SCHOOL OF NURSING AND MIDWIFERY

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA, LEGON

FACTORS AFFECTING ACCESS TO CARE FOR SEXUAL MINORITIES LIVING WITH HUMAN IMMUNE DEFICIENCY VIRUS AT GA-EAST MUNICIPALITY.

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTER OF SCIENCE IN NURSING DEGREE

NOVEMBER, 2024

DECLARATION

I, Priscilla Affum, hereby declare that this thesis is the result of the research I completed for the Master of Science in Nursing Degree program at the University of Ghana, Legon, School of Nursing and Midwifery with supervision from Dr. Gladys Dzansi in the School of Nursing and Midwifery, College of Health Sciences, University of Ghana. This research has not been submitted to any other school for a degree. All writers and publishers whose works were referenced were properly credited.

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ABSTRACT

Background: Men who have sex with men (MSM), a key subgroup within the sexual minority population, experience a disproportionately high burden of HIV, often compounded by stigma, discrimination, and social exclusion. Such stigma is linked to shame and rejection that hinder healthcare-seeking behaviour and adherence to antiretroviral therapy (ART).

Purpose: This study explored the factors influencing access to HIV care among sexual minorities living with HIV in Accra, Ghana, guided by Andersen's Behavioural Model.

Methods: A qualitative interpretive descriptive design was employed, involving in-depth interviews with 11 participants attending the International Health Care Centre (WAAF's Clinic). Data were audio-recorded, transcribed verbatim, and analysed deductively using thematic content analysis. Ethical principles, including informed consent, voluntary participation, and confidentiality, were strictly observed.

Results: Five major themes and 14 subthemes emerged: (1) individual experience in accessing HIV care and service (healthcare providers' relationship, impact of anti-LGBTQ+ legislation, satisfaction with services); (2) healthcare access and support systems (financial support and medication accessibility, confidentiality concerns); (3) peer and family support of sexual minorities living with HIV (stigma, family dynamics, peer and community support, discrimination); (4) individual experiences of sexual minorities living with HIV (reaction to diagnosis, antiretroviral medicine, personal history); and (5) coping mechanisms and adaptive strategies (religious and spiritual coping, psychological adaptation to treatment).

Conclusion: Stigma, discrimination, and limited policy awareness continue to hinder healthcare access for sexual minorities living with HIV, while resilience, peer support, and MSM-friendly facilities facilitate care. Addressing stigma and implementing inclusive policies are essential to

improving ART adherence and advancing Ghana's contribution to the UNAIDS 2030 goal of ending AIDS.

Keywords: stigma, sexual minorities, HIV care, discrimination, healthcare access

DEDICATION

This work is dedicated to the individuals who stood with me throughout the process of developing this work.

ACKNOWLEDGEMENT

I am deeply grateful for the invaluable support and guidance I received throughout the process of this research. First and foremost, I wish to express my sincere appreciation to my supervisor, Dr. Gladys Dzansi, and her assistant, Mr. Prosper Junior Anatsui for their continuous encouragement, constructive criticism, and insightful guidance, which provided the needed direction and focus for this study. Their patience and mentorship have been instrumental in the successful completion of this work.

My heartfelt thanks also go to Mr. Charles Owusu Obimpeh, whose unwavering support, sacrifices, and belief in my potential greatly motivated me during this journey. I am equally thankful to Lilian Owusuah for her understanding, support, and encouragement throughout this process.

Special appreciation goes to the West Africa AIDS Foundation and the International Health Care Centre for granting permission and providing the facilities and resources that made this research possible. I am also grateful to my colleagues and friends for their cooperation and participation, which enriched this study and made the experience more meaningful.

Finally, I extend my profound gratitude to my family and friends for their endless encouragement and moral support. Their inspiration and confidence in me have been a constant source of strength, both academically and personally. To all who contributed in diverse ways to the success of this work, I offer my sincere appreciation.

