

**SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



UNIVERSITY OF GHANA

PSYCHOSOCIAL EXPERIENCES OF A KEY POPULATION WITH

HIV

BY

RAFIATU MUSAH

(10637366)

**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON, IN PARTIAL FULFILMENT FOR THE AWARD OF
MPHIL. NURSING DEGREE**

JULY, 2019

DECLARATION

I, Rafiatu Musah, certify that this thesis is the product of a research I have undertaken towards the award of the Master of Philosophy in Nursing Degree in the School of Nursing and Midwifery, University of Ghana, Legon. This research has been taken with the guidance and supervision of Dr Gladys Dzansi, School of Nursing and Midwifery, University of Ghana, Legon and Dr Emmanuel Asampong of School of Public Health, University of Ghana. This study has not been submitted for any degree in any other institution. All authors and publishers whose works were used have been duly cited.

RAFIATU MUSAH
(STUDENT) (SIGNATURE) (DATE)

DR GLADYS DZANSI
(SUPERVISOR) (SIGNATURE) (DATE)

DR. EMMANUEL ASAMPONG
(SUPERVISOR) (SIGNATURE) (DATE)

DEDICATION

To the Almighty Allah who has been my strength and divine inspiration in everything I do.

To my loving husband, Abubakar Alhassan who has been my greatest source of inspiration and strength. He has offered me unconditional support and encouragement.

To my dear daughter, Faathimah-Zahraa Abubakar who fills my life with so much happiness and gives me every reason to work hard.

To my dear parents Humul-Krusum and Dr Imrana Mahama. To my brother Ahid Musah my sister Fati Musah and my cousin Mariam Musah for being there for me and encouraging me to work hard.

To my ever-supporting in-laws for their encouragement.

ACKNOWLEDGEMENT

I wish to acknowledge the Almighty Allah for giving me wisdom, strength, direction and protection throughout the work. I appreciate all the participants who volunteered to be part of this study, without whom the study would not have been a reality.

My sincere gratitude goes to my supervisors: Dr Gladys Dzansi who has mentored, guided and corrected every step of my thesis and Dr Emmanuel Asampong, who also assisted me greatly in the course of my thesis.

I wish to thank the director of Greater Accra Regional Hospital and the Deputy Director of Nursing Services, Mrs. Mercy Acquah Hayford of the Antiretroviral Clinic of GARH for giving me the opportunity to undertake my study in the hospital.

My profound gratitude to my research assistant, Sadat Bashiru who assisted me throughout the data collection.

I also acknowledge the support of my fellow classmates who contributed either directly or indirectly to the success of my research project, I am grateful for your constant encouragement throughout the research study

I acknowledge all my siblings and my friends who in diverse ways supported me through this journey. I am truly grateful and may the almighty bless all of them immensely.

To conclude, I am grateful to the authors and publishers whose journals, articles and books were used as reference for the work. May the almighty reward all of you.

TABLE OF CONTENTS

| | |
|---|------|
| DECLARATION | i |
| DEDICATION | ii |
| ACKNOWLEDGEMENT | iii |
| TABLE OF CONTENTS | iv |
| LIST OF TABLES | viii |
| LIST OF FIGURE(S)..... | ix |
| LIST OF ABBREVIATIONS | x |
| ABSTRACT..... | xi |
| CHAPTER ONE | 1 |
| INTRODUCTION | 1 |
| 1.1 Background of the Study | 1 |
| 1.2 Prevalence of HIV among MSM..... | 1 |
| 1.3 Problem statement | 9 |
| 1.4 Purpose of study | 11 |
| 1.5 Research objectives | 11 |
| 1.6 Research Questions | 11 |
| 1.7 Significance of study | 11 |
| 1.8 Definition of terms | 12 |
| CHAPTER TWO | 14 |
| LITERATURE REVIEW..... | 14 |
| 2.1 Conceptual framework underpinning the study | 15 |
| 2.1.1 Biopsychosocial model..... | 15 |
| 2.1.2 Social model of health | 16 |
| 2.2 Socio-ecological model | 17 |
| 2.2.1 Individual level | 18 |
| 2.2.2 Family and peers..... | 18 |
| 2.2.3 Community | 19 |
| 2.2.4 Structural..... | 19 |
| 2.3 Empirical literature on Individual level factors of psychosocial experience | 20 |
| 2.4 Family and peer level relationship of MSM living with HIV | 24 |
| 2.5 Community level experience of MSM living with HIV..... | 28 |
| 2.6 Institutional experiences of MSM living with HIV..... | 32 |

| | |
|--|----|
| CHAPTER THREE..... | 38 |
| METHODOLOGY..... | 38 |
| 3.1 Research paradigm | 38 |
| 3.2 Study Design | 39 |
| 3.3 Research Setting | 39 |
| 3.4 Target Population | 40 |
| 3.4.1 Inclusion Criteria | 41 |
| 3.4.2 Exclusion Criteria | 41 |
| 3.5 Sample Size and Sampling Technique | 41 |
| 3.6 Data Collection Tool | 43 |
| 3.6.1 Pre- testing of Interview Guide..... | 44 |
| 3.7 Procedure for Data Collection..... | 44 |
| 3.8 Data Analysis | 47 |
| 3.9 Data Management..... | 48 |
| 3.10 Methodological Rigor..... | 49 |
| 3.10.1 Credibility | 49 |
| 3.10.2 Transferability..... | 51 |
| 3.10.3 Dependability..... | 51 |
| 3.10.4 Confirmability..... | 51 |
| 3.11 Ethical Consideration | 52 |
| 3.11.1 Ethical Approval Process..... | 52 |
| 3.11.2 Informed Consent Process | 53 |
| 3.11.3 Right to Freedom | 53 |
| 3.11.4 Anonymity, Possible risk and Discomfort..... | 53 |
| 3.11.5 Confidentiality | 54 |
| CHAPTER FOUR..... | 55 |
| FINDINGS OF THE STUDY | 55 |
| 4.1 Demographic characteristics of participants | 55 |
| 4.2 Participants profile | 56 |
| 4.2 Organization of Themes | 57 |
| 4.3 Individual experiences of MSM living with HIV..... | 58 |
| 4.3.1 Personal history..... | 59 |
| 4.3.2 Reaction to diagnosis..... | 61 |
| 4.3.3 Medications (ARVs)..... | 62 |

| | |
|---|-----|
| 4.3.4 Adjusting to HIV life | 64 |
| 4.3.5 Recreation | 66 |
| 4.4 Family and peer relationship among MSM living with HIV | 67 |
| 4.4.1 Status disclosure | 67 |
| 4.4.2 Stigma | 69 |
| 4.4.3 Discrimination | 70 |
| 4.4.4 Broken relationships | 72 |
| 4.4.5 Family and peer support | 73 |
| 4.5 Community level experiences of MSM living with HIV | 75 |
| 4.5.1 Community level stigma..... | 75 |
| 4.5.2 Discrimination | 77 |
| 4.5.3 Abuse | 78 |
| 4.5.4 Community support | 80 |
| 4.6 Institutional experiences of MSM living with HIV..... | 82 |
| 4.6.1 Satisfaction with services..... | 82 |
| 4.6.2 Health care workers attitude | 84 |
| 4.6.3 Structural support..... | 86 |
| 4.6.4 Policy concerns | 87 |
| CHAPTER FIVE..... | 89 |
| DISCUSSION OF FINDINGS | 89 |
| 5.1 Psychosocial experiences of a key population with HIV | 89 |
| 5.2 Individual experiences of MSM living with HIV..... | 90 |
| 5.3 Family and peer relation among MSM living with HIV | 95 |
| 5.4 Community level experience of MSM living with HIV..... | 99 |
| 5.5 Institutional experiences of MSM living with HIV..... | 103 |
| 5.6 Application of Model to Study..... | 106 |
| CHAPTER SIX | 111 |
| SUMMARY, IMPLICATION, LIMITATIONS, CONCLUSION, AND RECOMMENDATIONS | 111 |
| 6.1 Summary of the study..... | 111 |
| 6.2 Reflexivity and Insight Gained..... | 114 |
| 6.3 Implications | 115 |
| 6.3.1 Nursing Practice..... | 116 |
| 6.3.2 Nursing Education | 116 |

| | |
|---|-----|
| 6.3.3 Nursing Research..... | 116 |
| 6.3.4 Policy Formulation | 117 |
| 6.3.5 Limitations of the study | 117 |
| 6.4 Conclusion..... | 118 |
| 6.5 Recommendations | 118 |
| REFERENCES..... | 121 |
| APPENDICES | 143 |
| Appendix A: Ethical Clearance | 143 |
| Appendix B: Ghana Health Service Clearance | 144 |
| Appendix C: Introductory Letter | 145 |
| Appendix D: Participant’s Information Sheet | 146 |
| Appendix E: Consent Form..... | 151 |
| Appendix F: Semi-Structured Interview Guide..... | 154 |
| Appendix G: Thematic codes and Descriptions | 157 |
| Appendix H: Summary of Demographic Characteristic of participants | 158 |

LIST OF TABLES

| | |
|---|----|
| Table 4.1: Participants Profile..... | 56 |
| Table 4.2: Themes and Sub-themes from Transcribed Data..... | 58 |

LIST OF FIGURE(S)

Figure 2.1: The Socio-Ecological Conceptual Framework (CDC, 2013)..... 17

LIST OF ABBREVIATIONS

- AIDS: Acquired Immune Deficiency Syndrome
- ARV: Antiretrovirals
- ART: Antiretroviral Therapy
- FSW: Female sex workers
- GAC: Ghana AIDS Commission
- GHS: Ghana Health Service
- HIV: Human Immunodeficiency Virus
- MSM: Men who have sex with men
- NACP: National AIDS Control Program
- NMC: Nurses and Midwifery Counsel
- UNAIDS: United Nations Program to Combat HIV & AIDS
- WHO: World Health Organization

ABSTRACT

Men who have sex with men (MSM) suffer disproportionate burden of HIV which is often associated with stigma and discrimination. HIV stigma is believed to be associated with negative psychosocial consequences that affects treatment outcomes. This study sought to explore the psychosocial experiences of key population (MSM) living with HIV using the socio-ecological model. A qualitative interpretive descriptive -approach was employed. Snowballing sampling technique was used to select fifteen (15) participants who were interviewed face to face. The interview was audio- taped, transcribed verbatim and analysed deductively using thematic content analysis. Participants' rights were protected through ensuring voluntary participation and signing of informed consent. Methodological rigor was ensured by selecting participants with psychosocial experiences, peer review and prolonged engagement. Findings revealed MSM living with HIV felt internal stigma, had depression and suicidal ideation. Family and peer relationships were broken, they felt discrimination, had challenges with status disclosure and lacked family and peer support. At the community level, MSM living with HIV suffered stigma, abuse and were denied community support. Institutionally, services were poor coupled with negative attitude of health workers. The lack of structural support, resources and knowledge about policy concerns affected the care of MSM living with HIV. Interventions for addressing HIV related stigma are required to promote psychosocial wellbeing of MSM living with HIV.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Historical perspectives on the emergence of HIV/AIDS associated it with men who have sex with men (MSM) and drug users (Aggleton, Bank, & Parker, 2003). The societal orientation about this group of individuals (MSM) remains a major ethical and legal tussle in most countries, especially sub-Saharan Africa (Baral et al., 2009; Beyrer, Sullivan, et al., 2012). HIV/AIDS remains one of the highly stigmatized illnesses in spite of all the interventions introduced to reduce the menace (Chambers et al., 2015; Rintamaki, Scott, Kosenko, & Jensen, 2007; Sapsirisavat, Phanuphak, & Keadpuksa, 2016). The level of stigma and discrimination is believed to be worse among MSM and is a major challenge to initiatives targeted at reducing the prevalence and burden of care. Stigma is associated with poor psychosocial health of individuals therefore exploring the experiences of these individuals will generate evidence to inform interventions geared towards improving psychosocial wellbeing of MSM living with HIV (Dowshen, Binns, & Garofalo, 2009a).

1.2 Prevalence of HIV among MSM

The inception of HIV in the world has claimed about 35 million lives and more than 70 million individuals have been infected with HIV (Mathers & Loncar, 2015). Global prevalence of HIV among key populations is disproportionately high among MSM (Beyrer et al., 2016; Drame & Foley, 2015; Halkitis, Kutnick, & Slater, 2005; Konou et al., 2016; Wirtz, Kirey, Peryskina, Houdart, & Beyrer, 2013). By the end of 2017, an average of 36.9 million (31.1 - 43.9 million) were living with HIV in the world. In the United States of America, MSM represents approximately 2% of the country's population and yet in 2015, they account for 70% of all persons diagnosed of HIV. Meanwhile, injection drug users

represent 3% of recorded HIV cases (Singh, S., Mitsch, A., Wu, 2017). In the Middle East and North African countries, the prevalence rate of HIV among MSM is estimated to be as low as 3% while in the Caribbean, it is at a higher peak of 25.4%. Conversely, in the North, South and Central America, South and Southeast Asia, the collective HIV prevalence is quite stagnant, the values are within the range of 14 – 18% (Beyrer, Baral, et al., 2012; Populations, 2014). In 2018, global HIV prevalence indicated 37.9 million (32.7 million – 44.0million) people were living with HIV and 74.9 million (58.3 million – 98.1 million) million people have become infected since the start of the epidemic(UNAIDS, 2019)

According to the World Health Organization (WHO), Africa remains the most severely affected, with nearly 1 in every 25 adults which represents 4.1% living with HIV and accounting for nearly two-thirds of the individuals living with HIV (Beyrer, Baral, et al., 2012). The introduction of antiretroviral medications have reduced the incidence of HIV in most countries including sub-Saharan African countries but incidence is still high with huge number of new infections (Kharsany & Karim, 2016). MSM has legal backing in 113 countries, 76 countries have no gazetted laws in support of MSM and it is punishable by death in 5 countries(Bruce-jones, Careaga, Sabbadini, & Co-secretaries, 2011).The prevalence of HIV among key population and their sexual partners account for 54% of new HIV infections globally. More than 95% of new HIV infection among key populations is in Eastern Europe and Southern Asia. 64% of new HIV infection among key population is located in Western and Central Africa (UNAIDS., 2019). Black MSM harbour HIV more than other races. They contribute a higher percentage in new HIV cases both in Canada, United Kingdom and the United States of America (Chartier et al., 2010; George et al., 2014). A fact sheet on global AIDS update 2019 by UNAIDS indicated that key populations like MSM risk of acquiring HIV is 22 times higher than the general population(Fact Sheet et al., 2019)

Sub-Saharan Africa has about 25.6 individuals living with HIV, accounting for two-thirds of the recent overall global HIV infections and more than 70% of all Acquired Immune Deficiency Syndrome (AIDS) related deaths (Amuche, Ifeanyichukwu,& Nweze, 2017). There is a decline in HIV prevalence including reduction in HIV/AIDS related deaths in many sub-Saharan African countries due to the increase access to anti-retroviral treatment including reduction in HIV/AIDS related deaths. Kenya had a decline of 32%, Ethiopia 37% followed by South Africa with a huge decline of 51%. This has also resulted in the reduction of HIV/AIDS related deaths in Malawi, Rwanda, Tanzania, Uganda and South Africa (Kharsany & Karim, 2016). However, HIV has continued to increase in countries like Lesotho (22.7%), Botswana(22.2%) and South Africa(19.2%) (Amuche, Ifeanyichukwu,& Nweze, 2017). From the just mentioned statistics on the decline of HIV/AIDS related death due to the introduction of ARVs, it is evident that access to Anti-retroviral treatment and its adherence on the part of MSM can cause a reduction of HIV in every country including Ghana. Individuals living with HIV suffer various forms of stigma and discrimination not only in Ghana but in numerous countries all over the world.

Prevalence of HIV in West Africa among MSM is consistently higher than the general population. The prevalence of MSM living with HIV is higher than 5% in the West African countries. Nigeria has an HIV prevalence of 15.1% among MSM as compared to 3.2% in the adult population who are of procreative age. 21.3% accounts for MSM living with HIV in Senegal. Kenya has an annual prevalence rate of more than 20% of MSM living with HIV (Beyrer, Baral, et al., 2012; Papworth et al., 2013; Wolf, Cheng, Kapesa, & Castor, 2013)

The rise of HIV infection in Ghana has recorded an alarming 70.15% increase in just one year which is 2017. Figures have risen from 12000 new infections in 2015 to 20,148 in the year 2016(Aids Programme, 2018) . The increase in new infections is a matter of concern because Ghana recorded significant gains in key target areas of ending HIV/AIDS for five

years (National AIDS Control Program, 2017). The Director –General of Ghana AIDS Commission, Ambassador Dr Adu-Gyamfi made a consensus effort to Ghanaians through an appeal to willingly go for HIV testing in order to help achieve the 90 90 90 projects by UNAIDS by the year 2030. Dr Adu-Gyamfi presented that the activities of gay community are to blame for the sharp increase in HIV infection (Aids Programme, 2018). Coupled with this view of Dr Adu -Gyamfi, the government of Singapore also blames the activities of MSM which raises the peak of HIV in the country(Goh, 2008). There were approximately 50,000 MSM in Ghana as at 2017 and the majority of them are found in Greater Accra Region, followed by Ashanti Region then Western Region(Ali et al., 2019). The gay community are involved in many high-risk behaviours or activities that predisposes them to HIV such as; binge alcoholism and substance abuse that can render them loose control of themselves. They are also involved in unprotected sex and illicit injection of drugs.

Overall, the national median prevalence for HIV in Ghana for 2016 is 2.4% which is a second consecutive increase from 1.6% in 2014 and 1.8% in 2015 respectively. Comparing the peak trends of HIV survey in Ghana, 2016 was the lowest (3.6% in 1992 and 2003, 2.9% in 2009, 2.4% in 2016). The overall HIV/AIDS prevalence in Ghana for 2017 is 1.6% with regional variation. The highest prevalence is in the Eastern region of Ghana recording 2.8%, with Western region recording 2.7% and Greater Accra region recording 2.5%. The lowest was recorded in the three Northern regions of Ghana (Upper East, Upper West and Northern) with less than 1% prevalence rate of HIV(Ali et al., 2019). Ghana's 2017 HIV prevalence was at 1.67% (Ali et al., 2019).

Denying an MSM access to health care frowns upon their fundamental human right, but this human right abuse still prevails. Practice of MSM is outlawed, as such MSM do not access service if they do not trust the system and the caregivers. MSM may experience psychological stress because they are part of the sexual minority everywhere in the world.

This makes them vulnerable to experiencing internal stigma, internal homophobia and negative mental health outcomes such as anxiety disorders and constant lowered mood including loneliness (Lick, Durso, & Johnson, 2013; Stahlman et al., 2016). Limited studies have been done internationally pertaining to psychosocial experiences of MSM living with HIV but findings of some studies proved that multiple psychosocial health outcome predisposes MSM with a stigmatizing health condition to have suicidal ideation but how the psychosocial experience emerge was a gap that wasn't addressed in the study (Konou et al., 2016). Other findings also revealed that MSM continues to face inequalities which negatively affect their psychological health (Maulsby, Millett, & Lindsey, 2013). They experience psychological distress because there is no integration of mental health professionals in HIV management. Limited studies pertaining to MSM living with HIV has been done in sub-Saharan Africa. Research have been done in South Africa and a number of West African countries concerning the incidence of HIV among MSM but not much has been done on psychosocial experience of MSM living with HIV. These countries are Togo, Ghana, Nigeria, Gambia and Senegal (Drame & Foley, 2015; Konou et al., 2016; Shaver et al., 2017; Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). "Despite the evidence of disproportionate burden, HIV in men who have sex with men continues to be understudied, under-resourced and inadequately addressed" (Beyrer, Sullivan, et al., 2012, p.425).

The HIV epidemic has been afflicted with stigma from its early stages in the 1980s. MSM living with HIV suffer a lot of psychosocial experiences and they tend to have disproportionate burden of HIV in many countries around the world (Beyrer et al., 2016; Beyrer, Sullivan, et al., 2012; Sapsirisavat et al., 2016). Despite the evidence of disproportionate burden, there is limited study into the area of MSM living with HIV (Beyrer et al., 2016). HIV positive MSM go through many psychological hurdles which is

detrimental to their mental health. Some of these psychosocial health problems they have are depression and suicidal ideation (Fendrich, Avci, Johnson, & Mackesy-amiti, 2013).

Depression is a key psychological health challenge experienced by HIV positive MSM which is recorded to be high (Fendrich et al., 2013; Logie, Newman, Chakrapani, & Shunmugam, 2012; Safren, Reisner, Herrick, Mimiaga, & Stall, 2011). MSM suffer emotional attacks from the masses in connection with homosexuality being tagged as a shameful act. These attacks culminate into self-stigma and withdrawal from society and all services that MSM can access. HIV positive MSM endure all sort of attacks because this attack makes them think they are less worthy of other males. It also makes them feel their sexual identity is absurd and that it should be hidden from the public. Also, there are limited avenues which would render them social support to overcome what they are going through because most religions frown at it. These negative attacks predisposes MSM to acquiring depression (Safren et al., 2011). MSM living with HIV experiencing depression also exhibits anxiety disorders.

Psychologically, there is presence of anxiety over knowing or not knowing one's HIV status but upon knowing the status of one's HIV test outcome, there should be limited anxiety because the outcome is now known to the individual. However, this is different when it comes to MSM living with HIV because some HIV positive MSM are diagnosed for a lifetime with anxiety disorders (Hart et al., 2018; Jr, Chiasson, & Hirshfield, 2016). MSM living with HIV have difficulty coping with the anxiety disorders on daily basis and this also predisposes them to other psychological issues like substance abuse.

Substance abuse or illicit drug use is one mechanism HIV positive MSM use to soothe their depressive and anxiety concerns (Jones, Rodriguez, De La Rosa, Dietch, & Kumar, 2018). Substances like alcohol, cocaine, heroin, marijuana, cigarette, methamphetamine,

“crack cocaine, hallucinogens” among others (Gibbie, Mijch, & Hay, 2012; Mustanski, Garofalo, Herrick, & Donenberg, 2007) which are central nervous system stimulants are mostly abused. Use of illicit drugs has increased within the MSM group due to their psychosocial experience (Jones et al., 2018). Use of illicit drugs causes poor cognitive function which can result into poor judgement. This can also end up into partner violence and high-risk behaviours like having unprotected sex.

Violence is a psychosocial problem experienced by MSM living with HIV. Violence causes them to have unstable mental balance so the least or no provocation, they become violent towards others especially their sexual partners. Violence has been an issue of public health concern over several years. Intimate partner violence can happen to both homosexual and heterosexual partners. The term intimate partner violence “describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner” (CDC, 2015; Finneran, Chard, Sineath, Sullivan, & Stephenson, 2012). The intimate partner is one that a person shares intimate relationship with (Li, Baker, Korostyshevskiy, Slack, & Plankey, 2012). Violence is also experienced by MSM living with HIV after their status disclosure. They suffer physical violence from the masses who have phobia for MSM and those living with HIV. MSM are recipients of physical and psychological violence from close relations like family members (Valleroy, 2014)

Unresolved psychosocial (Stahlman et al., 2016) health problems among MSM predisposes them to suicidal tendencies. Suicidal tendencies is higher among MSM than heterosexual individuals (Dowshen et al., 2009a; Gibbie et al., 2012; Karamouzian, Akbari, Haghdooost, Setayesh, & Zolala, 2015; Stahlman et al., 2016; Wilton et al., 2018). If MSM's have higher suicidal tendencies then the question remains, what about MSM living with HIV which is a highly stigmatized health condition?

Among all studies done on psychosocial health problems experienced by MSM living with HIV, there is suggestive indication of the establishment of integrated health care system for MSM living with HIV and health promotion. Another study revealed some organizations that provides social support for MSM living with HIV but that is not enough because these organizations are limited in number compared to the rising number of MSM living with HIV (Fendrich et al., 2013; Han, Lauby, Bond, LaPollo, & Rutledge, 2010; Mburu et al., 2014; Safren et al., 2011)

Family and peers are the source of support that everyone with a problem would love to lean on but sometimes, it is quite difficult when that same family and peers turn their back on the person who need their support. The support of family and peers eases psychosocial burden for MSM(Shrestha et al., 2014)

The health facility also harbours stigma and discrimination towards the sexual minority and they do not like them especially MSM. This negative attitude is exhibited by some health care professionals such as doctors, physician assistants, dentist, dental assistants, pharmacists, dispensary technicians and students in each of these professional group (Gagnon, 2015). This poor behaviour exhibited by the health professionals at the end of the day pushes MSM living with HIV to decide not to seek treatment. There is also poor establishment of rapport and interpersonal relationship between the health care provider and HIV positive MSM. Even if they report for treatment, they are denied health care services or not rendered quality services as others (Valleroy, 2014).

The society or community that we live in has social and cultural norms. HIV positive MSM experience double stigma and discrimination within our community (Davtyan, Olshansky, Brown, & Lakon, 2017; Gagnon, 2015). In sub-Saharan Africa, MSM is frowned upon, hence, they are stigmatized and discriminated against because it is seen as a taboo.

There are some sub-Saharan African countries that MSM is not criminalized such as Botswana and South Africa, but yet still there are issues of stigma among this key population (Shaver et al., 2017). Hence the socioecological framework will be used to explore individual, family/peers, community and structural level psychosocial experiences of MSM living with HIV.

1.3 Problem statement

Legal constrains and attitude of health professionals towards MSM is a barrier to service access (Magesa et al., 2014). Some MSM have heterogeneous partners (Montgomery, 2004), as such the risk of spread of HIV through that window will affect gains made in the fight against HIV. Exploring their psychosocial experience will elicit information on barriers and facilitators at four levels -individual, family/peers, community and peer level- within the care cascade. If service access improves and they receive treatment, risk of re-infection, transmission and early mortality will be minimized.

Studies done in liberal settings like Europe and United States of America where MSM is not criminalized have different level of psychosocial experiences than restricted setting like West Africa. In the liberal settings like the United States of America, a study revealed that poor psychosocial functioning is a health outcome for MSM living with HIV. They suffer considerable amount of stigma, depression, poor self-esteem and fear of disclosure (Dowshen, Binns, & Garofalo, 2009b). Another liberal setting such as South Africa revealed that MSM suffer greater social isolation, discrimination, loss of job and homes because of their HIV positive (Cloete, Simbayi, Kalichman, Strebel, Henda, et al., 2008). In a restricted setting such as West Africa MSM living with HIV suffer rejection, stigma and discrimination (Keogh, 2004). These psychosocial issues affect treatment access (Wheeler, Wolf, Kapesa, Surdo, & Dallabetta, 2015). If HIV positive MSM suffer psychosocial health

problems in liberal setting where MSM practice is not criminalized, then HIV positive MSM in restricted settings like Ghana are more likely to suffer severe psychosocial trauma.

There is an estimated 55,000 MSM in Ghana (Ali et al., 2019). The national prevalence rate of HIV among MSM in Ghana is 17.5% while among female sex workers (FSW), it is 11.1% (Ghana AIDS Commission, 2016). In Ghana, key population are mostly affected with HIV. FSW and MSM accounts for 28% of all new HIV cases. The prevalence of HIV among MSM was 17.5% in 2015 and it has risen to 18.1% in 2017 (Ali et al., 2019). This statistic calls for the need of study into the psychosocial experiences of MSM with HIV which hinders them from seeking treatment and leaving a healthy lifestyle. The results of this study would enhance how MSM should be treated devoid of any stigmatization because they are vulnerable. It would also increase the MSM's patronage of ART services which in one way or the other, lower the incidence of MSM living with HIV in Ghana.

As a registered general nurse in Ghana, I have been working for the past ten years in a government health institution. The last seven years of my working experience was at the ART clinic where our main job description is to counsel both HIV positive and negative clients, refill their Anti-Retroviral medications, check their vital signs, take them through physical assessment and provide HIV screening services. Anecdotal evidence coupled with my observation as an ART nurse made me realize that, HIV positive MSM hardly come for treatment and my focus is to investigate the psychosocial experiences that predisposes HIV positive MSM from withdrawing from antiretroviral services.

1.4 Purpose of study

The purpose of the study was to explore the psychosocial experiences that MSM living with HIV faces which hinders them from seeking health care. This will inform prospective interventions on improving psychosocial outcome in this population.

1.5 Research objectives

The specific objectives of the study are to:

1. Describe the individual experiences of MSM living with HIV.
2. Identify family and peer relationship of MSM living with HIV.
3. Assess community level experiences of MSM living with HIV.
4. Explore the institutional experience of MSM living with HIV.

1.6 Research Questions

1. What do MSM living with HIV encounter in accessing healthcare?
2. How does their individual characteristics affect their experiences?
3. How do MSM living with HIV evaluate their family and peer relationship?
4. What are the community experiences of MSM living with HIV?
5. What are the institutional factors that affect the experiences of MSM living with HIV?

1.7 Significance of study

MSM's have been marginalized for so long and with having HIV. They experience stigmatization and discrimination at the highest level (Aggleton et al., 2003; Beck, McNally, & Petrak, 2003; Pereira, Caldeira, & Monteiro, 2017). This study is of great significance as it will help enhance the right to attain health care which is a basic human right. This study when completed will enhance good care for MSM which will also influence their attendance

rate to ART clinic. This study will serve as a useful source of information for the Greater Accra Region and Ghana at large in the fight against HIV epidemic. The results of this study will also add to existing research work and knowledge on psychosocial experiences of MSM living with HIV. This study will improve the psychosocial wellbeing of MSM regardless of their HIV status. The findings of this study will help policy makers develop an integrated treatment in HIV management which includes psychotherapy.

1.8 Definition of terms

1. **Internal stigma-** Negative feeling about oneself
2. **Depression-** Constant feeling of low mood
3. **Anxiety-** A feeling of dread or apprehension
4. **Violence-** Inflicting pain upon oneself or others
5. **Coping strategies-** Strategies used to overcome an undesirable event(s) or human behaviour
6. **Health policies-** Laid down protocols that governs health
7. **Health systems-** A health system, also sometimes referred to as healthcare system is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations
8. **Key population-** Individuals or groups who are at higher risk of acquiring HIV due to specific high -risk behaviour such as having unprotected sex and injection drug use. Example of key populations are; MSM, FSW, people who inject drugs, transgenders, prisoners among others
9. **Psychosocial** – Interrelation of social factors and individual thought and behaviour

10. **Stigma**- It is a mark of disgrace
11. **MSM**- Men who have sex with men
12. **FSW**- Female sex workers are who receive money in exchange for sexual services
13. **ART Services** – They are services rendered to individuals living with HIV

CHAPTER TWO

LITERATURE REVIEW

This chapter entails the review of literature on psychosocial experiences of MSM living HIV and its attributes. The search was conducted in: 'PUBMED', 'GOOGLE SCHOLAR', 'CINAHL', 'SCIENCE DIRECT' and 'SAGE JOURNALS'. The key words used in the Boolean search included:

1. MSM, gay, bisexual
2. Experiences
3. HIV
4. key population
5. Peer support
6. Psychosocial
7. Structural barriers
8. Coping
9. Family relation
10. Peer relation

The search yielded several research articles; however, only studies addressing any of the under listed thematic areas either in the title or abstract were considered:

1. Experiences of a key population (MSM) with HIV/AIDS
2. How MSM overcome psychosocial experiences of HIV
3. Community level experiences of HIV positive MSM
4. Institutional experiences of MSM living with HIV
5. Family and peer relationship of MSM living with HIV
6. The criteria for inclusion ensured that only literature important to the study was reviewed. The literature excluded studies older than 10years (unless the information

was classical). Studies written in other languages except English language were excluded. The language restriction was used as to prevent misinterpretation of facts presented.

The chapter begins with an explanation of the conceptual framework. Empirical review on the psychosocial experiences covers individual (internal stigma, resilience), family and peers (disclosure, stigma, and personal relationships), community (stigma and discrimination), structural (health systems and health policies).

2.1 Conceptual framework underpinning the study

Conceptual framework serves as a guide for the research so that there won't be deviation from the main objectives

There are three frameworks possibly suggestive of this study. They are

1. Biopsychosocial model
2. Social model of health
3. Socio-ecological model

2.1.1 Biopsychosocial model

The biopsychosocial health model was postulated by an American psychiatrist by name George Engel in 1977 (Engel, 1981)The biopsychosocial model is an approach or ways of understanding individual or a group of people's health or illness through biological, psychological and social factors. The biopsychosocial model has a trio principle which are determinants of health. The determinants also dwell on its influence on disease occurrence and the quality of care that can be rendered to relieve the sick. According to Engel (1981), he elaborated that, the important aspect of care is the one rendered to a patient and the

measures put in place for the management of a patient's illness by doctors and the health care system (social context).

