in HIV care and treatment at each stage of the HIV continuum of care. These lead to sub optimum care, poor long-term health outcomes and the inability to achieve national targets in the control of HIV/AIDS. This Key Population Implementation Science (KPIS) study sought to assess client-level barriers and facilitators to HIV testing, enrollment, and retention in HIV care and treatment among Female Sex Workers (FSW) and Men having Sex with Men (MSM) in Accra and Kumasi. It also examined the service-delivery barriers and facilitators that impact the provision of accessible, acceptable, and sustainable services across the HIV continuum of care to KPs.

Methods: A descriptive, cross-sectional study employing mixed methods approach was used for this study. The settings were Kumasi and Accra. Participants were KPs, NGOs and Ghana Health Service (GHS) staff. KP participants were those who self-identified as either FSW or MSM and were 18 years of age or older and had consented to participate in the study. KP participants were stratified into users and non-users of HIV services and either HIV positive or negative/status unknown. For the qualitative study, FGDs were conducted for FSW, MSM and NGO staff. Key Informants Interviews (KIIs) were also conducted for MSM, FSW, and GHS staff. The quantitative study targeted 80 randomly selected GHS staff who were either clinicians or administrative staff in 6 health facilities in the 2 Metropolis. Rapid Assessment summaries and thematic analysis were used in analyzing the qualitative data. The quantitative data was entered into Epi Data™ (version2.0.8.56) and analysed in stata (version 13.0).Triangulation of the quantitative and qualitative data was done resulting in a synergized report without falsifications.

Results: A total of 80 respondents participated in the quantitative study. The socio demographic results of the quantitative study showed that majority, 32 (40.5%) were between 30-39 years of age with a mean age of ± 36.8. Females formed the majority (76.2%). They were made up of Pharmacists 38(47.5%), prescribers 15 (18.8%) who were either working as Medical Officers (doctors) or Physician Assistants (PAs). Nurses were 13 (16.3%) and data/research officers 7 (8.7%). Majority 24 (30.0%) of the GHS staff had worked for between 1-4 years and 21 (26.2%) for more than 14 years.

Two Hundred and Eighty - Eight (288) participants took part in the qualitative study. They were made up of FGD (198) and IDI (90). The sexes of the participants were as follows: FGD – (females 97 and males 101); IDI - (females 47 and males 43). Their ages ranged from 18 to 52 with majority (166) of them falling within the ages of 18 -29. Singles (213) were in the majority whilst 127 were either in JSS or SSS as compared to 93 with tertiary education.

Results from the quantitative study on respondents awareness of health workers unwillingness to attend to FSW and MSM, the results showed that majority, 66 (82.5%) and 65 (81.3%) of the respondents have in the past one month never experienced a health worker unwilling to attend to FSW and MSM respectively. Only 14 (17.5%) and 15 (18.7%) of respondents have experienced a health worker unwilling to provide service to FSW and MSM respectively. Similarly, majority, 63 (78.7%) and 58 (72.5%) of respondents have never experienced a health worker rendering poor quality of service whilst 17 (23.3%) and 22 (27.5.%) of the respondents indicated they have experienced a health worker render poor quality of service to FSW and MSM respectively. Results from the qualitative interviews indicated that KPs prefer to access services from facilities where they can get all the services under one roof; from well-trained friendly service providers who ensure privacy and confidentiality. They prefer focused services from one person who will attend to all their needs including dispensing of medications. The quest for confidentiality will drive KPs to travel far and avoid being seen by familiar faces when accessing HIV services. This also explains their preference for NGO services over GHS services. Prompt and judgement free services from competent staff also facilitate KPs' access to HIV services. Branding of service delivery area as ART centre and use of standalone visible centres purposely for HIV services served as a barrier to KPs. Some Peer Educators across Kumasi and Accra were perceived to be preaching and practicing vice. Nonetheless, the FSW in the 2 metropolis trust their "sisters" and are willing to confide in them. Lack of money and food, pill load and pill fatigue coupled with herbal and spiritual claim for HIV cure were also found to be barriers. Self-stigmatization and stigmatization from health workers and other patients hindered KPs enrolment and staying in consistent care. Frequent shortages of medicines, no NHIS enrolment for KPs, high cost of services especially laboratory and medications were also reported as barriers. Poor staff attitude towards KPs also stood out as a barrier.

Conclusion: KPs cherish privacy and confidentiality, a perceived breach in these factors; become barriers to accessing, enrolling, and retention in HIV treatment and care. Health workers believe KPs are entitled to good quality health care as other clients though there was the general belief that their acts may be immoral and unacceptable. Sigma and discrimination, financial challenges, fear of losing job, pill load/medication fatigue, Side effects of ARVs, were some of the client level barrier. While shortage of HIV commodities, long waiting time by KPs and desire for spiritual /traditional healings came out as service delivery barriers. Providing HIV care in quiet and private "one stop shops" sites would enhance and facilitate KPs access to health care. The need for discretion in dealing with KPs and their partners by service providers cannot be overemphasized in this study. It is time for GHS to review the policy on the need for a treatment monitor for HIV positive clients. Peer educators could be assigned instead of relying on people who are familiar to the KPs.

Recommendation

1. The Ghana Health Services should consider sensitizing health workers to take history on sexual orientation of clients with STIs and HIV to be able to offer them the specialized care they require.
2. The Ghana Health Service should organize training on stigma reduction towards MSM and FSW for health workers.
3. The Ghana Health Service should implement policies that will ensure that KPs access their services in a "one stop shop".
4. NGOs should recruit credible peer educators who would not engage in sexual relations with their clients and also apply sanctions to those who go against this rule.
5. Both the GHS and the NGOs should apply rewards and punishments to ensure privacy and confidentiality are adhered to in their facilities.
6. Ghana Health Services should intensify outreach and home visiting services to KPs.
7. The Ghana Health Service and NGOs should intensify education on NHIS and also encourage KP enrollment on the NHIS.

1.0 Background

Ghana is experiencing a mixed HIV epidemic characterized by a relatively low prevalence in the general population and a high prevalence among key populations (KP). The 2013 national HIV prevalence was estimated at 1.3% (GHS NACP, 2013) compared to 11.1% and 17.5% among FSW and MSM, respectively (Ghana AIDS Commission 2012; Ghana AIDS Commission 2011; Ghana Ministry of Health, 2011). Data from the 2011 Integrated Biological and Behavioral Surveillance Questionnaire (IBBSS) indicate high HIV prevalence among KPs, many of whom reside in urban areas. In the Greater Accra region16.3% of FSW and 34.3% of MSM tested HIV positive, while in the Kumasi region, 13.0% of FSW and 13.6% of MSM tested HIV positive (Ghana AIDS Commission 2012; Ghana AIDS Commission 2011; Ghana Ministry of Health, 2011).

1.1 HIV continuum of care among Key Populations

Given the disproportionate burden of HIV infection among KP compared with the general population in Ghana, it is essential that HIV services are more accessible and better utilized among both FSW and MSM to reduce HIV transmission. Unfortunately, in Ghana and in other countries experiencing mixed or concentrated HIV epidemics, KP face unique barriers at each stage of the HIV continuum of care. These barriers lead to suboptimal outcomes for HIV diagnosis, linkage to and retention in HIV care and treatment – all of which contribute to poor long-term health outcomes and the inability to achieve epidemic control.

1.2 Routine HIV testing among KP to promote early diagnosis

Infrequent HIV testing and late diagnoses among FSW and MSM are common, making timely entry into HIV care and treatment a challenge. Among all MSM enrolled in the 2011 IBBSS, only 19-27% reported having a test (and receiving their results) in the past year. Furthermore, 94-97% of MSM found to be HIV positive reported that they had never previously been tested and were unaware of their status (Ghana AIDS Commission 2012; Ghana Ministry of Health, 2011). While FSW appear to have more frequent testing behaviors, there remains room for improvement. Sixty percent of Ghanaian FSW (Accra 73.7%; Kumasi 65%) reported ever testing, while only 40% reported testing in the past year (Ghana AIDS Commission 2011).

1.3 Linkage to and uptake of HIV care and treatment

Very little data exist on the linkage and uptake of HIV care and treatment among key populations. The most recent IBBS questionnaire found that in Accra/Tema, 72.7% (8 of 11) of HIV-positive MSM who knew their status reported being in care while 45.4% (5 of 11) reported being on ARVs. In Kumasi, 40% (2 out of 5) of HIV-positive MSM who knew their status reported being in care while 100% (5 out of 5) reported being on ARVs (Ghana AIDS Commission 2012; Ghana Ministry of Health, 2011). These are the only existing data on care and treatment utilization patterns among HIV-positive MSM in

Ghana. The strength of these results are limited however by extremely small sample sizes and highlight the importance of obtaining a deeper understanding about HIV utilization patterns among KP for future program development. Similar HIV service utilization data for FSW are available but have not been analyzed (Ghana AIDS Commission, 2011). Understanding more explicitly the existing HIV programs and the aspects of service delivery that are associated with better health-seeking and health service utilization behaviors is essential for future HIV program development and the long-term wellbeing of FSW and MSM in Ghana.

1.4 KP-specific interventions

In response to the many barriers key populations face in accessing HIV services, the number of evidence-based interventions is increasing for improving linkage to and retention in HIV care and treatment services. Such programs include peer navigation, strengths-based case management, and drop-in centers (DIC) (PEPFAR, 2014). These types of programs have shown promise for engaging KP compared with more traditional methods of outreach and referral.

In 2011, Ghana developed a four-year National Strategic Plan (NSP) for Most-At-Risk Populations (MARPS): Leveraging a Public Health Approach for Universal Access. This NSP was exclusively focused on expanding access to HIV services for KP with its aim to reach 80% of all key populations by 2015 with a comprehensive package of HIV prevention, care, treatment, and support services that are evidence-based, accessible and acceptable to KP. These programs include community-based services such as peer education and mobile outreach; condom and lubricant distribution and sales; and mobile- or Internet-based services to provide counseling and other services (e.g., "Text me! Flash me! Call Me!" Helpline, mHealth) (MARITIME, 2013; MEASURE Evaluation, 2014). In 2013, 12 organizations were identified for an evaluation of HIV prevention services to FSW and MSM in Ghana (MEASURE Evaluation, 2014). Current interventions aimed at improving access to health services include increasing screening, testing, and referrals for HIV and STI diagnosis and treatment; developing KP-specific drop-in health centers; building skills of Ghana Health Service (GHS) HIV service providers for KP clients; and revising and training health staff on National STI Guidelines and the 2014 Standard Operating Procedures (SOPs) for HIV programming specific to KP. Additional efforts are underway to reach additional FSW sub-populations including young FSW, high-risk women who don't self-identify as FSW, as well as new MSM networks via social media/Facebook/Internet sites and through brothels and pimp networks (MARITIME, 2013).

2.0 Rationale

Concentrating HIV prevention and treatment activities on those with the highest HIV burden is likely to reduce HIV transmission more rapidly than targeting prevention

activities to the general population (Baral, et al., 2012; Kerrigan, Fonner, Stromdahl, & Kennedy, 2013). Given the disproportionately high burden of HIV among FSW and MSM, the Ghana AIDS Commission (GAC) and its partners have focused their efforts to bolster HIV prevention, care and treatment activities for key populations in recent years. Recently, GAC expanded its national efforts to assess the quality and reach of HIV *prevention* programs for KP (MEASURE Evaluation, 2013). Less has been done to comprehensively assess HIV *care and treatment services* for KP after an HIV diagnosis despite the NSP's recent emphasis on reaching KP with comprehensive services. Monitoring HIV-positive KP across the HIV continuum of care is a major concern given Ghana's lack of a national system that tracks individuals who test positive for HIV. The lack of capacity to monitor patients makes it difficult to identify gaps at each stage of the HIV continuum of care and requires labor-intensive efforts to maintain KP engagement in HIV service uptake.

In response to this gap in understanding, this formative phase study was designed to collect the necessary information for the development of an effective and efficient implementation model that improves the quality and coverage of HIV services for key populations in Ghana. Results from this formative study will inform future strategic planning and the implementation of HIV programming for KP in Ghana. Phase 1 will evaluate barriers and facilitators of service delivery along the *HIV continuum of care,* which includes diagnosis, linkage to and retention in care, as well as access and adherence to ART. Since NGOs and GHS facilities are the primary routes for delivering HIV services to KP, the study will include NGO staff, GHS clinicians, and GHS administrators as study participants.

3.0 Study objectives

For Phase 1 of this Key Population Implementation Science project, our objectives are:

1. To qualitatively assess client-level barriers and facilitators to HIV testing, enrolment, and retention in HIV care and treatment among FSW and MSM in the Greater Accra and Kumasi metropolitan areas; and

2. To qualitatively and quantitatively assess service-delivery barriers and facilitators to providing accessible, acceptable, and sustainable services across the HIV continuum of care to FSW and MSM in the Greater Accra and Kumasi metropolitan areas.

4.0 Methods

A descriptive, cross sectional study employing the mixed methods approach was used. Please refer to figure 1 for the conceptual framework on the study design. The settings were Kumasi and Accra. Participants comprised KPs, NGO and Ghana Health Service (GHS) staff from six randomly selected health facilities across Accra and Kumasi.

For the qualitative study, FGDs were conducted for FSW, MSM and NGO staff. Key Informants Interviews (KIIs) were also conducted for MSM, FSW, and GHS staff.

Study population: Thirty (30) each of MSM, FSW, and 15 each of NGO and GHS staff from the selected health facilities were engaged in IDIs.

Recruitment and Eligibility: FSW and MSM were recruited to participate in the study through multiple techniques including recruitment by peer educators, NGO and GHS staff, and word-of-mouth through other study participants. Peer educators played a key role in advertising the study to the FSW and MSM communities. Peer educators were trained specifically to conduct outreach to FSW and MSM who have not previously accessed NGO services and encouraged them to take part in the formative research to share insights about how to encourage more KPs to access available services. The peer educators also encouraged non-service users to refer their social network members to increase the potential to enrol those not affiliated with NGO services.

Key Populations: Potential KP participants were those who self-identified as either FSW or MSM and were 18 years of age or older and had consented to participate in the study. The KPs were expected to have lived in either Accra or Kumasi for a minimum of 12 months. Being users or non-users of HIV services, and being either HIV positive, negative/status unknown were included in the eligibility criteria. The quantitative study targeted 80 randomly selected GHS staff who were either clinicians or administrative staff in the 6 health facilities in the 2 Metropolis.

NGO staff: Prior to the launch of the study, an informational meeting was held with the directors/head administrators of the NGO sites to describe the study and request support. The director/head administrator informed their staff about the study and elicited volunteers. Staff from the NGOs who were interested in participating were provided with the name and phone number of the study research supervisor. The study research supervisor assessed each person's eligibility over the phone and provided a time and location for the FGD. Consent was obtained at the beginning of each FGD. Participating NGO staff composed of program managers, administrators, or outreach workers.

GHS clinicians and administrative staff: Study staff held a meeting with the directors/head administrators (from the regional GHS sites which were purposively selected) and described the study and requested their support. The director/head administrator informed their clinical and administrative staff about the study and elicited volunteers. GHS clinicians and administrative staff who were interested in participating were provided with the name and phone number of the study research supervisor. The

study research supervisor assessed each person's eligibility over the phone and provided a time and location for the IDI.

For the quantitative self-administered questionnaire, GHS participants were approached in person by study staff and requested participation. A convenient date was set for administering the questionnaires at each facility. Separate consents were obtained at the beginning of each data collection activity (i.e., IDI or questionnaire). Subsets of GHS staff were enrolled in both IDI and self-administered questionnaires. There was no restriction to being involved in both. All six selected GHS facilities were contacted for participation in both IDIs and quantitative data collection components.

The GHS healthcare providers composed of clinicians such as doctors, nurses, pharmacists, physician assistants, laboratory personnel and administrative staff such as frontline individuals who register patients during their first visit or other staff such as data managers or health insurance staff who had substantial interactions with new patients.

NGO and GHS participants were eligible if they were currently employed at one of the participating sites, had been working at the selected site providing HIV services for greater than one year, were 18 years of age or older, and were willing to give informed consent for participation.