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LIST OF ABBREVIATIONS

HIV:	Human Immune Virus
MSM:	Men who have Sex with Men
SDGs:	Sustainable Development Goals
UNAIDS:	United Nations Joint Programme on HIV/AIDS
GAC:	Ghana AIDS Commission
NACP:	National AIDS Control Program
WAAF:	West Africa AIDS Foundation
IHCC:	International Health Care Centre
FSW:	Female Sex Workers
ART:	Antiretroviral Therapy
SOPs:	Standard Operating Procedures
NGOs:	Non-Governmental Organizations
ARVs:	Antiretroviral Medication

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Despite major advances in HIV prevention and treatment, significant disparities persist among key populations, particularly men who have sex with men (MSM), who continue to contribute substantially to the global HIV burden. MSM represent a disproportionately large percentage of people affected by HIV, accounting for approximately 25% of new infections worldwide despite comprising only about 2–4% of the total population (UNAIDS, 2023). Globally, HIV remains a pressing public health concern, with an estimated 39 million people living with the virus as of 2023 (UNAIDS, 2024). MSM are 28 times more likely to acquire HIV compared to heterosexual men, a disparity influenced by both biological and social factors. Biologically, the efficiency of HIV transmission during anal intercourse increases susceptibility, while socially, entrenched inequalities such as stigma, discrimination, and criminalization continue to heighten vulnerability and restrict access to prevention and treatment services (Ogunbajo et al., 2023; Poteat et al., 2021; World Health Organization (WHO), 2025).

At the global level, progress toward ending the HIV epidemic has been uneven across populations and regions. High-income countries have made notable advances in reducing new infections and improving treatment outcomes among MSM, largely due to expanded access to pre-exposure prophylaxis (PrEP), routine testing, and targeted community interventions (Centers for Disease Control(CDC), 2025; UNAIDS, 2024). In contrast, low- and middle-income countries, particularly those with restrictive legal and sociocultural environments, continue to experience widening disparities in HIV outcomes among MSM. Globally, only about 70% of MSM living with HIV are aware of their status, and fewer than two-thirds are virally suppressed, reflecting

ongoing challenges in achieving the UNAIDS 95–95–95 targets (UNAIDS, 2024). These inequities highlight the persistent gap in global HIV response efforts, emphasizing the need to address structural, legal, and social barriers that impede effective HIV prevention and care among sexual minorities.

In sub-Saharan Africa, where cultural and legal barriers are deeply rooted, MSM experience layered stigma that significantly limits their access to HIV prevention, testing, and treatment services. Studies conducted in South Africa, Kenya, and Nigeria demonstrate that pervasive discrimination from healthcare providers, fear of disclosure, and a lack of MSM-friendly health services discourage early HIV testing and consistent treatment adherence (Manga et al., 2025; Mugambi et al., 2021). This was also similar in Tanzania where a study, reported that Participants expressed concern about stigmatization both at the family and community level. Some PLHIV were hesitant to attend clinics close to their residences or ask someone to collect their ART on their behalf for fear of being recognized. Despite international efforts to promote inclusive care through differentiated service delivery models, structural and cultural barriers continue to undermine these interventions and perpetuate health inequities (Poteat et al., 2021).

In Ghana, the HIV epidemic remains concentrated among key populations, including MSM, who experience an HIV prevalence of 18.1% compared to 1.7% among the general adult population This striking disparity highlights the heightened vulnerability of MSM within a sociocultural environment that criminalizes same-sex relationships and fosters widespread stigma (Kingombola et. al, 2023). These conditions compel many MSM to conceal their sexual orientation and avoid healthcare settings due to fear of discrimination or exposure, resulting in delayed testing, poor treatment adherence, and increased risk of onward transmission (Nyblade et al., 2021). Additionally, stigma and discrimination significantly impact the psychological well-being of these

minorities, leading to poorer overall health outcomes. For example, a study by Anuga et al. (2025) found that stigma and rejection were major factors contributing to the mental health challenges faced by many LGBTQ+ individuals, with many seeking asylum in more inclusive and welcoming jurisdictions. Although organizations such as the West Africa AIDS Foundation (WAAF) and the Ghana Health Service have implemented community-based testing and peer-led outreach initiatives to improve access, implementation challenges persist due to limited resources, confidentiality concerns, and deep-seated social prejudices.