This model is not ideal for this study because the biopsychosocial model also talks about disease occurrence but for this research work, the occurrence of disease has already happened so the aftermath of the disease in terms of psychosocial experiences is what would be looked at.

2.1.2 Social model of health

The social model of health was formulated in the later part of 1970's and 1980's. This model was formulated by community members who were not cared for with same strata of health care as others notwithstanding the understanding of the influence of routine and conduct of health (WHO, 2012) .

The model of disability gave rise to the social model of health. The social model of health is championed by the disability rights movement. This model was postulated as a response to the outmoded medical model.

The social model of health looks into all the dynamics that contributes to health which includes social, cultural, political, economic and environmental factors(WHO, 2012). This model also focuses on health prevention through the social determinants that can cause illness and the outline dynamics which are social, cultural, and political among others. The social model of health is of the view that, in order for individual to attain a good health, the social determinants has to be tackled.

The social model of health is not an ideal model of choice for this study because it is limited to social determinants that predisposes an individual to acquire a disease and also within that same social determinants, attainment of health would be achieved.

2.2 Socio-ecological model

The socio-ecological model is a model formulated by the Centre of Disease Control (CDC) on the 13th of July, 2013. The socio-ecological model was primarily formulated for understanding of violence and possible ways that violence can be prohibited. This model has four key variables which is the individual, relationship, community and structural or individual, family and peers, community and structural. Some socio-ecological models can also have five levels namely, individual, interpersonal, community, organizational and policy/enabling environment. At every stage of each of the variables in the socio-ecological model, it helps to understand the factors that predisposes an individual into falling into violence and the ways of preventing that from happening. In view of this, the individual is protected from violence. The overlying ovals in the model shows how each variable has an influence on the other

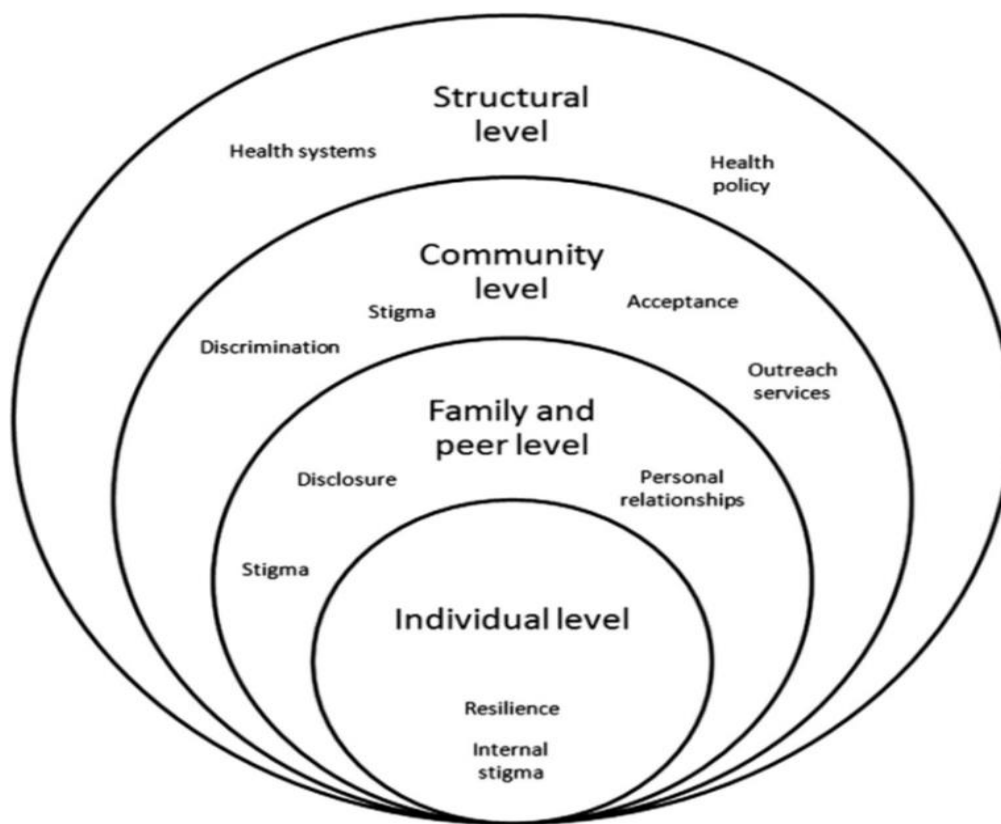


Figure 2.1: The Socio-Ecological Conceptual Framework (CDC, 2013)

2.2.1 Individual level

This level of the socio ecological model is the first which has to do with an individual's make up (genetic) and personal history that predisposes them to violence. Gender, age, history of abuse, occupation, substance abuse and so on are some of the factors that leads to violence. The identification of these helps for rendering of education and learning of vocation which would help prevent them from being violated. This would in turn also promote positive attitude and believes for the individuals' mental health.

The socio-ecological model has been adopted in the area of health for this study. The individual level in this study explains what the individual with HIV goes through psychologically and socially after the acquisition of HIV. The individual level also has to do with the preventive measures in place that individual with HIV rely on in order to relieve him or herself from these psychosocial experiences. A study also adopted the socio-ecological model in the area of responding to adolescents living with HIV in Zambia (Mburu et al., 2014).

2.2.2 Family and peers

Numerous relationships influence the occurrence of violence and this is the second level of the socio ecological model. This level believes that violence is inflicted on an individual through close relation like friends, family members and partners. Avoidance of violence here has to do with good parenting which in turn help the individual have a healthy relationship with others.

In this study, the family and peer level explain what the individual experiences psychosocially after disclosure of his/her HIV status to his/her family and friends. It also aided in finding out if whether there were any support measures from these family and friends to the individual living with HIV.

2.2.3 Community

Community is the third level of the socio-ecological model which has to do with the characteristics of the surrounding such as schools, market places, neighbourhood that influences violence. Violence occurs here due to the social relationships built. Organized community program by giving education on violence prevention including drawing up policies at work places and schools would help prevent violence occurrence. This would help boost individuals' self-esteem within the community.

The third level of the socio-ecological model explains what the individual with HIV goes through within the community in which they reside. It also helps in finding out the support system the community have for them when they go through psychosocial experiences.

2.2.4 Structural

The level four looks at the society as a whole or broad societal factor that influence violence occurrence. "These factors include institutions that support violence as an acceptable way to resolve conflicts. Other large structural factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society" (CDC, 2014).

The fourth level of socio-ecological model looks at structural factors that influences the occurrence of psychosocial experience among MSM living with HIV. To also find out if there is any support system or health policies for this vulnerable group.

A study adapted the socio-ecological model of CDC for his research work "the response of adolescents living with HIV in Zambia"(Mburu et al., 2014). The levels he used was also four which are interrelated factors at the individual, family/peer, community and structural levels that determined the experiences of adolescents living with HIV. This

framework has also been adapted in several areas such as health promotion, violent prevention, education ,agriculture among others (Berkovich, 2014; Cote & Nightingale, 2012; Cross et al., 2015; DiClemente, Salazar, Crosby, & Rosenthal, 2005; Elkington, Bauermeister, & Zimmerman, 2011; Vanlauwe & Giller, 2014)

2.3 Empirical literature on Individual level factors of psychosocial experience

Several diseases are threats to life (diseases of the heart, ‘cancer’, renal failure among others) and HIV is no exception. This turn to have serious physical and psychological outcomes for the ones involved with these disease conditions(Maia, Gomes, & Gonçalves, 2018). Disease occurrence starts with the manifestations of signs and symptoms. HIV positive MSM report with acute signs and symptoms of HIV such as diarrhoea, fever, rash, myalgia, weight loss, genital sores, ulcers in the mouth among others at their various health institutions before the final diagnosis of HIV was made (Rutering et al., 2016; Wong, Lye, Lee, & Leo, 2011). Some of the signs and symptoms were classified as acute. They manifested as headaches, fever, fatigue, upper respiratory tract infections such as pharyngitis and common cold (Hoenigl et al., 2016). Chronic manifestations of signs and symptoms surface when acute signs and symptoms are unresolved. Chronic signs and symptoms manifests in the form opportunistic infection. Lower respiratory tract infection, Kaposi sarcoma, cerebral toxoplasmosis among others are the opportunistic infections that presents when acute signs and symptoms are unresolved (Coelho, Veloso, Grinsztejn, & Luz, 2014; Rutering et al., 2016; Wong et al., 2011). Opportunistic infections cause quicker viral replication. This can cause an HIV positive MSM to an early grave. An individual living with HIV is more than living with any other chronic condition because HIV is a highly stigmatized condition that concurrently entails social and psychological problems (Maia et al., 2018).

MSM living with HIV have different responses to being diagnosed as having HIV and internal stigma is one of them. There are two types of stigma experienced by people living with HIV: (internal and external stigma). Internal stigma is experienced by the individual who has contracted HIV and it comes in the form of nondisclosure of HIV status, feeling of shame, self-withdrawal from events, feeling unhappy among others. External stigma is perpetrated by family, peers, community, health institutions among others (Bogart et al., 2008; Karamouzian et al., 2015; Pyun et al., 2014). MSM in a country where there is no legal backing for its practice and its practice has to be in hiding has a psychosocial burden on the individual. An HIV positive MSM suffer double psychosocial experiences which is internal (Chambers et al., 2015; Pereira et al., 2017). Internalized HIV stigma is high among MSM living with HIV. Due to the high rate of internalized stigma among HIV positive MSM, a study in South Africa exposed that 57% of their MSM sample population mentioned hiding their HIV status from others while 47% of them felt self-blame/guilty and 43% felt ashamed of being HIV positive (Cloete, Simbayi, Kalichman, Strebel, Henda, et al., 2008). In Ghana, the criminal code of 1960 (Act 29) makes “sexual intercourse with a person in unnatural manner” illegal (Attipoe, 2004). This makes MSM fall prey to this law. MSM suffer antigay stigma especially in countries where their act is declared illegal (Lick et al., 2013). This renders them to shy away from seeking health care, mingling with others and vacate attending social events. Side-lining and stigmatization enhances the susceptibility of key population to unbalanced mental health aftermaths (Logie et al., 2012). In addition, internalized stigma is experienced by MSM (Donnelly et al., 2016; Dowshen et al., 2009a; Karamouzian et al., 2015). MSM gives in to negative utterances about themselves such as negative beliefs, views and feelings and also toward the stigmatized group. Stigma and discrimination have been related with elevated degrees of downheartedness/ depression (Park, Kim, Cho, & Lee, 2015).

In religious context, MSM living with HIV are seen as immoral as they proceed to struggle to find meaning amidst difficulties of social stigma and individual degrading (Canoy & Ofreneo, 2017). Challenges of social stigma and personal devaluation. There are numerous ways they use to overcome this situation. Some are positive and others negative. Some studies done have revealed higher levels of psychological health problems in HIV positive populations as well as those under key populations such as MSM (Chambers et al., 2015; Gibbie et al., 2012). HIV/AIDS is often linked to MSM by the media in most countries like the United States of America (Goh, 2008).

Research, especially in countries with higher economic stability has shown higher rates of depression and psychological health disorders among MSM. Depression among MSM has higher public health inferences because of its association with risky sexual behaviour and HIV infection (Ahaneku et al., 2016). In higher income countries like Holland, MSM were three folds to be depressed than men who have sex with women (Sandfort, de Graaf, Bijl & Schnabel, 2001). Depression is a psychological issue among MSM living with HIV and it predisposes MSM to sexual risk behaviour if help is not provided for them health wise (Fendrich et al., 2013). The prevalence of depression among HIV positive population is 50% than in HIV negative population. The prevalence of depression among HIV positive individuals is 2 to 4 times higher than in the general population. HIV positive MSM are at a greater risk of acquiring depression than heterosexuals (Heywood & Lyons, 2016; Shrestha et al., 2014). Depression can cause an elevated risk of HIV disease progression among HIV positive individuals (Heywood & Lyons, 2016; Shrestha et al., 2014). The HIV disease progression causes increment in viral load and can lead to treatment failure. Depression also causes nonadherence to Antiretroviral Therapy (ART), HIV positive MSM with depression are likely not to listen to health care professionals advice and they have suicidal ideation in mind (Shrestha et al., 2014). Depression is experienced by HIV positive

MSM (Safren & Ph, 2004). The psychosocial issues they experience varies from individual to individual. They suffer from having continuous lowered mood which involves lack of self-worth and despair (Gibbie et al., 2012; Kubicek, McNeeley, & Collins, 2015).

Unresolved internal stigma and depression can give rise to suicidal ideation among MSM living with HIV. HIV has been recognized as one of the potential predictors of suicide behaviour (Courtenay-Quirk, Wolitski, Parsons, & Gómez, 2006). HIV positive MSM however, suffers more pressure from both the stigma of homosexuality and HIV infection. This attitude made them more vulnerable. A study conducted in China on “prevalence of suicidal ideation and its associated factors among HIV positive MSM” with a sample size of 200 participants revealed that suicidal ideation is very high among HIV positive MSM. Its findings revealed 31% suicidal ideation among HIV positive MSM and 5.4% among these same key population who have once attempted committing suicide (Anhui et al., 2014a). Developed countries like United States of America and Australia have recorded lower suicidal thought of above 20% among MSM as compared to developing countries like Nepal who have recorded 47% suicidal thoughts among HIV positive MSM (Gibbie et al., 2012; Pollack, P.J, Moskowitz, L., Canchola, J., Mills, J., Binson, T., Stall, D., Ron et al., 2002). Suicidal thoughts being high in developing counties among MSM might be due to its criminalization because most African countries are underdeveloped and African culture totally frowns on same sex relationship. Developed countries records a lower percentage on suicidal thoughts among HIV positive MSM and this might be due to its legalization and most of its citizen are culturally embracive to same sex relationship unlike Africa. Psychosocial issues like internal stigma and depression can make an HIV positive MSM prone to suicidal thoughts (Li et al., 2016b; Stahlman et al., 2016).

Living with a disease condition for a lifetime is quite difficult. HIV positive MSM are prone to a particular lifestyle such as substance abuse, dating multiple partners and

having unprotected sex (Carballo-Diéguez, Frasca, Dolezal, & Balan, 2012; Sapsirisavat et al., 2016; Thiede et al., 2009). Having contracted HIV contraindicates these lifestyles especially if the individual is on ARVs due to the fear of drug resistance. This has made most HIV positive MSM adjust their lifestyles due to the self-motivation of wanting to live a longer life and fear of death (Diana et al., 2011). MSM living with HIV have refrained from dating multiple partners and also uses protection during sexual intimacy with their partners (Heijman et al., 2012). Others have also reduced substance abuse post HIV diagnosis (Naar-King, Parsons, & Johnson, 2012; S.P., M.E., H.L., & R.D., 2012).

HIV positive MSM going through psychosocial problems and they have diverse ways of making themselves happy or temporary forgetting about the psychosocial problems they encounter. Recreation drugs or club drugs such as alcohol and cigarette smoking make HIV positive MSM happy and this helps them get relieved of the psychosocial tortures they go through. They do recreational drugs often when they go clubbing (Darrow et al., 2005; Grov, Bimbi, Nanin, & Parsons, 2006). MSM living with HIV are happy after they have been able to acquire knowledge concerning their ill health on the internet. They seek for more knowledge governing their health through social media and this amuses them and give them hope for the future (Sallar & Somda, 2011).

2.4 Family and peer level relationship of MSM living with HIV

Having to live with HIV as a sexual minority is a difficult task (Brooks, Etzel, Hinojos, Henry, & Perez, 2005). MSM tend to have many consequences when they reveal their HIV status coupled with their sexual orientation to family and friends. Status disclosure is a hurdle for MSM that they need to cross.

Status disclosure of HIV is an exceptionally tough mission for any individual. It brings about problems of confidentiality, helplessness, identification with a stigmatized role

and feelings of burden on others (Yoshioka & Schustack, 2002). Status disclosure for MSM living with HIV is a difficult task (Vu et al., 2012). HIV positive MSM find it comforting disclosing their HIV status to family and friends (Hightow-Weidman et al., 2013). Majority of MSM living with HIV, especially young MSM discloses their statuses to their female relatives more than they do to their male relatives (Hightow-Weidman et al., 2013; Serovich, Esbensen, & Mason, 2005). Among these female relatives, mothers are more likely to be the recipients of HIV status disclosure by MSM. They are followed by sisters then lastly fathers and brothers. Mothers are more accepting to MSM sexual orientation, sympathetic and more nurturing than fathers so MSM living with HIV find it more accepting for their mothers to know of their HIV status. While young MSM find it comforting to disclose their HIV status to female relatives, adult MSM discloses to friends than family. Disclosing HIV status to peer group members fosters the likelihood of acceptance and support upon disclosure than family members (Holt et al., 2012; Serovich et al., 2005). MSM who find it comforting disclosing to their peers only disclose to the family if they have other health issues which necessitates their family knowing (Yoshioka & Schustack, 2002). Some HIV positive MSM do not disclose their status to neither family nor friends. This is based on certain factors that prohibits them from disclosing their HIV status. Factors that influences status disclosure are, fear of being stigmatized and discriminated against, fear of being emotionally burdened, fading relationships, lack of intimacy and the desire to conceal one's homosexuality (Bird & Voisin, 2011; Yoshioka & Schustack, 2002). Due to the maltreatment HIV positive MSM received, some of them regretted disclosing the HIV status to their family and friends. Their status disclosure brought them more harm than good (Zhou, 2006)

HIV/AIDS-related stigma can be described as a 'process of devaluation' of people either living with or associated with HIV/AIDS" (UNAIDS, 2003). Stigma comes in so many

forms for people living with HIV. HIV related stigma stems from loved ones such as family after status disclosure (Preston et al., 2004). Stigma towards HIV positive MSM also emanates from trusted friends who totally had negative attitudinal change after status disclosure (Courtenay-quirk, Gómez, & Men, 2006). Stigma from loved ones has made individuals living with HIV forgo their medication at the appropriate time because of their peers and colleagues (Wasti, Simkhada, Randall, Freeman, & van Teijlingen, 2012; Wijngaarden, Scholten, & Wijk, 2012). The issue of HIV-related stigma possesses a challenge for the fight against HIV because it drains HIV positive MSM social, physical and psychological ability to want to fight their condition (Rintamaki et al., 2007). If the behaviour and attitudes of stigmatization and oppression against MSM living with HIV does not stop, the 90 90 90 goal to fight HIV epidemic by the year 2020 cannot materialize (UNAIDS, 2014).

MSM living with HIV suffer discrimination from family and friends after status disclosure. HIV related stigma can vary from mere gossip to total discrimination. This ends up bringing about negative consequences such as being evicted from home, being fired at work, being rejected by family and friends, they are being isolated and even being killed (Cloete, Simbayi, Kalichman, Strebel, Henda, et al., 2008; Ulasi et al., 2009). HIV positive MSM suffer total isolation from their family homes because of their HIV status. They are quarantined. They are not frequently interacted with and they are given different utensils to feed in due to the fear of infecting others (Grant, Vance, White, Keltner, & Raper, 2013). Another study agrees that discrimination of MSM living with HIV beginning from the family. In the home setting, MSM with HIV are restricted in the household. Some of these restrictions are having a separate cutlery, bowl, drinking glass/cup, not sharing common bathroom, not sleeping on same bed and not allowed to use the kitchen (Alessandretti, Sapiezynski, Lehmann, & Baronchelli, 2017).

Having gone through stigma and discrimination by family and friends, MSM living with HIV still receive some source of support from their family and friends (Audet, Mcgowan, Wallston, & Kipp, 2013). A research study agrees with the fact that availability of family support for MSM living with HIV, but there is also a disagreement of the fact that, despite HIV related stigma within the family setting is quite less, unable to fulfil a social role as a result of living with HIV, the family then becomes the main vehicle of promoting internalized and felt stigma for MSM living with HIV. In view of this, they still provide support for them to fight their condition (Öktem, 2015). Family and peers help MSM to keep on taking their antiretroviral medications religiously and they form an atmosphere where they can adjust to taking their medications which is new to them and coping with its side effects (Graham et al., 2016). They encourage them in order not to default but rather promote adherence by being their monitor. Most of this support is from trusted peers and senior family members (Mburu et al., 2014). Friends and family act as emotional therapy for HIV positive MSM throughout the psychosocial experience they have come across (Elkington et al., 2011; Lee, Yamazaki, Harris, Harper, & Ellen, 2015). Men infected with HIV get more support from their family as compared to infected women (Shrestha et al., 2014). Family support is a key factor to alleviate psychosocial problems like depression among patients with terminal disease conditions like cancer, end stage kidney disease, Acquired Immune Deficiency Syndrome (AIDS) including patients with psychiatric conditions. It is recorded that the lower level of depression has been associated with high level of family support (Shrestha et al., 2014). Family and peer support are a very crucial social support system in everyone's life. MSM with HIV go through stigma and discrimination within our society. Through all these psychosocial problems, they have coping mechanisms that helps them to survive on daily basis. Some of these coping mechanisms of MSM living with HIV is that, they try to seek social support which helps to

take their mind off their problems and also rely on family especially mothers who make them feel loved and this love shown them from an immediate family helps them to be able to alleviate their psychological experiences. There is strength in family so family ties especially with mothers provides MSM with enormous emotional support. However, it sometimes generate stress related to their wards sexual orientation of being an MSM(Gilbert, Barrington, Rhodes, & Eng, 2016). Another study is of the same view of family especially the nuclear family providing support for MSM with HIV when they experience stigmatization through the act of rejection by others(Young et al., 2017). From the two research studies findings, it is obvious that in family lies much strength. In view of all that an individual with a highly stigmatized disease condition suffers, when the family and peer care and support is available, one can pull through all these struggles in order to remain healthy and enjoy a less stressful life.

2.5 Community level experience of MSM living with HIV

There are numerous sensitizations of HIV to the public including rendering of anti-retroviral treatment services but yet still, indigenes within the community hold a negative and wrong perception about HIV. Community level experiences comes in the form of being called names and they are treated as social outcast and they are avoided and shunned at work (Bell et al., 2007; Karamouzian et al., 2015). Community level stigma is a bigger standing block in fighting against HIV epidemic among the sexual minority, MSM (Smit al., 2012). MSM have experienced pubic shaming and have been ridiculed due to their sexual orientation and HIV status (Thomas et al., 2013). People living in the community associate HIV acquisition to immoral act and that the mode of transmission of HIV to infected individuals was through a casual consent(Chambers et al., 2015; McHenry et al., 2017; Rahmati-najarkolaei, Niknami, Aminshokravi, & Bazargan, 2010). This statement can be

argued out because most infected individuals with HIV living in the community do not disclose their status to their partners, hence they have unprotected sex which is the main mode of transmission of HIV acquisition. Some of the stigma within the community came in the form of withdrawal of social and economic support for people living with HIV (McHenry et al., 2017). Places of worship is no exception towards stigmatization of HIV positive MSM. MSM are seen as sinful individuals because both Christianity and Islam frowns against homosexuality so they are shamed in the church and mosque after status disclosure to their church and mosque leaders (Neff, 2006; Rotheram-borus et al., 2003). Despite the place of worship being one of the centres of stigmatization against HIV positive MSM, the same place of worship is also used to educate the congregation against health-related issues which includes HIV and its psychosocial consequences (Coleman et al., 2012).

Unresolved community level stigma can enhance discrimination which comes in many forms. Every community has a prevalence of HIV but dominance of this HIV prevalence is among MSM. MSM go through many huddles in communities especially where there is black dominance. There is social and structural obstacles to repetitive screening and management such as less access to health insurance, higher rate of unemployment and higher rate of incarceration, homophobia and stigma (Beyrer et al., 2016; Kraft, Beeker, Stokes, & Peterson, 2000; Mdodo et al., 2014). Unjust and inhumane treatments such as suspension and immediate proceedings on leave involves losing their source of income has been levelled against HIV positive MSM (Friedland et al., 2018; Varas-Díaz, Serrano-García, & Toro-Alfonso, 2005).

Beatings, being stripped naked and humiliation are some of the abuses experienced by HIV positive MSM (Jeffries IV, Marks, Lauby, Murrill, & Millett, 2013). Others have

been hit with objects and have suffered verbal abuses (Baral et al., 2011; Hladik et al., 2012; Jeffries & Gary, 2012; Micheni et al., 2016). Physical injuries attained by the victims (HIV positive MSM) causes pain which can lead to psychosocial burden. Suffering from continuous abuse can make an individual go into a lot of negative thoughts like suicidal ideation which is quite evident in the lives of HIV positive MSM (Park et al., 2015). In Africa and Ghana to be precise, the community in which we live doesn't have cultural acceptance towards sexual minority. They believe that they acquiring HIV is due to punishment from God (Zou et al., 2009). A study indicated HIV positive MSM being ridiculed and being verbally abused (Bell et al., 2007). These negative attitudes levelled at HIV positive MSM within the community makes most of them withdrawn from social functions and community engagements. They become socially isolated and this predisposes them to more psychosocial issues (Bowen, Horvath, & Williams, 2007; Lauby et al., 2012). MSM have diverse self-identifications. Some see themselves as females, others as males and some also see themselves as versatile. The MSM often cross dress to suit their self-identified gender. A study mentioned HIV positive MSM who self-identify themselves as females are hooted at when they cross dress. They are also shamed at when they are walking within the community or attending social events (Thomas et al., 2013). In contrast, abuse of MSM living with HIV is orchestrated by law enforcers such as police officers. There are reports of police officers who have stripped off HIV positive MSM and offered them severe beatings (White & Carr, 2005). Those held in custody, as well as their family members have been verbally abused. They have been called names and they have also been refused to take their baths unlike other heterosexual inmates (Poteat et al., 2011).

Aside all these negative occurrences levelled against HIV positive MSM, there is also some support system rendered to them within the community. Partner disclosure is one key thing MSM are scared to do including heterosexual couples so often MSM with HIV do not

give contacts of their sexual partners. In view of this, there are well designed community based-organizations(CBO's) that serves as co-operators in forming a partnership with an MSM who has HIV/AIDS so that partner disclosure can be made on their behalf (Fu et al., 2016). CBOs' also encourages healthy relationship through negotiation of safer sex (condom use) among HIV positive individuals that is both men and women. CBO's develop and enhances decision-making skills for disclosure of HIV status to family, friends, and sex partners; and help them develop skills to maintain safer sex. Disclosure to prospective relationship allies is quite difficult because of fear of rejection and loneliness. CBOs' comes in to help disclose to curb these fears and also build up a self -efficacy skills in bargaining for safer sex and having a relaxed state of mind(Collins et al., 2010). There have also been other interventions by the community by providing financial support for CBO's to continue to provide their services especially, to key populations like MSM living with HIV. There has been the formation of health education teams in order to sensitize the community of the reality of HIV/AIDS (Davidson, 2011). The community also has Non-Governmental Organization (NGOs) that fights to protect the human rights of HIV positive MSM. They protect their basic rights like, the right to seek health care, the right to a fair trial among others and also provide them with safer place to receive treatment which is devoid of any stigma and discrimination (Lawrence & Brun, 2011). A study revealed NGOs who have fought for the wrongful accusations of HIV positive MSM and imprisonment to be withdrawn and the victims have gained their freedom (Danziger, 1994). These NGOs also provide professional help for HIV positive MSM who have psychosocial issues like depression and suicidal tendencies. Peer educators are also trained and offered job opportunities (Adams, 2014)

2.6 Institutional experiences of MSM living with HIV

HIV/AIDS related stigma and discrimination is very high among MSM and bisexual men (Beyrer et al., 2016; Drame & Foley, 2015; Konou et al., 2016; Stephenson, De Voux, & Sullivan, 2011). This tends to hinder the voluntary testing for HIV and going for ART services. In health care facilities within Africa and around the globe, MSM experience multiple stigma and discriminatory attitudes by health care providers when coming to seek for ART services so most of them default and never return to the health facility (Alessandretti et al., 2017; Maleke et al., 2017). MSM experience verbal abuse, they are denied privacy and their sexuality is disrespected by health care professionals and above all, they are mistreated. This behaviour by health care professionals makes it difficult for MSM to confide in them and brief them on their sexual health problems (Tim Lane, Mogale, Struthers, McIntyre, & Kegeles, 2009). The unfriendly environment created by the healthcare professionals towards MSM makes them seek refuge in wallowing into binge drinking rendering them to have unstable state of mind (Micheni et al., 2017). In many African countries such as Ghana and South Africa, everyone has equal right to treatment irrespective of the individuals sexual preference, yet still this right is violated by health care workers in numerous healthcare institutions (Maleke et al., 2017). The hospital environment and the healthcare providers have been recognized as one of the relevant causes of stigma. Stigma interferes with the quality of work outcome of health care professionals. Stigma within the hospital environment by health care professionals comes in the form of poor physical assessment of MSM due to partial contact, rendering health education on HIV which does not come with enough information on the subject matter, portraying of homophobia towards MSM (Davtyan et al., 2017). A research study done in an Arabian country of Iran also presented some findings of the form stigma takes in our health care settings. These are; MSM are not attended to in a lot of health facilities, substandard care is

rendered them, extreme precaution of Infection Prevention and Control (IPC) such as double gloving before a procedure is carried out is not part of the standard IPC protocol that is practiced before they are attended to. A study revealed a healthcare professional putting on gloves before providing an HIV positive MSM a glass of water he requested for (Rutledge, Abell, Padmore, & McCann, 2009). This is totally against the Universal precaution practiced by healthcare providers. HIV positive MSM have received humiliation and blaming including limit contact to HIV positive MSM (Rahmati-najarkolaei et al., 2010). All these stigmatizing behaviours pose a lot of psychosocial and emotional distress on people living with HIV and MSM to be precise.

Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status (UNAIDS, 2003). Individuals living with HIV encounter frequent levels of discrimination within the health care facility and the highest level of discrimination is encountered by MSM with HIV. A study done in London reported that more than 50% discriminatory practices occurs at the health facility by health care providers. The discriminations came in the form of MSM being refused treatment by their physicians/surgeons after discovering their HIV status. They refused to treat them without any apparent reason, also a nurse's rudeness and maltreatment towards a patient after discovering that the patient was HIV positive (Alessandretti et al., 2017; Chambers et al., 2015; Fay et al., 2011; Magesa et al., 2014). Suicidal ideation is associated with MSM being discriminated against which poses a very worrying mental health issue (Alessandretti et al., 2017). Stigma and discrimination violates the fundamental human right of any human being on earth and it manifests at diverse political, economic, social, psychological and institutional echelons (UNAIDS, 2003). Despite the strong legal backing frowning on violating fundamental human right of people, some health institutions carry out discriminatory activities that do not promote any physiological and mental health of the

patient (Rahmati-najarkolaei et al., 2010). Different beds and beds are also assigned to MSM living with HIV (Bond, Chase, & Aggleton, 2002). Unjustifiable reasons were given by some health care professionals towards their inhumane act of stigma and discrimination which are fear of acquiring HIV, their personal view on people living with HIV with regards to their sexual preference, lifestyle (taking excessive alcohol and illicit drug use), fornication, adultery, and commercial sex workers (Rahmati-najarkolaei et al., 2010). Bible quotations were read by health care professionals in the consulting room to HIV positive MSM against homosexuality as soon as their sexual orientation is known (Kushwaha et al., 2017). Despite the reasons rendered by the health care professionals, it is still not justifiable to stigmatize and discriminate against individuals living with HIV because these behaviours have bad consequences in relation to patients' health. In view of these, all health professionals have taken an oath to care for any human being no matter where one belongs, being it political, sexual preference, choice of occupation and so on. As such, they must stick to that in order to provide quality health services devoid of any negative utterances.

However, a number of HIV positive MSM had never experienced negative treatments from their health care providers, but they were rather satisfied with the care rendered them. Some health care providers were very sensitive, empathetic and had good gestures towards HIV positive MSM, and they do not stigmatize against them as reported in some studies (Beattie et al., 2012). The initiation of differentiated service delivery is a key relieve for key populations and this made MSM relieve and happy of acquiring their ARVs at any given time. They can also ask close relatives and trusted friends to do their medication pick- ups for them without any stress and this was revealed in a study by (Grimsrud et al., 2016). This initiative of differentiated service delivery has enhanced the promotion of HIV adherence among key population (Bemelmans et al., 2010). Differentiated service delivery has been an initiative developed for ART delivery to clients

who are clinically stable and this is implemented in large prevalence countries in Sub-Saharan Africa like Ghana . Healthcare professionals were non judgemental to MSM sexual orientation and HIV acquisition. These made HIV positive MSM very satisfied with the care they receive from their healthcare providers (Ma, Chan, & Loke, 2017).

Healthcare institutions provide some source of support for HIV positive MSM. Formation of peer support groups by some health facilities has made HIV positive MSM become self -confident about who they really are and as a result, they are able to share their problems and they receive solutions in return (Houglum, Venkataramani, Lyche, & Chojkier, 1997). Other health institutions provide foodstuffs , money and shelter for the vulnerable group living with HIV and MSM are part of these vulnerable group (Tim Lane et al., 2011). Contrary to this, some health facilities do not have any special package or support for key populations(Zhou, 2009).