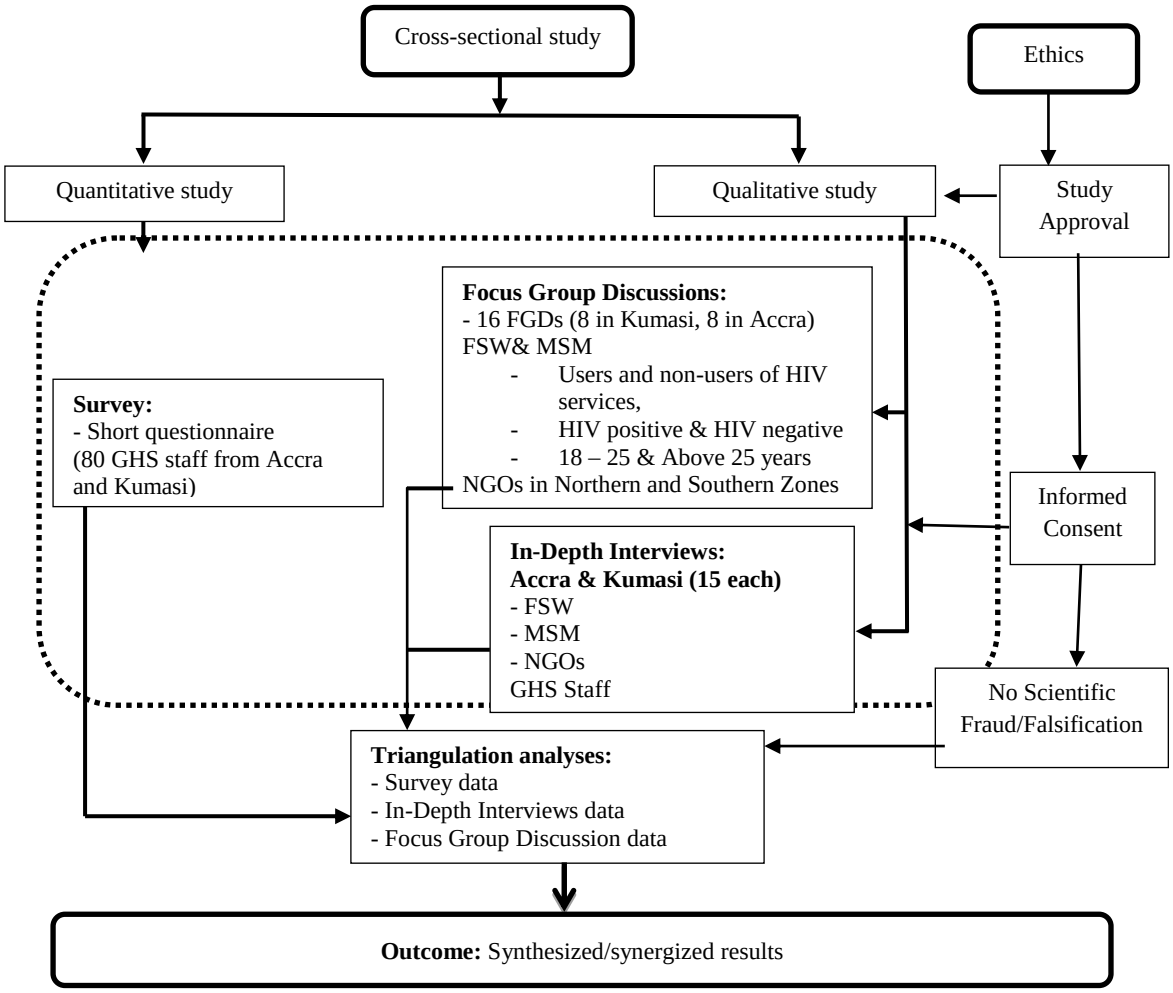
Data Collection: A mixed-methods approach that combined both qualitative and quantitative data was used to provide a more complete and comprehensive understanding of the problem. Furthermore, mixed methods allowed for triangulation of data by approaching the research question from different vantage points. By thoroughly integrating multiple perspectives from both service users and non-users, as well as from service providers across the HIV continuum of care, the data offered insights to health care usage patterns, revealed real or perceived barriers to different types of services, and drew out recommendations for improvements to HIV service delivery.

Analysis of data: Rapid Assessment summaries and thematic analysis were used in analyzing the qualitative data. The quantitative data was entered into Epi Data™ (version 2.0.8.56) and analysed in stata (version 13.0).Triangulation of the quantitative and qualitative data was done resulting in a synergized report without falsifications.

Limitations of the study: The rapid assessment summary was new to the research assistants. Despite the robust training, a few had of them had to be guided by the supervisors and study coordinator.

Delimitations of the study: This study assessed only FSW and MSM as the key populations. Other key populations such as people who inject drugs were not factored in this study.

Figure 1: Study design conceptual framework



5.0 Results

5.1 Demographic background (Qualitative)

The data for the qualitative study was taken from 24 FGDs and 90 IDIs. Two Hundred and Eighty - Eight (288) participants took part in the qualitative study. They were made up of FGD (198) and IDI (90). The sexes of the participants were as follows: FGD – (females 97 and males 101); IDI - (females 47 and males 43). Their ages ranged from 18 to 52 with majority (166) of them falling within the ages of 18 -29. Singles (213) were in the majority whilst 127 were either in JSS or SSS as compared to 93 with tertiary education. The breakdown of GHS staff who participated in the IDIs are as follows (Medical Officers 5; Nurses 11; Pharmacists 2; Administrators 3; biomedical scientists 3; Disease Control Officers 3; Accountant, Data Processing Officer and Environmental health Officer 1 each). Table 1 gives a breakdown of all the participants in the qualitative study.

Table 1 Background characteristics of the participants in the qualitative study

Characteristics	FGD	IDI
Sex		
Female	97	47
Male	101	43
Age		
18- 29	129	37
28-39	51	26
38-49	15	11
48-59	3	6
Marital Status		
Single	160	53
Married	29	20
Cohabiting	0	0
Divorced	9	17
Education		
No education	9	2
Primary	39	7
JHS/SSS	91	36
Vocational	9	2
Tertiary	50	43

5.1.1 Focus Group Discussions

A total of 24 focus group discussions were conducted, 8 each in Accra and Kumasi for Key populations (MSM and FSW) and 4 each for NGOs providing services to key populations working in the northern and southern sectors. The 8 key population FGDs in each region were sub divided into 4 FSW FGDs and 4 MSM FGDs. Of the 4 FGDs for each Key population, 2 FGDs targeted the youth (18 – 25 years) and 2, adult participants (>25 years). The 2 age groups were further divided into 1 HIV negative and 1 HIV positive group. The same classifications were used in Accra and Kumasi. Total KP participants for the FDGs were 149 comprising Female Sex Workers (80) and Men who have Sex with Men (69).

The KPs were further grouped as HIV negative (2) and positive groups (2) and were further categorized as 18 – 25 (1 each) and >25 (1 each). Table 2 and 3 depict the breakdown of participants in the FGD for the KPs and NGOs.

Table 2: Breakdown of FGD for KPs

Characteristics	**Key Population**			
	ACCRA		**KUMASI**	
	FSW	**MSM**	**FSW**	**MSM**
18 – 25				
HIV (+)	10	7	10	7
HIV (-)	10	10	10	10
>25				
HIV (+)	10	9	10	8
HIV (-)	10	7	10	9
Sex				
Female	40	0	40	0
Male	0	35	0	34
Age				
29	22	27	37	27
39	14	5	2	6
49	4	2	1	1
59	0	1	0	0
Marital status				
Single	32	27	39	32
Married	3	5	1	2
Cohabiting	0	0	0	0
Divorced	5	3	0	0
Education				
No educ.	0	6	6	0
Primary	2	7	7	0
JHS/SSS	23	26	26	22
Vocational	4	1	1	2
Tertiary	6	0	0	10

Forty – Nine (49) participants from Non-Governmental Organizations participated in the FGDs. They were categorized into administrative staff (20) and M& E staff (29). The peer educators were added on to the peer educator group. Majority of them were males (32), single (30) and within the 30 -39 age group (24). Thirty – Two (32) of them had tertiary education.

Table 3: Breakdown of characteristics of participants in FGD with NGO

	NGO	
	ACCRA	KUMASI
Category		
Admin staff	12	8
M & E Staff	16	13
Age		
18- 29	9	7
28 -39	13	11
38- 49	4	3
48- 59	2	0
Sex		
Female	8	9
Male	20	12
Marital status		
Single	14	16
Married	13	5
Cohabiting	0	0
Divorced	1	0
Education		
No education	0	0
Primary	0	0
JHS/SSS	6	11
Vocational	0	0
Tertiary	22	10

Focus Group Discussions in Accra

One Hundred and Three (103) participants were recruited for the 10 FGDs in Accra. They were KPs (75) and NGOs (28). Majority 55 were males as follows (MSM 35 and NGOs 20) whilst females were 48 as follows (FSW 40 and NGOs 8). Majority (58) of the respondents were within the 29 age range (NGO 9, FSW 27, and MSW 22). Seventy-Three (73) were married (NGO 14, FSW 32, MSM 27) whilst 55 (NGO 6, FSW 26, MSM 23) were educated up to JHS/SSS level. The main occupation for the KPs was sex work (FSW 19 and MSM 8). Others were students (MSM 7), traders (6), chef/cooks (5), unemployed and fashion designers (4 and 4) for the MSM. Other MSM occupations were dancer, hospitality industry, cosmetologist, beautician, driver and photographer. The occupations for the FSW were peer educators (6); traders (6), seamstress and hairdressing were in the minority (1 each).

The major occupation of the NGO staff was social work (10 out of 27), the rest of the occupation were peer educator, Accounting, M and E Officer, project Officer, Chef, Administrative assistants and Human Rights Advocates.

Focus Group Discussions in Kumasi

A total of 94 were recruited for the Kumasi FGDs Participants were made up of; NGO staff (20) in the Northern Zone, FSW (40) and MSM (34) based in Kumasi. Majority were females (49) within the ages of 29 for key populations and 39 (10) for NGO staff. Forty –seven of the participants were married. Majority of the key populations had primary (FSW 30) and JHS/SSS (MSM 22, NGO 11) education respectively. Nine (9) of the NGO staff and 10 of the MSM had tertiary education. The NGO staffs were made up of social workers (4), peer educators, and project officers (3 each). Other occupations were teaching (1), Public Health Worker (1) and Administrator (1). Most of the FSW (37) choose sex work as their occupation. Other occupations were student (2) and hairdresser (1). The MSM were unemployed (9), engaged in their own business (7), trader (3), students (3). Other occupations were peer educator (2), event planner (2), photographer (1), fashion designer (1), data processing officer (1) and footballer (1) among other occupations.

5.1.2 In-Depth Interviews

Ninety (90) IDIs i were conducted in the 2 study cities. Fifteen (15) participants each for GHS staff, FSW and MSM in both Accra and Kumasi.

IDIs in Accra

Forty-five (45) participants made up of GHS (15), FSW (15) and MSM (15) took part in the Accra IDI. Majority (MSM 10) fell within the 18 to 29year group whilst 7 each of the GHS staff and FSW fell in the 330 to 39 year group. They were made up of 23 females and 22 males. The key populations were primarily singles (22) whilst most (10) of the GHS staff were married. All the 15 GHS staff had tertiary education, whilst majority of the key populations were either JHS or SSS holders (8 and 9 for FSW and MSM respectively). For the GHS staff who participated in the Accra FGDs, six (6) were nurses, medical doctors (4), pharmacists (2), administrators (2) and accountant (1)

IDIs in Kumasi

Forty – five (45) individuals made up of GHS staff (15), FSW (15) and MSM (15) were interviewed. They were 23 females and 22 males Ages ranged from 18 to 52 with majority (21 and 17) of the participants being between the ages of 20 – 29 and 30 – 39 years respectively. Majority of the Key Populations were single (FSW – 12 and MSM – 15) whilst (5) of the GHS staffs were married. All the 15 GHS had attained tertiary education whilst the key population were mainly JHS/SSS holders (FSW -11, MSM- 8). Table 4 provides a breakdown of the IDIs in Accra and Kumasi.

Table 4: Breakdown of IDI for Accra and Kumasi

ACCRA				KUMASI		
TARGET	**GHS**	**FSW**	**MSM**	**GHS**	**FSW**	**MSM**
Age						
18-19	0	0	0	0	0	0
20 – 29	1	4	10	1	11	10
30 -39	7	7	5	9	4	5
49 – 49	4	3	0	4	0	0
50 – 59	3	1	0	1	0	0
Gender						
Female	8	15	0	9	15	0
Male	7	0	15	6	0	15
Ethnicity						
Akan	3	8	3	12	9	13
Ga	5	3	8	0	1	0
Ewe	3	4	3	0	0	2
Hausa	1	0	1	0	0	0
Other	3	0	0	3	5	0
Marital status						
Single	5	8	14	1	12	13
Married	10	3	0	5	1	1
Cohabiting	0	0	0	0	0	0
Divorced	0	4	1	9	2	1
Educ Level						
No Formal Educ	0	1	0	0	1	0
Primary	0	3	2	0	2	0
JSS/SSS	0	9	8	0	11	8
Vocational	0	0	1	0	0	1
Tertiary	15	2	4	15	1	6
Pop interviewed	**15**	**15**	**15**	**15**	**15**	**15**

Demographic Data of Respondents (Quantitative Study).

A total of 80 GHS staff participated in the quantitaive study. Results showed that majority, 32 (40.5%) of the respondents were between 30-39 years of age and 22 (27.9%) of the respondents were between the ages of 20-29 years. Also, 11 (13.9%) and 14 (17.7%) were between the ages of 40-49 years and 50-59 years respectively. The mean age of respondents was ± 36.8. Sex distribution showed that females were the majority as they constituted 61 (76.2%).

Results of data from the interview of GHS Staff

Regarding the professions of respondents, 15 (18.8%) were prescribers either working as medical officers (doctors) or Physician Assistants (PAs). Nurses constituted 13 (16.3%) of the respondents. Pharmacist formed the majority of the participants in this study representing, 38 (47.5%) of the total respondents. Other participants in the study were data/researcher officers which were made up of 7 (8.7%) of the respondents. The study also included other professionals such as cleaners, record keepers and these people constituted about 7 (8.7%) of the respondents. Data was also collected on the number of

years that the various participants had worked. The results showed that 24 (30.0%), 23 (28.8%) and 12 (15.0%) had worked for between 1-4 years, 5-9 years and 10-14 years respectively. Only 21 (26.2%) of the participants had worked for more than 14 years. Table 5 shows a summary of the demographic data of respondents in this study.

Table 5: Socio-demographic characteristics of respondents

Characteristics	Number (N)	Percentage (%)
Age (years)		
20 – 29	22	27.9
30 – 39	33	40.5
40 – 49	11	13.9
50 – 59	14	17.7
Sex		
Male	19	23.8
Female	61	76.2
Current job		
Doctors/Clinician/PAs	15	18.8
Nurses	13	16.3
Pharmacists	38	47.5
Data/Research officers	7	8.7
Other	7	8.7
Years working in healthcare		
1 – 4	24	30.0
5 – 9	23	28.8
10 – 14	12	15.0
15 +	21	26.2
Total	**80**	**100.00**

5.2 Thematic Results from the Qualitative study

5.2.1 General Health Services

The section analyses both the FGD and IDI questions which bordered on factors Key populations will consider when accessing health care services, factors that cause delay in accessing health services as well as reasons for the delay. The main services were testing, enrolment in care, retention in care and treatment.

Most of the HIV positive groups prefer a place where they will be anonymously, treated with confidentiality and ensure their privacy as well. They also prefer a place they can get education on their illness. Across the 2 MSM groups (+ and -), they also wanted a place where the nurses and health workers including the doctors are nice, polite and will treat them with gentleness, kindness and respect. Aside the service providers being nice, KPs prefer a “one stop shop” – a place where all service will be available and at minimal cost or fully covered by the NHIS.

The FGDs with the NGOs and IDIs with the GHS confirmed that KPs are particular about confidentiality hence their preference for particular health care providers and facilities. It was also revealed through the IDIs with the GHS staff that in order not to be seen by other people, KPs prefer to access clinic on "**no clinic"** days or report late to the clinic.

Main factors Key Populations consider when selecting facilities for health care services

Confidentiality was a major issue for both MSM and FSW across the country. The emerging themes common to all groups were privacy, hardworking heath staff, availability of medications and services, effective health insurance, gentle and kind staff, nurses who are professional/trained staff, (staff attitude) and the type of ailment. Other responses included a place recommended by a "sister" or friend, a place where FSW will be treated nicely and feel accepted and MSM friendly health centres. The same views were shared in the in -depth interviews across the groups both in Accra and Kumasi. Table 6 provides a summary of responses by FGD discussants in the 16 FGDs in Accra and Kumasi.

Table 6: Summary of responses on factors for choosing health services from Accra and Kumasi FGDs

FSW	Accra	Kumasi	MSM		
Factors for selecting health services	**Tally**	**Tally**	**Factors**	**ACC Tally**	**K'SI Tally**
Privacy and confidentiality	5	5	Will go far if disease can be stigmatized	5	0
Availability of service and medication	5	6	Consider free and friendly nurses	3	4
Type of illness/problem	8	8	Where doctor can keep my secrets	4	4
Friendly, gentle, kind staff (smile at me)	5	5	MSM friendly hospital	2	0
Professional/trained staff	1	1	Health insurance	6	4
Place recommended by "sister"/friend	2	2	Attitude of staff at the facility towards contagious diseases	1	3
A place I can get education	5	5	How fast they respond to emergency	2	2
Effective health insurance	3	3	I prefer a faraway place	4	3
Non-judgemental/no discrimination	3	5	where no one will identify me	5	4
Cost of treatment	2	2	Welcomed and treated kindly		
Proximity / where no one knows me	3	2			

Some quotes from the KPs to substantiate responses in table 6:

Figure 1: Some quotes from the FGD in Accra.

FSW - HIV+ (Accra)

"I will consider a place where my issues will not be out"

"I want a place where I will be welcomed and treated kindly"

"I will consider a place where I will be seen quickly and pampered"

"I want a place where my issues will not be broadcasted"

"I will prefer a place I won't feel shy and accidentally meet somebody I know"

The following were more quotes from the Accra FSW group[1]

FSW- HIV+ group 2 (Accra)

"I like a place where the nurses are friendly"

"I like a place that is close to me"

"I like a place where I can afford treatment"

"I look at the time it takes before I am seen"

"I like a place that has facilities like a laboratory"

"I prefer where I will be welcomed and treated nicely"

Some more quotes from the Accra HIV (-) MSM group:

"The way I was treated there in the past would influence my decision to go to a facility"

"A place that will be comfortable and friendly".