Furthermore, few studies in Ghana have qualitatively explored the lived experiences of MSM in navigating HIV care. Understanding these experiences within the context of health system capacity, stigma, and social exclusion is critical to achieving equitable HIV outcomes and meeting the UNAIDS 95–95–95 targets by 2030. A deeper exploration of the factors affecting access to HIV care among sexual minorities in Ghana, particularly within municipalities such as Ga East, is therefore essential to inform context-specific interventions and bridge the persistent gap in HIV service delivery for this marginalized population.

1.2 Problem Statement

In an ideal public health system, every individual, regardless of sexual orientation or gender identity, should have equitable access to HIV prevention, treatment, and care services. Global frameworks such as the WHO Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery, and Monitoring emphasize non-discriminatory care and universal access to antiretroviral therapy (WHO, 2025). Evidence shows that inclusive, stigma-free healthcare environments enhance service uptake among key populations, leading to improved adherence, viral suppression, and reduced HIV transmission (UNAIDS, 2024). Effective health systems

should therefore ensure that men who have sex with men (MSM) receive friendly, confidential, and equitable services that promote optimal health outcomes and contribute to epidemic control.

However, the reality in Ghana and many sub-Saharan African contexts differs sharply from these global ideals. MSM continue to encounter multiple and intersecting barriers that severely constrain access to HIV services. The criminalization of same-sex relationships, upheld by Section 104 of Ghana's Criminal Code, fosters fear, concealment, and mistrust toward healthcare facilities, while moral and religious condemnation deepens social exclusion (Atuguba, 2019; Nyblade et al., 2021). Within healthcare settings, studies reveal that MSM often experience overt discrimination, breaches of confidentiality, verbal abuse, and judgmental treatment from healthcare workers, which discourages them from seeking testing and treatment (Abu-Ba'are et al., 2024). Additionally, Anuga et. al 2025 reports that sexual minorities recounted instances where provider attitudes such as stigmatization made them feel dismissed and disrespected. These negative experiences are further compounded by systemic challenges such as long waiting times, inadequate provider training, limited availability of MSM-tailored services, and low health literacy (Desrosiers et al., 2019). As a result, many MSM rely on informal or alternative care sources or disengage entirely from antiretroviral therapy (ART) programs, leading to poor treatment adherence, increased viral load, and higher morbidity and mortality rates within this population.

The combined effects of stigma, discrimination, and insufficient healthcare responsiveness create a cycle of vulnerability that perpetuates HIV transmission among MSM. This situation undermines Ghana's national HIV response and threatens progress toward the UNAIDS 95–95–95 targets, which aim for 95 percent of people living with HIV to know their status, 95 percent of those diagnosed to receive sustained ART, and 95 percent of those on treatment to achieve viral suppression by 2030 (UNAIDS, 2024). The gap between policy commitments to equality and the

lived realities of MSM in accessing HIV services exposes systemic weaknesses within the health system and highlights broader human rights challenges.

Although several studies have examined HIV prevalence and risk behaviors among MSM in Ghana and other African countries, there remains limited empirical evidence on how social stigma, institutional barriers, and health system factors interact to shape MSM's experiences of HIV care. Most available studies have relied on quantitative surveys, which, while useful for estimating prevalence and service coverage, offer limited insight into the nuanced, lived experiences of MSM in navigating the healthcare system (Mugambi et al., 2022; Hassan et al., 2021). There is therefore a clear empirical and methodological gap in understanding how stigma, discrimination, and structural constraints influence healthcare access and engagement among MSM in specific local contexts.

It is in response to this gap that the present study seeks to explore and document the factors influencing access to HIV care among sexual minorities in Ghana, particularly in urban municipalities such as Ga East, where population density, cultural diversity, and socioeconomic disparities intersect. Addressing these gaps will generate context-specific evidence to inform targeted interventions, promote inclusive service delivery, and strengthen Ghana's commitment to equitable and rights-based HIV care for all populations.

1.3 Purpose of the study

This study investigated the factors influencing sexual minorities' specifically MSM access to HIV care at Ga-East municipality.

1.4 Objectives of the study

The objectives to be achieved by the end of the study were to:

1. Describe the barriers that MSM living with HIV face in accessing HIV care and treatment services in the Ga East Municipality.
2. Explore the facilitators that enable MSM living with HIV to access HIV care and treatment services in the Ga East Municipality.
3. Explore the personal health practices and coping strategies of MSM living with HIV who are receiving care in the Ga East Municipality.