Every well-organized program is guided with policies. There are laid down policies for key population living with HIV and also with people living with HIV. The 90 90 90 policy is an Initiative by UNAIDS and the first 90 states that; 90% of all those living with HIV should be tested in order to confirm their statuses. The second 90 also states that, 90% of those with HIV should be put on sustained HIV treatment and the final 90 states that, 90% of all those put-on sustained treatments should have viral suppression within 6 months(Ali et al., 2019; UNAIDS, 2014). “Treat all policy” states that all those infected with HIV should be put on immediate treatment if they have no opportunistic infections. “Treat all policy” applies to all no matter your sexual orientation, religion, tribe among others (Fox & Rosen, 2017). One of the most important policies that guides HIV screening and counselling is that it must be free. This policy applies to all who have HIV and it is implemented in many countries globally(Huang et al., 2012). This policy also applies to all MSM who want

to know their HIV status. They can walk to any government health institution to have that done at no cost. A study made mention of self-disclosure policy which is a decision-making policy for an HIV positive MSM. This policy involves plans of an MSM to disclose their HIV status to their partners prior to sexual intercourse (Rutledge, 2009). A combined study done in Malawi, Namibia, Botswana and another done in South Africa all agree with formation of a culturally competent health care professionals that can help bridge the gap of stigma and discrimination levelled against sexual minorities like the MSM. This initiative went on to suggest the formation of models of LGBT (Lesbian, Gays, Bisexual, Transgender) care in countries that MSM practice is illegal (Baral et al., 2009; Maleke et al., 2017). This initiative is going to help reduce the number of defaulters at the ART clinic in relation to MSM and it would also reduce negative utterances of health care professionals towards MSM with HIV. This would also promote a healthy psychosocial wellbeing for the individual and the LGBT community.

Individuals living with HIV especially HIV positive MSM have financial challenges and their financial support are uncertain for their access to treatment (Wasti et al., 2012). The government in most African countries like Ghana depends on foreign donor funding such as the Global Fund to deliver free ART to individuals living with HIV (Canoy & Ofreneo, 2017). This interferes with the continuous availability of the antiretroviral (ARV) medications because in situations where there is a delay in the arrival of the funds to purchase the ARV's or it is not forthcoming, MSM and others living with HIV would run out of medication and they would be without any daily dosages to take. This can make them grow resistance to the medications when they get access to it and this can give rise to virologic failure and increase access to opportunistic infections. The government of most developing country who solely depend on international funds should have other sources of funds locally in order to save guard its citizens who are infected with HIV. The accessibility

of health service where ART services are rendered is a huge problem. There is economic vulnerability, inadequate and inaccessible to health care. Also, there is lack of sustainability to global access to HIV care in a low income countries (Canoy & Ofreneo, 2017).

2.7 Summary of the Literature

Numerous evidence have shown that MSM suffer disproportionate burden of HIV (Beyrer et al., 2016). Moreover, evidence has shown that, MSM are 22 times at risk of acquiring HIV than heterosexuals (UNAIDS, 2019). HIV positive MSM suffer psychosocial experiences due to their sexual orientation and also being HIV positive. The psychosocial experiences they encounter emanates from themselves, family and peers, community and the health institution they attend. Moreover, the psychosocial issues they encounter comes in the form of Internal stigma, suicidal ideation, depression, enacted stigma and discrimination among others (Bogart et al., 2008; Karamouzian et al., 2015; Maulsby et al., 2013; Park et al., 2015; Pyun et al., 2014). Literature have cited the significance of family and peer support as a supportive therapy to lessen HIV positive MSM psychosocial issues (Hightow-Weidman et al., 2013). NGO's support HIV positive MSM in diverse ways. NGO's provide shelter employment and protect fundamental human right of HIV positive MSM (Lawrence & Brun, 2011). Literature has proven poor attitude directed at MSM living with HIV by healthcare professionals (Maleke et al., 2017). This compounds to their psychosocial problem and this make most of them desist from attending hospital on their appointment dates.

Most studies focus on individual psychosocial issues of HIV positive MSM such as substance abuse, violence, internal stigma, depression among others, hence the goal of this study is to understand through interpretive descriptive, the psychosocial experiences of HIV positive MSM that prevents them from seeking ART services.

CHAPTER THREE

METHODOLOGY

The methodology section describes how the research problem was investigated and why particular designs and techniques were used. It also describes the setting in which the study was carried out. The chapter also describes the research paradigm, study design, research setting, study population, inclusion criteria, exclusion criteria, sample size, data collection procedure, data management, data analysis, methodological rigor and ethical consideration.

3.1 Research paradigm

The researcher believes that psychosocial experiences of a key population (MSM) with HIV is a phenomenon with several meanings and interpretation. Hence, the constructivist paradigm which underlies qualitative enquiry was used. The aim was to determine what the psychosocial experiences of MSM that hinders access to treatment. Humanity throughout the research was maintained so it was impossible to escape the subjective experience (Antwi, Kasim, & Risk, 2015).

Other options of philosophical orientation about the truth do exist. The truth is the key revelation that both qualitative and quantitative paradigm seeks to find. Quantitative research paradigm, on one hand, is where social observations are treated as entities in a physical phenomenon because of the positivist orientation. Moreover, on the other hand, qualitative research paradigm oppose that genuineness is subjective, multiple and socially created by participants. Mixed methods offer a merging of both paradigms (pragmatism). Although the level of mixing continuous as a debate within literature (Creswell, 2014)

3.2 Study Design

This study sought to explore the psychosocial experiences of a key population (MSM) with HIV. An interpretive descriptive approach was employed to elicit in-depth information from MSM living with HIV within their natural setting (Thorne, Kirkham, & Macdonald-emes, 1997). Guided by the specific objectives, the socioecological model was selected to inform the structure and form of eliciting the narratives, coding, categorizing and grouping these narratives into concrete themes and constructs. Research design generally defines the structure of the study. The design serves as a logical blueprint of the research (Yin, 2011). It is the philosophical assumption the researcher brings to the study (Creswell, 2014). The advantage of this approach is that, it looks deeper into participants' attitudes, feelings and behaviour and also creates openness. Burns and Grove (2011) explains qualitative research as a systematic, subjective approach used to describe life experiences and give them meaning.

Alternatively, a qualitative interpretive phenomenology will have been appropriate for comparing narratives from the first to last participants to determine patterns. However, the interest of clinical application made the interpretive description a preferred approach. Additionally, quantitative methods could also have enabled a onetime evaluation of the various domains a comparison of relation between individual stigma, family, community and institutional level factors influencing psychosocial wellbeing of MSM living with HIV. Subsequent studies will employ these designs to further enhance knowledge in this area.

3.3 Research Setting

Research setting is a specific place for data collection. The setting for a qualitative research can take place in the field such as people's homes, work place or a designated siren

environment. It involves studying participants in many settings within the selected sites (Polit & Beck, 2008).

The setting of the study is the Greater Accra Regional Hospital (GARH). GARH is the second biggest hospital in the Greater Accra region of Ghana and the third largest hospital in Ghana. GARH was formerly called Ridge Hospital. It was established in 1928 by the colonial masters and was named the 'European Hospital'. In 1974, under President Acheampong's regime, the facility was turned into a district hospital. In 1996, under Ghana Health Service act 525, it was upgraded to a regional hospital for Greater Accra with a total of 192-bed capacity but as at December, 2016, the facility was upgraded to a 239-bed capacity hospital. The government constructed a new 420-bed capacity modern hospital and changed the name from Ridge Regional Hospital (RRH) to Greater Accra Regional Hospital (GARH). The hospital is a referral centre that receives cases from other facilities within and outside Greater Accra. The GARH has an average attendance of 700 patients on daily basis. The clinical and diagnostic departments of the hospital include Medicine, Child Health, Obstetrics and Gynaecology, Pathology, Laboratory, Anaesthesia, Surgery, Accident and Emergency Centre and Pharmacy. Other departments of the hospital include Estates, Engineering, Finance, General Administration and Pharmacy. GARH also provides scientific investigative procedure and specialization in different areas such as Antiretroviral Therapy, Orthopaedics, Ear Nose Throat (ENT), Dentistry, Neuro-surgery, Dermatology, Paediatric Surgery, Obstetrics, and Gynaecology among others. The hospital also has a school of anaesthesia that trains nurses to become nurse-anaesthetist.

3.4 Target Population

Target population for this study was MSM living with HIV from age eighteen (18) years and above who attend the Antiretroviral Therapy (ART) Clinic of the Greater Accra

Regional Hospital. Target population comprises of people with certain characteristics that the researcher for a study is interested in (Polit & Beck, 2008).

3.4.1 Inclusion Criteria

The following were the inclusion criteria for selecting participants for the study

1. MSM living with HIV who are 18 years and above
2. Participants must be able to communicate in English, Ga, Twi or Hausa language.
This is because the researcher and her assistant are very fluent in these four languages.
3. MSM living with HIV who are willing to partake in the study
4. MSM living with HIV who are on antiretroviral medications.
5. MSM living with HIV of any nationality who can communicate in English

3.4.2 Exclusion Criteria

1. Heterosexuals and bisexuals living with HIV are not included.
2. HIV positive MSM who are undergoing adherent counselling for the initiation of antiretroviral medications.
3. MSM living with HIV who are mentally challenged are not included in the study

3.5 Sample Size and Sampling Technique

The study recruited fifteen (15) HIV positive MSM have suffered psychosocial issues due to their HIV status and sexual orientation. Fifteen participants were also used in a research conducted in Malawi concerning healthcare providers' attitude towards MSM (Kapanda, Jumbe, Izugbara, & Muula, 2019). The interviews were truncated after the 15th participant when repetitive codes and categories were observed and no new information emerged, a concept referred to as saturation (Creswell, 2014; Yin, 2011).

It is through intense involvement of the researcher with a relatively small number of participants who have an in-depth knowledge and experience of the phenomenon under study that the researcher hopes to produce data worthy of note (Thorne, 2016).

Snowballing sampling technique was used to recruit participants who met the inclusion criteria for the study. The sample size was determined during data collection when data saturation was affirmed by the 15th participant as no new views elicited. No bisexual was recruited as a participant for this study because they suffer less or no psychosocial issues as compared to MSM. Hence, they were excluded because they did not meet the inclusion criteria.

Participants were recruited from various municipalities of Ghana who attend ART Clinic at the Greater Accra Regional Hospital. Snowballing method was used to solicit for information from targeted participants. A male research assistant who was also an MSM was informed and recruited for the study. He was also given the participant information sheet (Appendix D) to help in the recruitment of eligible participants. Snowball sampling is a type of non- probability sampling method where referrals among people who share or know others who possess characteristics that are of interest for the research under study or it is when random sample of participants is drawn from a specified finite sample. This method is good for a number of research purposes but it is particularly applicable when the focus of the study is on a sensitive issue which requires knowledge of an insider to locate specific participants for the study (Statistics, 2019). Sampling is a process of selection of participants to take part in an inquiry on the basis that the participants provide information that is well-thought-out important to the study. It involves the selection of the desired number of participants to be added in a study (Oppong, 2013; Yin, 2011).

Challenges encountered initially with the recruitment of participants was participants rescheduling the appointment date and time agreed on for conducting the interview. Some

participants during data collection called off the appointment dates they have been booked for the interviews but most of them followed suit on the rescheduled appointment date and time. This challenge was overcome after participants were reassured of confidentiality.

3.6 Data Collection Tool

The data collection tool is a semi-structured interview guide (Appendix F) which was developed and was used to conduct the interviews and a field diary was used. Participants felt relaxed and comfortable in voicing out their psychosocial experiences. The interview guide contained open-ended questions which was developed based on the study objectives, literature review and constructs of the socioecological model. The semi-structured interview guide facilitated in-depth exploration since there were probes while limiting irrelevant information (Yin, 2011). The semi-structured interview guide had two main sections, the first section covered participant's demographic data and the rest the study constructs. Participant profile data was excluded from any identifier but provided context to data interpretation. It also empowered participants to give out vital information needed to answer the research questions. The guiding questions and probes assisted in exploring the study.

The interviews were conducted in the language the patient was more comfortable with (English, Ga, Hausa, Twi). This is because the research assistant could speak all the four languages but instances where the participant did not understand any of the outlined languages, the services of an interpreter was sought. Each interview lasted between forty (40) minutes to an hour and it was recorded on an audio tape with a consent from the participants.

To facilitate the discussions, the researcher used communication techniques including clarifying, probing, reflecting, paraphrasing and summarizing. Pre-interview meetings was held where ethical issues regarding the study, permission to audio tape and

information sheet were explained. Field notes were also taken and they were useful during analysis of data.

3.6.1 Pre- testing of Interview Guide

Before the researcher interviewed participants with the semi-structured interview guide, it was first pre-tested. A convenient time and location were chosen for the trial run and this was done to ensure that the questions modelled will explore and describe what is intended to ask and to eradicate problems that could not be predicted when designing the interview schedule. This will enable the researcher to find and correct any mistakes in the interview schedule. Two participants who fell into the inclusion criteria were snowballed and interviewed at the Korle-Bu Teaching Hospital (Antiretroviral Clinic). The pre-test clarified the interview guide and helped the researcher fine-tuned the interview questions and also the voice recorder used in the main interview. The results from the pre-test informed the researcher and guiding questions were modified together with probes. This presented the researcher an opening to practice, modify the interview guide and interviewing skills. The interview guide was modified, probing questions added with the aim to ensure credible data in the study. Transcript of the pre-test was excluded from data analysis. In addition, participants used in the pre-test were not be included to participate in the main study.

3.7 Procedure for Data Collection

Data collection is a key component around which every study pivot (Yin, 2011). This includes purposefully selecting individuals or site for the proposed study. The motive is to help the researcher understand the problem and research questions (Creswell, 2008). The research setting was visited during proposal development to ascertain possibility of using the setting. Ethical approval sought from the Institutional Review Board of Noguchi

Memorial Institute for Medicinal Research (Appendix A) by the researcher and Ghana Health Service (Appendix B). An introductory letter (Appendix C) was obtained from the University of Ghana's School of Nursing and Midwifery and was sent to the institutional review board of GARH for a second approval and Ghana Health Service. The approval letters were sent to the administrators of GARH and deputy director of nursing services (DDNS) for the research settings and the instigation of data collection. The researcher sought the services of a research assistant who is an MSM living with HIV and has a tertiary qualification (degree or a diploma). A short training was conducted for the research assistant on how to recruit and collect data from participants. The research assistant was given the participants information sheet and orientation on how to explain the study to prospective participants was also done. The research assistant was trained to recruit specifically participants who have undergone psychosocial experiences. The researcher introduced the research assistant to the DDNS of the ART clinic of the GARH. With granted permission by the DDNS, researcher allowed for the introduction of research assistant to participants so that they can familiarize themselves with the research assistant and be comfortable to give him all the needed information per the semi-structured interview guide. This initiative made participants more expressive since they were more comfortable and relaxed to know the research assistant is a male.

The researcher had a model demonstration of recruitment sessions with the research assistant to be sure he understands the inclusion criteria. Recruitment of participants started in 5th of January and ended in 20th of February, 2019 which was the same period for the interview. The research assistant after gaining consent of participants, collected their phone numbers and gave his phone number and that of the researchers to participants as well. The research assistant made phone calls to participants to confirm decision and schedule meetings. There were arrangements for the date and time of the interview sessions with

participants. The venue of the meeting was at the GARH ART Clinic and participants were comfortable with the place. There was at least a meeting before the interviews were initiated. The first meeting was arranged to reinforce information about the study and rapport establishment. A call was placed a day prior to the interview to confirm schedule.

On the day of the interview, the study was explained again reminding participants about the study and consent form (Appendix E) endorsed. The course of consent included assurance of confidentiality, autonomy, safety and protection of privacy. A reminder about voice recording was confirmed. The participants were made comfortable and interview began. Questions were asked followed with probes where necessary. Observations and clues made by participants were documented as part of field notes. An interview lasted within a range of forty (40) to sixty (60) minutes. Further probing was done where necessary and participants were permitted to freely express themselves without interruption. All the interviews were conducted at the ART Clinic of Greater Accra Regional Hospital.

Data collection from participants continued until no new data emerged. Copies of the endorsed consent form were filled separately and kept as part of the audit trail. Some of the interviews were conducted in English, Ga, Twi and Hausa. This was because the researcher and the research assistant were fluent in these languages. There were minor interruptions during the data collection but this did not interfere with the interview in anyway. After each interview, data was transcribed and analysed accordingly. Participants were made aware that they will be contacted if there is the need for further clarifications of their responses in the course of the research within the following three to five months. After initial codes were generated, some participants were contacted and the outcome shared with them. They confirmed the categories reflected what they intended to say.

3.8 Data Analysis

Thematic content analysis was used to analyse the data and field notes that were collected from participants (Huberman & Mills, 1994). Analysis of the data was done concurrently with data collection. This method enabled the researcher to note areas of emphasis, clarified contraindications disregarded irrelevant contents. Each audio-taped recording was severally listened to. Transcripts of the interview were translated in English. The interviews were transcribed verbatim by the researcher because the interviews were conducted in English, Ga, Twi and Hausa. This helped the researcher know the areas that needed to be probed in subsequent interview. There was transcription of field notes and other important materials. Interview transcripts were judiciously read, listing meaningful recurrent ideas and key issues in the data. Recurring items such as events or comments that are unusual, worthy to note or contrary were all emphasized. The researcher was however, careful not be influenced by own stance by journaling personal perspective. Data was coded by identifying key elements, domain and dimensions were linked. Coding is the transitional process between data gathering and more extensive data analysis. A qualitative data analysis software, ATLAS.ti was used to organise the codes and the categorisations. Coding is also the mechanism by which data is organized, sorted and the basis for emerging analysis (Saldana, 2012)

Organization of codes was done by the researcher together with supervisors and the codes were compared in terms of similarities and difference and assigned a place to each cluster of codes in relation to the research questions. Codes were reviewed, undesirable cases were detected and codes associated to outline themes. The researcher and supervisor sorted codes into piles of parallel meaning and labelled using sentences or phrases to make meaning of the main ideas emerging from them. Themes were then recognized and defined in order to summarize the essence of what each theme was about and signal what aspect of

data each theme captured. The researcher and supervisors checked, confirmed and ensured a relative certainty about developed themes. In depth literature review was adjourned until after data gathering was accomplished in order to prevent presenting unfairness and perceived notions. Themes were developed using deductive approach. Themes and their variations were described to improve transparency and truthfulness and to enable transferability of findings to readers, giving attention to data saturation. The researcher together with supervisors developed a narration that described and linked various themes and answered the research questions. Lastly, summary of results was made and literature compared to answers. This aided the researcher to find likely clarifications to the findings and the information was prepared into a report.

Interpretive descriptive analysis is a qualitative inquiry approach that can be applied into human health and illness experiences for the purpose of developing nursing knowledge (Thorne et al., 1997). Interpretive description contributes directly to the understanding of how peoples experience their health and illness and what nursing can do to make a difference. In view of this, interpretive descriptions of increasing complexity and interrelatedness represent the foundation for nursing theoretical structure and its substantive body of knowledge. Interpretative descriptive analysis by Thorne et al., (1997) was used to analyse the data that was collected in the form of interviews and field notes from participants in the Greater Accra Regional Hospital.

3.9 Data Management

Data management comprises the proof of establishing and keeping data appropriately to enable easy access and analysis (Creswell, 2014). Information about each interview, the date, time and place were documented in the field diary including observations, interruptions recorded during the interview were unified during transcriptions. A different file was kept for each participant.

Participants name was excluded for reasons of anonymity, rather identification numbers were assigned in order of enrolment, gender orientation and identity (ie. MF, MM and MV. M is male, F is female and V for Versatile and 1st to be interviewed) for easy identification and recovery of information. Each transcribed interview was coded according to the order in which interviews were conducted, labelled and saved in a folder on a personal computer with a password known to only the researcher and supervisors. Transcribed interview folders were also put an external hard drive as a back- up. All consent forms and all other materials comprising identifiable information have been detached from transcribed data and saved separately. These and all other documents have been kept safely under lock and key away from anybody's reach in a drawer in the researcher's office. Soft copies of audio recordings were kept in a database and protected with a password. All data stored will be reachable to only the researcher and supervisors for up to five (5) years before it will be discarded or destroyed.

3.10 Methodological Rigor

Methodological rigor in qualitative inquiry is the criteria by which research is evaluated for validity and reliability of the research design. According to Lincoln and Guba as cited by Shenton (2004) in his book, methodological rigor can be achieved through credibility, transferability, dependability and confirmability.

3.10.1 Credibility

Credibility is one of the most relevant factors in creating trustworthiness. Credibility was ensured by the researcher by making provision to promote confidence of the phenomenon under investigation and these were; adopting a well research method, familiarizing with research setting of participants before the first data collection, snowballing participants, using triangulation, strategy to assist promote honesty in

participants, use of interactive questioning, negative case analysis, numerous debriefing meetings, peer scrutiny of the research project, reflexivity, use of the background, qualification and experience of the researcher and research assistant, member checking, use of detailed explanation of phenomenon under scrutiny and lastly, examination of research findings.

Adopting a well-researched method, the researcher developed and asked questions while gathering data. The researcher went to the research setting and studied the environment. This helped in gaining adequate understanding by the researcher and research assistant of the research environment and established a relationship with participants. An interactive questioning was employed by the researcher and research assistant to reveal deliberate lies that might be told by participants. This the researcher did by probing and returning to matters that had already been raised by participants. There were frequent debriefing sessions between the researcher and supervisors so as to have a broader vision of the phenomenon as the supervisors brought their experiences and acuties to bear. This helped to bring out flaws of the researcher within the period of the research. Research assistant was allowed to ask questions and report his observations after the presentation of the data by the researcher which was what was done in the aspect of peer scrutiny. This helped the researcher refine and explain the research design. Member checking was one of the relevant provisions that boosted the study's credibility. This was achieved by allowing participants read through the transcripts they participated in to consider whether what they voiced out during the interview matched what they actually intended to say in the audio recording. A dense description of the phenomenon under scrutiny was ensured as detailed account of the study was provided. The researcher channelled the actual situation under investigation and the context that surrounded them. Previous research findings were examined by the researcher in order to assess the level to which the project's results were

consistent with the past studies. The researchers personal and religious believe was totally distanced from the study to prevent any form of bias.

3.10.2 Transferability

Transferability is concerned with the extent to which findings of the study can be applied in other situations. Moreover, it is the readers who determines how confident they are in transferring the research results and conclusions presented to other situations. The researcher ensured transferability by providing sufficient background information about the research settings to help readers make the transfer of the findings themselves. A detailed description of the phenomenon under study was provided by the researcher to allow readers have a good understanding of the issue and compare the occurrences described in the research account with those that they have seen arisen in other situations. The researcher also ensured that the results of the study was understood by readers within the context the study was performed.

3.10.3 Dependability

Dependability was addressed by reporting the procedure engaged for the inquiry in detail in other to enable future researchers repeat the work and possibly get the same results. This will permit readers to assess the degree to which the appropriate research practices were followed by the researcher and develop a deeper understanding of the technique used and its usefulness. Dependability was also ensured by the researcher plus the research design and its enactment, details on the data was gathered and the philosophical evaluation of the inquiry assumed.

3.10.4 Confirmability

Confirmability defines objectivity. The relevance of confirmability is the extent to which the researcher acknowledges his own bias. The researcher ensured that findings were

exactly participants' ideas and experience and not the researcher's characteristics and preferences. Triangulation was also stressed on in other to reduce researcher bias. The beliefs behind decision made and methods adopted by the researcher were recognized in the report. Moreover, thorough description of the method was guaranteed to allow readers to determine how far the data and constructs evolving from the results may be embraced. Audit trail was another course that would permit the reader trace every step of the inquiry through the decision made and the measures described. Interview tapes, transcribed data and field notes which served as audit trial for an objective assessment and authentication of documents information were made accessible to the supervision of the researcher. The researchers personal and religious believe was totally distanced from the study to prevent any form of bias.

3.11 Ethical Consideration

Ethical issues are relevant and needs to be looked at by the researcher in order to prevent violating the rights of the participants (Polit & Beck, 2008)

3.11.1 Ethical Approval Process

Ethical clearance was sought from the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana, Legon and the Ethical Review Committee of Ghana Health Service. An introductory letter from the School of Nursing and Midwifery, University of Ghana, Legon was also used. Copies of the ethical clearance and introductory letter was sent to the Greater Accra Regional Health Directorate where introductory letter was gotten. Copies of the ethical clearance and introductory letters were sent to Korley-Klottey Sub- Metropolitan Assembly where an introductory letter was also obtained. Copies of the ethical clearance and introductory letters were sent to the head of the Greater Accra Regional Hospital and permission was sought to engage some clients

(MSM) at the Antiretroviral Clinic to conduct the research. Copies of the introductory letter from the School of Nursing and Midwifery and ethical clearance were given to the Greater Accra Regional Hospital as well to again inform them about the study. The principle of protecting subjects participating in a research study involve the right to freedom from risk, right to anonymity, privacy and confidentiality and these were tracked.

3.11.2 Informed Consent Process

Much explanation was made by the researcher to participants in their favoured language pertaining to the purpose, objectives, future benefits and risks of the study. Participants were given enough time to make a decision on their participation. A consent form was made available to those who meet the inclusion criteria to sign / thumb print and return them after due explanation pertaining to the study had been rendered them. Participants were made aware that interviews were to be recorded on a voice recorder.

3.11.3 Right to Freedom

Participants were also informed of their right to refuse to partake in the study or withdraw from the study at any time even after the consent form has been duly signed or thumb-printed. In addition, there were no consequences attached to opting out and also participants were made aware that opting out of the research was not going to affect the services they receive at the Greater Accra Regional Hospital's ART Clinic

3.11.4 Anonymity, Possible risk and Discomfort.

Codes were given to each participant during recruitment to ensure anonymity. The codes were subsequently used in all notes and transcripts. Codes were also used to substitute names that were declared during the interview and later in quoting verbatim expressions from participants. Participants were assured that they were going to be linked to the information they provide without their permission. Participants were comfortable with the

questions asked but one had an emotional breakdown and was referred to see a clinical psychologist who helped him overcome his emotions. The participant came back later for a session of the interview after he was declared stable by the clinical psychologist.

3.11.5 Confidentiality

Participants were made aware of the fact that, the data, consent forms, audio records, transcripts and all documents would be kept safely for at least five (5) years after the research. Participants were told that ethical clearance would be sought if the data was to be used for any other purpose in future. The participants were also told that the data was to be used for its purpose and it was accessible to only the researcher and her supervisor. Anonymity was guaranteed to participants during publications of any aspect of the research. Findings of the study will be shared to participants through debriefing and also inspire them to form self-motivation groups. Privacy was ensured because participants were provided with a very quiet environment where there is a designated research room at the Greater Accra Regional Hospitals ART Clinic. The interviews were conducted on non-clinic days at the ART Centre. Participants were given snacks as compensation. Transportation was also provided for participants because they journeyed to the research setting (ART Clinic of the GARH).

CHAPTER FOUR

FINDINGS OF THE STUDY

This chapter presents the findings that sought to explore the psychosocial experiences of a key population with HIV. The specific objectives for this study were to (1) Describe the individual experiences of MSM living with HIV (2) Identify family and peer relationship of MSM living with HIV. (3) Assess community level experiences of MSM living with HIV. (4) Find out institutional experiences of MSM living with HIV. The data derived from the research was analysed using interpretive descriptive analysis; stages acclaimed by (Thorne et al., 1997). This chapter begins with an overview of how the themes were organized and the profile of participants. The main themes and sub-themes were explained concurrently.

4.1 Demographic characteristics of participants

Fifteen (15) participants were interviewed guided by a semi-structured interview guide. Participants involved in this study were from different nationalities such as Ghana, Togo and Nigeria. The nationalities were twelve (12) Ghanaians being the majority, two (2) Togolese and a Nigerian. Their ages ranged from eighteen (18) to fifty-five (55) with an average age of thirty-two (32) years. Participants spoke a minimum of two (2) languages and a maximum of ten (10). Seven (7) participants spoke English, five (5) spoke Ga, two (2) spoke Twi and one (1) spoke Hausa. Twelve (12) of the participants were Christians whilst the remaining three (3) were Moslems. Their educational level ranged from primary school drop outs to tertiary. Only one (1) participant is unemployed but the rest had diverse occupation with the exception of two (2) participants who were traders. There were assigned roles MSM gave to themselves. Out of the research, nine (9) participants were females, four (4) Males and two (2) Versatile. The females are males that play females roles. The males

are also males that play male roles and versatile plays both female and male roles. Gender is the different ways in which sexual differences between people appear differently in different time and places, societies, cultures and across people's lifetimes while sex is the biological difference between males and females such as genitalia and genetic differences.

4.2 Participants profile

Participants profile comprises of individual characteristics of each MSM living with HIV. Participants profile consists of participants identification code, age, self - identification, religion, level of education, nationality and occupation. Below is the table for participants' profile.

Table 4.1: Participants Profile

| Participants | Age | Self-identification | Religion | Level of education | Nationality | Occupation |
|--------------|-----|---------------------|-----------|--------------------|---------------|-----------------------|
| MF001 | 30 | Female | Moslem | Upper primary | Ghanaian | Trader |
| MF002 | 26 | Female | Christian | Tertiary | Ghanaian | Businessman |
| MF003 | 31 | Female | Moslem | Senior School | High Togolese | Male sex worker |
| MM004 | 25 | Male | Moslem | Junior School | High Ghanaian | Formal worker/private |
| MF005 | 42 | Female | Christian | Junior School | High Ghanaian | Tailor |
| MV006 | 55 | Versatile | Christian | Middle school | Ghanaian | Caterer |
| MF007 | 51 | Female | Christian | Primary | Ghanaian | Petty trader |
| MV008 | 19 | Versatile | Christian | Senior School | High Ghanaian | Unemployed |
| MM009 | 39 | Male | Christian | Senior School | High Ghanaian | Bar attendant |
| MM010 | 33 | Male | Christian | Junior School | High Ghanaian | Photographer |
| MF011 | 23 | Female | Christian | Tertiary | Togolese | Fashion designer |
| MF012 | 28 | Female | Christian | Vocational school | Ghanaian | Fast food vendor |
| MF013 | 25 | Female | Christian | Primary | Ghanaian | Beautician |
| MM014 | 18 | Male | Christian | Tertiary | Nigerian | Student |
| MF015 | 40 | Female | Christian | Primary | Ghanaian | Hawker |

4.2 Organization of Themes

The thematic areas were from the Socio-ecological Model. Sub- themes were consistent with explanation of each model. Four (4) major themes were developed from the data with eighteen (18) sub-themes. One (1) theme and related sub-themes were acquired through a comparison of researcher's cluster of themes and supervisor's clusters. There was consistency in most of the coding with minimal reviews to structure the themes and sub-themes. The themes for this study are (1) Individual experiences of MSM living with HIV and the accompanying sub-theme for this theme are; personal history, reaction to diagnosis, medications (ARVs), adjusting to HIV life/ Resilience and recreation. (2) Family and peer relation of MSM living with HIV and its sub-themes are; status disclosure, stigma, discrimination, broken relationships and family and peer support. (3) Community level experiences of MSM living HIV and its sub-themes are community level stigma, discrimination, abuse and community support. (4) Institutional experiences of MSM living with HIV and its sub-themes are; satisfaction with services, health care workers attitude, structural support and policy concerns. Below is the table for themes and sub-themes for this study.

Table 4.2: Themes and Sub-themes from Transcribed Data

| Themes | Sub-themes |
|--|---|
| Individual experiences of MSM living with HIV | <ul style="list-style-type: none"> ● Personal history ● Reaction to diagnosis ● Medication (ARVs) ● Adjusting to HIV life/ Resilience ● Recreation |
| Family and peer relation among MSM living with HIV | <ul style="list-style-type: none"> ● Status disclosure ● Stigma ● Discrimination ● Broken relationships ● Family and peer support |
| Community level experience of MSM living with HIV | <ul style="list-style-type: none"> ● Community level stigma ● Discrimination ● Abuse ● Community support |
| Institutional experiences of MSM living with HIV | <ul style="list-style-type: none"> ● Satisfaction with services ● Health care workers attitude ● Structural support ● Policy concerns |

Beneath each major theme, a number of sub-themes surfaced. These sub-themes were under their corresponding themes and supported with exact quotes from participants. Codes were used to represent participants for the purpose of ensuring anonymity.