"How easy the place is accessible".

"A place where emergency sickness are attended to urgently".

"I consider the type of sickness and the facilities available".

"I look at how hygienic the place is"

"I consider the distance and the facility that they have".

"I consider how friendly and convenient the place is".

These quotes were from the Accra HIV (+) MSM group:

"I consider the way they receive and interact with us".

"I consider how they get time to treat and advise us on how to take our drugs".

"I consider the cost before going".

"I prefer where there is no stigmatization".

"I consider the facility that knows us as MSM and understands us".

"I consider the way they encourage us when you tested and you are positives".

"I consider the place the nurse can monitor us"

.

[1] FGD for FSW in the HIV+ group in Accra

The results from the IDI with KPs indicated the same reasons. Figure shows some of the quotes from the IDIs.

Figure 2: Quotes from the IDI with KPs from Accra and Kumasi

Accra MSM

I will consider how confidential and friendly the place is, I will consider a stigma free facility and how advanced the facility is in terms of providing health. I will also consider how cooperative the staff are. - R1

I look at accessibility and structure of the facility and staff. Sometimes I listen to stories about the facility and services provided there. I don't like people who will be looking at me too much. - R2

"I prefer a place where the staff are confidential and have passion for their job". - R4

Kumasi MSM

"I select a facility based on how friendly and open minded the staffs are to enable me share all that I want with them. I also select facilities based how well equipped it is to be able to provide health care to me no matter my illness"- R6.

I will make sure I go to a place where people or nurses won't judge or talk or even gossip about me because I walk too girlish

Accra FSW

"I look at the environment and consider the behaviour of the health staff whether they are caring"- R9

"I look at the nurses and the doctors, how they take their time to treat me, I look a place I will be treated nicely, I look at whether the medication I am given will treat my condition, I look at the environment e.g. toilet facility and I also look at whether the place has laboratory facility". -R15

Some quotes from the GHS IDIs

"Because of the stigma attached to KP's, most of them don't want to come in at the clinical hours, they prefer to come in at odd hours and we overstay to handle such cases as they will normally come in after everyone is gone" (Nurse, North Suntreso Hospital)

"The information that someone is MSM may make me take a second look at the person but this will definitely not affect the way I attend to them" (Nurse, Kumasi South Hospital)

Reasons for delay in seeking care**:**

This section bordered on factors that cause KPs to delay in seeking care. Stigmatization, perceived lack of confidentiality and preference for herbal medicine were some of the issues that emerged from this discussion. For some of the HIV positive MSM in particular, taking so many drugs was a problem that led to delay in seeking health care. Yet another MSM delayed seeking care because he was requested to send his partner to the health facility. Discussants in Accra and Kumasi gave the following reasons in table 7 for delay in seeking health care.

Table 7: Reasons for delay in seeking care in both regions[2]

Reasons given by FSW	Reasons given by MSM
1. lack of money	Judgement by mother discouraged seeking medical help
2. shy to disclose HIV status	
3. afraid of stigmatization	Uncomfortable with a doctor who was caring for me
4. the illness makes you very weak	Afraid and shy of myself
5. prefer to go to work	was asked to bring my partner which I couldn't do
6. due to laziness	Prefer herbal medicine
7. fear of being told of a problem	Taking so many drugs is tiring
8. don't want to miss a client	
9. illness not serious	
10. they frown at you in the hospital	
11. discrimination at the hospital	

The following are some quotes from KPs in support of the reasons in table 7:

Some quotes from FGDs with MSM in Accra:

"When you can't talk to your parents about the issue you have, you can't easily go for health care" - 1.

"How they talk about it scares us so we don't go for health Care" - 2.

"Some of the nurses the moment they know you are MSM, they will start preaching you that how can a man sleep with a fellow man, are you not a Christian? - 4"

"I delayed because of the side effect of the medication" -6.

"I delayed because of money issues"- 8.

"My delay is a result of stigmatization by the nurses"- 9

[2] Repeated reasons were captured only once

The ensuing quotes were from the FSW FGDs in Accra:

ACCRA FSW

"Some people believe that once you get the disease, you are going to die so there is no need for care"- 1.

"HIV is a spiritual disease so you have to try and pray against it".

"They think that they will be maltreated when they go for treatment".

"The first time it is difficult because you feel shy and don't know what to say".

"The stigma makes difficult to go for your treatment".

"If I don't have money, it may stop me from going from my treatment"

"I delay because sometime I don't have money to go for my treatment".

"Sometimes you are spoken to harshly by the nurses so that put you off from going for treatment"

The same reasons run through the IDIs with the KPs. The ensuing quotes were from some of the KPs in Accra.

Quotes from IDI with FSW at Accra:

"Sometimes getting money for transport fare is difficult"

"The stigma from others at the health facility"

"The laboratory investigations like CD4 count, liver function test are expensive"

"Some people think of the side effect of the medication"

"FSW don't like public places so if the ART center is a public place, we might not go"

"Many drink and smoke marijuana so they don't remember HIV care enrolment"

"They may have lost hope"

"HIV positive follow up test are very expensive"

"Some delay in going for medical appoints because of long queues."

Type of services provided by NGOs and GHS facilities

The NGOs play a key role in the provision of services to facilitate HIV Testing and Counselling services. The services range from counselling and testing through to support and adherence counselling. Most of their services extend to KP communities. They provide both group and individual services to the KPs hence majority of KPs feel comfortable with them and trust them. The GHS facilities provide mainly facility based services. One respondent from a Kumasi based GHS facility mentioned home visiting, defaulter tracing and education at churches. Please refer table 8 for services provided by both the NGOs and GHS facilities in Accra and Kumasi.

Table 8: Services Provided by NGOs and GHS facilities in Accra and Kumasi

NGOs	GHS
1. Testing and counselling 2. STI screening and Support for any Gender Based issues 3. Condom and lubricant distribution 1. Education and referral services 2. Referral of KPs to hospitals, clinics and DICs 3. Outreach services at KPs hot spots to provide HIV testing and education on HIV, condom use, abstinence, stigmatization and SGBV 4. Screening for gender based violence against KPs and refer victims to DOVSU, Social welfare and clinics. **4.** follow up on HIV reactive clients to go for adherence counselling and treatment	1. Testing and counselling services 2. provider initiatives 3. Adherence counselling for those to be put on treatment and any client who walks in with an STI is encouraged to test for HIV. 4. Treatment of opportunistic infections 5. Counselling of clients on the importance and adverse effects of taking the drugs 6. Provision of lab services, clinical services, psychosocial services and pharmacy services. 7. Contacting of defaulters. 8. Conducting of home visits 9. outreaches to churches and organizations to give health education 10. Provision of ARV treatment from babies, adolescents to adults. 11. Provision of other prophylactic treatments 12. PMTCT 13. Provision of nutritional supplements especially for children and malnourished adults 14. Post exposure prophylaxis

The following quotes support the assertions in table 8:

Figure 3: Services provided by NGOs in Accra and Kumasi – IDI with NGOs and GHS

Kumasi – GHS

This facility does counselling, testing, ART and treats opportunistic infections. (Medical Doctor)

Services provided are counselling, VCT, antiretroviral care and treatment. We also do adherence counselling, defaulter tracing, home visits, outreaches to churches and organizations to give health education too. (Disease Control Officer)

HTC services, PMTCT services, Post exposure prophylaxis services, ART we also provide nutritional supplements especially for children and malnourished adults. (Nurse)

Figure 4: Services Provided by GHS and NGOs

ACCRA - GHS

"We do different types of HIV counselling like pre-test counselling; post counselling, adherence counselling and reinforcement counselling. We also do HIV testing" – (ART in charge)

"We provide PMTCT to pregnant women and give medication". – (Nurse)

"We do HIV diagnosis, testing, counselling and treatment" (administrator)

ACCRA - NGO

"We do HIV prevention education through condom use demonstration and distribution of condoms and lubricants. We also do HTC and distribution of Behavioural Change Communication materials".

"We offer education on HIV and STI prevention by promoting the use of condoms and lubricants and also demonstrate the best way to use condoms to KPs. We also do testing for HIV, STI and TB and counsel and refer clients to the DIC nurses or to health facilities for care and treatment. We do home visits for FSW and counsel them on partner reduction, alcohol and drug use during work hours and quarterly visits to our nurses at the hospital for check-ups and not to wait until they notice bodily changes or feel sick. We also do SGBV education and help aggrieved or beaten FSW get justice by connecting them to legal services".

KUMASI – NGO

"All the NGOs provide Testing and counselling services for HIV, referral of KPs to hospitals, clinics and DICs. The NGOs also offer outreach services where they meet with KPs at their hot spots to provide HIV testing and education on HIV, condom use, abstinence, stigmatization and SGBV. We distribute condoms to KPs and screen for gender based violence against KPs and refer victims to DOVSU, Social welfare and clinics. Some also follow up on HIV reactive clients to go for adherence counselling and treatment"

5.2.2 HIV Prevention and Testing

This section targeted activities carried out within communities to enhance HIV testing. The KPs mentioned that the NGOs embark on several community activities to check on their health including the provision of HTC services. Peer Educators call KPs to remind them to test for HIV. HTC services are provided at parties and the inaccessible MSM are reached via social media. NGOs also use KPs called "model of Hope" as well as PEs called "sisters" to provide support for KPs who are HIV positive. The NGOs have interesting names such as love and trust, share and care, and community capacity building for their community activities. These activities were confirmed by the NGO administrators and Peer educators in their various FGDs.

Community activities that encourage HIV Testing

Community activities were mostly carried out by NGOs whilst the GHS facilities relied on facility based services. Facilitators to testing included promptings from NGOs in the form of test messages to key populations, organization of community outreach activities such as Community Capacity Enhancement (CCE) to educate them through storytelling.

Other forms of community activities were love and trust for FSW and Share and Care and friends night for the MSM (MICDAK). These activities target, testing, enrolment, retention and treatment in HIV care as depicted in table 9. Notable quotes from the Kumasi MSM included:

> *"In my community love and Trust is organized during which a nurse educates the members while another conducts testing and counselling for members".*
>
> *"It is easy to convince us to get tested at a party"*

"Yen sasofuo[3] *yepe anigeye paa"*- meaning *"We MSM like being happy (a term for partying)"*

Table 9: Community activities that encourage HIV testing in Accra and Kumasi

FSW	MSM
1. Education from the NGOs specifically WAPCAS	Testing services in Love and Trust activities by MICDAK
2. Giving KPs a focal person to coordinate testing activities	Adding HIV services to registration of Health insurance or during festivals
3. Teaching about STIs	Peer educators encourage us in the communities to test
4. Educating on condom use	Sale of condoms and testing services by Peer Educators
5. Offering screening services	Counselling on how to overcome stigma form HIV infection
6. Lead us to health facilities	PEs take HTS to the doorstep of KPs

A respondent in the Accra FSW group was encouraged to test by an advert on television and yet another FSW referred to the compulsory testing of pregnant women as a

[3] Saso is a twi term meaning "our type". It is widely used in Kumasi in reference to MSM. Sasofuo is a plural form of saso

community activity that enhances testing. These activities were confirmed by the NGOs. Responses from the KPs on activities in the communities that encourage them to test are shown in table 9 whilst figure (5) shows some of the quotes from the FGDs.

Figure 5: Community activities undertaken by NGOs

Kumasi –MSM

"During the registration of national health insurance for MSM in MICDAK office, HTC activities were added".

"I know of Outreach activities like Love and Trust where MSM gather to educate themselves, I also know of peer educators in my area who educate us on HIV and safe sex practices".

"Love and trust by MICDAK. It is easy to convince us to get tested at a party"

[paraphrased from twi: - We the MSM like to party].

"I also know of DIC activities where peer educators invite me to get tested".

FSW in Kumasi

"I had a peer educator who come to me and advise me to come for testing"

"Some ladies came to our community with nurses and did screening for us"

"A named NGO came to do testing and counselling in our community".

"Peer educators came around and invited them for testing"

MSM in Accra

"Peer educators organize programs to test us"

"Organizations come to do community outreach programs, love and trust and testing activities for us".

"They organize entertainment sessions such Ludo and games to motivate us to go and test.

"They organize "love and Trust activities"

FSW in Accra

Peer educators come around and tell me to get tested regularly. If I don't feel well they can take me for testing.

The peer educators also organize screening sessions occasionally and invite us.

"I saw an advert on TV so this pushed me to go get tested"

"I got tested through testing of pregnant women"

"There are no activities going on in my community, I just decided to go for testing myself"

Factors that influence KPs choice of testing location

The responses were similar to factors that guide their selection for health facilities. Confidentiality and being treated politely stood out amongst the other reasons. Some KPs prefer to test for HIV in obscure KP friendly locations. Table 10 and figure 6 elaborate the factors that influence KPs choice of testing locality.

Table 10: key factors for testing for HIV

FSW	MSW
1. Where confidentiality is assured	Good relationship from health personnel
2. a place where only a few people will attend to you	Service providers who keep quite If nurses are friendly
3. a place where KP will be treated politely	When all services are at a particular facility Prefer where I not meet my peer
4. a place where there is confidentiality and privacy	

The following are some quotes on Factors influencing KPs testing location.

Figure 6: Key factors for choosing testing locations

Accra – HIV(-) FSW

"I look at a place where they keep my issues private"

"I look at a place where the nurses are friendly and take your issues seriously"

"I look at a place that accepts national health insurance cardholders"

"I look at a place that will show interest in coming to educate us about HIV, this makes me trust them"

"I look at a place where the testing is free"

Accra HIV (+) **FSW**

"I would choose a place that is closer to me because at that time I may be weak"

"I would prefer to go to a place that is far from me because nobody would know me there"

"My mother was getting treatment there that is why I went there to get tested"

I prefer a place where the nurses are professional"

Kumasi- HIV (-) MSM

First of all I try to see that it's not in my locality where I will not see familiar faces.

I will consider the friendly nature of health care providers whether they are welcoming or not.

I will also consider permanent staff who will always attend to me all the time.

I will also consider confidentiality, MSM friendly environment and affordability or acceptance of NHIS.

HIV (-) MSM

"I look out for nurses who provide good services"

"I look for a place where my appearance is accepted"

"I look for a facility that has all the services I will need like a lab so that I don't need to go out for any other service "

"Some people say they feel scared whenever it is time for them to come for their drugs because they feel they will meet somebody who knows them" (Disease Control Officer, Kumasi).

How KPs are treated when they go for testing services

The KPs are mindful of confidentiality and will go an extra length to ensure this is not compromised. There were mixed responses on how they are treated at health facilities when they access testing services. Majority of the respondents perceive NGO services to be more friendly and confidential as compares to the GHS facilities where some service providers are seen as judgemental and not friendly. These perceptions by the KPs were confirmed by the NGOs and GHS staff. Table 11 provides a summary of the responses.

Table 11: summary of how KPs are treated during testing services

How KPs are treated during testing services	
Facilitators	**Barriers**
1. Some places they are nice 2. They are really nice 3. They do not shun us 4. They go through the procedure and advice on prevention 5. They help us get tested quickly 6. They ask for your consent, do counselling and test 7. The NGOs have patience and treat us well 8. The nurses treat me like family at a GHS facility 9. The NGO's don't discriminate. 10. The NGO provide tailored services	1. They refuse to take care of you without insurance 2. Treated harshly 3. Some staff are judgmental 4. No one is concerned about you 5. Nurse advice to get a better job 6. They are not patient 7. Some hospitals don't have patience to explain issues when they find out that the client is FSW. 8. No one was concerned about me 9. Perception that the doctors or nurse share information with others and stigmatize them 10. The person at the NGO may be known to you and break confidentiality

Kumasi MSM (+)

"The nurse placed her arms around my neck and spoke to me in a comforting manner".

Kumasi MSM (-)

"I witnessed the stigmatization of a lesbian couple at a health facility where I use to work. Upon the arrival of the couple, the health providers called colleagues to come and see the couple" – another FGD in Kumasi for MSM".

"Because of the pre -counselling I took the testing lightly but I know someone who was treated bad by not attending to him just because they suspect him of being MSM".

Accra MSM (+)

"I took a peer to a facility and the nurse there wasn't friendly at all, so we left"-

"With the NGOs nurse are being trained to contain us unlike the GHS"

Accra HIV (+) MSM

When I go to facility x (pseudo name) to test irrespective of the result they supply me with condoms and lubricants.

Accra HIV (+) FSW

"I was tested several times after the first test came out positive and when they were all positive I was counselled and encouraged by the nurse"

The ensuing quotes were in the same FGD for HIV (+) respondents in Accra

"I prefer the NGOs because they are specially trained and they are patient in dealing with their clients

I prefer the hospitals because the NGOs I may know someone and due to that confidentiality may be breached"

"Where I go they are very patient but they dislike it when you miss an appointment"

"Where I go they call me to check on me, they treat me like family"

Accra HIV (-)FSW S

"I told a nurse I am a "sister" and she told other nurses"

"At an NGO I was treated with patience and care"

"At NGOs, even though we are "sisters" we were pampered and entertained with games while to be attended to"

More quotes from IDIs and FGDs with KPs are listed in figure 7.