1.5 Research Questions

The research answered the following questions;

a. What are the barriers that MSM living with HIV face in accessing HIV care and treatment services in the Ga East Municipality?
b. What are the facilitators that enable MSM living with HIV to access HIV care and treatment services in the Ga East Municipality?
c. What are the personal health practices and coping strategies employed by MSM living with HIV who are receiving care at Ga-East Municipality?

1.6 Significance of the Study

This study will support the revision of SOPs for Key Population in addition to attending to their requirements and resolving issues that impact their social, mental, and physical health. Healthcare providers, policy makers and case managers can all benefit from this new intervention and knowledge. Despite being categorized as a general epidemic, HIV nevertheless poses a significant risk to public health in Ghana. Males who engage in sexual activity with other males (MSM) are a vulnerable population that faces various barriers to HIV prevention and treatment, including shame from healthcare providers and ignorance of efficient preventive techniques and viral suppression. Developing tailored strategies to stop HIV transmission within this population

can be guided by an understanding of the factors influencing MSMs' access to HIV treatment. It will be easier to create interventions that effectively halt HIV transmission and better understand MSM requirements as a consequence of this study's findings, which will assist HIV prevention organizations, lawmakers, and healthcare providers. This research also aims to contribute to the existing body of information to help UNAIDS's 2030 target of meeting the "95-95-95". Moreover, it will facilitate the development of policies that are customized to meet the distinct healthcare needs of underprivileged populations, thereby promoting the human rights necessity of HIV prevention and treatment programs.

1.7 Operational Definitions

Access to Care refers to the ability of individuals to obtain necessary health services.

Men Sleeping with Men (MSM): refers to men who were identified as males at birth who engage in sexual activity with other males, regardless of their sexual orientation or identity.

Treatment: The approaches employed to manage persons living with HIV to improve their health and wellbeing. This includes interventions like medications and surgeries, as well as therapeutic approaches such as counselling and rehabilitation.

Coping strategies: In this study, coping strategies are techniques or methods individuals use to respond to stress, anxiety, or difficult emotions.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter presents a comprehensive review of scholarly works relevant to the study and the theoretical framework guiding the research. The review is structured under two main sub-headings: Literature Review and Theoretical Framework. The literature review focuses on examining factors affecting access to care for sexual minorities living with HIV, with specific emphasis on stigma, discrimination, and care provision. It provides a critical analysis of existing knowledge, highlights key gaps, and establishes the context for the study within the Ga-East Municipality. To ensure the inclusion of high-quality and relevant sources, a systematic search was conducted using databases such as PubMed, Google Scholar, and ScienceDirect. The search targeted peer-reviewed articles published between 2014 and 2024. Additional resources, including review articles, books, and reference lists of identified studies, were also consulted to enrich the review.

The search strategy employed a combination of key terms, including "HIV Infection," "Stigma," "Sexual Minorities," "MSM" (Men who have Sex with Men), "Care Provision," and "Discrimination." This approach ensured a broad yet focused exploration of the literature to provide a well-rounded understanding of the topic.

2.1 Theoretical Framework

Several theoretical models have been used to explain healthcare access and utilization among vulnerable populations. These include the Health Belief Model (HBM), which emphasizes individual perceptions of susceptibility and benefits; the Socioecological Model (SEM), which accounts for multilevel influences on health behaviour; and Andersen's Behavioural Model of Health Services Use, which focuses on the interplay of predisposing, enabling, and need factors.

After evaluating these frameworks, Andersen's model was selected because of its comprehensive approach to understanding access and utilization of healthcare among marginalized populations such as MSM (Babitsch et al., 2012; Travers et al., 2020).

2.1.1 Anderson's Behavioural Framework

The Andersen Behavioral Model, developed by Ronald Anderson in 1968, provides a foundational framework in medical sociology and health services research for understanding the multifaceted factors influencing healthcare utilization. The model organizes determinants of healthcare use into three interconnected categories: predisposing characteristics, enabling resources, and need factors (Lederle et al., 2021).