4.3 Individual experiences of MSM living with HIV

This theme explains the experiences of MSM after being diagnosed as having HIV. The psychological and social effect they experienced, and how they were able to manage through or overcome all these experiences. It was observed from the narratives that, before being diagnosed with HIV, some suffered from illnesses which manifested into numerous

symptoms. Others were neither ill nor asymptomatic of any illness. According to participants, some of them were on admission for some days whilst others were battling with buying over the counter drugs which yielded no absolute results. Pertaining to the experiences of MSM with HIV, five sub-themes emerged. These were 1. Personal history 2. Reaction to diagnosis 3. Medication (ARVs) 4. Adjusting to HIV/Resilience 5. Recreation.

4.3.1 Personal history

Personal history is a collective information about an individual. It may entail a person's information about allergies, illnesses, surgeries, immunizations, results of physical exams, tests and screenings. Personal history can also be called personal medical history or personal health record. Participants presented their personal history by voicing out the illnesses they suffered as well as the duration of being an MSM. They reported about signs and symptoms they experienced for several days and weeks before being finally diagnosed as having HIV. Prior to knowing their HIV status, participants did not know that HIV could manifest with acute signs and symptoms which serves as differential diagnosis to participants. Participants also reported on how long they have been HIV positive. Participants account suggest that most of them were unaware they have contracted HIV. The initial symptoms they experienced were assumed to be minor ailments with sudden onset. A participant indicated that he had headache and fever initially and he was later diagnosed of having HIV. He recounted:

“I was having minor sickness like headache and fever. Whenever that happens, I take tab paracetamol. It will then resolve for a while and then start again. One Friday, I had running stomach throughout the night until Saturday morning, it still continued. I was thinking the hospital doesn't work on weekends so I planned going there on Monday. I wasn't still feeling well so I changed my mind and reported to “Clinic A”. I was admitted for two weeks and given 20 “drips” (intravenous infusions). Truthfully, I was screened for HIV and I tested positive. The result was placed in an envelope and I was given a referral letter to send to “Clinic B”. As at that time, ARVs were only administered at “Clinic B” and I was told that's where I would be given the ARVs. All these happened in 2003 and I have been gay for 24 years.” (MF007)

Similarly, another participant attributed his symptoms to a disease condition before he was been diagnosed. He said:

“Truthfully, in 2006, I felt ill. I had fever, headache, diarrhoea, rashes and I was thinking that it was malaria so I took some medications and for the next one week, I did not get better so I decided to go to the hospital. I went to the hospital and I was admitted on account of chicken pox, malaria and boils. I spent two days at the hospital. On the second day of admission, I was asked to do some labs and when I did, the results came out that I am HIV positive. So, I have been positive for the past 13 years and I have been gay throughout my life. I have been gay for the past 55 years. I was born gay.” (MV 006)

Others gave different narrations of not having experienced any ill-health before they were diagnosed as having HIV. He recounted:

“I learnt I was HIV positive through an NGO that was conducting men’s study and I went there to check my HIV status. I tested HIV positive. I was surprised because I was okay and I wasn’t having any complains like headache, vomiting, dizziness or something. I was diagnosed 8 years ago and I have been gay for the past 20 years” (MM004)

This participant also was well upon diagnosis but had a similar narration. He narrated:

“I wasn’t having any signs and symptoms. I wasn’t sick but I am someone who has been having unprotected sex. I just wanted to go for the HIV test and I came out positive. For 20 years now, I have been gay but I got to know my HIV status 4 years ago” (MF 001)

All participants mentioned they are HIV positive but where as some have similar personal history, others have different personal history. Some narrated being ill and even on admission whilst others never got ill before discovering their HIV status; they were asymptomatic and going about their daily activities. Some participants who indulged in high risk behaviours went in for voluntary screening and discovered their HIV status. Averagely, all of the participants have been gay for not less than a decade. They have also been HIV positive for at least four years. Most participants were clueless about the acute and chronic signs and symptoms of HIV. Health education needs to be intensified on the signs and symptoms of HIV by nurses and other healthcare providers.

4.3.2 Reaction to diagnosis

Reaction to diagnosis describes what participants did, felt or thought in response to being diagnosed as having HIV. It also shows/describes participants behavioural pattern/stability after they were diagnosed and how they took it in. Some participants reacted to their diagnosis in similar ways whilst others in a different way. Some participants exhibited suicidal tendencies, others exhibited internal stigma and some fell into depression. These psychological problems made them withdraw from people. Most participants could not eat for days making them lack nutritional nutrients for these number of days. They were all worried. Some exhibited extreme emotions and they were referred to see a clinical psychologist for counselling for which they returned later for the interview to continue. A participant commented stamping his feet on the ground:

“After I got the news that I am HIV positive, when I got out of “Clinic A”, I walked to the main road which is a one-way street. It used to be a double way so I decided to stand in the middle of the road for a car to knock me down and kill me. I had a change of mind and I went to “Clinic B. That was where I was referred to. I nearly committed suicide.

The news was a big blow to me and I couldn't eat for days and stayed indoors for two weeks.” (MF007)

Similarly, another participant shed tears and thought his world had come to an end.

He then mentioned:

“It affected me a lot when I first noticed I was HIV positive. It pained me. I shed tears. I felt so rejected. I felt like I wasn't a living soul in the world and I was feeling like, why won't I just kill myself or put an end to this? Because I don't know, it was so disturbing. Every day I cry. I have been thinking about it and even to eat was a problem for me. This is because I did not have the appetite to eat anymore and I wasn't even in the mood to talk to anybody. I just felt like being alone and alone. For two weeks, I totally lost appetite” (MF001)

A participant also expressed his reaction in quite a different way but alleged he was able to eat even on the day of diagnosis. He narrated:

“Hmmm. Boss, myself, I felt self-stigma because I was ashamed and did not feel like talking to anyone. I was indoors for days and did not want to step outside. I felt like people will notice I have HIV and point at me when I step out. I tried killing myself by taking a whole pack of quinine but I still survived due to quick response by some neighbours. They took me to the hospital. I just don’t know. I think God just want me to live so I tried eating a lot that day despite I am not a food fun. I did this, thinking if I force myself to eat a lot, I wouldn’t grow lean for people to notice I have HIV. It is not easy at all”. (MF002)

All the participants established in the study that, they all had suicidal tendencies and one still attempted suicide but survived it. They all exhibited signs of depression and self-stigma. While majority couldn’t eat for a couple of days, some ate a lot with the rational of gaining weight and not to be lean like an AIDS patient. The narration also established that participants had difficulties coming to terms with their diagnosis. They had several emotional breakdowns for which they were referred to see an antiretroviral therapy (ART) counsellor and others also saw a clinical psychologist. Counselling sessions need to be intensified by nurse counsellors and where appropriate, those with intense psychosocial needs should be referred to a clinical psychologist. Counselling should not be rushed so that proper psychosocial assessments can be made to rule out any problems with prompt solution.

4.3.3 Medications (ARVs)

Medications are drugs or other forms of medicine that are used to manage, treat or prevent diseases. ARVs are a combination of three drugs that are given to people living with HIV in order to achieve viral suppression and prolong life. Medications as a sub-theme describes participants concern about the ARVs they were taking since they were diagnosed with HIV. It also indicated the motivation behind the daily intake of the medication. Participants also disclosed the duration of taking the ARVs considering the side effects they experience. As some participants were seeking orthodox medicine intervention, others were into herbal and spiritual interventions. From participants’ narrations, the medications made

some participants want to give up their life while others took the medication due to fear of death. Fear of death is a psychosocial issue. Some participant indicated that the medication makes them go through a lot of symptoms while others have a counter response. One participant noted:

“Actually, the first day I took the medications, it wasn’t easy. I felt dizzy, I was feeling sleepy and I was not feeling fine. I was feeling like something was happening to me. It was really bad, it was really hard and if not for the intervention of the case manager, I wouldn’t have continued with the ARVs and I would have even thought that it is going to be the same way throughout but I realized it happened for two days and it stopped. I have been taking the ARVs for the past 8 years and what encourages me to take it is to live long and achieve my future carrier.” (MM 004)

Others stopped the medication due to numerous side effects and resumed later after they went through adherence counselling. He reported:

“I was initiated on drugs 10 years ago and I tell you, I went through hell. I was having horrible dreams with the first three days of taking the medicine. I also suffered rashes all over my body, joint pains and I always feel nauseous. For the first three days, it wasn’t easy so I stopped the medication for the past 4 months. I returned to the hospital because I felt very ill. Since then, I haven’t missed the medicine. I always take the medicine because I don’t want to die.” (MF 011)

In another instance, a participant indicated going to prayer camp and taking numerous herbal preparations for the cure of HIV. Laughing aloud, he reported:

“Boss, I nearly killed myself. Do you know that due to the stories I had heard about the ARVs from my friends, like the side effects, I then refused to take it. I went to a prayer camp in Kumasi. I heard of them on radio and they said they can cure HIV. While I was there, I was given some herbal medicine. For the 6 months I was there, I realised I was getting weaker and sicker than when I was first diagnosed. I then advised myself and went back to the hospital. I went through counselling and started my ARVs and for the past 14 years, I have never missed. I never experienced any side effects but only that it has increased my appetite. I can eat like 5 times a day. I am motivated to take the ARVs because I do not want to die looking lean for people to gossip about my corpse that I died of AIDS.” (MF 015)

All participants admitted taking their medications (ARVs) routinely despite some initially went in for spiritual and herbal intervention. Their statements support the ARVs

had different response of tolerance in each individual. This is because, while others were experiencing at least two (2) side effects, others did not experience any. Some participants had increased appetite. Most participants were motivated to take the ARVs because they do not want to die. All participants despite having side effects looked out for solutions that made them overcome the side effects they were experiencing and still continued taking their medications (ARVs). Adherence counselling needs to always be repeated should a client have a concern regarding the ARVs. Nurse counsellors should consistently make their knowledge on ARVs always available to clients who need them.

4.3.4 Adjusting to HIV life

Adjusting to HIV life as a sub-theme describes the behavioural process of balancing conflicting needs or challenges within the environment. This sub-theme describes how participants were able to manage living with HIV and the changes resulting from it. It further describes their responses of being diagnosed with having HIV or how they managed their way through all these experiences. A participant mentioned how he used to have unprotected sex and smokes many packs of cigarette in a day. Throughout the narrations, it is obvious that participants self-motivate themselves throughout their lifetime. Self-motivation is key in HIV management. This is because after family and friends motivate a positive-HIV MSM, eventually, the individual will be left alone to face their social and psychological issues. Hence the need for self-motivation to overcome the social and psychological problems that came along with HIV diagnosis. A participant proclaimed:

“Since I was diagnosed as having HIV, I have to self-motivate myself through a lot so that I can live. My life has totally changed. I used to have unprotected sex but now I always use condom though it is not really enjoyable. I have to manage so that I don’t infect anyone and also protect myself from being infected with other STIs. I have also avoided dating multiple partners which is boring. Hmm, my life is now boring because I used to be very adventurous. I take medicines everyday which I

wasn't used to. Now I smoke like four sticks of cigarette a day. Boss I used to smoke like 7 packs of king size cigarette a day and at least 2 rolls of marijuana." (MM 004)

Another participant who was used to group sex had a change of attitude after discovering his HIV status. He clapped his hands and mentioned:

"I am now okay but there are some permanent changes in my life which is not easy but it is a must. I love sex a lot so I used to go for MSM sex party where you can have sex with anybody you admire there. I am not used to condoms not until I was diagnosed. I now use condoms with lubricants. I love group sex a lot which I used to do with my friends when they come around but now all have stopped. I used to be very promiscuous but now I have only two partners that I always use condoms with. I routinely take my medicines. Sometimes I feel lazy to take but I have to manage to take it. This my life now. I think I have weaned myself off alcohol since I was diagnosed." (MF 012)

The lifestyle change indicated by participant suggest incomplete adjustment and with a teary eye, he said:

"Hmmm, it is difficult managing your life living with HIV. Imagine I am used to living my life in a certain way and all of a sudden, because of a disease, I am to live my life differently. Truthfully, I still have unprotected sex sometimes because I am human and I don't always remember to use condom because it is something, I wasn't used to so it is hard to adjust. At the moment, I sometimes don't take the ARVs. I am tired. It is difficult. I hardly eat out now because I was counselled to take less spicy diet and I like buying "indomie" a lot so I have to prepare it myself at home with less spices which is a waste of time. I have changed a lot of things about myself but it is difficult to keep up with them. I have tried to quit smoking marijuana but I smoke a pack of cigarette within 3 days. Previously I can smoke like 6 packs in a day" (MF013)

Under adjusting to HIV life, all participants admitted to changing their lifestyle. They all opined to trying to keep up with a healthy lifestyle despite it being quite difficult. They had to keep up in other to live. They have a source of self- motivation and case managers also help. Some turn to miss their appointment dates because they felt it is very difficult living a different life from the one is used to for years. A participant reduced unhealthy habits such as smoking, drinking alcohol and quitting the use of marijuana. Despite participants having tried reducing most of the behaviours that will make them unhealthy, most of them haven't

been able to totally abstain from these behaviours. All participants were adjusting to HIV without much professional help.

4.3.5 Recreation

Participants reported using social media in engagement, diversional therapy and meeting others. Recreation is an activity done for enjoyment especially when one is sad, stressed out or not working. It can be a form of distraction or diversion from an existing problem that one has. Recreation is fun and a form of entertainment that brings relaxation, pleasure and fun to those involved. This sub-theme addresses what relaxes and makes MSM living with happy. A participant reported getting his form of recreation from social media and hanging out at the beach. Reports from participants indicates that recreation serves as a diversional therapy for them. One participant narrated amidst smiling:

“Yeah, I do a lot. I have only some three things that I do. Sometimes, I just pick my phone and I just go on “facebook, whatsapp” and start chatting with friends to keep myself company or just put on my dress and go to the beach side, sit there and then relax myself.” (MF001)

Some participants preferred listening to music as their source of recreation. Another participated said:

“Oh, as for me, getting to a quiet place and listening to a cool country music makes me happy and takes off my sorrow. Country music when played gets into my heart and brain and it makes me feel okay.” (MM009)

There was a similar narration that went like this:

“For me like this, it is listening to music that recreates me and going for marriage ceremony and partaking in the dance as the music plays makes me very happy. Also, when fans cheer me up whiles I am dancing.” (MF003)

Another participant has a different way of recreation:

“When I go to clinic and meet my friends there makes me happy. You know most MSM do not like taking their medication and that is what is killing them and they need to be talked to but I take my medications. Taking the ARVs is quite difficult but

you have to take it. A lot of MSM are dying due to the refusal to take the ARVs but I am always happy when I meet them at the hospital going for their ARVs.” (MV006)

Participants responded to having similar ways of making themselves happy and relaxed. All participants agreed to having activities they do for pleasure and amusement. These activities help them to relax their body, mind and soul. Similar responses were listening to music, dancing and watching movies while others had different ways of making themselves happy which is seeing other MSM at the clinic taking their medications. All these forms of recreation helped them to get some distraction and helped them to forget about their problems.

4.4 Family and peer relationship among MSM living with HIV

Family and peer relationship define individual's belongingness by blood or by acquaintance. Every individual belongs to a family and the kind of relationship that exists between each family differs. Peer relation represents relationship or friendship based on mutual respect, appreciation and liking. Family and peer relation are very important in the life of every human being. Being ill and having family or peer showing their love and support helps one to overcome the health challenges. Disclosing one's illness to peers and family unveils different responses or reactions. Some of the family and peer reaction after HIV status disclosure can either be good or bad. Due to the nature of the responses the participants gave, 5 sub-themes were generated. These are: (1) Status disclosure (2) Stigma (3) Discrimination (4) Broken relationship (5) family and peer support.

4.4.1 Status disclosure

Status disclosure is the act of revealing one's HIV status to others. HIV is a condition that is associated with stigma and discrimination. As such, most infected individuals find it difficult coming out to disclose their HIV status. Some participants found

it comfortable disclosing their HIV status to both family and peers while others disclosed to only peers. Status disclosure was one of the most difficult tasks for the participants to do. They keep thinking of who to confide in about their HIV positive statuses. From participants' reports, status disclosure to close relations and friends interestingly relieves them of the psychological guilt of keeping their HIV status to themselves. A participant reported:

“Yes, I have disclosed my HIV status to a lot of my friends. Those friends of mine who have HIV are those who know about my HIV status. I also disclosed my status to my family that is my cousin because when I was first diagnosed, I was told to bring a monitor for counselling before I will be given drug. When I got home that day, I had to tell my cousin that I had HIV” (MV006)

Some participants were able to disclose their HIV status to both peers who are positive and those who are negative. They were also able to disclose their HIV status to their family as well. One reported:

“Actually, my family knows about my HIV status. My elder sister and nieces know about my HIV status. I have also told most of my friends. I have told those who I know are HIV positive and those I don't know their status. I am not bothered if they refuse to befriend me afterwards” (MF007)

Other participants have different response. A participant mentioned:

“Some friends of mine who are also HIV positive know about my diagnosis because I have told them. When I started growing lean, my family became suspicious of me having HIV. I was living in a family house by then so my auntie will say “Are you sure, you don't have HIV?” I ignored her. She told my grandmother who also started questioning me. The pressure became so much that they forcefully wanted to take me to our family doctor. Being scared that they might find out my HIV status, I had to pack some belongings and I left home unceremoniously. For four (4) years, I have never looked back” (MSM 002)

From participants' declarations, it is obvious that all of them did both disclosure of their HIV status to family and peers while some did the disclosure to either one of them. Some participants felt comfortable disclosing their HIV status to peers while others to family. Status disclosure is key with people living with HIV. It helps to relieve a

burden of secrecy on them. Nonetheless, some participants are scared to disclose their HIV status. They feared they might be stigmatised or discriminated against (fearful expectancy). Status disclosure should be encouraged among HIV positive MSM by nurse counsellors because that helps them to take less risk especially by having protected sex.

4.4.2 Stigma

Stigma is an undesirable or discrediting attribute that a person or a group possesses which results in the reduction of that group's or person's status in the eyes of the society. Stigma can result from a physical characteristic, such as symptoms of a disease or from negative attitude towards the behaviour of a group such as MSM and female sex workers (FSW) who are HIV positive. MSM living with HIV go through stigma every day of their lives. Aside from the stigma they experience as MSM, they also experience stigma as a result of being HIV positive. From the interpretation of their narrations, participants suffer double stigma. Some participants were called names instead of their birth names. This made them uncomfortable. A participant narrated:

“Boss, I for instance, I identify myself as a female in the gay world and when I started growing lean and started having rashes on my whole body, no friend wanted to come close to me. After disclosure to family and friends. They started calling me names like AIDS patient and that really made me sad” (MF014)

Another participant expressed being called a death sentence because he had HIV. He reported:

“After my status disclosure to my friends and family, they disassociated themselves from me. A friend once told me not to come near him and that AIDS is a death sentence that he doesn't want to be part of” (MV008)

A participant stated he experienced stigma from his family when he was going to have his bath. He mentioned:

“I once experienced stigma when I was living in my family house. I was going to have my bath when my cousin saw me and started shouting and I quote “look at the cursed one and he is so dirty with HIV infection.” In fact, I felt like burying myself alive because it was too early in the morning to hear such stigmatizing words. I least expected that from my own family.” (MM004)

Another participant stated:

“My family sacked me from home when they got to know my HIV status coupled with being gay. The stigma and discrimination I felt was from my best friend who I heard was in need of a white shirt we were to wear to a friend’s all white birthday party, I had two white shirts and I offered him one. He bluntly declined and I was shocked. When I offered him the shirt, he asked if I have worn it before and when I replied yes, he gave it back. We used to share everything together including the same bed. As soon as I disclosed my status to him, his attitude totally changed towards me. He doesn’t even want our skin to touch each other even when we are asleep.” (MSM 010)

All the participants expressed ever experiencing stigma from family or peers.

Others had their names replaced with the disease condition they are suffering. Stigma can predispose participants to many negative ideas. Name calling has been most experienced by participants. Unresolved stigma can lead to discrimination. Continuous stigma can cause suicidal ideation, depression and other psychological problems. All participants were not happy with the stigmatizing languages used at them. Nurses and other ART health professionals should develop and intensify consistent health education on avoidance of perpetrators of HIV stigma

4.4.3 Discrimination

Discrimination is expressed as both a negative attitude and a particular behaviour or actions directed towards a person due to a characteristic that person possess. It is also described as a distinction that is made about a person that results in their being treated unfairly on the basis of their belonging, or being perceived to belong to a particular group like homosexuals or suffering from a particular disease like HIV. Participants have experienced many forms of discrimination experienced from both family and friends.

Participants narrated how their cutlery, bowls and cups were isolated as soon as they came out as gay and also living with HIV. They also mentioned that limitations has been put on some of the things they used to do together with their friends and by their friends after their HIV status disclosure. Participants' statements brought out an interpretation of them feeling dirty and also feeling like an outcast due to the differential negative treatments given them by family and friends because of their HIV status. A participant reported:

“When my family got to know that I have HIV. I was given a different bowl, cup and spoon in the house. I wasn't allowed to use the family toilet and I always go and pay for shower and public toilet before I can bath and ease myself. With some of my friends, we used to eat in a group when we visit the “chop bar” but now when we go to eat, they all pick a different bowl and when I asked why, one boldly told me that they have to protect themselves from HIV.” (MF001)

Other participants disclosed losing group intimacy in what they used to do in a group. He stated:

“Since my friends noticed I am HIV positive, some of the things we used to do together has stopped. Some of the things are that; we used to cook in a group and eat, we used to share a room by sleeping together, we used to have group sex, we used to go out in a group and pass drink to each other but since they noticed I am HIV positive, all has stopped” (MF015)

A participant narrated being thrown out of his family house because he is HIV positive and an MSM. He stated:

“My family knew I am MSM and they tried stopping me from that act but they couldn't. They later accepted me for who I am. I then disclosed my HIV status to my family. I thought I was going to receive love from them but I was mistaken. From the time of status disclosure to the next 48 hours, I was thrown out of the house.” (MF013)

Discriminatory actions and practices on MSM living with HIV have caused them to suffer immensely. All participants agreed going through discrimination from both family and peers after their status disclosure. Some participants suffered discriminatory actions from family while others from peers. Some lost their homes; others family and friends. All

these discriminatory practices cause MSM living with HIV to go through psychological and social stress.

4.4.4 Broken relationships

Broken relationship surfaces when two or more people connected by family or friendship are no more in that connection. It also happens that those in the relationship are no more in contact with each other and the previous relationship ceases to exist. The emergence and disclosure of one's HIV status has resulted the tendency and resulting in broken relationships. There was loss of relationship with family, peers and partners when participant discloses their HIV status. Participants were left lonely and shuttered burdening them psychologically. A participant had a broken relationship with his uncle who is his sole financier after disclosing his HIV status to him. He reported:

“My uncle, that’s my mother’s brother. He always sees me with MSM friends moving around. He doesn’t say anything but one day we went for a family gathering and there were rumours that I am MSM. The rumours really hurt me because they called me to ask me about it. I finally confirmed the truth about who I was to them. My uncle used to support me financially but since he knew I was HIV positive coupled with being an MSM, he stopped sponsoring me. He told me never to step foot in his house again. I once went to his house for help. When I got there and called him, he told me to stand at his gate and not come near his house. It’s been years and I had never set eyes on him.” (MSM 004)

Another participant reported that the disclosure of his HIV status to his partner had caused their breakup and he has been heart broken. He mentioned:

“Yes, when I started this game (being an MSM), I have stayed with only one person. I wasn’t using protection because I trusted him. After I got to know my HIV status. I came home and talked to my partner. I told him that he has to go and do the HIV test because I know he is positive. He did not believe me. He said he won’t go for it and I said okay, if you won’t go for it, as I am talking to you now. I am HIV positive and apart from you, I have never been with anybody and I love the guy very much. Since I told him, he started giving me some dirty attitude so I was just left alone and heart broken. My partner got annoyed and he left. Since then, our relationship is over but I have been hearing he has moved on with a new lover.” (MSM 002)

A participant broke up with his partner because he was scared of infecting him after he got to know of his HIV status. He narrated:

“I just told my partner that I was tired of our relationship and I just want to go for some break. And he was like, why? You know I love you and I said I love you too but I want to do something. I need time so can you please give me some time? He wasn't happy but he has to agree. He kept coming back to me for about a year and I still tell him that I am not ready so he got tired and totally cut me off in his life.” (MSM 001)

The study found out that, participants went through different challenges when it came to broken relationships. One participant has not had a good relationship with his family after disclosing of his HIV status to them whiles, other participants had their partners break off their relationships. Meanwhile, one participant rather ended his relationship with his partner due to fear of transmitting the HIV to the partner. Some participants had to look out for other source of finance because there was a broken relationship with their sole financier. These relationship challenges can lead to participants experiencing more psychosocial problems. There should be available counselling services for them.

4.4.5 Family and peer support

Family and peer support describe an integrated help rendered to MSM living with HIV. The family and peer support can come in the form of reassurance and giving out words of encouragement to participants. It can also come in the form of financial support, material support and the provision of foodstuffs. This sub-theme addresses what family and peers did to support participants when they disclosed their HIV status to them. Participants' narrations indicated having emotional and psychological support that saw them through their diagnosis. They had food supplies and financial support from friends and friends when they lost their jobs due to being HIV positive. A participant reported having supports solely from friends in the form of money and food items. He received nothing from his family. He recounted:

“Some of my friends who know of my HIV status offered me support by reassuring me that Oh “AA” I’m so happy you know your status, is good, never give up in life. You know being HIV positive is not the end of the world. You can make it. I know who you are. You have a heart. You can do it. Sometimes they call me and give me financial support to use for transport fee to the hospital. They also give me extra money for expenses at the hospital. I always tell them that the nurses are very nice and they don’t sell the medicine to us. It is for free. They still insist that I take the money and that I can buy food with it. Some of my friends also bring me foodstuffs.” (MF001)

In another instance, a participant was offered health education including financial assistance when he did not have any financial means to the hospital. He mentioned:

“Whenever I feel lazy and do not want to go to clinic, they come to my place and drag me along. Always offer me health education on how to live a long life when one has HIV. That is taking the ARVs. They always ask if I do not love my life whenever I behave in that manner. God being so good, we take our ARVs at the same facility. Whenever I say I do not have money to go to the clinic, they always pay for my transportation to the hospital.” (MV008)

A participant who used to work as a beautician lost his job but due to a very good family, there was another job acquisition for him. He mentioned:

“I was out of job when my boss discovered I have HIV. My manager sacked me from her beauty salon. I was working as a beautician. My sister did all she could to provide for all my needs and also helped me secure another job in a different beauty salon. The new salon is even bigger than where I previously worked. Despite knowing that I am an MSM living with HIV, she still provided me with so much love. I love my work” (MF013)

The above expressions made by participants looked at family and peer support in the form of health education, financial, provision of foodstuffs and words of encouragement. While some participants were receiving integrated family and peer support, others indicated receiving only peer support. One participant also mentioned being very happy with his form of support from his sister by securing him a job he loves.

4.5 Community level experiences of MSM living with HIV

Community level experience is a practical contact with and observation of facts or events. It can also be an occurrence that leaves an impression on an individual or someone. Having to live within a community where people know of one's HIV status and sexual orientation is quite challenging. MSM go through many challenges when they attend social events within the community. Participants had various experience pertaining to this theme. They expected acceptance within their community but they had none. Almost all participants had bad experiences. The community level experience is a major theme with four (4) sub-themes which are: (1) Community level stigma (2) Discrimination (3) Abuse and (4) Community support

4.5.1 Community level stigma

Community level stigma is the mark of disgrace associated with a particular circumstance or a person within the community. These stigmatizing actions are carried out by people within and out of the community. These can happen at social gatherings like church, mosque, naming ceremony, funeral, marriage ceremony and so on. Community level sigma can make participants live a difficult life within their community especially with key affected populations such as MSM. Statements made by MSM living with HIV concerning community level stigma indicated that most participants suffered social isolation. Social isolation is not good for healthy mental health, yet participants are faced with it. Stigma experienced within the community can cause MSM living with HIV to vacate their homes as some participants reported. Looking at the ceiling and rolling his eyes a participant reported:

“Boss, because I am a bottom, meaning I am a female. I walk like a woman so anytime I walk in my area, people start this evil stir at me constantly and some make comments in Akan like see “the kojo besia” meaning female Kojo. Sometimes, they will be pointing at you and shouting on top of their voice calling you HIV people

and one time at a marriage ceremony I attended within the community, some people were referring to me that God Created Adam and Eve but some people prefer Adam and Adam, and she said that's why gays are cursed with HIV. I felt very bad.” (MM004)

In another circumstance, a participant experienced shaming within the community which rendered him to remain indoors for a long time. He stated:

“I don't know how my community got to know that I have HIV but I know that they knew I was gay. People who don't even know me also shame me and insult me just because I am a gay. There was a time I dressed up with my gay friends herding for a programme. Before I realized, a group of about 15 children and adults were chasing us clapping their hands and shouting: “ Kojo Besia HIV” Meaning a gay with HIV. Boss we all were on our heels. It is not easy. This alone can kill you so I decided to stay indoors during the day and only go out at night so often stay indoors because I don't want to experience such embarrassing situation again.” (MF 015)

Participants have experienced different types of stigma, while others experienced theirs within their community and at marriage ceremonies. Others experienced theirs at the place of worship. A participant narrated:

“I do face stigmatization in the mosque in my community because I am gay living with HIV. In the mosque, they said something in the “Koran” that whenever two or three people are standing to pray, they should stand close to each other. There shouldn't be any distance between them and their legs has to touch each other. Because they know I am a gay living with HIV, they see me to be something else to them so whenever I stand close to them and draw closer to them, then the person will hold their leg together and draw back so that makes me feel so bad. Their attitude makes me feel dirty. This made me stop going to the mosque to pray. I always perform my prayers in the house.” (MF 001)

Another participant added:

“Truthfully, every moslem must perform ablution before praying so some time ago, during Friday congregational prayers, the mosque environment was full to capacity. The area people perform ablution was also full so there was this person who knows about my HIV status. There was shortage of kettles for ablution due to the increase number of people at the mosque and people were waiting on others to finish performing ablution so that they can also have the kettle to perform theirs. This person who knows about my status was waiting on me for the kettle I was using but he did not know that I was the one performing the ablution. As soon as I was done and handed him the kettle, he declined it and someone else picked it up. This person

goes to know because the day my sister (cousin) insulted me for everyone to know that I am HIV positive, this person was also there.” (MSM 003)

The study revealed that participants experienced different community level stigma. A participant mentioned he was called names which were quite bad whiles, other participants experienced shaming together with name calling which was embarrassing to them. If an individual has any ill health, they need good mental health in order to focus on their health but participants are far from that peace of mind due to the community within which they find themselves. Community level stigma is present in every social gathering participants find themselves. The place of worship was not left out. Participants reported experiencing stigma even in the mosque during prayer session. The same places of worship would be used by nurses to intensify health education for the community to desist from stigmatizing against HIV positive MSM

4.5.2 Discrimination

The sub-theme discrimination is a negative attitude or a particular behaviour or action which often describes a distinction that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging or being perceived to belong to a particular group such as MSM living with HIV. Stigma often leads to discrimination. Participants encountered discriminatory behaviour within their community. Being HIV positive triggered discriminatory attitudes from employer. Participants were sacked from work upon disclosing their HIV status. Reports made by participants interpret more social and psychological burden on the negative actions bestowed on them by people. A participant mentioned:

“In fact, brother, I have been through a lot. I was thrown out of from the company I work with upon my status disclosure to my manager (MM009)

In other participant's narrations, he experienced a discriminatory behaviour of being suspended before losing his job. He reported:

“In the community especially being a gay and having HIV, is not easy. Upon knowing that I have HIV, I confided in my supervisor who then told the head of my department. Within the next 48 hours I was told to proceed on leave. When my leave ended and I arrived at the office, the Human Resource handed me a letter. When I opened it, I have been sacked and I was told it is because of my HIV status with the excuse of protecting other staff from acquiring it from me because we use the same toilet facility at work (MF011)

There was another expression by a participant who had a different discriminatory experience to share. He claims the community in which he lives knew that he was an MSM but when they got to know that he has HIV; a public toilet was abandoned for him. He narrated:

“Ahh, Boss, I don’t know whether to say that mine is a good or bad news. We don’t have a toilet facility in our house so everyone in that house visits the public toilet and that includes me. I once visited a cubicle in the public toilet and since then, the public toilet attendant told me that no one wants to visit that cubicle. When I enquired why? The attendant told me that there is a rumour going around the whole community that I have HIV so they abandoned that cubicle because they don’t want to be infected. Now, anytime I go to the public toilet and there is a queue, I just know that my cubicle is not occupied so I just walk straight in there and defecate I am no more bothered. You see I am now a VIP who owns a private toilet space in a public toilet.” (MM014)

The study unveiled that; participants experienced different discriminatory behaviour, a participant mentioned losing their sources of livelihoods. Another participant voiced out being asked to embark on an unexplained leave and finally got fired from his work without any tangible reason. Lastly, a public toilet used by the entire community, abandoned a whole cubicle to a participant when the community members found out his HIV status. These discriminatory attitudes can lead a participant to have psychological problems.