Figure 7: How KPs are treated

"The staffs at GHS facilities are not able to maintain confidentiality compared to the NGO staff." – An MSM from Kumasi.

An FSW shared similar views at Accra:

"*The NGOs staffs receives us better than the GHS facilities"*

The following quotes were from the same FGD in Accra:

"I prefer the NGOs because they are specially trained and they are patient in dealing with their clients" – R6.

"I prefer the hospitals because at the NGOs I may know someone and due to that confidentiality may be breached" –R7.

"Some of the nurses, the moment they know you are MSM; they will start preaching to you that how can a man sleep with a fellow man, are you not a Christian?" - (MSM - Accra).

"When I go to Facility Q, (name withheld) Aunti "B" (pseudonym) makes us feel comfortable but at Facility A, there is no friendly services"- (IDI- MSM in Accra).

"I took a peer to a facility and the nurse there wasn't friendly at all, so we left"- (IDI- MSM in Accra)

"*There is no difference in the GHS and NGO HIV testing facility, they are all trained well to do the same thing"* – (IDI- FSW in Accra)

Some Public facilities were praised for their services whilst others were labelled as boring. Others were also tagged as not friendly. Forty-seven (47) out of 60 IDI participants perceive NGOs to treat them better than Public Health Facilities whereas 8 preferred the GHSs to the NGOs. Their reasons for their choices bothered principally on stigma and confidentiality. The same views were shared by both MSM and FSW in both the IDIs and FGDs.

Of the few HIV positive clients who were happy about GHS services liked the way the nurses took their time to counsel and allay their fears.

Sharing of sexual history

KPs that were willing to share their sexual history were of the view that sharing their sexual history will help them access quality care. Those who perceive sharing their sexual history as a barrier would not do so because of perceived compromise on confidentiality, fear of stigma and poor attitude of staff towards them. Majority of MSM will not share their sexual history because they are "frowned upon" by society. Refer to table 12 for the facilitators and barriers in sharing sexual history.

Table 12: sharing of sexual history at health facility

Willingness to share sexual history at health facility	Unwillingness to share sexual history
1. Telling your sexual history helps so one can get good treatment	To Protect their work form family
2. The doctor will be confident if he knows the sexual history	Judgement from service providers
3. It is good to tell the doctor to help him know what to do	Discrimination from service providers
4. Some of the doctors are very friendly you can open up to them	sometimes you may meet someone you know
5. If you tell them it will help you	doctors link your name to your family
6. It is our work so there is no shyness in saying it	it is good to tell the doctor **but** you also need privacy
7. Say it because everyone needs someone to help	The sexual history **should not** affect anyone going for testing services
8. It depends. If doctor/nurse is MSM friendly	Unexpected reaction from people
9. We are not accepted,	The nurses will talk about you.
10. we will not share history	The person will welcome you initially but after you say it they change.
11. Never share your history as MSM	

During the in-depth interviews, it emerged that health workers generally believed all clients should be attended to and treated the same way irrespective of their sexual orientation. The following quotes support these assertions:

> *"We are all human beings … they should not be blamed for the situation"* (Laboratory Technician, Kumasi).

> *"We are all religious, either Christians or Moslems but we should not judge those people. They should all be treated as our clients and provide them with the same quality health care"* (Nurse, Kumasi).

"People will generally not disclose they are MSM… they will only do so when they are very sick or weak…they think when they disclose it the health worker will not accept them" (Nurse, Kumasi)

"Sometimes they don't believe in our ability to keep things secret unless probably they have been coming here severally" (Clinician, Kumasi)

Some comments from the FGDs were suggestive that KPs especially MSM are not comfortable sharing their sexual history.

"*A lot of people have had hetero-sexual sex and ended up with HIV so why should I tell the doctor that I am an MSM?"*- MSM at Kumasi.

"In today's world, we all have our choices. Some people think this is nasty. Others say we are demonic and we are not normal"- MSM Kumasi

"*I have sexual feelings for men; like black men…and there are over 2 million people who are like that so it's God who made us so…so I am just waiting for God to judge me. I won't let any human being, because I am not the only one"* MSM Kumasi

The FSW also had their reasons for or not sharing sexual history:

"*At an NGO, you should tell them but at any other hospital you should not tell them because they will discriminate against you*" –Accra.

"*I find it difficult to share my sexual history because of the stigma*" Accra.

"I think it is good to share your sexual history so that the health professional can advise" –Accra.

Views elicited from participants in the GHS IDI included:

"I use the way they sit; they high cross their legs and I ask them if they have a boyfriend or a girlfriend then they go like … most of them will say both, some of them will say initially boyfriend but recently girlfriend" - Medical officer, in a GHS facility in Kumasi.

"Sometime during physical examination, you find rashes at the anal region and some have haemorrhoids. These make you to suspect and you go further to ask them" - Nurse, in a hospital from Kumasi.

Reasons KPs will not test for HIV

Some of the reasons that run across the groups were fear, nurses may tell a stranger and it will become public. Some responses bothered on dislike for medications, the assumption that having one partner keeps you safe, anxiety and fear, the belief that it is better to be ignorant, difficulty in telling who to trust about your condition, problems that may crop up from fear of being positive, and some results of people who tested have been made public so these put KPs off from testing. In Kumasi 7 out of 15 MSM respondents (IDI) cited lack of confidentiality whilst their counterparts in Accra gave fear of positive result (6), stigma (4) and fear of meeting familiar faces (3) as the barriers to HIV testing.

It is evident that generally the fear of status being disclosed and its attendant stigma drives KPs desire for confidentiality in HIV testing. Table 13 shows some of the reasons KPs will not test for HIV.

Table 13: Reasons KPs will not test for HIV

Accra	Tally	Kumasi	Tally
Fear of positive results	6	Lack of confidentiality	5
Stigma	4		
Fear of meeting familiar faces	3		
Unfriendly design of testing sites	2		

A male respondent in one of the IDIs at Kumasi said:

"MSM also entertainment fears that their PEs who leads them to test sites to undergo HIV test may learn the results and spread it".

Another Kumasi based MSM said

"Also *I think some people don't believe that HIV is real*".

To other MSM disclosing sexual orientation and the request for a family monitor for clients who test positive are problems that will hinder them from testing. An HIV+ MSM, who is a non- user was of the view that

"*MSM do not like unfriendly public locations like Hospitals for their HIV test. They prefer private obscure and friendly location where no one knows them to conduct their HIV test.*

This was confirmed in an IDI with a positive non user in Accra. He was of the view that

"Some testing sites are designed for HIV positives so people don't feel comfortable going there to test". Another positive but service user said "*stigma!...self-stigma,…(Pause) most of us are afraid to know our status".*

A clinician from KATH confirmed KPs perception of the services at GHS with this quote:

"*Most health care providers are not committed and are judgemental about HIV clients so they should undergo training to change their attitudes towards KPs and HIV clients*".

The following quotes also supported the points raised by KPs:

"To be very honest…when I heard it and he entered the room I was like …wooow! Such a nice guy and he is being involved in such an act"…Sometimes I always imagine their act and what they do… and I am like … this is absurd… why do you have to do that"? - Nurse, a Hospital in Kumasi.

"The preaching to make them change their sexual orientation might make them not return to the facility" - Medical Officer, a Hospital in Kumasi.

Improving HIV services

Views were assessed from both FGDs and IDIs. KPs desired improvement on confidentiality, availability of logistics at the health facilities among others. Motivation for KPs, NGOs and GHS staff also stood out. Whereas GHS staff wanted snacks and lunch whilst attending to clients, the NGOs wanted telephone call credits and transportation allowances The KPs however, wanted NGOs to be resourced to provide ART services, subsidy on laboratory services and continuous supply of medicines among others.

Working on staff attitude also stood out in the responses from KPs, NGOs and the GHS staff. A quote from an administrative staff from KATH was on improving staff attitudes.

"*All health workers should be involved as the problem has to do with the attitude of health workers*"

This view was shared by an Accra GHS staff who put it succinctly that "*the health staff should treat KPs without prejudice*".

Notably among the GHS responses were the need to improve upon waiting time for KPs at health facilities and the need to get HIV services closer to KPs. Availability of drugs, laboratory services and reagents all the time and continuous education and training for staff was also mentioned. Table 15 presents findings from all the FGDs and IDIs.

A nurse from Suntreso was of the view that:

"*Service points should be increased so that they can have more options in the facilities to go to. We need to build confidence and create friendship between us and our clients. We have to do home visits and meet them in their associations. When drugs are always available and logistics like vehicles for health workers are provided it will improve services. For KPs, sometimes home visits, transport allowances and nutritional food can encourage them to use HIV services".*

A lab technician from untreso Suntreso said:

"*It is expected that patients who have been on ARV's for some time may experience drug resistance so our laboratory should be well equipped and we should have the technical know-how to carry out resistance tests to help patients".*

Table 14: improving HIV services

KPs Responses	NGOs and GHS responses
1. Tell others about how helpful the services are to us 2. Tell others of they are assured of confidentiality 3. We must tell people medications can easily help us 4. We can advise them 5. Educate our peers about the services 6. If we are employed as educators we can go around and do education 7. Advertisement e.g. T-shirt 8. Give us condoms to give out to people 9. Announce in churches to go for testing 10. Improve on the DICs to provide ART services	NGO IE&C materials should always be available to help in education of clients Decision and policies adopted at high level meetings about KP HIV services should be well communicated to the facilities to make engaging with the facilities easier. Capacity building for PEs. Regular distribution of condoms to KPs Incentives for PEs and professionals Games and entertainment should be provided at the DIC. **GHS** Most clinics should have a psychological counsellor that can address other issues apart from the clinician. KP's should be allowed to walk in at any time and not just on clinic days to avoid service provider fatigue. Staff need motivation (just lunch or snacks when attending to clients). Drugs should always be available

5.2.3 PEER EDUCATORS

Interactions and perceptions of Peer Educators

Some of the responses from the FSW indicate that they meet regularly to discuss safe sex practices. Barriers such as peer educators taking advantage of their clients exist in both Accra and Kumasi particularly among the MSM group.

KPs have mixed perceptions about the PEs. Some see peer educators as people who have interest in their welfare. They identify with them and trust them. Whereas the FSW in Accra and Kumasi trust and confide in their Peer Educators, a few MSM in Kumasi and Accra however have some reservations about Peer educators. They do not trust them and see them as not capable of keeping their issues in confidence. Again an MSM remarked that PEs teach and practice vice which 4 out of the 6 participants nodded in agreement in Kumasi. This remark was also repeated in the Accra group that "they mix business with pleasure"

A respondent (R8) from a Kumasi MSM FGD said the PE in his area is hardly seen as a PE by outsiders, R10 gave a long hiss then the group laughed out loud. R8 then remarked that:

"He has more sexual contacts than your phone contact list" and "I know at least 6 of his sexual partners who are still actively having sex with him".

R4 also replied that:

"He has never advised me to go for HIV test before…….you call yourself as a Peer Educator"

Another Kumasi MSM FGD respondent remarked that:

"*Because my PE was well known for his bad attitude I don't even want to be seen or associated with him at all".*

Another respondent raised his voice and summed it up by saying:

"*Are all these ones among PEs? Excuse me he is not classy"* (The statement was made in a local dialect in Ghana Twi).

These perceptions run through all the 4 MSM FGDs at Kumasi. Two out of the 4 Accra FGD for MSM commended PEs whilst two bemoaned their attitude. Table 15 shows some of the quotes made by both FSW and MSM in Accra and Kumasi.

Ways PEs help with HIV services

Responses from both MSM and FSW on how it's assist with HIV services centred on education, provision of commodities; follow up services and reminding KPs when they are due for testing. In instances where they know KPs who are HIV positive they encourage them and remind them when they are due for check-ups at the health facilities. They bridge the gap between the KPs and the health facilities by reminding KPs when they are due for testing and other services. They also suggest to KPs facilities that are KP friendly. Table15 provides reference to the findings.

Table 15: Some quotes on perceptions of PEs by KPs in Accra and Kumasi

Accra	Kumasi
Facilitators	**Facilitators**
They are very discreet so they don't draw attention Some of them appear as our personal friend so they are seen as our personal friends I trust the PE more than the nurses PEs are agents helping us to voice out things that we can't tell our parents and those we live with PEs are always at our service I have trust for my PE We see PEs as very helpful, but I prefer 1 PE to 2 PEs	They have good relationship with us
Barriers	**Barriers**
Some PEs need some qualities to relate with us well. Some life styles of some PEs are not OK with us. PEs mix business with pleasure, I have noticed it several times.	Some of them are good but they talk and gossip a lot. They are known for not keeping secrets We see Peer educators as talkative or gossips In my community ordinary people hardly get to see PEs except we the MSM also they don't live u to expectation, because they don't practice what they teach like reduction of multiple partners while they practice vice PEs are arrogant and disrespectful

Some KPs commended PEs for their role in HIV services whilst others complained about them. The following quotes substantiate the findings.

I was suspicious at first because I thought they were coming for our information but later as I realized they were educating us about STIs and safe sex" – Accra FSW (-).

We see them as people who have time for us and they can provide us with our needs – Accra MSM (-).

Some lifestyles of some peer educators do not go down with us and as such need training Accra MSM (+).

Some behaviour of peer educators makes it difficult for us to trust them Accra MSM (+).

How PEs can play a larger role in helping KPs utilize HIV services

KPs wanted PEs to motivate their peers to organize love and trust at Kumasi periodically. The MSM group in Accra wanted Peer educators to visit with doctors occasionally whilst the FSW in Accra felt the PEs could be given some medications to assist them at home. The NGOs on the other hand felt PEs should be attached to NHIS to register the KPs with challenges. Another IDI respondent from an NGO at Kumasi suggested that HIV+ PEs should strengthen the model of hope services and also trace defaulting HIV+KPs. An FGD participant in one of the NGO groups for PEs and M&E staff had this to say.

"In Accra, some of the MSM who are PEs have given themselves the charge that as long they live they will not let a peer die from HIV. They will not let you isolate yourself when you are reactive and die"

Table 16: Help offered by Peer Educators in the utilization of health services

Responses
1. Teach safe sex
2. Teach how to use condoms
3. Demonstrate how to wear the female condom
4. The condom they sell is not expensive
5. Demonstrate how to use gel
6. Teach how to test for HIV
7. Provide HTC services
8. Educate KPs on their status
9. Encourage hospital attendance
10. Provide support services for HIV+ KPs
11. Refer for other services such as STI

Some of the suggestions from the Accra NGO FGD included building the capacity of the Peer educators to ART managers. Suggestions from the GHS IDIs focused on strengthening defaulter tracing of KPs by the PEs. Table 16 provides further reference on the findings.

5.2.4 HIV CARE AND TREATMENT

Factors HIV+ KPs consider before selecting health services

The choices of health services for KP+ depend on several factors of which privacy and confidentially play key roles. Results from the IDIs with the GHS staff showed that KPs, in order not to be identified by several service providers would skip their appointments and come on days and times their favourite providers would be at post. Their choices for health facilities as per this study were influenced by three main issues as stated below.

a. Facility: medication and services available, short waiting time, availability of privacy, free of stigmatization, cost of services,
b. Health staff: confidentiality, patience, experience, helpful doctors and nurses, nurses and doctors who understand KPs and will treat them nicely.
c. KP: where they cannot be identified by other patients, cost of transportation and privacy

The following are a few quotes to substantiate the quotes from Accra MSM:

"I prefer a place that is close to me"

"I prefer a government facility so that care is free"

"I prefer a place where I will be received and treated very well"

"I consider the cost of transportation."

Some quotes from HIV(+)MSM in Accra

"I consider the availability of Medicine".

"I consider the distance".

"I consider the way the staff at the facility treat us".

This is what the HIV (-) FSW in Kumasi had to say

"I will go to a place where I won't meet a familiar face"

"They prefer to go to a place where the nurses treat them like humans being and not stigmatized them"

Some quotes from HIV (+) FSW

"I prefer a place I will be treated nicely"

"I prefer a place am not known"

"I will not go to place I will be discriminated against"

What KPs prefer over others in choice of health facilities

Preference for DICs and NGO services stood out. The MSM in Accra prefer certain public health facilities due to the way nurses relate l with them and the availability of a range of services at those facilities. The Kumasi KPs, like those in Accra, will choose a facility that welcomes especially MSM and will not discriminate or leak information about them. Some facilities in Kumasi were also tagged as KP friendly. All KPs need is a facility where confidentiality is assured, they are secure from being seen by familiar faces, there is short waiting time and all services are available and rendered by friendly, competent staff at affordable cost. KPs detest moving from one unit to another to access other components of the HIV care services.

Table 17: Preference for some facilities over others

FSW	MSM
Facilitators	Facilitators
1. When pampered at a facility,	NGOs have time for us
2. They teach and pray with us,	Donors monitor NGOs so they do the right things
3. nurses take you as a friend and check on you	
4. where nurses bring the medication to you	
5. short distance between counselling and testing points	
Barriers	**Barriers**
Nurses do not speak nicely to you	GHS staff hate to see us
Inquisitive patients want to know KP's status	GHS staff are hostile to MSM
Some of the nurses give you away and people shun you	Some nurses counsel us to stop being KPs
	Long waiting time at some GHS facilities

KPs perceive NGOs as more friendly; notwithstanding, a few of the Kumasi MSM perceive some PEs as gossips, breach confidentiality and lack professionalism. They also perceive other patients receiving care at the health facilities as inquisitive who are eager to find out what is happening to other patients. The following are some quotes to substantiate the findings in table 17.