Predisposing characteristics encompass demographic and social variables such as age, gender, education level, and cultural beliefs which shape an individual's propensity and likelihood of seeking healthcare services. Enabling resources comprise both individual-level factors (income, insurance coverage, health literacy) and community-level infrastructure (proximity to healthcare facilities, availability of services, transportation systems) that either facilitate or hinder access to care. Need factors include both perceived health needs (an individual's subjective understanding of their health status) and evaluated health needs (clinician-assessed health conditions), which collectively drive demand for medical services (Lederle et al., 2021).

The model also incorporates outcomes including changes in health status, satisfaction with care, and future healthcare behaviors with a feedback loop indicating how prior experiences influence subsequent utilization patterns. This comprehensive framework enables examination of barriers and facilitators of healthcare access and informs targeted interventions to improve equity and service delivery (Anderson, 1995; Babitsch et al., 2012).

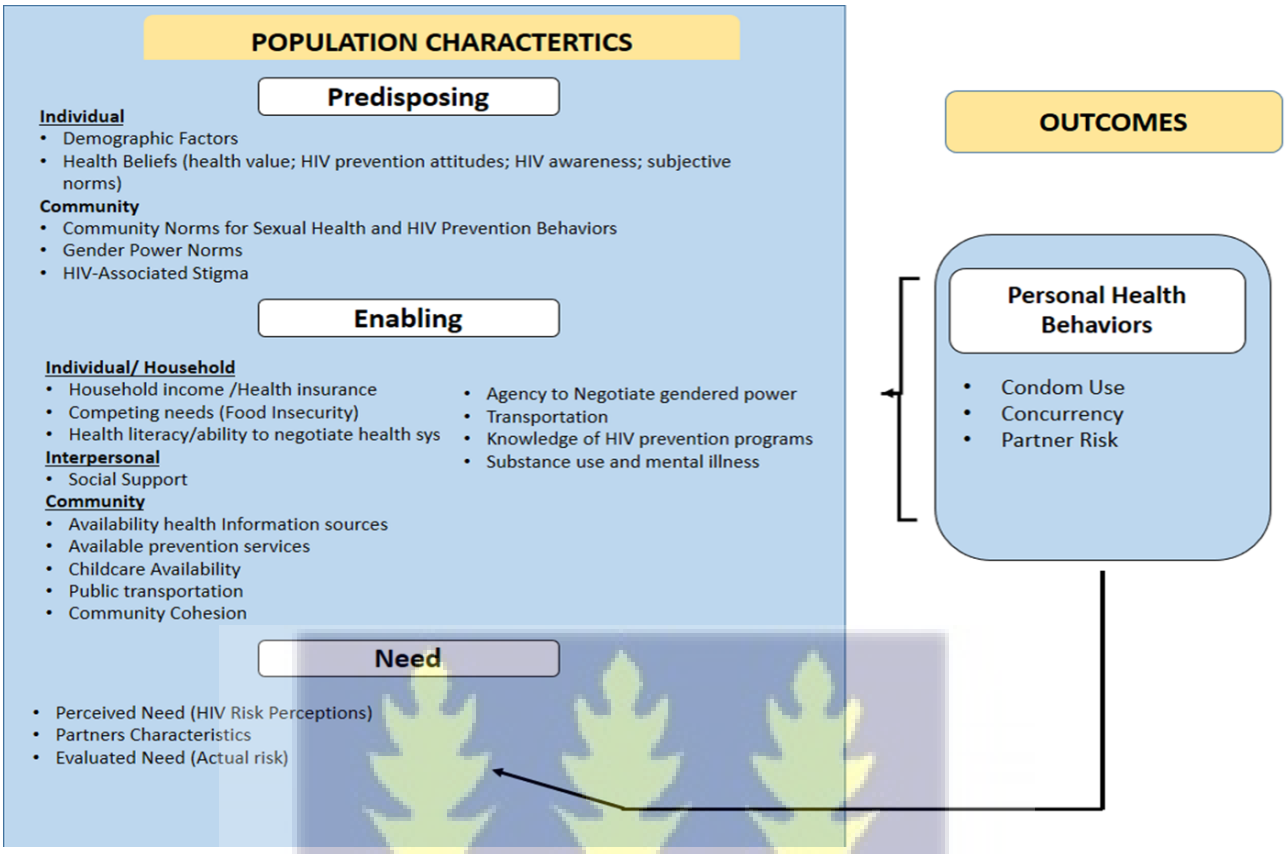

Figure 1: Anderson's Health Behavioral Model

2.1.2 Application of the Theoretical Framework

The Andersen Behavioral Model (ABM) provides a comprehensive framework for analyzing health service utilization by emphasizing the dynamic interaction between individual characteristics, enabling resources, and perceived or evaluated need for care. This model is particularly relevant for examining HIV service utilization among men who have sex with men (MSM) in Ghana, a context characterized by pervasive stigma, discrimination, and legal as well as structural barriers that impede engagement in care. Applying the Andersen framework to this

population enables a systematic understanding of how individual, institutional, and systemic factors intersect to influence healthcare-seeking behaviors and service utilization outcomes.

In the Ghanaian sociocultural context, predisposing factors significantly influence MSM's attitudes and orientation toward HIV services. Beyond demographic attributes, cultural norms, religious ideologies, and the criminalization of same-sex relationships, as contained in Section 104 of Ghana's Criminal Code, serve as powerful determinants of health-seeking behavior. These factors collectively contribute to psychological barriers such as fear, concealment, and mistrust toward healthcare institutions, thereby discouraging MSM from seeking HIV testing and treatment services (Atuguba, 2019; Nyblade et al., 2022). Moreover, internalized stigma, coupled with limited health literacy within the MSM community, further undermines individuals' perceived susceptibility to HIV and diminishes their willingness to engage with formal healthcare systems. Consequently, predisposing factors operate both at the individual and societal levels to reinforce exclusion and healthcare avoidance among MSM.