4.5.3 Abuse

MSM living with HIV suffers various forms of abuse. Abuse describes the continuous cruelty or violence showered on people who are disliked by others. There are

many forms of abuse within the community. It comes both in verbal and physical abuse or either of them. Participants expressed how they suffered abuse for being an MSM living with HIV. Some participants stated suffering from verbal abuse while others suffered physical injury by mobs. Participants suffered from all forms of abuse which made some of them vacate their then home of comfort prematurely to different homes. The abuse also makes participants feel less of a human for being treated negatively due to ill health. They suffer anxiety and panic attacks making them not wanting to go out due to fear of the unknown. Participants are always scared of anticipated attacks when they are going out for social events within the community. All these are not socially and psychologically healthy for participants. A participant stated suffering bottle cuts due to bottles thrown at him. A participant narrated:

“For example, the formation of gangs. There are various gangs in my community and especially being gay living with HIV, when you walk pass their base, they will insult you. This has made me not feel like getting out even when I am in the house. This is because when I get out, some guys in the gangs will say something silly or trash to me. Sometime ago, some people threw bottles at me without any reason. I had cuts on my shoulders so, I had to report at the hospital. I spent a lot of money at the hospital.” (MF002)

Another participant indicated experiencing mob beatings for being gay living with HIV in Accra. He said that was the most embarrassing situation he has ever faced. He narrated:

“I was walking in Accra with my friends and we were all dressed up in female attire because we believe we are genetically females. As we were walking, I just heard someone shouting “Naa Saso AIDS biii eeehe”. Meaning, these are the gay people with HIV. Within the next few minutes, there was a large crowd around us and we were stripped half naked, beaten and paraded through Accra. I bowed my head throughout. I couldn’t feel less embarrassed. Just because I am a gay living with HIV so I should suffer abuse? The answer is no but it is happening.” (MV006)

A participant experienced insults within his community because he is a gay living with HIV. He stated:

“Verbal violence. Verbal abuses. Even in our house, some people do not talk to me because I am an MSM living with HIV. When their friends come around and they see me, they abuse me verbally by insulting me. I’m like let me keep quiet and step back.” (MSM 004)

A lot of submissions were made by participants. All participants opined that, they have experienced one abuse or the other. Some experienced physical injury from an object while others experienced abuse through mob action. Another was disturbed by the insults he received and some of his neighbours refusing to talk to him. These abuses leave a lasting effect on participants’ life. They go through both physical and emotional problem. All participants became victims of abuse and these actions predisposes them to withdrawing from the community.

4.5.4 Community support

This sub-theme explains the kind of support received by participants since they are within the vulnerable group. Community support goes on to explain any source of support organized for the vulnerable living with HIV which includes MSM. The support can be government initiative, Non-profit organization initiative or a community- based initiative. The support can be in the form of provision of jobs, helping out with hospital bills and health education on healthy living. MSM are a sexual minority who are at higher risk of acquiring HIV hence they face many psychosocial problems after getting infected with HIV. Participants communicated not having any support from the government with the exception of being given their Antiretrovirals (ARVs). Some of them mentioned some community based Non-Governmental Organizations (NGOs) that have offered them support in one way or the other. Participants had psychotherapy and material support from NGOs. A participant voiced out:

“Yeah, actually, they have done their best because if I can remember I went to prison because of this gay thing in 2012 that’s because I am an MSM and it is this same NGO that came to my rescue. They got me a lawyer and granted me bail. They did

a lot and I was able to get my freedom because I was accused of rape. When I discovered who I was and I went for my HIV test, I tested positive. The NGO were the ones who paid for all my baseline labs. They also prepared an NHIS card for me, they paid for my baseline labs before I started my ARVs. They also assisted me by employing me to work with them for some time as a peer educator. Another NGO also gave me money to start my own business. They even also promised to do my passport for me and they are doing it. The first NGO that helped me out of prison is called CEPERGH” (MF001)

A participant further mentioned being depressed but due to the help of an NGO, they were able to take him for sessions with a clinical psychologist. This really was of help to him.

He reported:

“I was very depressed and it was an NGO called Family Health International (FHI) that helped me. They paid for all my labs when I was told I had HIV and they also paid for me to see a clinical psychologist when I was depressed. They also organize support group meetings for us which really helps us overcome some of our problems. For the government of Ghana, I do not know of any support given to MSM living with HIV.” (MM014)

Other participants expressed not getting any help from the government but the community youth annually organizes health talk within their community for everyone. Hence, he benefitted from it too. He reported:

“I don’t know of any support for MSM living with HIV. My community does well in organizing health talks and health screening for all community members. I do benefit. The medicated spectacles that I am wearing now, I got it from last year’s community health program. I had eye problem for so long but I had no money to go to the eye clinic.” (MF007)

Some participants agreed to having support from the community. Moreover, the support is mostly from NGOs but not from government. An NGO was able to get a participant out of prison and secured him a job as well. However, other participants also got support from annual community health programs. The participant secured a medicated spectacle for his poor eye sight problem. A participant was very grateful for an NGO helping him out of his depression. He was happy seeing a clinical psychologist. Support groups also help some participants get their psychological and social issues off their shoulders. Other participants

also mentioned not knowing of any available support rendered by the government to MSM living with HIV. They also responded having never heard of any NGO that offers help to MSM living with HIV within the community. Others have benefitted from the community-based NGO in terms of finance, job and psychosocial support.

4.6 Institutional experiences of MSM living with HIV

Institutional experiences reveal the emotions, intense feeling that MSM living with HIV go through when they go to the hospital to seek for ART services. This major theme also exports the source of support they derived from the health institution including knowing the health policies that guides their care. It was observed from the narratives that, most of the emotions and intense feeling felt by participants were with health care professionals which were negative while a few had positive feeling of the health institution they attended. While, some of the participants voiced out being shouted upon by health care workers, others had nice things to say like, being talked to calmly and not stigmatized. With regards to the elements of institutional experiences, five sub themes emerged from the analysis of the data at hand. These were:

1. Satisfaction with services
2. Bad Moments
3. Health care workers attitude
4. Structural support
5. Policy concerns

4.6.1 Satisfaction with services

Satisfaction with services measures the outcome of service expectation to a consumer/ customer (MSM). This will determine whether the customer was content with the rendered services or not. Participants have numerous experiences to share on this sub-theme. Having to receive unsatisfying care from a health facility that cares for an individual's health needs, leaves the individual in a dilemma as to whether to return to that same facility or not. One is therefore psychologically pressured on what decision to make.

Some participants like the way health workers communicate calmly with them. A participant narrated:

“Oh, for me the health facility where I take my medication, I like that place because the nurses are very good to me. They call me whenever my date is due and I always go there. Even sometimes when I’m not around, I call them to let them know I have some 5 days’ worth of medicine in it. My appointment date is then rescheduled. They understand me well. I love that place and I love the way they treat people. Whenever I go there, they smile with me, they laugh with me, play with me, I disturb them a lot and we crack jokes together. I always feel happy whenever I’m going there” (MF001)

Other participants stated being very satisfied with the health facility that renders them ART services. In addition to good interpersonal relationship and communication skills, participant said they were not stigmatized. A participant reported:

“Health care workers at my facility don’t stigmatize against MSM when we visit. Health care workers are always happy with me. The way they chat with me, I like it. Also, the way they talk with me, is with much patience and respect. I am very happy with where I am because they are very supportive. MSM like people who do not stigmatize against them. This is because, with MSM living with HIV, if you stigmatize against them, they will just move away from you and that is what I would have done if I had experienced that. I am very satisfied at where I am currently receiving treatment.” (MM004)

For other participants, they were satisfied with their health institution because they experienced differentiated service delivery and they liked it. A participant stated:

“One thing I like about the hospital is that a friend can go for your medication for you when you are declared stable and also when you are very busy. This was because recently, I was very busy at work and I couldn’t go to the hospital on my appointment date so I asked a friend to go for my medication for me. He went and the medicine was given to him. I was very happy. I love my hospital and I wouldn’t change it for anything.” (MF011)

Other participants had a different experience. A participant reported:

“There is nothing I like about where I take my ARVs. They maltreat us a lot and I sometimes do not even feel like going for my clinical appointments” (MM009)

Most participants opined that; they were satisfied with where they receive ART services.

Other participants were concerned and happy about the interpersonal relationship between

their health care providers and them. Others experienced a divergent mode of satisfaction. A differentiated service delivery made the assessment of ART services easier for some participant even if they had other essential appointments. However, almost all participants were satisfied with the services rendered them at the ART clinic they attend.

4.6.2 Health care workers attitude

With regards to HIV many people living with the condition have experienced some level of maltreatment. Findings of the study reveal the unpleasant situation participants encountered at the various health institutions that made them upset or angry. Some participants reported of an unhappy state due to the bad services they received at the health facility. Some health workers are against homosexuality so this has made them provide nonprofessional care to MSM living with HIV. Statements by participants showed that most of the health institutions participants attended were not key population friendly. A participant commented:

“A peer educator was the one who tested me for HIV so when I tested positive. He took me to “health institution A”. As soon as the nurse at the ART clinic realized I am MSM, she quickly went to wore gloves and dropped the medicine in my hands. “Eeeei”, the way she gave me the medicine was too bad.” (MF012)

Other participants stated being denied care by health care providers because they are MSM.

Shaking his head, he mentioned:

“I have been denied services because I am gay. One Wednesday afternoon, I went to the hospital with my partner around 12:30pm. We joined the queue waiting to be seen and we were the last to be seen. As soon as it got to my turn around 1:00 pm, the nurse upon seeing me just said she has closed. I begged her but she refused me treatment, insisting, she has closed. The clinic closes at 2:00pm. I was denied care. But others’ who were not gay were seen.” (MM014)

With an awkward facial expression, he added:

“Truthfully, healthcare workers have been maltreating us. Also, where we take our medications, they really waste our time. I can spend more than five hours queuing

to be served with my medications by the pharmacist. Secondly, the nurses like insulting us and if you go to them, they ask you unnecessary questions because you are an MSMHIV and they will be shouting at you. One female doctor once opened a bible quotation on homosexuality for me to read. I really felt bad.” (MM014)

A lot of participants encountered bad moments at the health facility. A participant mentioned being given a straight face on subsequent occasions by health care providers even during adherent counselling. Stirring at the ceiling, he reported:

“Can you imagine going through counselling for your medication and the counsellor wasn’t even empathetic and was not even looking at my face nor my direction. After just 5 minutes, she told me she was done and did not even allow me to ask question.” (MF015)

A participant reported spending his entire day at the hospital making it difficult to do anything else. He stated:

“Anytime I am due to go to the clinic, I feel very bad because I know I can’t do any other fruitful thing that day. The long waiting hours kills me. I go and queue around 3am because I live close to the hospital. I leave the premises around 3:30pm. That’s just too much.” (MF007)”

From all the narrations of the participants, it is obvious that there are countless bad moments they have experience due to their sexual orientation and being HIV positive. Aside from the long waiting hours, they are also given substandard treatments. Others were totally denied treatment although it is their right. Participant’s rights are violated and perpetrators are left unpunished. Hence, the same bad encounter continues. A participants’ orientation was questioned by being harassed with bible quotations. All participants believed that the maltreatment they received from healthcare workers was due to their sexual orientation. This is because they see heterosexuals being treated right. Some of these bad attitudes by healthcare providers pushes MSM away from coming for treatment and this also serves as a psychosocial stressor to them.

4.6.3 Structural support

Structural support is a sub-theme that uncovers whether there is any available assistance in the form of finance, provision of foodstuffs, and formation of support groups rendered to MSM living with HIV. MSM is a marginalized group and they are considered vulnerable. Hence, there should be a source of support rendered to all vulnerable groups within the health structure. Some institutions however, do not provide this support. Participants had economical and psychological support from the health institution that provides them with health care services. Some health structures had support groups formation that helped them share their experiences and helped them to socialize. A participant voiced out:

“When I got to know that I have been tested positive for HIV, I was so worried and confused. I communicated to my health care provider and he introduced to me a support group of MSM living with HIV that the hospital organizes for MSM living with HIV. I joined and I never regretted doing so. I am so relaxed now with my condition.” (MF005)

Other participants expressed getting support in the form of grains given to MSM living with HIV in the Northern region of Ghana. A participant narrated:

“When I was in Tamale, I get rice, millet or maize from the hospital. On every hospital appointment, I get foodstuffs. This really helped me a lot and I am always eager to go to the hospital.” (MM004)

He added:

“The story became different when I came to school in Accra, I haven’t received any source of support at where I attend ART clinic. It hasn’t been easy. When I am out of money, I have to call home and wait till my parents send me money but if Accra were also giving out grains like what Tamale does, the grains would have sustained me for some time.” (MSM 004)

Other participants have a different support system from their health facility. They stated having financial support from a healthcare provider. A participant stated:

“Whenever I go to the hospital and I confine in my healthcare provider that I have no money on me, she gives me 20 Ghana cedis for transportation home. She doesn’t do this for me alone but she extends this generosity to other MSM living with HIV in her health facility.” (MSM 009)

Support system in the healthcare facility helps MSM living with HIV become adherent to treatment. They already have psychosocial problems so a form of support extended to them helps to alleviate some of the social and psychological issues they undergo. From the above narrations, participants opined that, receiving support from their facility makes them always eager to go back to that facility. If this support continues, most MSM living with HIV will achieve viral suppression and become stable. Support came in the form of material such as money and foodstuffs while others came in the form of non-material such as creation of social support groups. Structural support should therefore be encouraged.

4.6.4 Policy concerns

A policy is a deliberate system of principles to guide decision and achieve those decisions. Policy concerns are laid down principles to guide decision on HIV and its achievement. While some participants mentioned about known HIV health policies. Others indicated never hearing of it. HIV has its guideline policies to work with which includes that of key population. Participants had little knowledge about HIV policies concerning key population. A participant reported having heard of the 90 90 90 goal projects used by World Health Organization (WHO) to curb HIV epidemic. He narrated:

“I don’t know of any policy governing MSM living with HIV. I only know of one that I read on the internet. That is the 90 90 90 projects. It stated that this policy will help eradicate HIV by 2030. I learnt that basically it means that all people living with HIV should be put on treatment.” (MF002)

In another instance, a participant stated knowing of a policy that guides key population like MSM living with HIV. He said:

“Boss, I know of the treat all policy. It states that all persons who have tested positive to HIV should be put on treatment. It doesn’t matter your sexual orientation.” (MF011)

Most participant reported not knowing of any policy concerns governing HIV. A participant narrated:

“I do not know of any policy concerning HIV. Mine is just to come for my medications on my appointment date. I have never been educated on any policy regarding HIV for key population.” (MF003)

A lot of the participants did not know of any policy concerns regarding key population at the structural level. Those who knew about the 90 90 90 goal propagated by WHO misunderstood its agenda. Although the target of the policy is to reduce HIV epidemic, participants thought its agenda is meant for HIV eradication. Furthermore, some participants knew about the “treat all” policy, but they did not know that it is part of the 90 90 90 goal projects. The “treat all” policy indicates that all those with HIV should be put on treatment. The study revealed that just few participants knew about policy concerns of key population living with HIV.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter discusses the findings in this study. The findings will be used in comparison with the relevant literature reviewed to confirm or build on ideas gained from this study. The findings were discussed under the five themes that emerged from the study. These were: (a) Individual experiences of MSM living with HIV (b) Family and peer relationship of MSM living with HIV (c) Community level experience of MSM living with HIV and (d) Institutional experiences of MSM living with HIV.

5.1 Psychosocial experiences of a key population with HIV

Under the subtheme personal history, it manifested that most participants did not know about the clinical manifestations of HIV. However, some participants observed having symptoms of ill health. This made some participant visit the pharmacy while others visited the hospital for treatment. Upon laboratory investigations at the hospital, participants were confirmed with the diagnosis of HIV. Participants went through psychological and social issues. These psychological and social issues stemmed from internal stigma, depression, suicidal ideation, discrimination, social isolation to issues with status disclosure. Their general sense of wellbeing was affected as well. Family and peer relationship of participants suffered a break due to status disclosure. Community experience was another psychosocial hurdle for participants which was difficult to overcome. These included stigma, abuse and community support. Institutional experiences of MSM living with HIV brought out negative attitudes encountered when participants visited the health institution for treatment (Sun et al., 2015)

5.2 Individual experiences of MSM living with HIV

Individual experiences of MSM living with HIV has five identified elements which were personal history, reaction to diagnosis, medications (ARVs), adjusting to HIV life / resilience and recreation. Although participants did not know what was wrong with them, they suffered symptoms like headache, diarrhoea, and fever among others. Others also had rashes. HIV has acute signs and symptoms in the early stages of the infection. In the early stages of acute HIV infection, symptoms like fever, headache, diarrhoea, sore throat, cough among others manifest. Sore throat is an upper respiratory tract infection while in the advance stages of HIV, opportunistic infection like lower respiratory tract infection, Kaposi sarcoma, cerebral toxoplasmosis among others sets in (Coelho et al., 2014; Ruterling et al., 2016; Wong et al., 2011). Most participants lacked knowledge of acute signs and symptoms being associated with HIV. In a similar study, participants admitted not having adequate knowledge on the acute symptoms of HIV and there was also inadequate knowledge about HIV (Beattie et al., 2012). It was also recognized that, some participants never manifested any signs and symptoms prior to diagnosis. HIV can be asymptomatic in the acute stages. The individual living with HIV might not present with any complains of ill health (Templeton, Read, Varma, & Bourne, 2014). However, a study conducted in low and middle income countries concerning HIV knowledge among Men Who Have Sex With Men (MSM) and another study in Vietnam on HIV knowledge and risk factors among MSM indicates that; MSM living with HIV had adequate knowledge concerning the signs, symptoms and mode of transmission of HIV (Holt et al., 2012). This was therefore different from what was found in this current study.

Some of the participants had suicidal ideation when they got to know of their HIV diagnosis. They wanted to end their lives on account of being HIV positive. They could not come to terms with being HIV positive when they were initially diagnosed. A study

conducted in China concerning the prevalence of suicidal ideation and associated factors among HIV- positive MSM in Anhui revealed that suicidal tendencies was common among MSM living with HIV. The same study also showed that the prevalence rate of suicidal tendencies among HIV- positive MSM were higher than the lifetime prevalence of 3.1% and 1%. The study further indicated that, when an individual is diagnosed as having HIV, the person starts to think of the stages of coping with HIV diagnosis. In view of this, suicidal ideation comes in when the individual envisions future images of a future life with HIV which was what this study found out (Anhui et al., 2014b). Some participants actually attempted suicide but still survived it after a quick response to the hospital. This finding is similar to a study conducted in Canada which found out that, suicide and HIV were a leading cause of death among gay and bisexual: a comparison of estimated mortality and published research (Salway, Ferlatte, & Gesink, 2016). This study further on concluded that; suicidal attempt by gays is evident but some survived it. Moreover, a study done in Nepal revealed lower tendencies of suicidal ideation among individuals living with HIV which includes MSM. Furthermore, the same study linked low level of suicidal ideation to family support and acceptance of individuals living with HIV (Amiya, Poudel, Poudel-tandukar, Pandey, & Jimba, 2014).

Most participants suffered depression. They complained of staying indoors, not eating for days. They preferred being quiet and not talking to anyone. Participants had depressed moods and did not feel like participating in everyday activities. Studies have also revealed depression to be one of the dominant psychosocial factors that affects HIV- positive MSM (Stall et al., 2003).

In some instances, they complained suffering from internal stigma and felt they will be noticed as having HIV when they step out of their houses. These feelings rendered them

wallow in sorrow. MSM living with HIV live in fear of the unknown. They are scared of how people would relate to them. Participants revealed feeling guilty for acquiring HIV. They perceive stigma/ internalize stigma in themselves when society had not yet stigmatised them. A similar study revealed MSM suffer internal stigma. Due to their sexual orientation and coupled with having HIV, they feel scared as to what people will think when they get to know about their HIV status. They feel ashamed to reveal their sexual orientation and HIV status (Courtenay-quirk et al., 2006). MSM living with HIV experience high levels of enacted stigma than perceived stigma as proven by a research conducted in Canada (Logie et al., 2012).

MSM living with HIV in their bid to finding solution to ill health seek various interventions. They were introduced to highly active antiretroviral therapy (HAART) which is a combined medication therapy. These combined medications are also known as the antiretroviral medications (ARVs). Participants had similar and different opinions on the ARVs. They commented having experienced side effects. Despite this, they still continued taking the ARVs for many years and they felt- healthy. These findings, therefore, supports the claims of a study that found out that, ARVs helps participants experience viral suppression and makes them look healthy (Phillips et al., 2013). The same study also revealed that, despite the introduction of ARVs, there is still higher incidence of HIV among men who have sex with men. In another instance, participants sought spiritual help due to conspiracy believes about the ARVs that they have heard from friends. Participants tried spiritual help and their condition worsened. It also led to poor health outcome for them and this is as similar to findings of a study by (Bogart, Wagner, Galvan, & Banks, 2011). Another finding of this study reported of the side effects of ARVs such as dizziness, feeling sleepy horrible/ frightening nightmares, skin rashes which made some participants nearly give up the medications but for the intervention of nurse counsellors and case managers.

Moreover, participants reported not feeling fine when they started the ARVs for a couple of days which made some of them discontinue taking the ARVs for a couple of months before being initiated back onto the medications. That notwithstanding, a study's findings mentioned that, people living with HIV suffer adverse drug reaction when they are initiated on the ARVs. They may suffer vomiting, diarrhoea, nausea and Central Nervous System Disturbance such as experiencing scary nightmares, dizziness and light headedness (Li et al., 2017). Experiences of taking ARVs is linked with psychological disturbance and emotional suffering in some HIV infected individuals like MSM. The psychological disturbance and constraints are usually related to the lifelong therapy associated with HIV infection. Also, visually noticeable adverse drug reaction such as diarrhoea, nausea, vomiting among others can disrupt daily routines of an HIV positive MSM which in turn can increase psychological and emotional burden. This suffering may further exacerbate self-stigma and decrease self-esteem of the HIV positive MSM. If these adverse drug suffering is not addressed, it can contribute to non-adherence of ARVs among HIV positive- MSM or forms as a barrier to adherence of ARVs (Kumarasamy et al., 2005). Contrary to the adverse drug reaction experienced by some MSM living with HIV, findings of the study on "The impact of specific HIV treatment-related adverse events on adherence to antiretroviral therapy: A systemic review and meta-analysis" showed that, some individuals living with HIV have never experienced any adverse drug reaction or side effects since they were initiated on the ARVs. (Al-dakkak, Patel, Mccann, Gadkari, & Maiese, 2013).

Adjusting to HIV was quite challenging for some participants, but they do well to adjust. There is a source of motivation behind HIV positive MSM adjusting to their HIV status. Most participants motivation was not wanting a premature death. In view of this, they self-motivate themselves in taking the ARVs. Participants also reported reducing their risk behaviours in order to live long. Similarly, findings from Heijman et al., (2012) discovered

that MSM living with HIV avoided certain behaviours like dating multiple partners and having unprotected sex. HIV negative MSM are involved in high risk behaviours like dating multiple partners and engaging in unprotected sex but alternatively, HIV negative MSM who have seroconverted for HIV and become aware of their HIV status have a significant reduction on the number of sexual partners they possess and start condom use. All these reduction in high risk behaviour after an MSM is positive for HIV can be attributed to adherent counselling they had before been initiated on ARVs. In order to have viral suppression while an individual is on ARVs, one has to desist from all things that can interrupt with the pharmacodynamics and pharmacokinetics of the ARVs. Some of these contraindications are having unprotected sex with partners whose HIV status is unknown and also having multiple partners. HIV negative individuals and MSM whose HIV status are unknown to them are those who increase the risk of HIV among MSM. Some have reduced their smoking habits from taking high number of cigarette or marijuana rolls in a day to the barest minimal. Nonetheless, participants still smoke which can make them experience drug resistance with the ARVs. Findings from this a study revealed HIV positive MSM having drug resistance due to smoking and taking ARVs at the same time which contraindicates the ARVs (Pergam, Gottlieb, & Horwitch, 2008). Contrary to participants assertions, Reynolds (2009) there was an increase of substance abuse in MSM after they became aware of their HIV positive status. This may be because MSM finds it difficult disclosing their HIV status to anyone post HIV diagnosis. They find soothing solution in smoking which helps them forget their problems. It might also be that they could not quit smoking on their own and they needed a professional's intervention which they could not afford or rehabilitation centre which they did not know existed (Mamary, Bahrs, & Martinez, 2002).

Recreation was used as a source of entertainment and diversional therapy amongst the participants. HIV infected MSM go through psychosocial experiences and they use music, and social media to relieve themselves from all the negative psychosocial experiences they encounter. To reinforce the findings, another study elaborated that HIV positive MSM go through psychological and social issues. Like the findings of Sallar & Somda,(2011), for a form of entertainment, participants look out for information pertaining to HIV through social media so as to educate themselves more and to rule out any misconceptions. This helps them be informed and happy because knowledge is power. Having adequate knowledge about ones' health status can help them overcome any potential psychosocial issues that will result from any HIV related misconceptions. The findings of a study by Mimiaga et al.(2010) was contrary to that of this research findings. According to Mimiaga et al.(2010), MSM living with HIV use alcohol as a means of entertainment to forget about the psychological and social issues they encounter because they have acquired HIV. Mimiaga et al.(2010) also provided evidence that; MSM living with HIV enjoy alcohol intake especially when having sex with their partners.

5.3 Family and peer relation among MSM living with HIV

Most of the participants ascribed difficulty in disclosing their HIV positive status to their family and friends. As some participants were comfortable disclosing their HIV status to friends or peers, others felt comfortable disclosing to their family. The fear of disclosing their HIV status to either family or friends or both is mainly due to fear of broken relationship or being stigmatized as this research findings revealed. Disclosure of HIV status to family was a source of relieve for some participants because family is very relevant to them and this was supported by the findings of Serovich, Graftsky, & Craft (2011). Other participants sought comfort in disclosing their HIV positive status to only their friends, especially those they knew were also HIV positive because they believed that they will

understand them better than friends who were HIV negative. In the same way, findings from Holt et al.(2012) revealed that MSM living with HIV tend to feel relaxed disclosing their status to MSM with similar status like themselves. HIV positive MSM's disclosure of their status to either family or peers is one step of relieving a psychosocial issue. Voicing out a troubling issue is one way of psychosocial recovery. Some participants believe in disclosing their HIV status to both family and peers (Hightow-Weidman et al., 2013). MSM living with HIV find it difficult to disclose their HIV status especially in a country where MSM is illegal and a criminal act. Despite this, some MSM do well to disclose their HIV status to friends and family hoping for acceptance and reassurance that they will be well. Not all the participants had affirmative assurances from their family and friends after disclosing their status. Findings of a study revealed HIV positive MSM regret disclosing their status to family and friends (Zhou, 2006). This might be due to stigma and discrimination they experienced from family and friends.

After HIV status disclosure to family and friends, participants experienced stigma in the form of shaming and name calling. This stirred embarrassment for participants because they could not believe the sort of treatment they received coming from loved ones. This finding was endorsed by a study conducted by Preston et al.(2004) who states that HIV related stigma experienced by MSM emanated from family after status disclosure. This behaviour by family of MSM living with HIV can increase the risk of HIV positive MSM experiencing other psychosocial problems. The findings of this study also brought forth HIV positive MSM experiencing stigma from friends they trusted with their status disclosure(Courtenay-Quirk et al., 2006). This goes on to explain that, most of their friends limited their interaction with them after status discovery and this, in effect, had negative effect on the mental health of an MSM living with HIV.

Findings of this research exposed many forms of discrimination MSM living with HIV encountered. For instance, assigning them different cutlery, bowl and cup different from the ones shared by the entire household. Others were also not allowed to use the family's bath and toilet facilities. They were absolutely isolated and quarantined in their own home. Their utensils were separated and findings from Grant et al. (2013) agreed with this. MSM living with HIV feels like outcasts and not humans when these negative attitudes were directed at them. This facilitated the breakage of bonds that existed between families of an HIV positive MSM and an HIV positive MSM himself. It was also found out that, some participants were thrown out of family homes because they were infected with HIV. This made them homeless and they had no shelter when they made their HIV status known. This findings relates to a study done in South Africa which indicated HIV positive MSM to losing their houses after HIV status disclosure (Cloete, Simbayi, Kalichman, Strelbel, & Henda, 2008). In most African countries, MSM is a sexual activity that is frowned upon unlike Europe where most of the European countries have legalized same sex practices. Despite South Africa being one of the limited African countries that have legalized MSM practice, there is still stigma and discrimination experienced by HIV positive MSM coupled with being a sexual minority (Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008; Rispel & Metcalf, 2009). Friends tend to be one of the greatest companions for the sick. This makes HIV positive MSM take the ultimate decision of disclosing their ill health to them. When some of the participants revealed their HIV status to their peers, they received a negative feedback from them. In addition, limitations were put on whatever they used to do together prior to their HIV status disclosure and they were also avoided. A study's findings is also linked to this research findings (Emlet, 2006). There were also reports of positive feedbacks after disclosure to family and friends which was contrary to the findings of this study. The opposite findings of the study was by one conducted in Argentina which exposed that

majority of HIV positive MSM receive support from family and friends after HIV status disclosure (Carballo-Diéguez et al., 2013). This might be because Argentina is one of the most gay friendly countries in the world and has legalized its practice, so they embrace both MSM living with HIV (Almario, Riggle, Rostosky, & Alcalde, 2013).

Participants disclosed cutting ties with their families after status disclosure. They reported being stigmatised and discriminated against by their family to the extent that they could not bear it anymore. They had to cut off with these family members in order to stay focused on maintaining good health throughout their ill health. In contrast, some participants also mentioned some friends who knew about their HIV status tended to be either very supportive or walked away from the friendship altogether. The findings complemented a study done in Nashville, Tennessee in the United States of America which revealed that there are broken relationship with family and friends after HIV disclosure but some friends still stay on to give out their support to their HIV infected peers (Audet et al., 2013). This goes on to explain that, HIV positive MSM with broken relationship are often not judged by the previous relationship they had with their family and friends but they were judged based on their HIV status. It is sad to share a long bond with family and friends and it is broken because of a disease disclosure. This put affected individual in continual states of psychological and social instability.

In spite of all these negative experiences MSM living with HIV go through, there is still positive experiences that MSM get due to the support given them by family and friends. Some of these supports came in the form of emotional, financial and material. HIV positive MSM's already experienced problems both socially and psychologically. The presence of family and friends as support structures helped in relieving them of some of these problems. Findings of a study conducted in the United States of America attested to the fact that friends

and family acted as emotional relieve for the sexual minority (MSM) living with HIV throughout the psychosocial experiences they encountered (Elkington et al., 2011; Lee et al., 2015). Looking at the findings of this research and that of another study by Graham et al.(2016), it is obvious to note that, despite HIV positive MSM having more friends supporting them through difficulties they have encountered, this should not be construed to mean that family are not consequential. This is because the support of both can be a positive drive towards achieving a healthy mental health status for HIV infected MSM. Friends have showed commitment of being there for some participants during difficulty in facing their HIV status all by themselves. Participants disclosed feeling comfortable when they disclose their HIV status to friends who also have HIV. This in turn helps them to know their secret is safe with someone who has the same problem as them. Participants mentioned being encouraged by friends to take their ARV. A study finding is in line with this research findings stating that, HIV positive MSM are more comfortable disclosing their status to friends who have already acquired HIV because they in turn do not stigmatize against them like the HIV negative MSM. Those who are already HIV positive show them support to overcome the difficulties that come with being HIV positive (Graham et al., 2016). Graham et al. (2016), the experienced MSM guides the newly diagnosed MSM in taking the ARVs and makes them know the benefits involved in taking them. This boosts their confidence which includes their psychosocial health. Contrary to these findings, some MSM living with HIV have not received support either from friends nor family (Poteat et al., 2011; Rhodes et al., 2011; Saleh, van den Berg, Chambers, & Operario, 2016). Family and friends refuse to accept their sexual orientation plus their HIV positive status.

5.4 Community level experience of MSM living with HIV

Occurrences leave a mark on an individual or people. There are both negative and positive experiences of an individual or people living with HIV. HIV positive MSM

experience negative behaviours from members of their communities. Some of these negative behaviours are community level stigma, discrimination and abuse.