One MSM at Kumasi remarked in Twi that:

"Even if am sad and I see this nurse, my sadness varnishes. She is good!"

How KPs are treated when they go for HIV care and treatment services

The study also elicited responses on how KPs are treated at the various facilities they access HIV care and treatment services. Whiles some prefer the NGOs; others prefer the GHS facilities due to various reasons primarily on confidentiality and quality of care. It was revealed that staff attitude from the NGOs positively outweigh that of the GHS Staff. A few of the staff from the GHS facilities were recommended on their exceptional friendliness. Some PEs from the NGOs were also perceived as unprofessional. The ensuing quotes throw more light on the issue.

Quotes from Kumasi on GHS Staff:

"Some are nice and others make you sit for about 30 minutes without any question, some have time for you, some are good, the nurses treat people according to how they carry themselves".

A quote from FSW Kumasi:

"*ebi koraa de adeɛ hyɛ wɔn hwene na ɔde ahyɛ nensa, onyaa kotoku koraa anka ɔde bɛ hyɛ aka ho"*

This translates as:

"*Some wear masks and gloves and even behave like they would wear a sack over themselves if they could"*

This statement from a clinician in Kumasi supports the fact that KPs face discrimination from service providers-

" *Some went to facility X (name withheld) and came crying that the lady told them that God will punish them and so many things so they never went there again…this was last year"*

Seeking HIV care and treatment

The questions bothered on what would influence KPs to seek HIV care and treatment. Some of the facilitators included avoidance of stigmatization, poor customer care practices such as poor time management and staff attitudes. The nature of KPs work especially the "roamers" were also stated as factors. Table 18 depicts some of the factors revealed in this study.

Table 18: Seeking HIV care

KPs	Service providers
Barriers to seeking care and treatment 1. Not wanting to meet people they know at the facility 2. Waste of time at the hospital 3. Fear of the results of the test 4. Transportation cost 5. Cost of some medications 6. Fear of knowing status 7. People attach death to HIV 8. Shyness 9. Fear of stigmatization 10. Stigmatization 11. Harsh treatment from nurses 12. HIV is a spiritual disease	**Barriers to seeking care and treatment** 1. High level of suspicion from MSM 2. State of denial 3. Isolated area for service provision to KPs 4. The roaming nature of the FSW's work 5. Waiting time at the health facilities

What makes it difficult for KPs to be retain in care

The reasons KPs gave for not staying in consistent care included branding of HIV services and facilities. A few KPs related issues such as not caring for self because one is sentenced to die, pill load, self-stigma and fear of losing job were mentioned. Both KPs and service providers gave similar responses per table 19.

Table 19: staying in consistent care

KPs reasons	Service providers reasons
1. Avoid branding drugs to avoid suspicions 2. Bring medication to our door step 3. Financial difficulty 4. Shortage of prescribed medication at health facilities 5. Laziness 6. Shyness 7. Some people don't care about their health 8. Perception that medication is not working Disbelief (can't believe they are positive)/ denial	1. Forgetfulness and complacency. Because they feel stronger and better. 2. Desire for spiritual and traditional healing 3. Fear of other people knowing their status 4. Fear of losing job 5. ART centre stands alone so attracts stigma 6. KPs "profession" not accepted so they hide 7. Pill load 8. Medicine or no medicine, death will surely come

"Personally I think that we should stop branding specific places for accessing HIV services because it's a major hindrance in accessing HIV care services. Because the place is branded, there is a lot of stigma attached to it." – A quote from a service provider in Accra.

"Their self-conscience prevents them from seeking care and treatment because they know biblically; it's not good to engage in MSM". - (GHS Accountant from Accra). This quote supports stigmatization from service providers.

Difficulties in taking medications as prescribed

The difficulties in taking the medicines were assessed from both the service providers and KPs factors. Key among the issues were the perception that the medication is not working, interference from religious leaders, side effects of the medications and lack of funds came up strongly. Other reasons are displayed in table 20.

Table 20: Difficulty in taking medications consistently

KPs perspective	GHS staff perspectives
1. Perception that the medication is not working 2. cost of medications 3. Forgetfulness 4. Religious leaders claiming they can cure HIV 5. Side effects of drugs 6. Waiting time (clinic and dispensary) 7. Hopelessness (after all the virus is in you) 8. Prolonged period of taking drug (tiredness/fatigue) 9. Stigmatization 10. Restrictions in life style associated with medicines 11. Inability to hide the pill from people 12. Fear for taking medicines	1. Fear of unsuspecting partners seeing the drugs 2. Lack of money to buy food 3. Tiredness of taking medications 4. Difficulty in modifying life style while on medication 5. Lack of funds 6. Side effects of the drugs 7. Some think they are OK after a while

Some of the quotes from the IDIs to substantiate the findings are as follows:

"I have MSM guys diagnosed of HIV about 3 or 4 years ago and they are now coming in, we lost one of them… so we asked them and they told us they say the side effects of the drug are very bad" (Medical officer, North Suntreso Hospital)

The study also showed that clients often expect quick recovery upon commencement of treatment, however, where there are delays in recovery, spiritual help is sought as illustrated:

"Client often expect a magic… one month after taking AVR's they expect 100% improvement…I saw my patient on Obinim TV [local television station where healing service are often telecast] and *he wants to stop the ARV's and take the anointing oil prescribed for them"* (Medical officer, North Suntreso Hospital)

"FSW's sometimes believe bewitchment made them get the infection because of the job they do….The pastor may tell them, I have done the spiritual aspect of helping you, now you must go to the hospital to get the rest of the treatment" (Nurse, Suntreso Hospital)

Irregular supply of drugs also account for the challenges in taking drugs consistently as stated below:

"Sometimes you get people coming to fight the doctors because they don't get their drugs and they say you put us on drugs and tell us not to miss it but now you are saying go and come back another time" (Medical Officer, Kumasi South Hospital).

Experiences KPs encounter with Peer Counsellor at GHS facility

KPs perceptions on PEs at the health facilities are different from those at the NGOs. The PEs at the health facilities are seen as encouraging and helpful as per table 21.

Table 21: KP's experience with GHS counsellors

Facilitators
1. Encourage clients
2. They are role models - (we see them in good health so it encourages us to keep taking medication)
3. Sharing of their personal experience encourages us
4. interaction with a peer educator has given me enough knowledge on STIs and MSM

"Years back, a friend accompanied me to the hospital, I will forever remember the nursing sister I met there. She told me about how her positive HIV son who refused to take the HIV medication because he opted for religious solutions died. Although taking daily medication is difficult it is good- Kumasi MSM.

"Yes, I have met Mr John (pseudonym) He told me that he has had HIV for 16 years but because of medication he is still healthy"- FSW in Accra

The following are more quotes on GHS PEs from Accra HIV (+) FSW group:

"Yes, I have encountered one and because they take their medication and look so good it encourages me to also take my medication"

"They organized a club and got us to meet together and have fun activities"

"I was crying but she consoled me and told me her story and that encouraged me"

Some comments on GHS PEs from Kumasi (MSM+).

"I met one who advised me not to consider suicide but rather go for medication"

"I met one who told to rest and eat well and take care of myself"

Comments from FSW (+) in Kumasi

"Yes I met someone who used herself as an example that the medicine works"

"I met someone who also told me that if I was positive I could have a child who is negative"

None of the KPs gave barriers on their experience with the PE counsellors at the GHS facilities.

Recommendations to improve GHS staff provider and care for KPs

The recommendations to improve care from GHS providers have been grouped into three main themes which are structural, human resource material resources and policy issues.

The issues are depicted in table 22.

Table 22: recommendations from KPs to improve upon GHS service provision

Accra	Kumasi
Human Resource	**Policy**
1. Train and retrain health workers to accept our sexual orientation	1. Subsidize the medication
2. Step up and continue education to KPs	2. Add food to the medication
3. Provide supervision for taking medication	3. Every hospital should be KP friendly
	4. Assist KPs to get NHIs
logistics	5. Put together a package for KPs
4. Ensure regular supply of medication	6. Assist KPs get vocational training
Make more CD4 count machines available	7. Fight stigmatization of KPs
Medications should be supplied in advance (to shorten frequency of visit to facility.	8. Ensure affordable laboratory investigations
	9. Government should dedicate some facilities purposely for MSM
	10. Legalize MSM activities to streamline treatment for MSM
	11. Rights of MSM should be strengthened

"All health workers should be involved as the problem has to do with the attitude of all health workers" (Administrative Staff, KATH)

Recommendations from GHS and NGO service Providers

There were several recommendations from KPs and NGOs alike. Majority of the recommendations were in support of training service providers to be KP friendly. One surprising recommendation from one of the MSM in Kumasi was about strengthening Article 21 clause 1E. When asked which of the articles he retorted that *"you guys should know better"*. Table 23 and 24 shows some of the findings on recommendations from the NGOs, GHS staff and KPs.

Table 23: Recommendations from NGOs

Accra	Kumasi
1. Education through social media. 2. More days can be given to peer Educators to work. 3. More condoms and Lubricants must be made available 4. Peers Educators must be neutral during their interactions with MSM groups. 5. We should build capacity to be confidential and approachable by KPS. 6. Consistent supply of Commodities such as First and Second Response Test Kits, condoms, lubricants 7. We should have role models who are accessing services to tell their success stories to encourage others. 8. The Aids bill which are about to be passed must be checked, because it will increase the number of people who wouldn't want to check. 9. Ghana Health Services, CHRAJ, and DOVSU Should we be involved in the improvement.	1. More DICs should be created across KP communities it will encourage them to come and test more. 2. Some basic STI drugs should be made available at the DICs this will encourage more people to visit the DICs 3. Quality of condoms supplied should be improved and also condoms and lubricants should always be available as we sometimes have shortages. 4. Condom vending machines can be provided in certain identified hot zones in KP communities so people can go and serve themselves when they urgently need some at night. 5. Nurses should also go into the community to visit KPs frequently just like PEs. So if PEs counsel then Nurses also counsel this will drum the message about prevention home more. 6. Some nurses who are good in providing HIV services should be identified and motivated with small allowances . this will motivate them to attend quickly to KPs when referred KP friendly nurses should also talk to their fellow nurses about how to handle clients and not to openly rebuke them.

The following were some recommendations from the KPs and GHS staff to improve

The PEs are the best people to talk to positive KPs and sometimes even accompany them to come for care so they should improve in doing that.- GHS staff from Kumasi.

I think it will be very helpful if GHS will consider bringing the ARTs to the NGOs instead.

I think it will also be very helpful if they could make routine calls to check on us and even meet us up at other places to deliver the drugs to us HIV(+MSM, Kumasi.

I also think that while we wait for the drugs at the facilities, some general counselling can be given to all of us – MSM, Kumasi.

Table 24: Recommendations from the KPs and GHS staff in Kumasi

GHS	FSW	MSM
1. Promote know your status outreaches. 2. Link reactive clients to health facilities. 3. Provide care and treatment to reactive clients during counselling. 4. Improve Peer Education. Improve drug supply. 5. Intensify education on importance of VCT. 6. Health workers must also reduce stigma and provide quality care. 7. Labs and other treatment should be made free to encourage people to get into treatment. 8. Motivate staff with Milo and other provisions to boost their immune system and this can be provided for clients too. 9. Provide staff with phone credits to remind clients of appointments. 10. Provide transportation allowances to go to KP sites. 11. Visit KP families to interact with them and provide maybe food and general home upkeep information.	1. Medication to be brought to us or given to the NGOs. 2. We need to have our own doctor who sees us specially. 3. Train health staff to avoid stigmatization or discrimination. 4. Avoid shortage of medication. 5. Follow up and provide assistance to patients who default about two months even if it is financial. 6. Train the doctors and nurses on how to treat the sisters. 7. Get people to go around and do education on HIV issues 8. Improve the NHIS coverage. 9. Provide centres that treat STIs only 10. Reduce the prices of the drugs [ARTs]. 11. Train nurses and how to passionately care for HIV positive people (sisters) 12.	1. Free medication. 2. Well informed peer educators 3. Availability of Counsellors. 4. Available or accessible health care 5. The models of hope should be more involved in outreach programs. 6. Availability of HIV medication. 7. More education for HIV facility personnel. 8. Need for more nurses and doctors who understand KPs and know how to keep secrets. 9. More KP friendly health facilities in addition to the two main ones. 10. Health insurance to cover STI treatment. 11. GHS to include KP Peer Educators in trainings for nurses so that they can understand us better. 12. Ghana Health Service to adopt a more personal approach like the NGOs to reduce the stigma at the general health facilities. 13. GHS should build the capacity of peer educators. 14. Peer educators allowances should be increased and paid on time. 15. GHS need house peer educators for effective community liaison services.

Some quotes to substantiate the findings in table 24:

"If you are not like me, no matter how much you think you understand me, you can never fully understand me" msm ksi

Table 25: Recommendations from GHS and KPs from Accra

GHS	FSW	MSW
1. Provide continuous education on radio and television. 2. Educate KPs to know the benefits of treatment 3. There should be motivation for staff 4. encouraged KPs to get tested 5. Provide the necessary logistics for service providers. 6. Get ART services close to KPs. 7. Some MSM should serve as models in the hospital to help peers to access services. 8. KPs to given special considerations (no queuing for KPs) 9. Get KPs a special place. 10. Other organizations and philanthropist can help with logistics to make our patients comfortable. 11. There should be good customer care between clients and staff. 12. Provide more doctors. 13. Laboratory services should be free.	1. GHS to make the medications available. 2. Service providers should learn how to talk to those who are positive. 3. GHS should have a dedicated place for getting HIV care for sisters 4. GHS should help reduce the cost of treatment 5. GHS should help us get health insurance card 6. GHS should help with feeding after medication 7. GHS should make sure medication is always available 8. Subsidize the medications. 9. Add food to the medication.	1. GHS to train its staff on Sexual Orientation and Gender Expression issues. 2. Need for more CD4 counts machines. 3. Funds to be made available for the doctors and nurses to visit KPs regularly with our medications. 4. Education should be given to the peer educators.

Linkages

With regards to linkages, GHS staffs, NGOs and KPs were of the view that GHS should get some liaison officers who would be a link between them, the NGOs and the KP community. Some of the finding included intensifying public education. There is the need to stress that many people are HIV positive but are not on treatment because they do not know their status. Government Health workers should work through NGO PEs to get more people to test.

Views from Accra:

"There should be more adverts to draw the key population out instead of the general population".

"Health workers, community nurses, key players in these association and their peers can all be involved".

"We should create awareness that we have the services".

Views from Kumasi

"Health care workers, nurses, counsellors and physician should be engaged in the process to get more KPs and we need data on KPs so that we can treat them. PEs should also be involved".

"Special staff can also be identified to attend to KPs … they can attend to them privately, go for their meetings and parties and utilize those occasions to reach them"

"Peer educators and health care providers can help link more KP's to services".

Thematic Analysis of the quantitative study

Knowledge and Awareness of Quality of Service to Key Populations

Knowledge and awareness of the quality of service rendered to MSW and FSW is an important consideration in the uptake of HIV service. Therefore this study collected data from respondents on their experience with the quality of service that is provided to this key population. The study looked at this in four main areas: number of clients seen in the past one month, experience of poor quality of health care being rendered to key populations, availability of resource materials at facilities to render good services to key populations and the health care workers receiving training of stigma and discrimination among MSM and FSW.

The results of the study showed that majority, 35 (43.8%) of respondents were un ware if they had attended to any client who was an MSM, 11 (13.7%) indicated they had attended to none. Twenty-two (27.5%) of the respondents had attended to between 1-9 MSM whilst 12 (15.0%) had attended to more than 10 MSM. Data from the qualitative aspect of the study showed that generally health workers believed they had attended to MSM. Generally it was believed that at least 3 in 10 clients that they attend to may be MSM.

Regarding respondents awareness of health workers unwillingness to attend to FSW, the results showed that majority, 66 (82.5%) of the respondents have in the past one month not experienced a health worker unwilling to attend to FSW. Only about 14 (17.5%) of respondents have experienced a health worker unwilling to provide service to FSW. Similarly, majority, 63 (78.7%) of respondents have never experienced a health worker rendering poor quality of service to FSW, whilst 17 (23.3.%) of the respondents indicated they have ever witness a health worker providing poor quality service to FSW.

With MSM, the results of the study showed that many participant, 65 (81.3%) have never experienced a situation where a health worker was unwilling to provide service to MSM. Fifteen respondents however indicate they have ever experienced a health worker indicating their unwillingness to provide services to MSM. In a similar vein, the results of the study further revealed that 58 (72.5%) of respondents have never experienced a health worker providing poor quality service to MSM. Nonetheless, 22 (27.5%) indicated they have ever experienced an MSM receiving poor quality health care.This study also elicited information of respondents on the commonness of people making derogatory comments about FSW and MSM. With FSW, the results of the study showed that 25 (31.2%) of the respondents indicated that they have never heard health workers making bad comment about MSM. However, 25 (31.2%) of respondents indicated they have never heard a health care worker passing a bad comment about MSM in one and two times, whilst 30 (37.6%) of the respondents have ever heard it several times. Regarding FSW, the result further showed that majority 28 (35.0%) of respondents have never heard health workers making bad comments about FSW. In 1-2 times, 25 (31.2%) have heard health workers make offensive comments about FSW whilst 25 (31.2%) have heard such comments on several occasions.