Community level stigma remained one of the major challenges of MSM living with HIV. According to participants, they are called names, people made mockery of their sexual orientation and they are insulted when they attend community programs like naming ceremonies, funerals, marriage ceremonies among others. They also admitted being pointed at when they attended social events within the community. This was similar to a study conducted in South Africa which discovered that, within the community, MSM living with HIV are harassed and made fun of through name calling. They are also insulted and ridiculed (Bell et al., 2007). All these negative attitudes by the community towards MSM living with HIV makes them feel stigmatized and withdrawn from the community. Community level stigma is a major challenge in fighting HIV epidemic especially among the key population and Smit et al. (2012) attest to this. Participants also reported experiencing public shame because of their HIV status and also being an MSM. When they cross dress as self-acclaim females, they are hooted at, and they are shamed when they attend events or walk within the community. Findings of Thomas et al. (2013) affirms what this study revealed. It revealed public shaming and humiliation thrown by MSM living with HIV. The place of worship is not an exception in stigmatizing against MSM living with HIV. Participants indicated receiving negative attitudes from their religious groups when they disclosed their HIV status and sexual orientation. They were seen as “sinful creations” because homosexuality was against both Christianity and Islam. They were labelled and shamed. Some study findings also found similar results of shaming HIV positive MSM in their research works (Neff, 2006; Rotheram-borus et al., 2003). Their findings discovered shame being experienced by HIV positive MSM. Contrary to these findings, a study mentioned that churches and mosques were mechanisms used to educate the congregants on HIV related stigma. Hence,

the informed congregants received health education on HIV related stigma which helped them have a change of attitude towards HIV positive MSM and all people living with HIV (Coleman et al., 2012). These religions had places of worship situated in the community. Health education about HIV and stigmatisation of the disease bearers would go a long way in reducing the overall stigma experienced by key populations such as MSM. A positive attitude from the church or mosque towards MSM living with HIV would go a long way to gradually yield an HIV stigma free community.

Discrimination is also an issue within the community when it comes to MSM living with HIV. Participants have encountered many forms of stigma in their reportage. Participants have experienced unjust treatments because of who they have identified themselves with in terms of sexual orientation and having HIV. The community does all these with the notion of preventing themselves from being infected with HIV from an HIV positive MSM. Participants expressed losing their means of livelihood. They lose their job after status disclosure coupled with being an MSM. Similarly, some study findings also has same revelations(Friedland et al., 2018; Varas-Díaz et al., 2005).

There has been continuous violence recorded towards HIV positive MSM. Abuses encountered by participants came in many forms. Participants reported being stripped half naked in public when they cross dressed as females attending events. They also experienced name calling and they were beaten. This study also found that, some MSM living with HIV were publicly stripped naked and are called insulting names coupled with being hit or beaten (Baral et al., 2011; Jeffries & Gary, 2012). Participants experienced injuries which were both physical and psychological. These attacks were unbearable to them. Physical injuries caused pain and psychological problems like depression. Participants live in fear because they are scared of these negative occurrences. Insults and verbal abuses were also suffered

by participants in their communities. They mentioned being insulted without any provocations when taking a walk in their neighbourhoods to the perpetrators of these negative acts. Study findings in Uganda and Tanzania showed that verbal abuse, insults and maltreatments are evident in the lives of HIV positive MSM (Hladik et al., 2012; Micheni et al., 2016). These behaviours push MSM living with HIV to fall victims of psychosocial problems. Suffering abuses makes an individual go into many negative thoughts like suicidal ideation which most MSM living with HIV experience (Park et al., 2015). All these abuses were perpetuated by the public but contrary to this, a research conducted in Senegal revealed that abuses of MSM living with HIV were performed by law enforcement personnel. Police officers stripped off MSM naked, called them names, verbally abused their family and they were refused a bath throughout their custody in prison (Poteat et al., 2011). This explains infringement of the right of every prisoner or human being. If those to protect people/citizens are abusing them and breaking the law, then what about if the public does same? This can bring an MSM living with HIV unstable mental and social health.

Community support is key with regards to the psychosocial issue's HIV positive MSM have faced within the community. Participants voiced out not getting any special support from the government. They believed to have been given a special support in terms of foodstuffs and finances because they are part of the vulnerable group when it comes to individuals living with HIV. Participants agreed receiving supports from Non-Governmental Organizations that helps MSM living with HIV. The supports they had, came in the form of protecting their human right from being violated, financial support, offering them job opportunities, sponsoring their health needs and organizing health programs like peer support groups for them. These helped to address some of their psychological health needs. Findings of these studies syncs with the findings of a study in India which revealed creation of support groups for MSM living with HIV helped them to share their problems

and provided them with professional help for psychosocial health needs. As a recommendation, they also added providing a safer place for MSM receiving treatment in order not to experience any psychosocial issues at the institutional level (Lawrence & Brun, 2011). Community-based organization such as NGOs also provided funds for MSM living with HIV to be trained as peer educators. They have been offered job and are paid (Adams, 2014). Peer educators are MSM living with HIV who help identify their peers and serve as a channel of referral for a drop-in centre or a hospital should their peer test positive for HIV. They also provide education on prevention of high-risk behaviour like consistent use of condoms and lubricants, counselling, illicit drug and alcohol use, mental health and self-esteem, among others. NGOs are integral part of civil society especially in developing countries like Ghana. They do not work as a civil society alone but they also work as a transformative force as well for a lot of MSM living with HIV. Participants disclosed of a wrong accusation and imprisonment but an NGO that fights for the rights of HIV positive MSM came to their aid and they had their freedom back. Similarly, a study's revelation stated an NGO that has fought for the human rights of not only HIV positive MSM but also others who are infected with HIV. Their lawyers have fought for wrongful accusations and imprisonment to be withdrawn and they have gained their freedom (Danziger, 1994).

5.5 Institutional experiences of MSM living with HIV

Most participants had negative experiences when they went to seek for ART services in their various health institutions. Participants felt intense dislike which mostly came from healthcare professionals. There are four sub-themes to be discussed under this theme. These are (1) Satisfaction with services (2) Health care workers attitude (3) Structural support and (4) Policy concerns.

It was realized from the interviews that; some participants were content with the services they received from the ART clinic. Participants stated being always happy whenever they are going to clinic because their health care provider (nurse) are good to them. They expressed not being stigmatized against and they are satisfied with the current treatment they are receiving. In addition to these statements, it was also reported by a study that MSM living with HIV are happy with the care they receive at the hospital. It further on elaborated that, MSM living with HIV described their healthcare providers as kind, sensitive nurse counsellors and medical staff who do not stigmatize against them (Beattie et al., 2012). Other participants were satisfied with the differentiated service delivery the facility has adopted. This enables an MSM living with HIV to pick up their ARVs even if it is not clinic hours and can-do pickups within the community. They can also send a trusted friend or relative to go for their ARVs for them if they were caught up with other engagements on their review date. This is applicable to clients who are stable. Another study findings stated satisfaction of care and promotion of ART drug adherence due to differentiated service delivery (Grimsrud et al., 2016). A differentiated service delivery is a client centred approach that simplifies and adopts HIV services across to people living with HIV. This helps to serve the health needs of an MSM living with HIV without encountering any psychosocial problems like stigma and discrimination. This initiative is also for ART delivery to clients who are clinically stable and this is largely implemented in large prevalence countries like in sub-Saharan Africa like Ghana.

People look up to healthcare workers for assistance towards a speedy recovery (Magee, Davis, & Coulter, 2003). Findings of this study indicated harsh and unfriendly treatments from health workers. Some of the health workers treated the MSM clients badly which had the potential of worsening their health condition both physically and psychologically. Narrations by participants revealed that some of them were discriminated

against. They mentioned that, as soon as healthcare providers got to know of their sexual orientation as an MSM, they quickly went to put on gloves before their ARVs were dropped in their hands. MSM living with HIV experience healthcare professionals using universal precaution on them while their immediate situation doesn't call for it. A study findings also revealed a healthcare professional putting on gloves before providing water and oral medications for an HIV positive individual who requested for it (Rutledge et al., 2009). Administering or serving ARVs and also pouring a client who is HIV positive water doesn't call for putting on gloves. Participants also mentioned being denied services because they were MSM living with HIV and this goes in line with a study finding. It revealed that, HIV positive MSM are refused care by healthcare providers because of their sexual orientation (Fay et al., 2011; Magesa et al., 2014) . Bible quotations were read to HIV positive MSM as soon as their sexual orientation was known. All these quotations were biblical quotes against homosexuality. A study findings attest to this fact (Kushwaha et al., 2017). Contrary to this, a research finding revealed HIV positive MSM being treated nicely by their healthcare professionals who were non- judgmental about their sexual orientation and HIV status (Ma et al., 2017).

Receiving support from a hospital that provides an MSM living with HIV help relieves them of some economic and psychosocial burden. From some participants narrations, their healthcare facility had organized a support group for the HIV infected vulnerable population of which MSM living with HIV were inclusive (Houglum et al., 1997). They expressed being happy with this initiative. Some participants also expressed being given foodstuffs by the health facility they attend. Others stated being given transportation home occasionally if need be. A study revealed institutional support for MSM living with HIV which includes food, money and shelter (Tim Lane et al., 2011). Despite the fact that the study findings of this research did not include shelter, it is also inclusive in

the package of some hospitals in South Africa for the high -risk group (MSM). Some of the participants had however not received any form of support from their health institution apart from going for their regular ARVs. Despite some hospitals providing support for the high-risk population in terms of food, money and creation of peer support groups, other health institution had no such support for HIV positive MSM. Their health institution does not have any special package for MSM living with HIV and a research findings revelation agreed to this fact (Zhou, 2009).

In every well- organized programme, there are policies that guides them. These policies are deliberate system of principles to guide decisions and achieve those decisions. The laid down principles pertaining to MSM living with HIV was unknown to some of them. Others were able to mention some policy concerns pertaining to people living with HIV but not with key population where HIV positive MSM are inclusive. Some participants mentioned the “treat all policy” which was initiated by WHO. This policy applies to all people living with HIV which includes HIV positive MSM. Some participants also mentioned of the 90 90 90 goal projects by UNAIDS to combat HIV by a stipulated period of 2020 (Ali et al., 2019; UNAIDS, 2014). Participants were able to explain “treat all policy” being having to put all those who have tested positive for HIV on treatment but they did not know that both the 90 90 90 project and treat all policy are targeting the same goal same goal (Of et al., 2016).

5.6 Application of Model to Study

The findings of the study were consistent to with the socioecological model. In line with the first part of the model, the individual experiences with HIV, this study has established that MSM living with HIV have suffered many psychosocial experiences. It pointed out that most MSM living with HIV did not know the signs and symptoms of HIV

prior to their diagnosis. Others were totally asymptomatic. In another development, HIV positive MSM had diverse and similar responses when it came to their reaction after HIV diagnosis. HIV positive MSM unknowingly suffered internal stigma. They suffered depressed mood. It therefore emerged as an additional subtheme. Some participants also had suicidal ideation as their initial reaction to their diagnosis..was part of their reaction. A few of the participants attempted suicide but still survived it due to the quick intervention by concerned neighbours. The internal stigma, depression and suicidal thoughts had negative effect on them because they could not even concentrate on activities of daily living like bathing and even enjoying three square meals was a problem. In view of all these psychosocial health issues they encountered, they tried to be resilient and adjusted their lifestyle to suit their current health condition by reducing the number of sexual partners they had, having protected sex and minimizing smoking. In addition to these changes, they still found ways of making themselves happy. Some resorted to recreational drugs while others did well to research more about their health on the internet which made them happy. This acts as a psychosocial relief for most HIV positive MSM.

The second part of the socioecological model is at the family and peer level. Majority of MSM living with HIV were stigmatized by those very close to them who are family and peers. Status disclosure is one difficult task that every individual living with HIV has to bear. Disclosing HIV status to family and friends was quite a difficult task for participants. HIV positive MSM still found it difficult to disclose to both family and friends. Some participants disclosed their HIV status to friends alone and others also to family alone. While some of the participants were stigmatised only by their family, others were only stigmatised by their peers. This drained them psychologically and socially because MSM living with HIV were called names other than their birth names. They were held prisoners in their own home and insulted without any provocations. Discrimination set in when the stigma levelled against

MSM living with HIV was not resolved. Discrimination came in the form of HIV positive MSM being denied family amenities like use of shared washroom and toilet facilities. Different utensils were given to them on account of their ill health and HIV status. They were evicted from home. Peers also limited interactions when they discovered the HIV status of participants. Group eat outs were limited to some group of individuals which excluded the HIV positive MSM. In addition, there were broken relationships after status disclosure to family and friends. Financial sponsorships were lost from family. Peer relationships was also dissolved on account of HIV status revelation. Moreover, aside all these negative encounters experienced by HIV positive MSM, they still had some sort of support from some family and peers. Support came in the form of reassurance, reminders to take their ARVs, provision of money, foodstuffs among others.

The third phase of the socioecological model is community level. MSM living with HIV suffered a lot of misups in the community. They have been insulted, called names and shamed. Places of worship were no exemption to stigmatising and discriminating behaviour levelled against HIV positive MSM. Loss of means of income was inhuman act bestowed on HIV positive MSM. Moreover, they suffered abuses by being stripped naked in public, hit with bottles and unjustly jailed for wrongful accusations. To add more to injuries, some public amenities like public toilet were abandoned because an HIV positive MSM visited it. MSM living with HIV inadvertently suffered social isolation. They stayed indoors and some of them only stepped out when night fell. All these psychosocial problems experienced intensified by the day but some NGOs have provided some form of support for MSM living with HIV within the community. The support came in the form of training of peer educators and employig them, provision of allowances for programs attended, payment of their baseline laboratory investigations, provision of psychosocial care by health professionals among others. These have built the self confidence of some HIV positive MSM while others

who do not know of such support system in the community still suffer psychosocial problems. Acceptance and outreach services were sub-themes that was not used in the study because the community still does not accept HIV positive MSM. Outreach services was excluded from the study because it had no link with the topic under study.

The final phase of the socioecological model is the structural level. Satisfaction with health services is paramount to MSM living with HIV . Some of them were pleased with the care rendered them by non stigmatizing and empathetic staff. The initiative of differentiated service delivery made MSM living with HIV very happy. They need not come to the hospital on clinic days to pick up their ARVs. In view of this, they would not encounter any form of stigma nor discrimination from any health personnel. In another area, HIV positive MSM encountered bad attitude from healthcare providers which rendered them not sticking to their appointment dates for their ARV medication refills. Some of the negative attitudes were denial of health care, rushing through ART services provided and practicing universal precaution on patient with procedures that did not warrant the need for it. Most health care workers are not key population friendly so they showed negative attitude towards HIV positive MSM. Some end up preaching to them and opening bible quotations that is against homosexuality to HIV positive MSM. Despite all these bad experiences, HIV positive MSM still have some health institutional support given them. There was formulation of peer support groups that have helped relieve most MSM living with HIV from emotional problems with provision of transportation fee on clinic days and provision of foodstuffs. These helped relieve them of financial burden of transportation fee when their appointment date was due for them to come to the hospital. There are many health policies for individuals living with HIV which includes MSM. HIV positive MSM were familiar with only two health policies. These policies were the “90 90 90” and “treat all policy”.

The socioecological model was used as a guiding framework for this study. For the first construct, there can be modification of additional sub constructs such as depression and suicidal ideation. Also, in the second phase of the model which is the family and peer level, an additional sub-construct of discrimination can be considered. Two sub constructs under the community level were removed because they do not relate to the topic under study. These sub-constructs were acceptance and outreach services. The final level of the socioecological model should be modified to include stigma and discrimination.

CHAPTER SIX

SUMMARY, IMPLICATION, LIMITATIONS, CONCLUSION, AND RECOMMENDATIONS

This chapter presents the summary of the study, its implication to nursing education, practice as well as research. It also looks at the limitation, conclusion and recommendation.

The objectives of the study were as follows:

- I. Describe the individual experiences of MSM living with HIV.
- II. Identify family and peer relationship of MSM living with HIV.
- III. Assess community level experiences of MSM living with HIV.
- IV. Explore the institutional experience of MSM living with HIV.

6.1 Summary of the study

The study explored the psychosocial experiences of a key population with HIV. It was carried out to ascertain the psychosocial experiences MSM living with HIV face as well as what can be done to reduce or correct this. The study was qualitative, an interpretive descriptive approach was employed. The socioecological model was adopted to guide the inquiry. Snowballing technique was the sample type used. Fifteen (15) participants from the ages of eighteen (18) to fifty-five (55) years took part in this study. Face to face in-dept interviews were conducted with the help of a male research assistant. Interview conducted were audio recorded, transcribed verbatim and analysed accordingly. Through thematic analysis approach, four main themes emerged, namely; individual experiences of MSM living with HIV, family and peer relation of MSM living with HIV, community level experience of MSM living with HIV and institutional experience of MSM living with HIV which met with the resources derived from the constructs of the model.

Individual experiences of MSM living with HIV ranged from many narrations from participants. Participants initially suffered some signs and symptoms which ranged from headache, fever, diarrhoea, rashes among others. Some attributed the symptoms of malaria to malaria while others sought for over the counter drugs to curb the symptoms. Despite the initiatives taken, symptoms were still present until final diagnosis of HIV was made at the hospital. Some participants were asymptomatic prior to HIV diagnosis. After diagnosis, participants felt shame, self-blame and experienced internal stigma. They explained having difficulties in response to HIV diagnosis but they finally had to give in and adjust their lifestyles. Participants took different response to the management of HIV. Some sought spiritual help but later all participants fell on ARVs. Taking medications every day was not easy with participants coupled with its adverse drug reactions. Some participants quit taking their medications for a while but they were encouraged by nurse counsellors and peer educations to continue with the ARVs. These notwithstanding, self-motivation was key in participant's life because of fear of premature death. Participants experienced depression by having continuous lowered mood, not talking to anyone, stayed indoors for days, neglect of food and personal hygiene. Suicide was attempted by some participants but they still survived. Others were also contemplating of committing suicide. Despite all the psychosocial experiences participants had gone through at the individual level, they still found ways to make themselves happy. They explored more knowledge on social media so that they will be more informed about HIV. Some took alcohol as a form of recreation. They confessed knowing it was not good for their health status but they claimed it made them happy.

Participants found it difficult disclosing their HIV status to friends and family. They finally did status disclosure. Some disclosed their HIV status to either family or friends while others did to both. There were both negative and positive outcome expressed by

participants. Some participants' experienced were called names and shamed by family members and friends, neighbours and strangers. There were discriminatory attitudes like limited interactions from family and friends. Some participants lost their homes while others were ejected from their homes. Family ties and friendships were lost as a result of this. Positive experiences manifested in the form of emotional support participants had from some family and friends. Others also had financial support and donation of foodstuffs given to them.

Stigma was key in the community. Some of the MSM living with HIV lost their jobs after disclosing their HIV status. Abuse was also dominant in the lives of participants. They experienced abuse in the form of public beatings, hitting, being stripped naked and paraded around the community. This made some participants isolate themselves from the community and others had to change homes. However, there was support also given to HIV positive MSM within the community. Most of this support came from NGOs. The support came in the form of protecting the abused rights of HIV positive MSM, provision of employment, financial assistance, health screening and HIV education among others.

Many participants disclosed experiencing negative attitudes from healthcare workers. They also stated experiencing some good healthcare workers too. MSM living with HIV expressed being treated unfairly by some healthcare workers. Extreme precautions were taken when dealing with them including the practice of universal precautions on participants while the procedure, they were carrying on them did not call for it. For example, procedures like feeding patient, offering patient water or oral medications among others. Some also mentioned having good interpersonal relationship and good communication skills from their healthcare providers. There is some support rendered to MSM living with HIV by some health institutions. Supports ranged from having a support group for key populations, provision of food stuffs and financial assistance. There was not

any form of support in other health institutions for key populations. Policy concerns were limited with participants. HIV positive MSMs had some level of knowledge concerning available health policy for all people living with HIV but not specific to key population. They mentioned knowing of the “treat all policy” and the “90 90 90” project by UNAIDS.

6.2 Reflexivity and Insight Gained

Reflexivity is a continuous process of reflection by researchers on their values and of recognizing, examining and understanding how their social background, location and assumptions affect their research practice and also to ensure rigor (Palaganas, Sanchez, Molintas & Caricativo, 2017).

The researcher’s background is registered general nursing with an additional certificate on clinical management of HIV. The researcher has ten and half years working experience but has seven year’s working experience caring for people living with HIV positive. The facility the researcher is working at has been accredited as key population friendly by an NGO known as John Snow Incorporated (JSI) which deals with the issues of HIV especially among key population. This has shaped the researcher’s reflexivity on the psychosocial experience of key population with HIV. The researcher acknowledged that conducting this research was insightful and conveyed ideas from MSM living with HIV who have had psychosocial experiences. During the data collection, there were times where the researcher and research assistant emphasized with plights of participants. During coding and presentation of the findings, the researcher was concise and exact in identifying categories and themes and also was mindful of detaching the researchers own interpretation at the stages of the data processing. The researcher was discriminatory in selecting core data from those that were non-relevant. This is to provide due significance to the information provided by participants. As the researcher listened to the audio tape on participants’ stories on

psychosocial experiences, the researcher cherished how participants accepted their fate and have adjusted to the situations despite what they have been through. The researcher and research assistant therefore, told the participants that they wished the study will serve as a tool that will be utilized by policy makers. Conducting the study has aided the researcher develop technical skills and basic values as an individual.

Conducting this research was difficult and very tedious but very interesting. There was so much fear and anxiety so much that, at a point, the researcher thought it was impossible to conduct the study. The supervisor came in to encourage researcher that it was possible. However, the researcher learnt a lot during the study. For example, understanding the research process itself, explaining research well as the interview process of participants. Being able to analyse data personally, to the researcher, was a plus. This has therefore given the researcher the zeal to be able to conduct other studies in future and also supervise others even though the researcher was a novice prior to conducting this study.

That notwithstanding, there were few challenges encountered, one of which a participant called and asked for financial assistance to carry out his routine laboratory investigations. The researcher organized some money to help participant with the laboratory investigations but politely made participant aware there was not going to be a repeat. Finally, conducting this research has been quite an experience that will live with participant for a long time if not forever. This has given the researcher so much confidence and encouragement to even aspire higher education.

6.3 Implications

The findings of this study have some implications in relation to nursing practice, nursing education, nursing research and policy formulation.

6.3.1 Nursing Practice

Healthcare professionals especially, registered general nurses at the ART clinic should be equipped with the necessary logistics like a psychosocial tool to enable them provide good counselling to MSM living with HIV and identify any psychosocial problems they are encountering. Nurses should be trained in cultural competency to accommodate MSM living with HIV and provide them with the necessary ART services they require. This is because, most nurses were found to have negative attitude towards HIV positive MSM. Health education on HIV should always be intensified at the general OPD and the ART clinic to remind the population of HIV awareness. The health education should be clear on providing ART services for key population as well. If this happens, some hidden MSM living with HIV will come for ART services.

6.3.2 Nursing Education

HIV as a disease condition is included in the curriculum of all schools of nursing. However, there is emphasis on clinical management of HIV to all people living with HIV but not specifically key population. Continuous educational program and short courses should be developed on special counselling techniques and cultural competency for key populations and clinical and psychological management of HIV for key population. This will enable nurses to provide a more focused care.

6.3.3 Nursing Research

Quantitative method to measure the association between the constructs of the socio-ecological models: individual level, family and peer level, community level and structural level is lacking. Establishing the relationship between HIV positive MSMs psychosocial experiences and its psychosocial management will be a ground breaking study which will unearth the complexities in managing HIV positive MSM with psychosocial health issues.

Developing and validating a simple tool to assist health care professionals to assess HIV positive MSM with psychosocial issues should be conducted. Intervention study exploring the use of psychosocial therapy in managing HIV positive MSM with psychosocial issues should be considered. However, other models could also be used to ascertain the psychosocial experiences of a key population with HIV to give a broader meaning to the phenomenon. Quantitative studies to evaluate the quality of life of a key population living with HIV could be carried out.

6.3.4 Policy Formulation

Mandatory psychosocial assessment for HIV positive MSM should be ensured to aid in easy identification of HIV positive MSM with psychological and social burden. ART clinics should collaborate with the telecommunication companies to institute helplines that HIV positive MSM can call in cases of any emergencies and psychosocial health challenges. Policy makers and Ghana AIDS Commission (GAC) should establish foundations across the country that can support HIV positive MSM with funds to run their basic laboratory investigations, provide them with food supplements and psychosocial reviews. Integrated ART services should be encouraged to help bridge the gap in psychosocial health for key populations living with HIV. The HIV care should focus on dealing with emotional, psychological and social issues in addition to the issuance of ARVs.

6.3.5 Limitations of the study

The study was conducted within the Greater Accra Region of Ghana: hence, the study results cannot be generalized to the entire population of MSM living with HIV. HIV positive MSM are cared for in all government hospitals, polyclinics and most health centres in Ghana. Some private hospitals in Ghana also offer ART services. It will be relevant for further studies to be conducted in other regions of the country. There were recurrent heavy

downpours on two occasions of scheduled interviews. This resulted in rescheduling of the interviews which delayed data collection. The interview focused on adults MSM living with HIV, hence, bisexual men and heterosexual men with psychosocial experiences were not included. The issue of comorbidity was ruled out so that the researcher could not attribute their behaviour solely to HIV.

6.4 Conclusion

HIV positive MSM go through psychosocial experiences. These experiences affect all aspects of the lives of MSM living with HIV. The psychosocial experiences they encounter stem from the individual level of experience, family and peer relation, community level of experience and structural/institutional level. Understanding these experiences is key in improving the care of HIV positive MSM. There is the need for an integrative approach to care, hence the need to include a clinical psychologist at ART centres for managing psychosocial experiences.

6.5 Recommendations

Based on the findings of this study, the following recommendations are suggested:

1. Ministry of health (MOH) and Nurses and Midwifery Council (NMC) should include cultural competency in nursing curriculum at the nurses training colleges and universities so that upon completion of the nursing course, nurses will become culturally competent in caring for all patients equally no matter their sexual orientation, religion, culture among others.
2. There should be a development of a psychosocial tool by the Ghana Health Service (GHS) and Ghana AIDS Commission (GAC) that will help identify HIV positive MSM with psychosocial health needs so that they can promptly be provided with solution to their psychosocial needs.

3. The GAC and National AIDS Control Program (NACP) should introduce and implement an integrated health approach that most Ghanaian hospitals are lacking. The ART clinic should have a physician, nurses, a pharmacist, a clinical psychologist, a social worker, a model of hope, a mental health nurse, a data officer among others. This will help curb problems of an HIV positive MSM from all angles. Being it physical, psychosocial and financial
4. GHS, GAC and NACP should introduce and implement the formation of more support groups of MSM living with HIV in all ART facilities. This will help them share ideas and support each other.
5. Health education on HIV should be intensified by every health institution so as to correct the mindset of the general public which includes family and friends on the myths, misconceptions and misunderstanding surrounding HIV. This should be ensured by GHS and NACP.
6. In as much as ART services is free, it is not totally free. Individuals living with HIV still have to pay for most of their labs and purchase hematinic. The Ghana Health Service in collaboration with Ghana AIDS Commission (GAC) and National AIDS control Program (NACP) should ensure that laboratory investigations and purchase of hematinic are subsidized or captured under the National Health Insurance Scheme to lessen the financial burden of MSM living with HIV.
7. There should be in-service training on cultural competency at all ART sites for all ART service providers so that they will become culturally competent to attend to HIV positive MSM. This in-service training should be organised by the healthcare facilities.

8. Most support systems for HIV positive MSM were NGOs so government together with GAC and NACP should establish community support systems for HIV positive MSM

REFERENCES

- Adams, D. (2014). DigitalCulture&Education-V6-I3.compressed, (November).
- Aggleton, P., Bank, I. D., & Parker, R. (2003). Stigma , Discrimination and HIV / AIDS in Latin America and the Caribbean.
- Ahaneku, H., Ross, M. W., Nyoni, J. E., Selwyn, B., Troisi, C., Mbwambo, J., ... Depression, S. M. (2016). Depression and HIV risk among men who have sex with men in Tanzania, *121*. <https://doi.org/10.1080/09540121.2016.1146207>
- Aids, N., Programme, C., Region, V., & Region, B. A. (2018). Ghana records jump in new HIV infections by 70.15% - MyJoyOnline.com. *Myjoyonline.com*. Retrieved from <https://www.myjoyonline.com/lifestyle/2018/January-13th/ghana-records-80-increase-in-hiv-in-2017-report.php>
- Al-dakkak, I., Patel, S., Mccann, E., Gadkari, A., & Maiese, E. M. (2013). The impact of specific HIV treatment-related adverse events on adherence to antiretroviral therapy : A systematic review and meta-analysis, *121*. <https://doi.org/10.1080/09540121.2012.712667>
- Alessandretti, C., Alessandretti, L., Sapiezynski, P., Lehmann, S., & Baronchelli, A. (2017). *City Research Online City , University of London Institutional Repository mobility* (Vol. 12). <https://doi.org/10.6084/m9.figshare.4596346>
- Ali, H., Amoyaw, F., Baden, D., Durand, L., Bronson, M., Kim, A., ... Swaminathan, M. (2019). Ghana ' s HIV epidemic and PEPFAR ' s contribution towards epidemic control, *53*(1), 59–62.
- Almario, M., Riggle, E. D. B., Rostosky, S. S., & Alcalde, M. C. (2013). Positive Themes in LGBT Self-Identities in Spanish-Speaking Countries, (January). <https://doi.org/10.1037/a0031055>
- Amiya, R. M., Poudel, K. C., Poudel-tandukar, K., Pandey, B. D., & Jimba, M. (2014). Perceived Family Support , Depression , and Suicidal Ideation among People Living with HIV / AIDS : A Cross- Sectional Study in the Kathmandu Valley , Nepal, *9*(3). <https://doi.org/10.1371/journal.pone.0090959>
- Amuche, N. J., Emmanuel, E. I., & Innocent, N. E. (2017). HIV/AIDS in sub-Saharan Africa: Current status, challenges and prospects. *Asian Pacific Journal of Tropical Disease*, *7*(4), 239–256. <https://doi.org/10.12980/apjtd.7.2017d6-366>
- Anhui, M. S. M., Wu, Y., Yang, H., Wang, J., Yao, H., & Zhao, X. (2014a). Prevalence of suicidal ideation and associated factors among HIV-positive MSM in Anhui , China,

- (July). <https://doi.org/10.1177/0956462414544722>
- Anhui, M. S. M., Wu, Y., Yang, H., Wang, J., Yao, H., & Zhao, X. (2014b). Prevalence of suicidal ideation and associated factors among HIV-positive MSM in Anhui , China, (April 2016). <https://doi.org/10.1177/0956462414544722>
- Antwi, S. K., Kasim, H., & Risk, B. S. (2015). Qualitative and Quantitative Research Paradigms in Business Research : A Qualitative and Quantitative Research Paradigms in Business Research : A Philosophical Reflection, (February 2016).
- Attipoe, D. (2004, June 24). MSM and HIV in Ghana. The Gully. Retrieved May 9, 2018 from http://www.thegully.com/essays/gaymundo/0403_gaymen_hiv_ghana/msm_ghana_intro_summary.html.
- Audet, C. M., McGowan, C. C., Wallston, K. A., & Kipp, A. M. (2013). Relationship between HIV Stigma and Self-Isolation among People Living with HIV in Tennessee, 8(8), 13–16. <https://doi.org/10.1371/journal.pone.0069564>
- Baral, S., Adams, D., Lebona, J., Kaibe, B., Letsie, P., Tshehlo, R., ... Beyrer, C. (2011). A cross-sectional assessment of population demographics , HIV risks and human rights contexts among men who have sex with men in Lesotho, 1–8. <https://doi.org/10.1186/1758-2652-14-36>
- Baral, S., Trapence, G., Motimedi, F., Umar, E., Ipinge, 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), 4–11. <https://doi.org/10.1371/journal.pone.0004997>
- Beattie, T. S. H., Bhattacharjee, P., Suresh, M., Isac, S., Ramesh, B. M., & Moses, S. (2012). Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. *Journal of Epidemiology and Community Health*, 66(Suppl 2), ii42-ii48. <https://doi.org/10.1136/jech-2011-200475>
- Beck, A., McNally, I., & Petrak, J. (2003). Psychosocial predictors of HIV/STI risk behaviours in a sample of homosexual men. *Sexually Transmitted Infections*, 79(2), 142–146. <https://doi.org/10.1136/sti.79.2.142>
- Bell, E., Mthembu, P., Sullivan, S. O., Moody, K., Bell, E., Mthembu, P., ... Sexual, K. M. (2007). Sexual and Reproductive Health Services and HIV Testing: Perspectives and Experiences of Women and Men Living with HIV and AIDS, 8080(May). [https://doi.org/10.1016/S0968-8080\(07\)29029-9](https://doi.org/10.1016/S0968-8080(07)29029-9)

- Bemelmans, M., Van Den Akker, T., Ford, N., Philips, M., Zachariah, R., Harries, A., ... Massaquoi, M. (2010). Providing universal access to antiretroviral therapy in Thyolo, Malawi through task shifting and decentralization of HIV/AIDS care. *Tropical Medicine & International Health*, *15*(12), 1413–1420. <https://doi.org/10.1111/j.1365-3156.2010.02649.x>
- Berkovich, I. (2014). A socio-ecological framework of social justice leadership in education. *Journal of Educational Administration*, *52*(3), 282–309. <https://doi.org/10.1108/JEA-12-2012-0131>
- Beyrer, C., Baral, S. D., Collins, C., Richardson, E. T., Sullivan, P. S., Sanchez, J., ... Mayer, K. H. (2016). The global response to HIV in men who have sex with men. *The Lancet*, *388*(10040), 198–206. [https://doi.org/10.1016/S0140-6736\(16\)30781-4](https://doi.org/10.1016/S0140-6736(16)30781-4)
- 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. *The Lancet*, *380*(9839), 367–377. [https://doi.org/10.1016/S0140-6736\(12\)60821-6](https://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. [https://doi.org/10.1016/S0140-6736\(12\)61022-8](https://doi.org/10.1016/S0140-6736(12)61022-8)
- Bird, J. D. P., & Voisin, D. R. (2011). A conceptual model of HIV disclosure in casual sexual encounters among men who have sex with men. *Journal of Health Psychology*, *16*(2), 365–373. <https://doi.org/10.1177/1359105310379064>
- Bogart, L. M., Cowgill, B. O., Kennedy, D., Ryan, G., Murphy, D. A., Elijah, J., & Schuster, M. A. (2008). HIV-related stigma among people with HIV and their families: A qualitative analysis. *AIDS and Behavior*, *12*(2), 244–254. <https://doi.org/10.1007/s10461-007-9231-x>
- Bogart, L. M., Wagner, G., Galvan, F. H., & Banks, D. (2011). NIH Public Access, *53*(5), 648–655. <https://doi.org/10.1097/QAI.0b013e3181c57dbc>. Conspiracy
- Bowen, A. M., Horvath, K., & Williams, M. L. (2007). A randomized control trial of Internet-delivered HIV prevention targeting rural MSM. *Health Education Research*, *22*(1), 120–127. <https://doi.org/10.1093/her/cyl057>
- Brooks, R. A., Etzel, M. A., Hinojos, E., Henry, C. L., & Perez, M. (2005). Preventing HIV Among Latino and African American Gay and Bisexual Men in a Context of HIV-Related Stigma, Discrimination, and Homophobia: Perspectives of Providers.