Data on facility-based service confidentiality and availability of resource materials for FSW and MSM was taken in this study. The results showed that majority, 52 (65%) of the respondents strongly agreeing that their facility provided enough confidentiality whilst another 23 (28.7%) agree to same. Only 5 (6.3%) of the respondent were of the view that their facility did not provide enough environment for confidentiality.

Furthermore, the study results showed that majority, 67 (83.7%) and 61 (76.3%) of the respondents believed their health facilities did not have facilities available to specifically address the needs of FSW and MSM. Training of health workers is also an important consideration in the knowledge, attitude and practices of health workers. Thus this study collected data on the training of health workers on specific areas of HIV control. The results showed that majority, 64 (80%) of respondents had received training on HIV stigma and discrimination, with 16 (20%) indicating they had not received such a training. With infection prevention, the results showed that 65 (81.3) and 15 (18.7%) had received and not received training in this area respectively. Again, 57 (71.3%) and 57 (71.3%) had received training in post-exposure prophylaxis and patients' informed consent, privacy, and confidentiality respectively. However, training on ways to reduce stigma to FSW and MSM was low as only 25 (31.3%) had received training in this direction. Table 26 give a summary of the data from the study.

Table 26: Knowledge and Awareness of Quality of Service to on Key Populations (1)

Variable	Response Option	Frequency (n)	Percentage (%)
Number of FSW attended within last month	None	11	13.7
	1-9	22	27.5
	10^{+}	12	15.0
	Don't Know	35	43.8
Unwilling to attend to FSW	Never	66	82.5
	One/Twice	10	12.5
	3-5 times	3	3.7
	6 times	1	1.3
Health worker rendering poor service to FSW	Never	63	78.7
	1-2 times	9	11.3
	Several times	8	10.0
Number of MSM attended within last month	None	**16**	20.5%
	1-9	**21**	26.5%
	10^{+}	**7**	8.7
	Don't Know	**35**	44.3
	Several times	8	10.0
Unwilling to attend to MSM	Never	65	81.3
	One/Twice	13	16.2
	3-5 times	2	2.5
Health worker rendering poor service to MSM	Never	58	75.5
	1-2 times	13	16.3
	Several times	7	8.7
	Most of times	2	2.5
	1-2 times	25	31.2
	Several times	25	31.2
	Most of times	2	2.6

Table 27: Knowledge and Awareness of Quality of Service to on Key Populations (2)

Variable	Response Option	Frequency (n)	Percentage (%)
Health worker making bad comment about MSM	Never	25	31.2
	1-2 times	25	31.2
	Several times	30	37.6
Health worker making bad comment about FSW	Never	28	35.0
	1-2 times	25	31.2
	Several times	25	31.2
	Most of times	2	2.6
Availability of facilities specifically for FSW	Yes	26	32.5
	No	67	67.5
Availability of facilities specifically for MSM	Yes	19	76.3
	No	61	23.7
Received Training:			
HIV stigma and discrimination	Yes	64	80.0
	No	16	20.0
Infection control	Yes	65	81.3
	No	15	18.7
Post-exposure prophylaxis	Yes	57	71.3
	No	23	28.7
Patients' informed consent, privacy, and confidentiality	Yes	57	71.3
	No	23	28.7
Key population stigma and discrimination	Yes	25	31.3
	No	55	68.7
Keeping health information confidential	Strongly agree	52	65
	Agree	23	28.7
	Disagree	5	6.3

Association between Selected Variables and Type of Health Personnel

The study further conducted a bivariate analysis for selected variables and the professional background of respondents. The response showed that among doctors and clinicians, 4 (26.7%) had not attended to any FSW in the past month, 2 (13.3) attended to between 1-9 clients whilst 2 (20.0) attended to more than 10 clients, but 6 (40.0) were unsure if they had attended to FSW. Also, among nurses, 11 out of the 13 nurses had at least attended to one FSW. Furthermore, the study showed that at least 55.5% of 38 Pharmacists who participated in this study had attended to a FSW. With regards to service to MSM, the study found that no doctor/clinician had attended to any MSM within the past one month. Across all the participants it was only among pharmacists that about 55.2% of 38 pharmacists indicated they had attended to MSM.

With regards to the experience of health workers showing their unwillingness to take care of MSM, the results showed that majority of doctors, 13 (86.7%) have never observed a health work showing discontent on taking care of MSM. No nurse indicated she has ever observed a health working showing unwillingness to take care of MSM. Among pharmacist, majority, 28 (73.7%) and 10 (26.3%) indicated they have never and ever observed a health worker showing discontent in caring for MSM respectively

The study showed that health workers talking ill about MSM were common. About 60%, 69.3% and 81.5% of doctors/clinicians, nurses and pharmacist respectively have ever heard a health worker saying bad things about MSM.

Concerning training of health workers on key HIV-related issues majority of doctors (60%), nurses (69.2%), and pharmacists (86.8%) had received training in HIV stigma and discrimination. Also across all the category of respondents at least over 60% have also received training in infections. However, regarding post-exposure prophylaxis, nurses (92.3%) and pharmacists (71.1%) had received training compared to doctors where only 46.7% of them had received training. The results showed that at least over 60% of each category of respondents had received training on patients' informed consent, privacy, and confidentiality. Meanwhile only a few received training in stigmatization and discrimination towards KPs. Among the doctors, only 13.3 had received training whilst among nurses and pharmacists only 38.5% and 57.1% respectively had received training. Table 27 shows a summary association between selected variables and the professional background of respondents.

Table 28: Distribution of selected variables among professional background of respondents

Characteristics	Doctor/ Clinician/ PA	Nurses	Pharmacist	Data/ Research Officer	Other
No. HIV + FSW seen for care or services in the past month					
None	4(26.7)	2(15.4)	3(7.9)	1(14.3)	1(14.3)
1-9	2(13.3)	2(15.4)	15(39.5)	2(28.6)	1(14.3)
10+	3(20.0)	1(7.7)	6(15.8)	1(14.3)	1(14.3)
I don't know FSW Clients	6(40.0)	8(61.5)	14(36.8)	3(42.9)	4(57.1)
No. HIV+ MSM seen for care or services in the past month					
None	5(35.7)	3(23.1)	6(15.8)	1(14.3)	1(14.3)
1-9	1(7.1)	0(0.0)	17(44.7)	3(42.9)	0(0.0)
10+	0(0.0)	1(7.7)	4(10.5)	1(14.3)	1(14.3)
I don't know FSW Clients	8(57.1)	9(69.2)	11(29.0)	2(28.6)	5(71.4)
Observed or heard about GHS employees unwilling to provide services to MSM (past 12 months)					
Never	13(86.7)	13(100.0)	28(73.7)	5(71.4)	6(85.7)
Once or twice	2(13.3)	0(0.0)	8(21.1)	2(28.6)	1(14.3)
Three or more times	0(0.0)	0(0.0)	2(5.3)	0(0.0)	0(0.0)
Observed or heard about healthcare workers talking badly about MSM (past 12 months)					
Never	6(40.0)	4(30.8)	7(18.4)	2(28.6)	6(85.7)
Once or twice	3(20.0)	7(53.9)	14(36.8)	1(14.3)	0(0.00
Several times	6(40.0)	2(15.4)	17(44.7)	4(57.1)	1(14.3)
Health care facility have educational materials available to address the needs of FSW					

Yes	9(60.0)	2(15.4)	12(31.6)	2(28.6)	I(14.3)
No	6(40.0)	11(84.6)	26(68.4)	5(71.4)	6(85.7)
Health care facility have educational materials available to address the needs of MSM					
Yes	6(40.0)	1(7.7)	10(26.3)	1(14.3)	1(14.3)
No	9(60.0)	12(92.3)	28(73.7)	6(85.7)	6(85.7)
Training on key HIV-related areas					
HIV stigma and discrimination Yes/No	9/15(60.0)	9/13(69.2)	33/38(86.8)	7/7(100.0)	6/7(85.7)

Attitude of health worker towards MSM and FSW

Attitude of health worker towards MSM

The results of the study generally showed health workers believed they had an obligation to attend to any client irrespective of their personal belief and moral orientation. Over 90% of the respondents held this view with less than 4% disagreeing with this stand. Furthermore, 32 (40.0%) and 36 (45.0%) of the respondents strongly disagree and disagreed respectively that it was possible to assume the sexual orientation of client based on their appearance. About 15% of the respondent held a different view. Regarding the most appropriate place of health services for MSM, the study found that about 70% of the respondent believed GHS facilities were the most appropriate health care outlets for MSM. This notwithstanding, some respondents also believed NGO facilities and private health outlets were also deemed appropriate. Results from questions on the most preferred clients health workers would like to provide HIV-related services to revealed that 49 (61.3%) of respondents were comfortable providing health service to gay men whilst 31 (38.7%) felt uncomfortable. Regarding FSW, 58 (72.5%) of respondents to this question indicated their ease in providing services to FSW whilst 22 (27.5) felt they were uncomfortable providing HIV-related services to FSW. Half of the respondents however felt comfortable providing services to injection drug users.

Data on participant attitude towards the availability and provision of services showed that majority, 67 (83.8%) indicated it was appropriate for health facilities to provide services to MSM. Regarding visual cues for MSM-friendly facilities, out of the 80 respondents to the question on using posters, 69 (86.3%) indicated it was inappropriate to use poster to identify such facilities. Similarly, majority, 67 (83.7%) of respondents deemed it inappropriate using gay magazines. The use of gay staff was also uncommon regarding respondents views on the most appropriate visual cues to indicate MSM-friendly health facilities. Despite this, data from the qualitative arm of this study showed that clients engage in multiple help-seeking behaviour including biomedical and spiritual.

Spiritual assistance is also sought because, it was believed that the practices had some spiritual undertones or one could be bewitched into engaging in such practices. Thus, some anointing or such spirit needs to be exorcised. The study also found that there was already some collaboration between the biomedical practitioners and the spiritual healing centres as client are often referred from healing centres to health facilities.

The study further collected data on which group of male clients should providers ask about same-sex behaviour. The results showed that majority, 62 (78.8%) of the

respondents believed all male clients could be asked about their sexual orientation. In-depth interview with health workers showed that MSM will often not willingly disclose their sexual orientation except when they are sick and need assistance. This was because MSM often believed they may be stigmatized if they disclose their sexual orientation to health workers or they have the feeling that the health workers may not treat the information as confidential.

However, some health workers employ some visual cues or gestures of clients to identify potential MSM. Some health workers believed that MSM will usually cross their legs at waiting area of consulting rooms. Other also believed that MSM are often shy during history taking and may be unwilling to be physically examined. Another clue often employed by health workers to suspect that a given client may be MSM is when they see rashes at the anal region or when client report with haemorrhoids.

The study also found that majority (Over 70%) of respondents think people should not be compelled to change their sexual orientation from homosexual or bisexual to heterosexual. Despite this view by respondents, anal sex was generally believed to be abnormal as 71 (88.7%) disagree that anal sex was normal. Nonetheless, a little over half (53.7%) believed that MSM should not be encouraged into heterosexual marriages. Nonetheless, in-depth interviews showed that some health worker often attempt to encourage MSM to change their sexual orientation. This in the view of some health workers discourages MSM to patronize the services at health facilities.

The study further found that overwhelming majority, 79 (98.7%) of the respondents firmly held the view that non-clinical staff should be trained in MSM-related stigma and discrimination. This was also supported by in-depth interview with health workers.

There were however, varied views on the type of stigma that MSM people suffer but in all, the study showed stigma was low across all categories. For example, only 23 (28.8%) of respondent believed MSM could be stigmatized by health workers refusing their needs for health care. Also, 25 (31.3%) and 33 (41.3%) were of the view that refusing to touch a gay or MSM client and using harsh or abusive language respectively were common form of MSM-related stigma. Table 28 provides a summary of the attitude of health workers to MSM.

Table 29: Attitude of health worker towards MSM

Variables	Response Options	Frequency (n)	Percentage (%)
General Attitude to HIV-related Services			
Health worker have obligation to attend to all client regardless of providers personal beliefs or morals	Strongly disagree	1	1.3
	Disagree	2	2.5
	Agree	18	22.5
	Strongly agree	59	73.7
Healthcare workers should assume sexual orientation of their clients based on appearance	Strongly disagree	32	40.0
	Disagree	36	45.0
	Agree	6	7.5

	Strongly agree	6	7.5
Most appropriate facility for rendering services to FSW & MSM			
GHS facility	Yes	56	70.0
	No	24	30.0
NGO facility	Yes	45	56.2
	No	35	43.8
Private facility	Yes	29	36.2
	No	51	63.8
Others		6	100
Key population groups do you feel most comfortable providing HIV services to in your clinic setting			
Gay men	Yes	49	61.3
	No	31	38.7
FSW	Yes	58	72.5
	No	22	27.5
Injection drug users	Yes	40	50.0
	No	40	50.0
I do not feel comfortable providing HIV services to any of the previously mentioned population	Yes	14	17.5
	No	66	82.5
Attitude to availability and provision of services to MSM			
I would prefer that this facility did not provide services to men who have sex with men/ Guy men.	Strongly disagree	36	45.0
	Disagree	31	38.8
	Agree	7	8.7
	Strongly agree	6	7.5
Visual cue to show that a facility or clinic is friendly towards gay men and other MSM?			
Posters or signs	Yes	11	13.7
	No	69	86.3
Gay magazines	Yes	13	16.3
	No	67	83.7
No discrimination policy	Yes	41	51.3
	No	39	48.7
Gay staff	Yes	7	8.7
	No	73	91.3
All the above	Yes	15	18.7
	No	65	81.3
Group of men should providers ask about same-sex behaviour	Young men only	4	5.0
	Married men only	2	2.5
	Self-identified gay men	4	5.0
	All male clients	63	78.8
	All the above	2	2.5
	Don't know	5	6.3
Change one's sexual orientation from homosexual or bisexual to heterosexual	Strongly disagree	8	10.0
	Disagree	20	25.0
	Agree	38	47.5
	Strongly agree	14	17.5
Anal sex normal	Strongly disagree	39	48.7
	Disagree	32	40.0
	Agree	6	7.5
	Strongly agree	3	3.8
Encourage MSM into heterosexual marriage	Strongly disagree	15	18.7

	Disagree	28	35.0
	Agree	26	32.5
	Strongly agree	11	13.8
Train non-clinical staff in stigma and discrimination	True	79	98.7
	False	1	1.3
Types of MSM-related stigma			
Refusing their needs for health care	Yes	23	28.8
	No	57	71.3
Refusing to touch a gay or MSM client	Yes	25	31.3
	No	55	68.7
Using harsh or abusive language	Yes	33	41.3
	No	47	58.7
Blaming the gay or MSM client for their health status	Yes	27	33.7
	No	53	66.3
Telling them they should stop being MSM	Yes	24	30.0
	No	56	70.0
Total		**80**	**100.0**

This notwithstanding, in-depth interviews with health workers showed that MSM/FSW-related stigma do occur especially among other clients. As a result of that MSM/FSW will often report at facilities outside the regular clinic times to avoid stigma.

Distribution of Knowledge of Health Care Professionals on Key Populations across type of health workers

The results showed across all professional groupings majority disagreed with the fact that MSM should be encouraged to change their sexual orientation. About 13 (93.3%) and 12 (92.3%) of clinicians and nurses respectively held this view. Regarding the fact that same sex behaviour and penetrative anal sex between men are normal aspects of human sexuality, the study found that about 66.7% of clinicians agree that it was normal. However, 7 (53.8%) of nurses believed both same sex and anal sex were abnormal. The study further revealed that there was unanimity across all professionals regarding the need for nonclinical staff to be trained in stigma and discrimination.

Table 30: Distribution of Knowledge of Health Care Professionals on Key Populations across type of health workers

	Doctor/ Clinician/ PA	Nurses	Pharmacist	Data/ Research Officer	Other	Total
It is possible and advisable to change ones sexual orientation from homosexual to heterosexual						
Strongly agree	1(6.7)	0(0.0)	2(5.3)	0(0.0)	0(0.0)	3
Agree	0(0.0)	1(7.7)	3(7.9)	0(0.0)	2(28.6)	6
Disagree	3(20.0)	10(76.9)	15(39.5)	3(42.9)	1(14.3)	32
Strongly disagree	11(73.3)	2(15.4)	18(47.4)	4(57.1)	4(57.1)	39
Same sex behavior and penetrative anal sex between men are normal aspects of human sexuality						
Strongly agree	6(40.0)	0(0.0)	6(15.8)	1(14.3)	1(14.3)	14
Agree	4(26.7)	6(46.2)	21(55.2)	4(57.1)	3(42.8)	38
Disagree	5(33.3)	5(38.5)	6(15.8)	2(28.6)	2(28.6)	20
Strongly disagree	0(0.0)	2(15.3)	5(13.2)	0(0.0)	1(14.3)	8
Non clinical staff need to be trained in stigma and discrimination despite their role						
True	15(100.0)	13(100.0)	37(97.4)	7(100.0)	7(100.0)	79
False	0(0.0)	0(0.0)	1(2.6)	0(0.0)	0(0.0)	1
When it is safe, which of these visual cue will show a facility or clinic is friendly towards MSM						
Posters or signs showing male couples Yes/No	2/15(13.3)	1/7(7.7)	6(15.8)	2(28.6)	0(0.0)	11
Presence of guy friendly Magazines in the clinic Yes/No	1/15(6.7)	1/13(7.7)	8(21.1)	1(14.3)	2(28.6)	13
Posting non- discrimination policies that include guy men and other MSM Yes/No	6/15(40.0)	9/13(69.2)	19/38(50.0)	5/7(71.4)	2/7(28.6)	41
Presence of men who are Guy or MSM Yes/No	0/15(0.0)	1/13(7.7)	3/38(7.9)	2/7(28.6)	1/7(14.3)	7
All of the above Yes/No	5/15(33.3)	1/13(7.7)	8/38(21.1)	0/7(0.0)	1/7(14.3)	15
None of the above Yes/No	3/15(20.0)	3/13(23.1)	8/38(21.1)	1/7(14.3)	2/7(28.6)	17
TOTAL	**15**	**13**	**38**	**7**	**7**	**80**

Attitude of health workers towards FSW

The study also collected data on the attitude of health workers towards FSW, examining it from the people's view of providing them with services and their willingness to provide FSW with health care. The results showed that majority of the respondents believed health facilities should provide FSW with service. About 42 (53.2%) and 31 (39.2%) of the respondents indicated they strongly disagree and disagree respectively that given the opportunity, they will prefer health facilities not to provide health services to FSW. Less than 8% of the respondents felt they will prefer health facilities not to render services to FSW. When respondents were asked to indicate the reasons why they will not be willing to provide health services to FSW, the results showed that generally health workers in this study have no reservations in providing or attending to FSW. Generally, health workers did not believe that attending to FSW posed a risk to them, 76 (95%), only 4 (5.0%) felt though otherwise. Majority of the respondents, 75 (93.7%) will not be unwilling to attend to FSW because they believed their act was immoral but 5(6.3%) were of the view that their act was immoral and therefore inappropriate for one to attend to their health needs.

Regarding the importance of addressing the health need of FSW, respondents generally believed that it was important to attend to them as this could reduce the transmission of infection to others, improve their general well-being, and ensure a longer health life. About 58 (75.5%) of respondents held this view. Furthermore, respondents generally believed training of non-clinical health staff on stigma and discrimination was essential. This view was held by 76 (95%) of respondent in this study.

This study further elicited information on the common forms of stigma and discrimination that FSW endure. The results showed that 25 (31.3%) believed FSW could be refused their needs as a form of stigma, 24 (30.0%) believed people could refuse to touch them. Another 18 (22.5%) and 31 (38.7%) believed inappropriate touch and use of abusive words were the common types of stigma and discrimination against FSW respectively. Blaming FSW and asking them to stop being FSW was also less common as it was reported by 23 (28.7%) and 10 (12.5%) of respondents. Generally from the results, stigma and discrimination for FSW was uncommon in health facilities.

In addition, the study found that 43 (63.2%) of respondents actually take the sexual history of clients they attended to in the health facility with only 40 (59.7%) taking history of the gender of clients partner. However, several barriers were found in this study to inhibit the history taking process. Thirty-six (45%) of the respondents think clinician often make a false assumption regarding the sexual behaviour and level of risk of clients. The study further showed that 36 (45%) and 32 (40%) of respondents believed they often feel uncomfortable and lack the knowledge to respond to issues on FSW respectively as a barrier to history taking. Another 34 (42.5%) were of the view that lack of time was a main barrier to history taking. Table 30 gives a summary of the attitude of participants to FSW.

Table 31: Respondents attitude to FSW

Variable	Response options	Frequency (n)	Percentage (%)
Attitude to availability and provision of services to MSM			
I would prefer that this facility did not provide services to FSW	Strongly disagree	42	53.2
	Disagree	31	39.2
	Agree	4	5.1
	Strongly agree	2	2.5
Reason for not wanting to provide services to FSW			
Pose Risk to Self (Service provider)	Yes	4	5.0
	No	76	95.0
Perceived immoral act	Yes	5	6.3
	No	75	93.7
Not trained to provide such service	Yes	6	7.5
	No	74	92.5
Importance on the health of female sex workers			
Reduced disease transmission and progression	Yes	24	30.0
	No	56	70.0
Improved physical and mental well-being	Yes	5	6.5
	No	75	93.7
Longer, healthier lives	Yes	5	6.5
	No	75	93.7
All the above	Yes	58	75.5
	No	22	27.5
Train non-clinical staff in stigma and discrimination	True	76	95.0
	False	4	5.0
Types of FSW-related stigma			
Refusing their needs for health care	Yes	25	31.3
	No	55	68.7
Refusing to touch a FSW client	Yes	24	30.0
	No	56	70.0
Inappropriate touch	Yes	18	22.5
	No	62	77.5
Using harsh or abusive language	Yes	31	38.7
	No	49	61.3
Blaming the FSW client for their health status	Yes	23	28.7
	No	57	71.3
Telling them they should stop being FSW	Yes	10	12.5
	No	70	87.5
History Taking of Clients during consultation			
Taking of sexual history of all clients	Yes	43	63.2
	No	25	36.8
Take gender history of client partner	Yes	40	59.7
	No	27	40.3
Barriers to taking a proper sexual history			
Making a false assumption regarding the sexual behaviour	Yes	36	45.0
	No	44	55.0
Discomfort discussing sexuality with patients	Yes	36	45.0
	No	44	55.0
Lack of knowledge about how to respond to issues that arise	Yes	32	40.0
	No	48	60.0
Lack of time	Yes	34	42.5
	No	46	57.5
Expressing judgments about client's sexual behaviors	Yes	32	40.0
	No	48	60.0

Distribution of Key Population-related Services across Years of Experience of Health Workers

The study showed that across all the number of groups people have received training on HIV stigma and discrimination, infection prevention, post-exposure prophylaxis, patients consent and privacy. More than 70% of respondents across all five categories regarding years of experience, respondents had received training in HIV stigma and discrimination. About 66.7%, 86.9% and 83.3% of respondents who had worked for 1-4 years, 5-9 years and 10-14years respectively had received training on infection prevention. However, the differences were not significant. Regarding post-exposure prophylaxis, the study showed that the number of people who had received training increased with increasing working experience and peaked at those who had worked for between 10-14 years as 91.7% of those who had received training.

The results of the study also showed that the people with lower number of working experience generally believed that it was possible and advisable to change ones sexual orientation from homosexual to heterosexual. Among respondents who had worked for between 1-4 years, 58.4% believed people should be encouraged to change their sexual orientation to heterosexual. Among those who had worked for between 5-9 years, 78.3% held a similar view. It was also unanimous across the various groups that non clinical staff need to be trained in stigma and discrimination despite their role. Table 31 shows the years of working experience among Health Care Workers and Knowledge on Key Populations

The study showed that one way to improve the quality of care to MSM is to engage counsellors at various health outlets. In doing this health workers will concentrate on the clinical aspect of health care and refer the clients to counsellor to take care of other psycho-social aspects.

Also the education and sensitization of KP's on taking of their drugs was essential to improve adherence to treatment. Inadequacy in infrastructure in handling KP's was also reported as a barrier to providing services to the MSM and FSW. Thus providing infrastructure was believed to be capable to improving the quality of services that is currently being rendered to MSM and FSW. Another strategy that can be used to improve quality of care to MSM/FSW was to motivation of staff working at the HIV clinic

The study also found that sometimes there are stock out of medication for HIV which has the potential to affect adherence to treatment. Health workers were also of the view that service provision to FSW could be enhanced by providing the service outlets with vaginal spatulas in addition to assigning specific clinic days solely for them.

Table 32: Distribution of Key population-related service across Years of working experience among Health Care Workers

Characteristics	1-4yrs	5-9 yrs.	10- 14yrs	15yrs+	Total
Ever received training in the following Subjects					
HIV stigma and discrimination **Yes/No**	17/24(70.8)	20/23(86.9)	9/12(75.0)	18/21(85.7)	
Infection control **Yes/No**	16/24(66.7)	20/23(86.9)	10/12(83.3)	19/21(90.5)	
Post exposure prophylaxis **Yes/No**	12/24(50.0)	18/23(78.3)	11/12(91.7)	16/21(76.2)	
Patient informed consent privacy and confidentiality **Yes/No**	14/24(58.3)	17/23(73.9)	9/12(75.0)	17/21(80.9)	
Key population stigma and discrimination **Yes/No**	5/24(20.8)	6/23(26.1)	5(41.7)	9/21(42.9)	
It is possible and advisable to change ones sexual orientation from homosexual to heterosexual					
Strongly agree	7(29.2)	1(4.4)	2(16.7)	4(19.1)	14
Agree	7(29.2)	17(73.9)	6(50.0)	8(38.1)	38
Disagree	7(29.2)	1(4.4)	4(33.3)	8(38.1)	20
Strongly disagree	3(12.5)	4(17.4)	0(0.0)	1(4.8)	8
Same sex behavior and penetrative anal sex between men are normal aspects of human sexuality					
Strongly agree	0(0.0)	1(4.4)	0(0.0)	2(9.5)	3
Agree	2(8.3)	3(13.0)	0(0.0)	1(4.8)	6
Disagree	10(41.7)	9(39.1)	7(58.3)	6(28.6)	32
Strongly disagree	12(50.0)	10(43.5)	5(41.7)	12(57.1)	39
Non clinical staff need to be trained in stigma and discrimination despite their role					
True	24(100.0)	22(95.7)	12(100.0)	21(100.0)	79
False	0(0.0)	1(4.3)	0(0.0)	0(0.0)	1
TOTAL	**24**	**23**	**12**	**21**	**80**

6.0 Discussion

This study sought to qualitatively assess client-level barriers and facilitators to HIV testing, enrollment, and retention in HIV care and treatment among Female Sex Workers (FSW) and Men having Sex with Men (MSM) in Accra and Kumasi. It also sought to qualitatively and quantitatively assess service-delivery barriers and facilitators to providing accessible, acceptable, and sustainable services across the HIV continuum of care to KPs.

FSW and MSM in Ghana have equal access to health care. There are an array of HIV services from the Public Health Facilities (Ghana Health Service) and NGOs. Whereas the NGOs majored in providing community based services in the form of counseling, testing, education, sale of commodities and support for PLHA, GHS on the other hand ensured availability of facility - based care from diagnosis to treatment mingled with pockets of home visiting services.

Knowledge and Awareness of Quality of Service to Key Populations

Generally, the quest for confidentiality and privacy drive KPs preference for health care services such as testing, enrolling in care and staying in consistent care. One of the underlying factors for KPs seeking confidentiality and privacy in this study was fear of being seen by an acquaintance and fear of stigmatization by other clients and health workers. This also accounted for KPs preference for a "one – stop – shop". Accessing HIV care in a "one – stop – shop has the tendency of minimizing interactions with different people who may "tell their story" to others and its repercussions. Stigmatization of MSM is a common occurrence (Altman et al., 2012; Hatzenbuehler, O'Cleirigh, Mayer, Mimiaga, & Safren, 2011; Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008). In line with this study, Obemeyer and Osborn (2007) reported fear of stigmatization as a major barrier to HIV services. The same phenomenon was found in Swaziland by Risher et al.,(2013) and in South Africa by (Cloete et al., 2008). These place stigmatization as an issue of grave concern in planning for quality of HIV care.

Furthermore, KPs in this study also exhibited stigma related behaviours such as reporting late or at odd hours to clinics. Stigma related behaviours have been reported by Li et al., (2012) as a barrier to HIV prevention and control. It is likely to undermine the "Know your status" from voluntary testing and counselling services currently being used as a major strategy by the Ghana national HIV control programme (NACP, 2013). Although stigma was an issue in both the quantitative and qualitative study, the factors contributing to stigmatization was not assessed in this study. Rather community activities on HIV testing facilitated testing for HIV by the KPs in this study.

High prevalence of HIV has been reported among FSW (Baral et al., 2012; Lawan, Abubakar, & Ahmed, 2012). Therefore having access to HIV-related services and counselling will inform better health seeking and sexual behaviour. Where services are not sought, FSW may continue to pose risk to their clients' with negative effects on HIV control. For example, a study in Nigeria found that 29.6% of FSW were HIV positive and

were routinely engaged in unprotected sexual intercourse with clients (Lawan et al., 2012). For the FSW, the health workers had no negative attitude towards providing health services to them. Despite majority of the respondents, 75 (93.7%) believing that FSW was an immoral act, about 42 (53.2%) strongly disagreed that given the opportunity, they will prefer health facilities not to provide health services to FSW. Generally, health workers did not believe that attending to FSW posed a risk to them, 76 (95%), only 5 (5.0%) felt otherwise. Nonetheless, this studies found that majority of workers in this study were not trained on how to reduce stigma and discrimination for FSW and MSM. However, a study among health workers in Nigeria found that previous training played a role in the reduction of shame and blame (Sekoni & Owoaje, 2013). Stigma is not merely an attribute, but represents a language of relationships (Alonzo and Reynolds, 1995). Thus it would be important to institute training for health workers in this direction.

This study revealed that 35 (53.8%) of respondents were unaware if they had attended to any client who was an MSM. Some studies have shown that the burden of HIV among MSM (14–18%) have been high especially in sub-Saharan Africa (Beyrer et al., 2012). Baral et al., (2009) also found 17.4% HIV prevalence among MSM in Malawi, Namibia and Botswana. Clinicians ought to inquire about the sexual orientation of their clients in order to provide holistic services to them.

The study found that there were facilities equipped to provide services to MSM. Participants also confirmed the availability of basic HIV services including access to HIV testing and counselling, condoms, and appropriate lubricants to prevent anal scarring. With regards to availability or willingness of service providers, majority of the health workers in this study believed services should be provided to all clients irrespective of their sexual orientation. This is an improvement of what Sullivan et al., (2012) ‘s report on lack of access to health services by MSM. The few health workers in this study who were uncomfortable providing services to such people as their act was deemed unnatural and against religious values need to be re oriented on value clarifications and the ethics of the health service. This would augment global targets to achieve HIV control through extending HIV-related services to MSM as they bear high burden of HIV (Beyrer, Sullivan, et al., 2012).

Logistics wise, in this study were pill burden and periodic shortage of ARVs were found as barriers in this study. These are issues that need effective policies across the levels of health care in Ghana.

Service delivery level facilitators

Structure wise, KPs had preference for services rendered from NGO premises over GHS facilities. Their desire for privacy and assurance of confidentiality support their choice for prompt services from NGO facilities where they are likely to meet less people. According to the KPs, NGO staffs are appraised periodically. In one of the FGDs in Kumasi, a staff confirmed that they are requested to sign and abide by confidentiality agreements and

strive to exhibit tolerance since they work with a sensitive population. They can be laid off when they go contrary to rules and regulation which earns them a reputable image before the KPs. This assertion is also supported by a finding in Pauw and Brener, (2003)'s study. According to them, sex workers in general do not feel comfortable accessing health care services from clinics because of perceived stigmatization from service providers. It has also been found that KPs are quick to complain about medical personnel (Adebajo et. al 2003; Wojcicki and Malala 2001). Meeting different people in GHS facilities as compared to meeting the same staff at NGO settings heightens KPs anxiety on perceived breach of confidentiality.

GHS facilities that have secluded ART centres were favoured by KPs as well. KPs who visit such facilities also showed preference for particular service Providers they tag as "nice to us". That is why KPs who access HIV services in facilities that have special clinic days or designated areas for KPs go contrary to time and days to access their services.

Having all the needed services and logistics at one place was a facilitator as well. The emphasis was on a "one stop shop". KPs prefer nurses to hand their medications over to them instead of accessing medicines from different people and different locations. They perceive having "everything" under one roof as limiting interactions with other people who will eventually get to know of their sexual orientation or HIV status. Much as they desire a "one stop shop" they detest a stand-alone branded facility.

Service delivery level facilitators and barriers to HIV care

Service Providers

Service provider attitude was both a barrier and a facilitator in the qualitative study. KPs, NGO and GHS service providers alike mentioned friendly and accommodating service providers as a facilitator to access of HIV care by KPs. Despite GHS service providers' assurance of providing quality and confidential service to KPs, passing of derogatory remarks and speaking ill of KPs negate that assertion.

From the NGO perspective, tailoring services to meet KP needs enhances access to HIV care hence the use of various community based approaches to enhance KPs access to health care services. The KPs confirmed their likeness for social activities. Majority of the FGD discussants got to know about HTC, treatment and staying in consistent treatment from such outdoor activities and PEs.

Service delivery barriers to HIV care

Service delivery barriers

Newly diagnosed HIV positive KPs are required to bring a monitor for ART services likewise those with STI. MSM and FSW alike find it difficult to present their partners for STI treatment. This serves as a hindrance to staying in consistent care. With the proliferation of adverts on spiritual and herbal cures for HIV coupled with the ease of

accessing almost all medications over the counter, KPs will resort to such services where the involvement of another person will be required.