- AIDS Patient Care and STDs*, 19(11), 737–744.
<https://doi.org/10.1089/apc.2005.19.737>
- Bruce-jones, E., Careaga, G., Sabbadini, R., & Co-secretaries, I. (2011). State-sponsored Homophobia A world survey of laws criminalising consenting adults, (May).
- Burns, N. and Grove, S.K. (2011). *Understanding Nursing Research - Building an Evidence-based Practice* (5th edn). Maryland Heights, Missouri: Elsevier Saunders.
- Canoy, N. A., & Ofreneo, M. A. P. (2017). Struggling to care: A discursive-material analysis of negotiating agency among HIV-positive MSM. *Health (United Kingdom)*, 21(6), 575–594. <https://doi.org/10.1177/1363459315628040>
- Carballo-Diéguez, A., Balán, I. C., Dolezal, C., Ibitoye, M., Pando, M. A., Marone, R., ... Ávila, M. M. (2013). HIV Status Disclosure Among Infected Men Who Have Sex With Men (MSM) in Buenos Aires, Argentina. *AIDS Education and Prevention*, 25(6), 457–467. <https://doi.org/10.1521/aeap.2013.25.6.457>
- Carballo-Diéguez, A., Frasca, T., Dolezal, C., & Balan, I. (2012). Will gay and bisexually active men at high risk of infection use over-the-counter rapid HIV tests to screen sexual partners? *Journal of Sex Research*, 49(4), 379–387.
<https://doi.org/10.1080/00224499.2011.647117>
- CDC. (2015). Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements. *Centers for Disease Control and Prevention*, 11.
<https://doi.org/10.2307/1319341>
- CDC (2013). The socio-ecological conceptual framework.
- Chambers, L. A., Rueda, S., Baker, D. N., Wilson, M. G., Deutsch, R., Raeifar, E., ... Travers, R. (2015). Stigma, HIV and health: A qualitative synthesis. *BMC Public Health*, 15(1), 1–17. <https://doi.org/10.1186/s12889-015-2197-0>
- Chartier, M., Vinatieri, T., DeLonga, K., McGlynn, L. M., Gore-Felton, C., & Koopman, C. (2010). A pilot study investigating the effects of trauma, experiential avoidance, and disease management in HIV-positive MSM using methamphetamine. *Journal of the International Association of Physicians in AIDS Care*, 9(2), 78–81.
<https://doi.org/10.1177/1545109709360065>
- 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 - Psychological and Socio-Medical Aspects of AIDS/HIV*, 20(9), 1105–1110. <https://doi.org/10.1080/09540120701842720>

- Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., Henda, N., Simbayi, L. C., ... Henda, N. (2008). Stigma and discrimination experiences of HIV- positive men who have sex with men in Cape Town , South Africa, *121*.
<https://doi.org/10.1080/09540120701842720>
- Coelho, L., Veloso, V. G., Grinsztejn, B., & Luz, P. M. (2014). Trends in overall opportunistic illnesses, *Pneumocystis carinii* pneumonia, cerebral toxoplasmosis and *Mycobacterium avium* complex incidence rates over the 30 years of the HIV epidemic: A systematic review. *Brazilian Journal of Infectious Diseases*, *18*(2), 196–210. <https://doi.org/10.1016/j.bjid.2013.10.003>
- Coleman, J. D., Ph, D., Lindley, L. L., Annang, L., Ph, D., Saunders, R. P., ... Gaddist, B. (2012). Development of a Framework for HIV / AIDS Prevention, *26*(2).
<https://doi.org/10.1089/apc.2011.0163>
- Collins, C. B., Hearn, K. D., Whittier, D. N., Freeman, A., Stallworth, J. D., & Phields, M. (2010). Implementing packaged HIV-prevention interventions for HIV-positive individuals: considerations for clinic-based and community-based interventions. *Public Health Reports (Washington, D.C. : 1974)*, *125* Suppl, 55–63.
<https://doi.org/10.2307/41434871>
- Cote, M., & Nightingale, A. J. (2012). Resilience thinking meets social theory: Situating social change in socio-ecological systems (SES) research. *Progress in Human Geography*, *36*(4), 475–489. <https://doi.org/10.1177/0309132511425708>
- Courtenay-quirk, C., Gómez, C. A., & Men, U. (2006). Is HIV / AIDS dividing the gay community ? Perceptions of HIV-positive men who have sex with men IS HIV / AIDS STIGMA DIVIDING THE GAY COMMUNITY ? PERCEPTIONS OF HIV – POSITIVE MEN WHO HAVE SEX WITH MEN, (May 2014).
<https://doi.org/10.1521/aeap.2006.18.1.56>
- Courtenay-Quirk, C., Wolitski, R. J., Parsons, J. T., & Gómez, C. A. (2006). Is HIV/AIDS stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men. *AIDS Education and Prevention*, *18*(1), 56–67.
<https://doi.org/10.1521/aeap.2006.18.1.56>
- Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Method Approaches* (V. Knight, J. Young, & B. Bauhaus Eds. 4th ed.). California: Sage

- Creswell, J. W. (n.d.). *QUALITATIVE Choosing Among Five Approaches*.
- Creswell, J.W. (2008). *The Selection of a Research Approach. Research Design: qualitative, quantitative and mixed method approaches*, 3-22. Retrieved on 1st Dec., 2018 from <https://doi.org/45593:01>
- Cross, D., Barnes, A., Papageorgiou, A., Hadwen, K., Hearn, L., & Lester, L. (2015). A social-ecological framework for understanding and reducing cyberbullying behaviours. *Aggression and Violent Behavior*, 23, 109–117. <https://doi.org/10.1016/j.avb.2015.05.016>
- Danziger, R. (1994). Discrimination against people with HIV and AIDS in Poland. *Bmj*, 308(6937), 1145. <https://doi.org/10.1136/bmj.308.6937.1145>
- Darrow, W. W., Biersteker, S., Geiss, T., Chevalier, K., Clark, J., Marrero, Y., ... Obiaja, K. (2005). Risky sexual behaviors associated with recreational drug use among men who have sex with men in an international resort area: Challenges and opportunities. *Journal of Urban Health*, 82(4), 601–609. <https://doi.org/10.1093/jurban/jti122>
- Davtyan, M., Olshansky, E. F., Brown, B., & Lakon, C. (2017). A Grounded Theory Study of HIV-Related Stigma in U.S.-Based Health Care Settings. *Journal of the Association of Nurses in AIDS Care*, 28(6), 907–922. <https://doi.org/10.1016/j.jana.2017.07.007>
- Diana, J., Mavungu, D., Monbaliu, S., Scippo, M., Schneider, Y., Larondelle, Y., ... Maghuin-rogister, G. (2011). determination in food supplements To cite this version : r P Fo r R w On ly.
- DiClemente, R. J., Salazar, L. F., Crosby, R. A., & Rosenthal, S. L. (2005). Prevention and control of sexually transmitted infections among adolescents: The importance of a socio-ecological perspective - A commentary. *Public Health*, 119(9), 825–836. <https://doi.org/10.1016/j.puhe.2004.10.015>
- DJ, C. (2003). HIV knowledge and risk factors among men who have sex with men in Ho Chi Minh City, Vietnam. TT -. *Journal of Acquired Immune Deficiency Syndromes*, 32(1), 80–85.
- Donnelly, L. R., Bailey, L., Jessani, A., Postnikoff, J., Kerston, P., & Brondani, M. (2016). Stigma Experiences in Marginalized People Living With HIV Seeking Health Services and Resources in Canada. *Journal of the Association of Nurses in AIDS Care*, 27(6), 768–783. <https://doi.org/10.1016/j.jana.2016.07.003>
- Dowshen, N., Binns, H. J., & Garofalo, R. (2009a). Experiences of HIV-Related Stigma Among Young Men Who Have Sex with Men. *AIDS Patient Care and STDs*, 23(5),

371–376. <https://doi.org/10.1089/apc.2008.0256>

- Dowshen, N., Binns, H. J., & Garofalo, R. (2009b). Experiences of HIV-Related Stigma Among Young Men Who Have Sex with Men, *23*(5).
- Drame, F. M., & Foley, E. E. (2015). HIV/AIDS in mid-sized cities in Senegal: From individual to place-based vulnerability. *Social Science and Medicine*, *133*, 296–303. <https://doi.org/10.1016/j.socscimed.2014.11.038>
- Elkington, K. S., Bauermeister, J. A., & Zimmerman, M. A. (2011). Do parents and peers matter? A prospective socio-ecological examination of substance use and sexual risk among African American youth. *Journal of Adolescence*, *34*(5), 1035–1047. <https://doi.org/10.1016/j.adolescence.2010.11.004>
- Emler, C. A. (2006). A Comparison of HIV Stigma and Disclosure Patterns Between Older and Younger Adults Living with HIV/AIDS. *AIDS Patient Care and STDs*, *20*(5), 350–358. <https://doi.org/10.1089/apc.2006.20.350>
- Engel, G. L. (1981). The clinical application of the biopsychosocial model. *Journal of Medicine and Philosophy (United Kingdom)*, *6*(2), 101–123. <https://doi.org/10.1093/jmp/6.2.101>
- Factsheet., Update, G. A., Hiv, N., & Hiv, N. (2019). 2018 GLOBAL HIV STATISTICS, 1–6.
- Fay, H., Baral, S. D., Trapence, G., Motimedi, F., Umar, E., Iiping, S., ... Beyrer, C. (2011). Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. *AIDS and Behavior*, *15*(6), 1088–1097. <https://doi.org/10.1007/s10461-010-9861-2>
- Fendrich, M., Avci, O., Johnson, T. P., & Mackesy-amiti, M. E. (2013). Addictive Behaviors Depression , substance use and HIV risk in a probability sample of men who have sex with men. *Addictive Behaviors*, *38*(3), 1715–1718. <https://doi.org/10.1016/j.addbeh.2012.09.005>
- Finneran, C., Chard, A., Sineath, C., Sullivan, P., & Stephenson, R. (2012). Intimate Partner Violence and Social Pressure among Gay Men in Six Countries. *Western Journal of Emergency Medicine*, *13*(3), 260–271. <https://doi.org/10.5811/westjem.2012.3.11779>
- Fox, M. P., & Rosen, S. (2017). A new cascade of HIV care for the era of “ treat all ,” (Stage 1), 4–11. <https://doi.org/10.1371/journal.pmed.1002268>
- Friedland, B. A., Sprague, L., Nyblade, L., Baral, S. D., Pulerwitz, J., Gottert, A., ... Geibel, S. (2018). Measuring intersecting stigma among key populations living with

- HIV: implementing the people living with HIV Stigma Index 2.0. *Journal of the International AIDS Society*, 21, e25131. <https://doi.org/10.1002/jia2.25131>
- Fu, X., Qi, J., Hu, Y., Pan, X., Li, Y., Liu, H., ... Sun, J. (2016). Partner notification in cooperation with community-based organizations among HIV-positive men who have sex with men in two Chinese cities. *International Journal of STD & AIDS*, 27(10), 821–831. <https://doi.org/10.1177/0956462416648827>
- Gagnon, M. (2015). Re-thinking HIV-Related Stigma in Health Care Settings : A Qualitative Study, 26(6), 703–719. <https://doi.org/10.1016/j.jana.2015.07.005>
- George, C., Makoroka, L., Rourke, S. B., Adam, B. D., Remis, R. S., Husbands, W., & Read, S. E. (2014). HIV testing by black MSM in Toronto: Identifying targets to improve testing. *SAGE Open*, 4(2). <https://doi.org/10.1177/2158244014529776>
- Ghana AIDS Commission.(2016). *The national response to HIV and AIDS*. Ghana AIDS Commission
- Gibbie, T. M., Mijch, A., & Hay, M. (2012). High levels of psychological distress in MSM are independent of HIV status. *Journal of Health Psychology*, 17(5), 653–663. <https://doi.org/10.1177/1359105311425272>
- Gilbert, P. A., Barrington, C., Rhodes, S. D., & Eng, E. (2016). Saliendo adelante: Stressors and coping strategies among immigrant Latino men who have sex with men in a nontraditional settlement state. *American Journal of Men's Health*, 10(6), 515–525. <https://doi.org/10.1177/1557988316647704>
- Goh, D. (2008). It's the gays' fault: News and HIV as weapons against homosexuality in Singapore. *Journal of Communication Inquiry*, 32(4), 383–399. <https://doi.org/10.1177/0196859908320295>
- Graham, S. M., Micheni, M., Kombo, B., Elst, E. M. Van Der, Mugo, P. M., Kivaya, E., ... Medical, A. (2016). HHS Public Access, 29(0 3), 1–16. <https://doi.org/10.1097/QAD.0000000000000897>.Development
- Grant, J., Vance, D., White, Keltner, N., & Raper. (2013). Why people living with HIV/AIDS exclude individuals from their chosen families. *Nursing: Research and Reviews*, 33. <https://doi.org/10.2147/nrr.s39504>
- Grimsrud, A., Bygrave, H., Doherty, M., Ehrenkranz, P., Ellman, T., Ferris, R., ... Bekker, L. G. (2016). Reimagining HIV service delivery: The role of differentiated care from prevention to suppression: The. *Journal of the International AIDS Society*, 19(1), 10–12. <https://doi.org/10.7448/IAS.19.1.21484>

- Grove, S. K., Gray, J. R., & Burns, N. (2015). *Understanding nursing research*. St. Louis, MO: Elsevier
- Grov, C., Bimbi, D. S., Nanin, J. E., & Parsons, J. T. (2006). Exploring racial and ethnic differences in recreational drug use among gay and bisexual men in New York City and Los Angeles. *Journal of Drug Education, 36*(2), 105–123.
<https://doi.org/10.2190/1G84-ENA1-UAD5-U8VJ>
- Halkitis, P. N., Kutnick, A. H., & Slater, S. (2005). The social realities of adherence to protease inhibitor regimens: Substance use, health care and psychological states. *Journal of Health Psychology, 10*(4), 545–558.
<https://doi.org/10.1177/1359105305053422>
- Han, C. S., Lauby, J., Bond, L., LaPollo, A. B., & Rutledge, S. E. (2010). Magic Johnson doesn't worry about how to pay for medicine: Experiences of black men who have sex with men living with HIV. *Culture, Health and Sexuality, 12*(4), 387–399.
<https://doi.org/10.1080/13691050903549030>
- Hart, T. A., Wolitski, R. J., Purcell, D. W., Gómez, C., The, S., May, N., ... Halkitis, P. (2018). Sexual Behavior among HIV-Positive Men Who Have Sex with Men : What s in a Label ? Perry Halkitis Stable URL : <https://www.jstor.org/stable/3813754> Sexual Behavior Among HIV-Positive Men Who Have Sex With Men : What s in a Label ?, *40*(2), 179–188.
- Heijman, T., Geskus, R. B., Davidovich, U., Coutinho, R. A., Prins, M., & Stolte, I. G. (2012). Less decrease in risk behaviour from pre-HIV to post- HIV seroconversion among MSM in the combination antiretroviral therapy era compared with the pre-combination antiretroviral therapy era, (November 2011), 489–495.
<https://doi.org/10.1097/QAD.0b013e32834f9d7c>
- Heywood, W., & Lyons, A. (2016). HIV and Elevated Mental Health Problems : Diagnostic , Treatment , and Risk Patterns for Symptoms of Depression , Anxiety , and Stress in a National Community-Based Cohort of Gay Men Living with HIV. *AIDS and Behavior, 20*(8), 1632–1645. <https://doi.org/10.1007/s10461-016-1324-y>
- Hightow-Weidman, L. B., Phillips, G., Outlaw, A. Y., Wohl, A. R., Fields, S., Hildalgo, J., & Legrand, S. (2013). Patterns of HIV disclosure and condom use among HIV-infected young racial/ethnic minority men who have sex with men. *AIDS and Behavior, 17*(1), 360–368. <https://doi.org/10.1007/s10461-012-0331-x>
- Hladik, W., Barker, J., Ssenkusu, J. M., Opio, A., Tappero, J. W., & Hakim, A. (2012). HIV Infection among Men Who Have Sex with Men in Kampala , Uganda – A

- Respondent Driven Sampling Survey, 7(5), 1–9.
<https://doi.org/10.1371/journal.pone.0038143>
- Hoenigl, M., Green, N., Camacho, M., Gianella, S., Mehta, S. R., Smith, D. M., & Little, S. J. (2016). Signs or symptoms of acute HIV infection in a cohort undergoing community-based screening. *Emerging Infectious Diseases*, 22(3), 532–534.
<https://doi.org/10.3201/eid2203.151607>
- Holt, M., Rawstorne, P., Wilkinson, J., Worth, H., Bittman, M., & Kippax, S. (2012). HIV testing, gay community involvement and internet USE: Social and behavioural correlates of HIV testing among Australian men who have sex with men. *AIDS and Behavior*, 16(1), 13–22. <https://doi.org/10.1007/s10461-010-9872-z>
- Houglum, K., Venkataramani, A., Lyche, K. I. P., & Chojkier, M. (1997). A Pilot Study of the Effects of. *file:///C:/Users/HP/Desktop/lack of Support.pdf*, 16(2), 1069–1073.
- Huang, Z. J., He, N., Nehl, E. J., Zheng, T., Smith, B. D., Zhang, J., ... Wong, F. Y. (2012). Social network and other correlates of HIV testing: Findings from male sex workers and other MSM in Shanghai, China. *AIDS and Behavior*, 16(4), 858–871.
<https://doi.org/10.1007/s10461-011-0119-4>
- Huberman, A.M. & Miles, M. B. (1994). Data management and Analysis methods.
- Jeffries, W. L., & Gary, I. V. (2012). Homophobia is Associated with Sexual Behavior that Increases Risk of Acquiring and Transmitting HIV Infection Among Black Men Who Have Sex with Men Homophobia is Associated with Sexual Behavior that Increases Risk of Acquiring and Transmitting HIV Infection, (May).
<https://doi.org/10.1007/s10461-012-0189-y>
- Jeffries IV, W. L., Marks, G., Lauby, J., Murrill, C. S., & Millett, G. A. (2013). Homophobia is associated with sexual behavior that increases risk of acquiring and transmitting HIV infection among black men who have sex with men. *AIDS and Behavior*, 17(4), 1442–1453. <https://doi.org/10.1007/s10461-012-0189-y>
- Jones, D. L., Rodriguez, V. J., De La Rosa, A., Dietch, J., & Kumar, M. (2018). The role of sleep dysfunction in the relationship between trauma, neglect and depression in methamphetamine using men. *Neurology Psychiatry and Brain Research*, 30(March), 30–34. <https://doi.org/10.1016/j.npbr.2018.05.002>
- Jr, M. J. D., Chiasson, M. A., & Hirshfield, S. (2016). Recent anxiety symptoms and drug use associated with sexually transmitted infection diagnosis among an online US sample of men who have sex with men. <https://doi.org/10.1177/1359105315587135>

- Kapanda, L., Jumbe, V., Izugbara, C., & Muula, A. S. (2019). Healthcare providers' attitudes towards care for men who have sex with men (MSM) in Malawi, 3, 1–9.
- Karamouzian, M., Akbari, M., Haghdoost, A. A., Setayesh, H., & Zolala, F. (2015). "I Am Dead to Them": HIV-related Stigma Experienced by People Living With HIV in Kerman, Iran. *Journal of the Association of Nurses in AIDS Care*, 26(1), 46–56. <https://doi.org/10.1016/j.jana.2014.04.005>
- Keogh, P. (2004). Outsider status.
- Kharsany, A. B. M., & Karim, Q. A. (2016). HIV Infection and AIDS in Sub-Saharan Africa: Current Status, Challenges and Opportunities. *The Open AIDS Journal*, 10(1), 34–48. <https://doi.org/10.2174/1874613601610010034>
- Konou, A. A., Vidal, N., Salou, M., Anato, S., Singo-Tokofaï, A., Ekouevi, D. K., ... Dagnra, A. Y. (2016). Genetic diversity and transmission networks of HIV-1 strains among men having sex with men (MSM) in Lomé, Togo. *Infection, Genetics and Evolution*, 46, 279–285. <https://doi.org/10.1016/j.meegid.2016.05.030>
- Kraft, J. M., Beeker, C., Stokes, J. P., & Peterson, J. L. (2000). Finding the "Community" in Community-Level HIV/AIDS Interventions: Formative Research with Young African American Men Who Have Sex with Men. *Health Education & Behavior*, 27(4), 430–441. <https://doi.org/10.1177/109019810002700406>
- Kubicek, K., McNeeley, M., & Collins, S. (2015). "Same-Sex Relationship in a Straight World": Individual and Societal Influences on Power and Control in Young Men's Relationships. *Journal of Interpersonal Violence*, 30(1), 83–109. <https://doi.org/10.1177/0886260514532527>
- Kumarasamy, N., Safren, S. A., Raminani, S. R., Pickard, R., James, R., Krishnan, A. K. S., ... Mayer, K. H. (2005). Barriers and Facilitators to Antiretroviral Medication Adherence Among Patients with HIV in Chennai, India: A Qualitative Study. *AIDS Patient Care and STDs*, 19(8), 526–537. <https://doi.org/10.1089/apc.2005.19.526>
- Kushwaha, S., Lalani, Y., Maina, G., Ogunbajo, A., Wilton, L., Agyarko-Poku, T., ... Nelson, L. E. (2017). "but the moment they find out that you are MSM ...": a qualitative investigation of HIV prevention experiences among men who have sex with men (MSM) in Ghana's health care system. *BMC Public Health*, 17(1), 1–18. <https://doi.org/10.1186/s12889-017-4799-1>
- Lane, T., Mogale, T., Struthers, H., McIntyre, J., & Kegeles, S. M. (2009). "They see you as a different thing": The experiences of men who have sex with men with health care workers in South African township communities. *Sexually Transmitted Infections*,

- 84(6), 430–433. <https://doi.org/10.1136/sti.2008.031567>.
- Lane, T., Mogale, T., Struthers, H., McIntyre, J., & Kegeles, S. M. (2008). “They see you as a different thing”: the experiences of men who have sex with men with healthcare workers in South African township communities. *Sexually Transmitted Infections*, 84(6), 430–433. <https://doi.org/10.1136/sti.2008.031567>
- Lane, T., Raymond, H. F., Dladla, S., Rasethe, J., Struthers, H., McFarland, W., & McIntyre, J. (2011). High HIV prevalence among men who have sex with men in Soweto, South Africa: results from the Soweto Men’s Study. *AIDS and Behavior*, 15(3), 626–634. <https://doi.org/10.1007/s10461-009-9598-y>
- Lauby, J. L., Marks, G., Bingham, T., Liu, K. L., Liao, A., Stueve, A., & Millett, G. A. (2012). Having supportive social relationships is associated with reduced risk of unrecognized HIV infection among black and Latino men who have sex with men. *AIDS and Behavior*, 16(3), 508–515. <https://doi.org/10.1007/s10461-011-0002-3>
- Lawrence, P. G., & Brun, M. C. (2011). NGOs and HIV/AIDS advocacy in India: Identifying the challenges. *South Asia: Journal of South Asia Studies*, 34(1), 65–88. <https://doi.org/10.1080/00856401.2011.549085>
- Lee, S., Yamazaki, M., Harris, D. R., Harper, G. W., & Ellen, J. (2015). Social support and human immunodeficiency virus-status disclosure to friends and family: Implications for human immunodeficiency virus-positive youth. *Journal of Adolescent Health*, 57(1), 73–80. <https://doi.org/10.1016/j.jadohealth.2015.03.002>
- Li, H., Marley, G., Ma, W., Wei, C., Lackey, M., Ma, Q., ... Tucker, J. D. (2017). The Role of ARV Associated Adverse Drug Reactions in Influencing Adherence Among HIV-Infected Individuals: A Systematic Review and Qualitative Meta-Synthesis. *AIDS and Behavior*, 21(2), 341–351. <https://doi.org/10.1007/s10461-016-1545-0>
- Li, R., Cai, Y., Wang, Y., Sun, Z., Zhu, C., Tian, Y., ... Gan, F. (2016a). Psychosocial syndemic associated with increased suicidal ideation among men who have sex with men in Shanghai, China. *Health Psychology*, 35(2), 148–156. <https://doi.org/10.1037/hea0000265>
- Li, R., Cai, Y., Wang, Y., Sun, Z., Zhu, C., Tian, Y., ... Gan, F. (2016b). Psychosocial syndemic associated with increased suicidal ideation among men who have sex with men in Shanghai, China. *Health Psychology*, 35(2), 148–156. <https://doi.org/10.1037/hea0000265>
- Li, Y., Baker, J. J., Korostyshevskiy, V. R., Slack, R. S., & Plankey, M. W. (2012). The association of intimate partner violence, recreational drug use with HIV

- seroprevalence among MSM. *AIDS and Behavior*, *16*(3), 491–498.
<https://doi.org/10.1007/s10461-012-0157-6>
- Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Perspectives on Psychological Science*, *8*(5), 521–548.
<https://doi.org/10.1177/1745691613497965>
- Logie, C. H., Newman, P. A., Chakrapani, V., & Shunmugam, M. (2012). Adapting the minority stress model: Associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. *Social Science and Medicine*, *74*(8), 1261–1268.
<https://doi.org/10.1016/j.socscimed.2012.01.008>
- Ma, P. H. X., Chan, Z. C. Y., & Loke, A. Y. (2017). The Socio-Ecological Model Approach to Understanding Barriers and Facilitators to the Accessing of Health Services by Sex Workers: A Systematic Review. *AIDS and Behavior*, *21*(8), 2412–2438. <https://doi.org/10.1007/s10461-017-1818-2>
- Magee, H., Davis, L., & Coulter, A. (2003). Public views on healthcare performance indicators and patient choice.
- Magesa, D. J., Mtui, L. J., Abdul, M., Kayange, A., Chiduo, R., Leshabari, M. T., ... Tungaraza, D. (2014). Barriers to men who have sex with men attending HIV related health services in dar es salaam, Tanzania. *Tanzan J Health Res*, *16*(2), 1–10.
<https://doi.org/10.4314/thrb.v16i2.8>
- Maia, Â., Gomes, H., & Gonçalves, M. (2018). Relationship Between HIV and Depressive Symptomatology in Patients From Northern Portugal: Analysis of Individual, Health, and Social Predictors. *Journal of the Association of Nurses in AIDS Care*, *29*(2), 275–286. <https://doi.org/10.1016/j.jana.2017.09.006>
- Maleke, K., Daniels, J., Lane, T., Struthers, H., McIntyre, J., & Coates, T. (2017). How social stigma sustains the HIV treatment gap for MSM in Mpumalanga, South Africa. *Global Health Promotion*, *0*(August), 175797591773750.
<https://doi.org/10.1177/1757975917737509>
- Mamary, E. M., Bahrs, D., & Martinez, S. (2002). Individuals Living with HIV, *16*(1).
- Mathers, C. D., & Loncar, D. (2015). Projections of Global Mortality and Burden of Disease from 2002 to 2030, *3*(11). <https://doi.org/10.1371/journal.pmed.0030442>
- Maulsby, C., Millett, G., & Lindsey, K. (2013). HIV among Black men who have sex with men (MSM) in the United States : A HIV Among Black Men Who Have Sex with Men (MSM) in the United States : A Review of the Literature, (May 2014).

<https://doi.org/10.1007/s10461-013-0476-2>

Mburu, G., Ram, M., Oxenham, D., Haamujompa, C., Iorpenda, K., & Ferguson, L.

(2014). Responding to adolescents living with HIV in Zambia: A social-ecological approach. *Children and Youth Services Review*, 45(C), 9–17.

<https://doi.org/10.1016/j.chilyouth.2014.03.033>

McHenry, M. S., Nyandiko, W. M., Scanlon, M. L., Fischer, L. J., McAteer, C. I., Aluoch, J., ... Vreeman, R. C. (2017). HIV Stigma: Perspectives from Kenyan Child

Caregivers and Adolescents Living with HIV. *Journal of the International Association of Providers of AIDS Care*, 16(3), 215–225.

<https://doi.org/10.1177/2325957416668995>

Mdodo, R., Thomas, P. E., Walker, A., Chavez, P., Ethridge, S., Oraka, E., & Sutton, M.

Y. (2014). Rapid HIV testing at gay pride events to reach previously untested MSM: U.S., 2009-2010. *Public Health Reports*, 129(4), 328–334.

<https://doi.org/10.1177/003335491412900407>

Micheni, M., Kombo, B. K., Secor, A., Simoni, J. M., Operario, D., van der Elst, E. M., ...

Graham, S. M. (2017). Health Provider Views on Improving Antiretroviral Therapy Adherence Among Men Who Have Sex with Men in Coastal Kenya. *AIDS Patient Care and STDs*, 31(3), 113–121. <https://doi.org/10.1089/apc.2016.0213>

Micheni, M., Rogers, S., Wahome, E., Darwinkel, M., Gichuru, E., Graham, S. M., ...

Centre, A. M. (2016). HHS Public Access, 29(0 3).

<https://doi.org/10.1097/QAD.0000000000000912.Risk>

Mimiaga, M. J., Reisner, S. L., Bland, S., Cranston, K., Isenberg, D., Driscoll, M. A., ...

Mayer, K. H. (2010). “It’s a Quick Way to Get What You Want”: A Formative Exploration of HIV Risk Among Urban Massachusetts Men Who Have Sex with Men Who Attend Sex Parties. *AIDS Patient Care and STDs*, 24(10), 659–674.

<https://doi.org/10.1089/apc.2010.0071>

Montgomery, J. P. (2004). The extent of bisexual behaviour in HIV- infected men and implications for transmission to their female sex partners, (April 2014).