Service Provider level

Donning of masks and gloves to attend to KPs are seen as barriers. As part of Universal Precautions for Infection Prevention, health workers don gloves, masks and gowns. KPs interpret this as shunning or stigmatizing. One KP remarked that even if possible service providers will wear sacks when attending to them. The qualitative study supports that service providers (37%) always hear their colleagues pass derogatory remarks at KPs. Again on several occasions, 31% of service providers have heard health workers making offensive remarks about KPs.

Poor service provider attitudes and poor service delivery such as long waiting times, poor logistics management (shortage of essential drugs and lack of basic equipment) and dispersed or non-available services deter KPs from accessing and staying consistently in HIV care. There is need for innovation in HIV care where Peer educators will operate from public health facility levels. GHS should consider adopting some of the NGOs approaches in serving KPs for the KPs to feel that their health is the concern of GHS.

Client Level Facilitators

With regards to general health services, KPs prefer to access services from facilities where they can get all the services under one roof; from well-trained friendly service providers who ensure privacy and confidentiality. KPs also prefer focused services from one person who will attend to all their needs including dispensing of medications. The quest for confidentiality will drive KPs to travel far and avoid been seen by familiar faces when accessing HIV services. Similar studies have found the need for confidentiality and privacy as factors that influence HIV service uptake by FSW and MSM alike (Kwapong *et. al*, 2014; Awad et al, 2004). This need for privacy also explains KPs especially the MSM preference for NGO services over GHS services. Likewise, prompt and judgement free services from competent staff also facilitate KPs' access to HIV services.

HTC services, enrolment in care, and staying consistently in care:

There were varieties of HIV services from both the Public Health Facilities (Ghana Health Service) and NGOs for KPs. KPs cited promptings and IE&C activities from PEs as facilitators to accessing HTC services. This finding is congruent with similar services provided for club based FSW in Catalonia (Folch et al, 2013). Mandatory HTC at antenatal clinics and TV adverts were also mentioned as facilitators to testing for HIV by KPs. Yawson, Dako-Gyeke and snow (2012) found a higher patronage of testing (about twice the number) through know your status (KYS) campaigns than testing done at DCs each year. However, the KYS captured a relatively low proportion of HIV-positive individuals compared to medically referred testing at the DICs. KPs in this study prefer testing in community programmes and DICs. Equipping, and collaborating care from GHS and the DICs would go a long way to enhance HIV care in Ghana.

Education remains an important tool in HIV prevention and service uptake. From this study, knowing the difference between HIV and AIDs and the assurance of ART also

served as motivation to knowing one's status. This is in agreement with Apanga et al (2015)'s finding that having formal education increases the chance of using VCT services. It was also revealed that belonging to a group encourages testing. In one of the FGDs, an NGO staff remarked that a group of MSM in Accra have sworn to ensure that none of the group members die from AIDS. They encourage HIV positive clients to stay in care and help the negative clients to practice safer sex including periodic testing. Such group support is commendable and needs further research to inform policies on HIV care.

Other facilitators to enrolling in HIV care were linked to the liaison role of the Peer Educators and the "model of Hope". This study revealed that PEs recommend KP friendly facilities to KPs whilst the model of hope encourage "pill burdened" clients to focus on treatment. They also provided immense support to newly diagnosed HIV clients.

Client level barriers to access to HIV services

Notwithstanding, KPs have barriers to accessing health care services. The major barriers for testing, enrolling, and staying in HIV services were confidentiality issues and stigmatization. These form the basis for KPs' preference for services from NGOs above GHS facilities. The Ghanaian culture is yet to embrace MSM and FSW activities though it is known that they exist in the society. The lack of legal backing for KP activities in Ghana make it difficult for them to declare their sexual orientation even at the detriment of their health. HIV positive KPs are already burdened with the fact that they are responsible for their disease, due to poor choices and immoral lifestyles leading to internal stigma. This has been confirmed by Bogart et al, (2013) as a major barrier to HIV care. This explains why majority of KPs in this study were not willing to declare their sexual history to service providers. With reference to the bi-variate analysis, 40% of the doctors providing HIV care were unsure if they have ever attended to FWS but 52% of Pharmacists were aware they had attended to FSW. It is possible doctors are not asking about sexual history or orientation due to case overload; whilst Pharmacists have the luxury of time to do so.

The same reasons discussed above also lead to stigmatization and discrimination from society. From this study, KPs would not mind accessing HIV services from distant facilities just to avoid being seen by familiar people. This explains why stigmatization is a major health access barrier in this study. It is consistent with the findings from King et al (2013); Folch et al (2013) and Ghimire & van Teijlingen, (2009). Similarly Moura et al. (2010) found out that stigmatization drives FSWwho are HIV positive to hide their status, fail to purchase medicine and to attend medical consultations.

Other barriers to accessing HIV services such as lack of money, fear of losing their sexual partners (clients) or job and fear of positive test result were found in this study. Majority of the KPs interviewed chose sexual work as their occupation, followed by student or trader. Not having adequate money to buy perceived expensive medications served as a barrier to seeking and staying in HIV diagnostic, treatment and care services. Poverty and HIV are bedfellows since one aggravates the onset of the other (Türmen, 2003). Women

in particularly as found in this study were vulnerable to poverty. Although some MSM complained of lack of money for transportation, the FSW were in the majority. One of them said because of poverty she would report to duty at the expense of seeking health care. This was also reported by Barennes et al, (2015), Sarnquist et al, (2011) and Mill and Anarfi, (2002).

Similarly Morin et al, (2006), found cost as a barrier in addition to fear of breach of confidentiality. Lack of food has also been identified as a barrier to staying consistently in HIV care such that HIV positive clients skipped their medications when they did not have food (Weiser et al, 2010). Social interventions similar to the "enablers" package in Tuberculosis care could be evaluated and replicated for HIV care by the government and health partners.

Attaching HIV with "death sentence" is dreadful. It is an issue KPs detest. This also forms a basis for the fear of a positive HIV test. Others felt it is better one does not know his or her status to spare him or her agony or mental torture one will go through should the results be positive. Fear has also been cited as a barrier to HIV services in many studies including

The lack of perceived susceptibility to HIV and denial particularly among MSM also accounted for either not testing or enrolling and staying in consistent HIV care. Other issues such as forgetfulness, complacency, laziness feeling better and desire for spiritual of traditional cure hinder enrolment and consistent stay in HIV care.

Side effects of the medicines, medication fatigue, pill load and change in lifestyle while on medication were seen as barriers to retention in care from the service providers' perspectives. Others would not take the medication because it is difficult to hide taking medications from people they live with. These factors led to delay as well as hindrances to enrolment and staying in HIV treatment and care (Sundaram, et al 2015). There is the need for the GHS to consider the use of combination therapy whilst clinicians step up counselling on HIV care in general. Home visits to support clients would be welcoming.

7.0 Conclusion

KPs cherish privacy and confidentiality, a perceived breach in these factors; become barriers to accessing, enrolling, and retention in HIV treatment and care. Health workers believe KPs are entitled to good quality health care as other clients though there was the generally believe that their acts may be immoral and unacceptable. Sigma and discrimination, financial challenges fear of losing job, pill load/medication fatigue Side effects of ARVs, were some of the client level barrier. While shortage of HIV commodities, long waiting time by KPs and desire for spiritual /traditional healings came out as service delivery barriers. Providing HIV care in quiet and private "one stop shops" sites would enhance and facilitates KPs access to health care. The need for discretion in dealing with KPs and their partners by service providers cannot be overemphasized in this

study. It is time for GHS to review the policy on the need for a treatment monitor for HIV positive clients. Peer educators could be assigned instead of relying on people who are familiar to the KPs.

Recommendations

The king pin in increasing access to HIV care services in GHS facilities is the need for a "one stop" shop focused services for KPs.

National AIDS/STI Control Programme, GHS

It is imperative that the NACP/GHS ensure that interventions are rolled out based on the findings of this study. Key among the proposed interventions is the need to roll out an implementation research on a package of interventions for KPs from NGO and GHS facilities. The aim is to determine which of the facilities would enhance KP access to HIV care services.

NACP/GHS needs to conduct further research into community activities and the role of the Peer Educators in HIV care.

NACP/GHS needs to consider reviewing and scaling up the "model of Hope" and other group support for HIV positive clients.

Ministry of Health and Ghana Health Service:

Challenges such as lack of finance for transport, payment of laboratory service and medicines require effective policies from the GHS.

It is important that GHS assess and implement an enablers fund for HIV services to enhance compliance to care services by KPs.

There is the need for Ministry of Health to consider the use of combination therapy for HIV care to reduce the "pill load / pill burden" barrier.

While GHS works at reducing periodic medication stock out; Health Partners could work on equipping Drop In Centers with treatment resources and food supplements or aid.

GHS should consider partnering with NGOs by re orienting and sending some of its ARV providers to provide support at the DICs. Public Health Officers (PHN, DCO, NO, HEO) could also be re oriented to provide support at NGO sites. This will enhance linkage and standardization of services thereby assuring quality care to KPs.

The Ministry of Health should put in the necessary measures to ensure that the NHIS cover essential service including STI care for KPs.

GHS and Health Partners need to consider capacity building for the PEs from the NGOs and GHS service providers on customer care and effective linkages.

HIV programme managers and coordinators should expand access to services by considering integration of community services with GHS facility based services in their localities.

Policy wise, GHS should consider piloting and scaling up the mainstreaming of focused HIV care services in its facilities to ensure KPs access services from "brand free" buildings.

GHS should come out with a model of home visiting programme for all HIV positive clients specifying the goal, dosage, content and duration of visit. This would go a long way to enhance compliance, support for pill burden and increase access to HIV care among key populations whilst providing indicators to evaluate the fidelity and cost effectiveness of the Home visitation programme.

The extra duty hours imposed on health workers staying beyond their normal working hours to attend to such clients call for incentive packages. Assigning special clinic days for the key population could also be considered.

There is the need to evaluate community activities on HIV services to inform policy decisions and also delve in to the causes and types of stigmatization KPs face in assessing health care services

REFERENCES

Adebajo, S. B., Bamgbala, A. O., & Oyediran, M. A. (2003). Attitudes of health care providers to persons living with HIV/AIDS in Lagos State, Nigeria. African Journal of Reproductive Health, 7(1), 103–112.

Alanzo, A. A, and Reynolds, N. R. (1995). Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. Sot'. Sci. Med. Vol. 41. No. 3. pp. 303-315.

Altman, D., Aggleton, P., Williams, M., Kong, T., Reddy, V., Harrad, D., … Parker, R. (2012). Men who have sex with men: Stigma and discrimination. *The Lancet*. http://doi.org/10.1016/S0140-6736(12)60920-9

Apanga, P. A., Akparibo, R., Awoonor-Williams, J. K. (2015). Factors influencing uptake of voluntary counselling and testing services for HIV/AIDS in the Lower Manya Krobo Municipality (LMKM) in the Eastern Region of Ghana: a cross-sectional household survey. Journal of Health, Population and Nutrition 33:23

Awad, G. H., Sagrestano, L. M., Kittleson, M. J.and Sarvela, P. D. (2004). Development of a measure of barriers to HIV testing among individuals at high risk. AIDS Education and Prevention, 16(2), 115–125. The Guilford Press

Baral, S., Beyrer, C., Muessig, K., Poteat, T., Wirtz, A. L., Decker, M. R., … Kerrigan, D. (2012). Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis. *The Lancet Infectious Diseases*, *12*(7), 538–549. http://doi.org/10.1016/S1473-3099(12)70066-X

Baral, S., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., Dausab, F…, & Beyrer, C. (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*, *4*(3). http://doi.org/10.1371/journal.pone.0004997

Barennes H, Frichittavong A, Gripenberg M, Koffi P (2015) Evidence of High Out of Pocket Spending for HIV Care Leading to Catastrophic Expenditure for Affected Patients in Lao People'smDemocratic Republic. PLoS ONE 10(9)

Beyrer, C., Baral, S. D., van Griensven, F., Goodreau, S. M., Chariyalertsak, S., Wirtz, A. L…, & Brookmeyer, R. (2012). Global epidemiology of HIV infection in men who have sex with men. *Lancet (London, England)*, *380*(9839), 367–77. http://doi.org/10.1016/S0140-6736(12)60821-6

Beyrer, C., Sullivan, P. S., Sanchez, J., Dowdy, D., Altman, D., Trapence, G., … Mayer, K. H. (2012). A call to action for comprehensive HIV services for men who have sex with men. *The Lancet*, *380*(9839), 424–428. http://doi.org/10.1016/S0140-6736(12)61022-8

Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., & Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, *20*(9), 1105–10. http://doi.org/10.1080/09540120701842720

Folch, C., Esteve, A., Sanclemente, C., Martro, E., Lugo, R., Molinos, S., Casabona, J. (2008). Prevalence of human immunodeficiency virus, Chlamydia trachomatis, and Neisseria gonorrhoeae and risk factors for sexually transmitted infections

among immigrant female sex workers in Catalonia, Spain. Sexually Transmitted Diseases, 35, 178183.

Genberg, B.L.; Hlavka, Z., Konda, K. A., Mamanc, S. et al. (2009). A comparison of HIV/AIDS-related stigma in four countries: Negative attitudes and perceived acts of discrimination towards people living with HIV/AIDS Social Science & Medicine 68; 2279–2287

Ghimire, L., & van Teijlingen, E. (2009). Barriers to utilisation of sexual health services by female sex workers in Nepal. Global Journal of Health Science, 1, 1222.

Hatzenbuehler, M. L., O'Cleirigh, C., Mayer, K. H., Mimiaga, M. J., & Safren, S. A. (2011). Prospective associations between HIV-related stigma, transmission risk behaviors, and adverse mental health outcomes in men who have sex with men. *Annals of Behavioral Medicine*, *42*(2), 227–234. http://doi.org/10.1007/s12160-011-9275-z

Hodorogea, S., & Comendant, R. (2010). Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia. International Journal of Gynecology and Obstetrics, 110, S34S37.

Johnson, M. et al. (2015), Barriers to access to care reported by women living with HIV across 27 countries, AIDS Care, 27(10):1220–1230.

Kwapong, G.D., Boateng, D., Agyei-Baffour, P., Addy, E. A. (2014), Health service barriers to HIV testing and counseling among pregnant women attending ANC; a cross-sectional study BMC Health Services Research 2014, 14:267 doi:10.1186/1472-6963-14-267

Lawan, U. M., Abubakar, S., & Ahmed, A. (2012). Risk perceptions, prevention and treatment seeking for sexually transmitted infections and HIV/AIDS among female sex workers in Kano, Nigeria. African Journal of Reproductive Health, 16(1), 61–7. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22783669

Li, X., Lu, H., Ma, X., Sun, Y., He, X., Li, C., … Jia, Y. (2012). HIV/AIDS-related stigmatizing and discriminatory attitudes and recent hiv testing among men who have sex with men in Beijing. *AIDS and Behavior*, *16*(3), 499–507. http://doi.org/10.1007/s10461-012-0161-x

Mill, J. E., Anerfi, J. K. (2002) . HIV risk environment for Ghanaian women: challenges to prevention. Social Science & Medicine 54; 325–337.

NACP. (2013). National HIV and AIDS , STI Policy. Accra, Ghana: NACP.

Obermeyer, M. M., Osborn M. (2009). The Utilization of Testing and Counseling for HIV: A Review of the Social and Behavioral Evidence. American Journal of Public Health | October 2007, Vol 97, No. 10.

Pauw, I, Brener, L., (2003), 'You are just whores—you can't be raped': barriers to Safer sex practices among women street sex workers in Cape Town, culture, health & sexuality, Vol. 5, No. 6, 465–481

Risher, K., Adams, D., Sithole, B., Ketende, S., Kennedy, C., Mnisi, Z., … Baral, S. D. (2013). Sexual stigma and discrimination as barriers to seeking appropriate

healthcare among men who have sex with men in Swaziland. *Journal of the International AIDS Society*, *16*(3 Suppl 2). http://doi.org/10.7448/ias.16.3.18715

Sekoni, O., & Owoaje, E. (2013). HIV/AIDS stigma among primary health care workers in Ilorin, Nigeria. *Afr J Med Med Sci*, *42*(1), 47–57.

Sullivan, P. S., Carballo-Diéguez, A., Coates, T., Goodreau, S. M., McGowan, I., Sanders, E. J., … Sanchez, J. (2012). Successes and challenges of HIV prevention in men who have sex with men. *The Lancet*, *380*(9839), 388–399. http://doi.org/10.1016/S0140-6736(12)60955-6

Türmen, T. (2003). Gender and HIV/AIDS. International Journal of Gynecology and Obstetrics 82; 411–418

Weiser SD, Tuller DM, Frongillo EA, Senkungu J, Mukiibi N, et al. (2010) Food Insecurity as a Barrier to Sustained Antiretroviral Therapy Adherence in Uganda. PLoS ONE 5(4): e10340. doi:10.1371/journal.pone.0010340

Wojcicki, J. M. and Malala, J. (2001) Condom use, power and HIV/AIDS risk: sex workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. Social Sciences and Medicine, 53, 99–121.

Yawson, A. E., Dako-Gyeke, P. and Snow, R. (2012). Sex differences in HIV testing in Ghana, and policy implications. AIDS Care Vol. 24, No. 9, 1181;1185.