<https://doi.org/10.1080/09540120310001618676>

Mustanski, B., Garofalo, R., Herrick, A., & Donenberg, G. (2007). Psychosocial health problems increase risk for HIV among urban young men who have sex with men:

Preliminary evidence of a syndemic in need of attention. *Annals of Behavioral Medicine*, 34(1), 37–45. <https://doi.org/10.1007/BF02879919>

- Naar-King, S., Parsons, J. T., & Johnson, A. M. (2012). Motivational interviewing targeting risk reduction for people with HIV: A systematic review. *Current HIV/AIDS Reports*, 9(4), 335–343. <https://doi.org/10.1007/s11904-012-0132-x>
- National AIDS Control Program (NACP) Page 30-333
- Neff, K. (2006). The HIV / AIDS Pandemic in African American MSM :, 1(1), 109–126.
- Öktem, P. (2015). The Role of the Family in Attributing Meaning to Living With HIV and Its Stigma in Turkey. *SAGE Open*, 5(4). <https://doi.org/10.1177/2158244015615165>
- Oppong, S. H. (2013). ASIAN JOURNAL OF MANAGEMENT SCIENCES AND EDUCATION THE PROBLEM OF SAMPLING IN QUALITATIVE RESEARCH, 2(2), 202–210.
- Palaganas, E. C., Sanchez, M. C., Molintas, M. P., & Caricativo, R. D. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report*, 22(2), 426–438.
- Papworth, E., Ceesay, N., An, L., Thiam-niangoin, M., Ky-zerbo, O., Holland, C., ... Drame, F. M. (2013). Review article Epidemiology of HIV among female sex workers , their clients , men who have sex with men and people who inject drugs in West and Central Africa, 16(Suppl 3), 1–11. <https://doi.org/10.7448/IAS.16.4.18751>
- Park, S., Kim, M. J., Cho, M. J., & Lee, J. Y. (2015). Factors affecting stigma toward suicide and depression: A Korean nationwide study. *International Journal of Social Psychiatry*, 61(8), 811–817. <https://doi.org/10.1177/0020764015597015>
- Paul, J. P., Catania, J., Pollack, L., Moskowitz, J., Canchola, J., Mills, T., ... Stall, R. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents.
- Pereira, H., Caldeira, D., & Monteiro, S. (2017). Perceptions of HIV-Related Stigma in Portugal Among MSM With HIV Infection and an Undetectable Viral Load. *Journal of the Association of Nurses in AIDS Care*, 29(3), 439–453. <https://doi.org/10.1016/j.jana.2017.12.002>
- Pergam, S. A., Gottlieb, G. S., & Horwitch, C. (2008). NIH Public Access, 49(2), 205–211. <https://doi.org/10.1097/QAI.0b013e318185727e>.Transmission
- Phillips, A. N., Cambiano, V., Nakagawa, F., Brown, A. E., Lampe, F., Rodger, A., ... Delpech, V. C. (2013). Increased HIV Incidence in Men Who Have Sex with Men Despite High Levels of ART-Induced Viral Suppression: Analysis of an Extensively Documented Epidemic. *PLoS ONE*, 8(2), 15–16. <https://doi.org/10.1371/journal.pone.0055312>

- Polit, D.F., & Beck, C.T. (2008): *Essentials of Nursing Research: Appraising evidence for nursing practice* (7th Ed). Philadelphia: Lippincott Williams & Wilkins
- Populations, K. A. (2014). Men Who Have Sex with Men (MSM) - Factsheet, (March).
- Poteat, T., Diouf, D., Drame, F. M., Ndaw, M., Traore, C., Beyrer, C., & Baral, S. (2011). HIV Risk among MSM in Senegal : A Qualitative Rapid Assessment of the Impact of Enforcing Laws That Criminalize Same Sex Practices, *6*(12).
<https://doi.org/10.1371/journal.pone.0028760>
- Preston, D. B., D'Augelli, A. R., Kassab, C. D., Cain, R. E., Schulze, F. W., & Starks, M. T. (2004). The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention*, *16*(4), 291–303.
<https://doi.org/10.1521/aeap.16.4.291.40401>
- Pyun, T., Santos, G. M., Arreola, S., Do, T., Hebert, P., Beck, J., ... Ayala, G. (2014). Internalized homophobia and reduced HIV testing among men who have sex with men in china. *Asia-Pacific Journal of Public Health*, *26*(2), 118–125.
<https://doi.org/10.1177/1010539514524434>
- Rahmati-najarkolaei, F., Niknami, S., Aminshokravi, F., & Bazargan, M. (2010). Experiences of stigma in healthcare settings among adults living with HIV in the Islamic Republic of Iran, 1–11.
- Reynolds, N. R. (2009). Cigarette smoking and HIV : More evidence for action, 106–121.
- Rhodes, S. D., Hergenrather, K. C., Vissman, A. T., Stowers, J., Davis, A. B., Hannah, A., ... Marsiglia, F. F. (2011). Boys must be men, and men must have sex with women: A qualitative CBPR study to explore sexual risk among African American, Latino, and White gay men and MSM. *American Journal of Men's Health*, *5*(2), 140–151.
<https://doi.org/10.1177/1557988310366298>
- Rintamaki, L. S., Scott, A. M., Kosenko, K. A., & Jensen, R. E. (2007). Male Patient Perceptions of HIV Stigma in Health Care Contexts. *AIDS Patient Care and STDs*, *21*(12), 956–969. <https://doi.org/10.1089/apc.2006.0154>
- Rispel, L. C., & Metcalf, C. A. (2009). Breaking the silence: South African HIV policies and the needs of men who have sex with men. *Reproductive Health Matters*, *17*(33), 133–142. [https://doi.org/10.1016/S0968-8080\(09\)33442-4](https://doi.org/10.1016/S0968-8080(09)33442-4)
- Rotheram-borus, M. J., Brooks, R., Rotheram-borus, M. J., Bing, E. G., Ayala, G., & Henry, C. L. (2003). HIV and AIDS Among Men of Color Who Have Sex With Men and Men of Color Who Have Sex With Men and Women : An Epidemiological

- Profile HIV and AIDS Among Men of Color Who Have Sex With Men and Men of Color Who Have Sex With Men and Women : An Epidemiological, (March).
<https://doi.org/10.1521/aeap.15.1.5.1.23607>
- Rutering, J., Ilmer, M., Recio, A., Coleman, M., Vykoukal, J., Alt, E., & Orleans, N. (2016). 乳鼠心肌提取 HHS Public Access. *Nature Rev Drug Discovery*, 5(6), 1–8.
<https://doi.org/10.4172/2157-7633.1000305.Improved>
- Rutledge, S. E. (2009). Formation of Personal HIV Disclosure Policies among HIV-Positive Men Who Have Sex with Men. *AIDS Patient Care and STDs*, 23(7), 531–543. <https://doi.org/10.1089/apc.2008.0179>
- Rutledge, S. E., Abell, N., Padmore, J., & McCann, T. J. (2009). AIDS stigma in health services in the Eastern Caribbean. *Sociology of Health and Illness*, 31(1), 17–34.
<https://doi.org/10.1111/j.1467-9566.2008.01133.x>
- Shenton A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Educ Inf.* 2004;22(2):63–75
- S.P., K., M.E., B., H.L., S., & R.D., S. (2012). Resilience, syndemic factors, and serosorting behaviors among HIV-positive and HIV-negative substance-using MSM. *AIDS Education and Prevention*, 24(3), 193–205.
<https://doi.org/10.1521/aeap.2012.24.3.193>
- Safren, S. A., & Ph, D. (2004). Mental Health Concerns of HIV-Infected Gay and Bisexual Men Seeking Mental Health Services: An Observational Study, 18(11).
- Safren, S. A., Reisner, S. L., Herrick, A., Mimiaga, M. J., & Stall, R. (2011). NIH Public Access, 55(Suppl 2). <https://doi.org/10.1097/QAI.0b013e3181fbc939.Mental>
- Saldana, J. (2012). An introduction to codes and coding. *The Coding Manual for Qualitative Research*, 2006, 1-31. Retrieved on 10th August, 2018 from <https://doi.org/10.1519/JSC.0b013e3181ddfd0a>
- Saleh, L. D., van den Berg, J. J., Chambers, C. S., & Operario, D. (2016). Social support, psychological vulnerability, and HIV risk among African American men who have sex with men. *Psychology and Health*, 31(5), 549–564.
<https://doi.org/10.1080/08870446.2015.1120301>
- Sallar, A. M., & Somda, D. A. K. (2011). Homosexuality and HIV in Africa: An Essay on Using Entertainment Education as a Vehicle for Stigma Reduction. *Sexuality and Culture*, 15(3), 279–309. <https://doi.org/10.1007/s12119-011-9094-1>

- Salway, T. J., Ferlatte, O., & Gesink, D. (2016). Hottest Suicide and HIV as leading causes of death among gay and bisexual men, (March).
- Sandfort, J.G., deGraaf, R., Bijl, R.V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: findings from the Netherlands mental health survey and incidence study (NEMESIS). *Archive of General Psychiatry*, 58(1): 85-91
- Sapsirisavat, V., Phanuphak, N., & Keadpuksa, S. (2016). Psychosocial and Behavioral Characteristics of High-Risk Men Who Have Sex with Men (MSM) of Unknown HIV Positive Serostatus in Bangkok, Thailand. <https://doi.org/10.1007/s10461-016-1519-2>
- Serovich, J. M., Esbensen, A. J., & Mason, T. L. (2005). HIV Disclosure by Men Who have Sex with Men to Immediate Family over Time. *AIDS Patient Care and STDs*, 19(8), 506–517. <https://doi.org/10.1089/apc.2005.19.506>
- Serovich, J. M., Grafsky, E. L., & Craft, S. M. (2011). Does family matter to HIV-positive men who have sex with men? *Journal of Marital and Family Therapy*, 37(3), 290–298. <https://doi.org/10.1111/j.1752-0606.2009.00177.x>
- Shaver, J., Sullivan, P., Siegler, A., Voux, A. De, Phaswana-mafuya, N., Bekker, L., ... Stephenson, R. (2017). Comparing Provider and Client Preferences for HIV Prevention Services in South Africa among Men Who Have Sex with Men, 16(6), 562–571. <https://doi.org/10.1177/2325957417736611>
- Shrestha, S., Poudel, K. C., Poudel-Tandukar, K., Kobayashi, J., Pandey, B. D., Yasuoka, J., ... Jimba, M. (2014). Perceived family support and depression among people living with HIV/AIDS in the Kathmandu Valley, Nepal. *Journal of the International Association of Providers of AIDS Care*, 13(3), 214–222. <https://doi.org/10.1177/1545109712456741>
- Singh, S., Mitsch, A., Wu, B. (2017). HIV Care Outcomes Among Men Who Have Sex With Men With Diagnosed HIV Infection — United States, 2015. *Morbidity and Mortality Weekly Report*, 66(37), 969–974. <https://doi.org/http://dx.doi.org/10.15585/mmwr.mm6637a2>
- Smit, P. J., Brady, M., Carter, M., Fernandes, R., Meulbroek, M., Ohayon, M., ... Jürgen, K. (2012). HIV-related stigma within communities of gay men : a literature review, 121. <https://doi.org/10.1080/09540121.2011.613910>
- Smith, A. D., Tapsoba, P., Peshu, N., Sanders, E. J., & Jaffe, H. W. (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *The Lancet*, 374(9687), 416–422. [https://doi.org/10.1016/S0140-6736\(09\)61118-1](https://doi.org/10.1016/S0140-6736(09)61118-1)

- Stahlman, S., Grosso, A., Ketende, S., Pitche, V., Kouanda, S., Ceesay, N., ... Baral, S. (2016). Suicidal ideation among MSM in three West African countries: Associations with stigma and social capital. *International Journal of Social Psychiatry*, 62(6), 522–531. <https://doi.org/10.1177/0020764016663969>
- Stall, R., Mills, T. C., Williamson, J., Hart, T., Greenwood, G., Paul, J., ... Catania, J. A. (2003). Association of Co-Occurring Psychosocial Health Problems and Increased Vulnerability to HIV / AIDS Among Urban Men Who Have Sex With Men, 93(6), 939–942.
- Statistics, M. (2019). Snowball Sampling Author (s): Leo A . Goodman Source : The Annals of Mathematical Statistics , Vol . 32 , No . 1 (Mar . , 1961), pp . 148-170
Published by : Institute of Mathematical Statistics Stable URL : <https://www.jstor.org/stable/2237615>, 32(1), 148–170.
- Stephenson, R., De Voux, A., & Sullivan, P. S. (2011). Intimate Partner Violence and Sexual Risk-taking among Men Who Have Sex with Men in South Africa. *Western Journal of Emergency Medicine*, 12(3), 343–347. Retrieved from http://escholarship.org/uc/uciem_westjem.
- Sun, X., Qian, H., Liu, Y., Yin, L., Yan, Z., Wang, L., ... Amico, K. R. (2015). Qualitative Assessment of Barriers and Facilitators of Access to HIV Testing Among Men Who Have Sex with Men in China, 29(9). <https://doi.org/10.1089/apc.2015.0083>
- Templeton, D., Read, P., Varma, R., & Bourne, C. (2014). Australian sexually transmitted infection & HIV testing guidelines 2014 for asymptomatic men who have sex with men, (May 2013), 217–229. Retrieved from http://stipu.nsw.gov.au/wp-content/uploads/STIGMA_Testing_Guidelines_Final_v5.pdf
- Thiede, H., Jenkins, R. A., Carey, J. W., Hutcheson, R., Thomas, K. K., Stall, R. D., ... Golden, M. R. (2009). Determinants of recent HIV infection among Seattle-area men who have sex with men. *American Journal of Public Health*, 99 Suppl 1(1). <https://doi.org/10.2105/AJPH.2006.098582>
- Thomas, B., Mimiaga, M. J., Mayer, K. H., Perry, N., Swaminathan, S., & Safren, S. A. (2013). have sex with men in Chennai , India, 24(11), 1401–1406. <https://doi.org/10.1080/09540121.2012.672717>.
- Thorne, S.E. (2016). *Interpretive Description*. New York: Routledge
- Thorne, S., Kirkham, S. R., & Macdonald-emes, J. (1997). Focus on Qualitative Methods Interpretive Description : A Noncategorical Qualitative Alternative for Developing Nursing Knowledge, 169–177.

- Ulasi, C. I., Preko, P. O., Baidoo, J. A., Bayard, B., Ehiri, J. E., Jolly, C. M., & Jolly, P. E. (2009). Health & Place HIV / AIDS-related stigma in Kumasi , Ghana, *15*, 255–262. <https://doi.org/10.1016/j.healthplace.2008.05.006>
- UNAIDS. (2003). Fact sheet. *Aids*, (December). Retrieved from http://data.unaids.org/publications/fact-sheets03/fs_stigma_discrimination_en.pdf
- UNAIDS (2019). Fact Sheet- Global AIDS Update, 2019. Retrieved on 5th August, 2019 from aidsinfo.unaids.org
- UNAIDS. (2014). 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Http://Www.Unaids.Org/Sites/Default/Files/Media_Asset/90-90-90_En_0.Pdf, 40. <https://doi.org/10.7448/IAS.16.4.18751>
- Valleroy, L. (2014). Violence and HIV-related risk among young men who have sex with men Violence and HIV-related risk among young men who have sex with men, (December 2006). <https://doi.org/10.1080/09540120500467182>
- Vanlauwe, B., & Giller, K. (2014). Ojiem 2006 Int J Agr Sustain Socio-ecological niche : a conceptual framework for integration of legumes in smallholder farming systems, (February 2013).
- Varas-Díaz, N., Serrano-García, I., & Toro-Alfonso, J. (2005). AIDS-related stigma and social interaction: Puerto Ricans living with HIV-AIDS. *Qualitative Health Research*, *15*(2), 169–187. <https://doi.org/10.1177/1049732304272059>
- Vu, L., Andrinopoulos, K., Mathews, C., Chopra, M., Kendall, C., & Eisele, T. P. (2012). Disclosure of HIV status to sex partners among HIV-infected men and women in cape town, South Africa. *AIDS and Behavior*, *16*(1), 132–138. <https://doi.org/10.1007/s10461-010-9873-y>
- Wasti, S. P., Simkhada, P., Randall, J., Freeman, J. V., & van Teijlingen, E. (2012). Factors influencing adherence to antiretroviral treatment in Nepal: A mixed-methods study. *PLoS ONE*, *7*(5), 1–11. <https://doi.org/10.1371/journal.pone.0035547>
- Wheeler, T., Wolf, R. C., Kapesa, L., Surdo, A. C., & Dallabetta, G. (2015). Scaling-Up HIV Responses with Key Populations in West Africa, (August 2018). <https://doi.org/10.1097/QAI.0000000000000534>
- White, R. C., & Carr, R. (2005). Homosexuality and HIV/AIDS stigma in Jamaica. *Culture, Health and Sexuality*, *7*(4), 347–359. <https://doi.org/10.1080/13691050500100799>
- WHO. (2012). Modules Of Health. Retrieved from www.who.int/social.determinants
- Wijngaarden, J. D. H. Van, Scholten, G. R. M., & Wijk, K. P. Van. (2012). Strategic

analysis for health care organizations : the suitability of the SWOT-analysis.

International Journal of Health Planning and Management, 27(July 2015), 34–49.

<https://doi.org/10.1002/hpm>

Wilton, L., Chiasson, M. A., Nandi, V., Lelutiu-weinberger, C., Frye, V., Hirshfield, S., ...

Koblin, B. (2018). Characteristics and Correlates of Lifetime Suicidal Thoughts and Attempts Among Young Black Men Who Have Sex With Men (MSM) and Transgender Women. <https://doi.org/10.1177/0095798418771819>

Wirtz, A. L., Kirey, A., Peryskina, A., Houdart, F., & Beyrer, C. (2013). Uncovering the

epidemic of HIV among men who have sex with men in Central Asia. *Drug and Alcohol Dependence*, 132(SUPPL1), S17–S24.

<https://doi.org/10.1016/j.drugalcdep.2013.06.031>

Wolf, R. C., Cheng, A. S., Kapesa, L., & Castor, D. (2013). Building the evidence base for

urgent action : HIV epidemiology and innovative programming for men who have sex with men in sub-Saharan Africa, 16(Suppl 3), 1–4.

<https://doi.org/10.7448/IAS.16.4.18903>

Wong, C. S., Lye, D. C., Lee, C. C., & Leo, Y. S. (2011). Acute HIV infection in

Singapore: Predominance of men who have sex with men. *Singapore Medical Journal*, 52(12), 860–863.

Yin, R. K. (2011). *Qualitative Research From Start to Finish*. New York: The Guilford Press.

Yoshioka, M. R., & Schustack, A. (2002). Disclosure of HIV Status: Cultural Issues of

Asian Patients. *AIDS Patient Care and STDs*, 15(2), 77–82.

<https://doi.org/10.1089/108729101300003672>

Young, L. E., Jonas, A. B., Michaels, S., Jackson, J. D., Pierce, M. L., & Schneider, J. A.

(2017). Social-structural properties and HIV prevention among young men who have sex with men in the ballroom house and independent gay family communities. *Social Science and Medicine*, 174, 26–34. <https://doi.org/10.1016/j.socscimed.2016.12.009>

Zhou, Y. R. (2006). Homosexuality, seropositivity, and family obligations: Perspectives of

HIV-infected men who have sex with men in China. *Culture, Health and Sexuality*, 8(6), 487–500. <https://doi.org/10.1080/13691050600847455>

Zhou, Y. R. (2009). Help-seeking in a context of AIDS stigma: Understanding the

healthcare needs of people with HIV/AIDS in China. *Health and Social Care in the Community*, 17(2), 202–208. <https://doi.org/10.1111/j.1365-2524.2008.00820.x>

Zou, J., Yamanaka, Y., John, M., Watt, M., Ostermann, J., & Thielman, N. (2009).


Religion and HIV in Tanzania : influence of religious beliefs on HIV stigma , disclosure , and treatment attitudes, *I2*, 1–12. <https://doi.org/10.1186/1471-2458-9-75>

APPENDICES

Appendix A: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979A Constituent of the College of Health Sciences

INSTITUTIONAL REVIEW BOARD



Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH

My Ref. No: DF.22
Your Ref. No:

University of Ghana
Post Office Box LG 581
Legon, Accra
Ghana

7th November, 2018

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 019/18-19 **IORG 0000908**

On 7th November 2018, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Psychosocial Experiences of a key Population With HIV**


PRINCIPAL INVESTIGATOR : **Rafiatu Musah, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 6th November, 2019. You are to submit annual reports for continuing review.

Signature of Chair: 

Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

Appendix B: Ghana Health Service Clearance

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
14th December, 2018

MyRef. GHS/RDD/ERC/Admin/App18/464
Your Ref. No.

Rafiatu Musah
School of Nursing and Midwifery
P.O. Box LG43
Legon-Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

| | |
|------------------|---|
| GHS-ERC Number | GHS-ERC022/11/18 |
| Project Title | Psychosocial Experiences of a Key Population with HIV |
| Approval Date | 14 th December, 2018 |
| Expiry Date | 13 th December 2019 |
| GHS-ERC Decision | Approved |

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix C: Introductory Letter



UNIVERSITY OF GHANA
DEPARTMENT OF ADULT HEALTH
SCHOOL OF NURSING

Ref. No.: SON/A.12

November 7, 2018

The Chairperson
Ethical Review Committee
Ghana Health Service
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Musah Rafiatu, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: **“Psychosocial Experiences of a Key Population with HIV”**.

I hope that the Ethical Review Committee will consider the proposal to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Gladys Dzansi
Ag, Head of Department, Adult Health

COLLEGE OF HEALTH SCIENCES

• P. O. Box LG 43, Legon, Accra, Ghana. • Telephone: +233 (0) 302 513 250 / 0289 531 213
• Email: adulthealth.son@chs.ug.edu.gh • Website: www.nursing.chs.ug.edu.gh

Appendix D: Participant's Information Sheet

Title of study: Psychosocial experiences of a key population with HIV

Introduction

Principal Investigator: Rafiatu Musah

Address: University of Ghana

School of Nursing and Midwifery

P. O. Box LG 43

Legon-Accra.

Phone number: 0249202029

Email: rafty113@gmail.com

Place of study: University of Ghana

Background of research

The research is about the psychosocial experiences key population (Men who have Sex with MSM) with HIV go through. The study site is Greater Accra Regional Hospital (GARH). Men who have Sex with Men (MSM) have disproportionate burden when it comes to HIV prevalence in the world. Ghana has a prevalence of 17.5 % as compared to 11.1% representing that of Female Sex workers (Ghana AIDS Commission, 2016). MSM living with HIV shy away from coming for treatment putting them at risk of numerous opportunistic infection. This behavior is due to numerous experiences they have gone through which stems from psychological experience to social experience. Some of these experiences are internal stigma, depression, anxiety, substance abuse, loss of job, discrimination among others. Research in this area has been understudied, under resourced and inadequately addressed, hence the need to go into the study of psychosocial experiences of key population with HIV.

Nature of the study

The project is about exploring the psychosocial experiences of a key population (MSM) with HIV. The nature of this research is exploratory. A qualitative research approach will

be used in other to gain an understanding of underlying reasons, opinions and motivations MSM living with HIV go through since they were diagnosed with HIV. This will help understand why their attendance rate is low at various Antiretroviral Clinics in Ghana despite them having a high prevalence rate of HIV. This type of approach will include interviewing participants with a semi-structured interview guide which will help them provide insight into their problems. I am interested in finding what my participants go through after they are being diagnosed of having HIV coupled with being an MSM, also how the community in which they live in treats them, family and friends including where they seek for health care. I also want to find out whether they have any form of support and how they prevent all these experiences from happening.

Participants involvement

Duration

Participants would be required to give out information per the semi-structured interview guide. Participants would be engaged in an interview which will last for 40 – 50 minutes.

Potential Risks

The study will expose you to no harm. Nonetheless, if you experience any emotional upset in the course of sharing your psychological and social experiences, the researcher will direct you to a specialist counsellor for emotional support at no cost to you.

Benefits

There will be no direct benefit from the study. However, the information you will provide will add on to knowledge for upcoming nurses working at the ART clinic and also create awareness for prospective support. Also, in the future, the information you have given out can influence policy makers for the establishment of an integrated health care for MSM living with HIV.

Costs

The cost involved like that of transportation to interview site would be paid by the principal investigator. Another cost incurred will be the compensation they will be given. The compensation will be in the form of mineral drinks and snacks and the principal investigator will pay for the cost as well.

Compensation

Remuneration will not be given to participants but rather refreshment in the form of mineral drinks and snacks will be given to each participant.

Confidentiality

The interview will be audiotaped; however, you will be asked not to mention your name in the conversation during recording. Initials will be used instead of your real name. Identifiable data will be separated from non-identifiable data. The information will be locked up in a safe accessible to only the researcher and supervisor who oversees the work.

Voluntary participation/withdrawal

Participation in the study is voluntary. Your willingness or withdrawal from the study is without any penalty nor any other consequence. You have the right to withdraw without giving any reasons.

Outcome and Feedback

Data will be placed under lock and key in the supervisor's office. Data will be only be accessible to the researcher and her supervisor. Data will be destroyed after it had been kept in a safe for five years.

Appropriate alternative Procedures and Treatment

Men are more comfortable giving out information to their fellow man. Hence a research assistant who is an MSM living with HIV and has a minimum qualification of a diploma or a degree will be trained to collect data from participants.

Funding information

This study is fully self-funded.

Conflict of interest

The data for this study is fully owned by the principal investigator.

Provision of information and consent for participants

Copies of the information sheet and consent form will be given to participants after they have agreed and have signed or thumb printed to partake in the study. Participants will also be informed that the interview will be audiotaped including the writing of field notes.

Who to contact for clarification

1. Rafiatu Musah (Principal Investigator)

University of Ghana

School of Nursing and Midwifery

Phone number: 0249202029

E-mail address: rafty113@gmail.com

2. Dr. Gladys Dzansi (Supervisor)

University of Ghana

School of Nursing and Midwifery

Department of Adult Health

P. O. Box LG 43

Legon-Accra

Phone number: 0243059316

E-mail: gladysdzansi@gmail.com

3. Ethics Committee Administrator

Ghana Health Service

Phone number: 0302681109

Appendix E: Consent Form

CONSENT FORM

Title: Psychosocial experiences of a key population with HIV

Principal Investigator: Rafiatu Musah

Address: University of Ghana

College of Health Sciences

School of Nurses and Midwifery


Department of Adult Health

General Information about Research

I would like to seek information from you concerning your experiences as a key population (MSM) with HIV at the Greater Accra Regional Hospital. The information collected will provide additional information to nurses at the Antiretroviral Therapy Clinic (ART) upon how to treat MSM with HIV. It will also provide awareness for future support from policy makers and stakeholders. I would engage you in a conversation for 40-50 minutes. The conversation will be in English, Twi, Ga or Hausa language. There will be no right or wrong answer and therefore your experiences are considered to be unique and credible. You are expected to ask questions as you want to. The interview will concern the experiences you go through as an MSM with HIV both psychologically and socially, the challenges you encounter, the support system that aid you in coping or overcoming these challenges, the effect of the care on your personal, social life and on your general health. You will be asked to sign a consent form before interview begins if you agree to partake in the study. The interview will be tape recorded for academic study with your consent.

Possible Risks and Discomforts

The study will expose you to no harm. Nonetheless, if you experience any emotional upset in the course of sharing your psychological and social experiences, the researcher will direct you to a specialist counsellor for emotional support at no cost to you.

 1

Possible Benefits

There will be no direct benefit from the study. However, the information you will provide will add on to knowledge for upcoming nurses working at the ART clinic and also create awareness for prospective support.

Confidentiality

The interview will be audiotaped; however, you will be asked not to mention your name in the conversation during recording. Initials will be used instead of your real name. Identifiable data will be separated from non-identifiable data. The information will be locked up in a safe accessible to only the researcher and supervisor who oversees the work.

Compensation

Refreshment will be done at the end of the interview. Participants will be given mineral drink and pie after the interview.

Voluntary Participation and Right to Leave the Research

Participation in the study is voluntary. Your willingness or withdrawal from the study is without any penalty nor any other consequence.

Contacts for Additional Information

1. Rafiatu Musah

School of Nursing and Midwifery, University of Ghana

Phone number: 0249202029

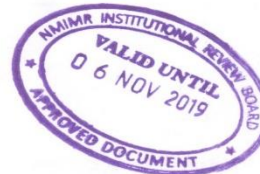
E-mail address: rafty113@gmail.com

2. Dr. Gladys Dzansi

School of Nursing and Midwifery, University of Ghana

Phone number: 0243059316

E-mail: gladysdzansi@gmail.com



Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the land line 0302916438 or email addresses: nirb@noguchi.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "Psychosocial experiences of a key population with HIV" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

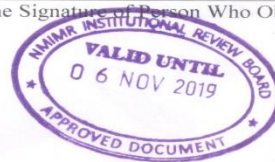
Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent



3

Appendix F: Semi-Structured Interview Guide

INTERVIEW GUIDE

TOPIC: PSYCHOSOCIAL EXPERIENCES OF A KEY POPULATION WITH HIV

Code Number.....

1. Please tell me about who you are

Probes

- How old are you?
- What about your educational background?
- Your location, residence and place of work
- What language(s) do you speak?
- How long have you known about who you really are?
- How long have you known about being sick?
- Tell me about your medication (when did you start and how long have you been taking it)

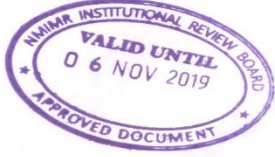
2. What are your experiences living with HIV/AIDS?

Probes

- How did the diagnosis affect you?
- How do you feel about telling other people about your diagnosis?
- How does your mindset about what people think about you affect how you relate with other people?
- How do you respond to other patients who know about your condition?
- How do you feel about how nurses relate with you?

3. Tell me how your diagnosis has influenced your life in general?

Probes



- a. How has the condition affected your eating habit?
 - b. What about your work?
 - c. How did it affect your sexual life?
 - d. What about recreation and relaxation?
4. Please tell me how your family and peers have influenced your experiences of living with HIV?
- b. What are your lived experiences with regards to HIV disclosure to family and peers?
 - c. What are the family and peers support received by you?
5. Tell me how your community has influenced your experiences of living with HIV?

Probe

- a. What are your experience when you go to church/mosque?
 - b. What are your experiences when you go to funeral, naming ceremony, marriage ceremony?
 - c. What within your community contribute to the discomfort of you as an MSM living with HIV after disclosure of your HIV status?
 - c. What are the available support rendered to MSM living with HIV within the community?
6. Tell me how the hospital influences your experience living with HIV?

Probe

- a. What are some of the things you dislike when you visit the hospital?
- b. What are some of the things you like when you visit the hospital?

2



c. How does the hospital setting support you as an MSMHIV to overcome your experiences?

d. What available support services does the health system have for you?



Appendix G: Thematic codes and Descriptions

Themes and Sub-themes from Transcribed Data

| Themes | Sub-themes |
|--|---|
| Individual experiences of MSM living with HIV | <ul style="list-style-type: none"> ● Personal history ● Reaction to diagnosis ● Medication (ARVs) ● Adjusting to HIV life/ Resilience ● Recreation |
| Family and peer relation among MSM living with HIV | <ul style="list-style-type: none"> ● Status disclosure ● Stigma ● Discrimination ● Broken relationships ● Family and peer support |
| Community level experience of MSM living with HIV | <ul style="list-style-type: none"> ● Community level stigma ● Discrimination ● Abuse ● Community support |
| Institutional experiences of MSM living with HIV | <ul style="list-style-type: none"> ● Satisfaction with services ● Health care workers attitude ● Structural support ● Policy concerns |

Appendix H: Summary of Demographic Characteristic of participants**Participants Profile**

| Participants | Age | Self-identification | Religion | Level of education | Nationality | Occupation |
|---------------------|------------|----------------------------|-----------------|---------------------------|--------------------|-----------------------|
| MF001 | 30 | Female | Moslem | Upper primary | Ghanaian | Trader |
| MF002 | 26 | Female | Christian | Tertiary | Ghanaian | Businessman |
| MF003 | 31 | Female | Moslem | Senior High School | Togolese | Male sex worker |
| MM004 | 25 | Male | Moslem | Junior High School | Ghanaian | Formal worker/private |
| MF005 | 42 | Female | Christian | Junior High School | Ghanaian | Tailor |
| MV006 | 55 | Versatile | Christian | Middle school | Ghanaian | Caterer |
| MF007 | 51 | Female | Christian | Primary | Ghanaian | Petty trader |
| MV008 | 19 | Versatile | Christian | Senior High School | Ghanaian | Unemployed |
| MM009 | 39 | Male | Christian | Senior High School | Ghanaian | Bar attendant |
| MM010 | 33 | Male | Christian | Junior High School | Ghanaian | Photographer |
| MF011 | 23 | Female | Christian | Tertiary | Togolese | Fashion designer |
| MF012 | 28 | Female | Christian | Vocational school | Ghanaian | Fast food vendor |
| MF013 | 25 | Female | Christian | Primary | Ghanaian | Beautician |
| MM014 | 18 | Male | Christian | Tertiary | Nigerian | Student |
| MF015 | 40 | Female | Christian | Primary | Ghanaian | Hawker |