The enabling resources dimension of the Andersen model provides critical insights into how structural determinants shape healthcare access. While individual-level resources such as income, employment, and health insurance remain important, the Ghanaian context underscores the salience of community- and system-level enablers. Inadequate healthcare infrastructure, insufficient provider training on MSM-sensitive care, and the scarcity of MSM-friendly services significantly constrain service accessibility (Desrosiers et al., 2019). Additionally, institutional discrimination manifested through breaches of confidentiality, verbal abuse, and judgmental attitudes by healthcare providers creates a hostile care environment that deters MSM from seeking or continuing care (Abu-Ba'are et al., 2023). The absence of safe, stigma-free healthcare spaces effectively disables access to HIV services, even among those with a high clinical need.

MSM in Ghana bear a disproportionate burden of HIV, which underscores a high clinical need for prevention, testing, and treatment services. However, the interaction between perceived need, which is influenced by stigma, fear, and denial, and evaluated need, which is clinician-determined, often results in delays in diagnosis and suboptimal adherence to treatment. Consequently, many MSM resort to informal care networks or disengage from antiretroviral therapy programs altogether, leading to poor health outcomes, elevated viral loads, and increased morbidity and mortality within this population (Abu-Ba'are et al., 2023). The persistence of these outcomes highlights systemic shortcomings rather than individual-level failures.

In sum, the application of the Andersen Behavioral Model to the Ghanaian MSM context highlights that barriers to HIV care are deeply rooted in predisposing sociocultural stigmas, inadequate enabling resources, and the misalignment between perceived and evaluated needs. The framework thus offers a multidimensional perspective for identifying leverage points where interventions can be targeted to enhance service accessibility, strengthen health system responsiveness, and foster equity in HIV care. Ultimately, operationalizing this model supports Ghana's progress toward achieving the UNAIDS 95–95–95 targets and reinforces national commitments to inclusive, rights-based HIV prevention and treatment services.

2.2 Literature Review

2.2.1 Overview of HIV/AIDS

HIV, or human immunodeficiency virus, is a virus that causes an infection to the human body. According to Deeks et al. (2015), the virus primarily targets CD4+ T lymphocytes, which are crucial for immune function. This leads to a gradual decline in immune capacity, making individuals more susceptible to opportunistic infections and certain cancers. The progression from

HIV infection to AIDS can take several years, typically around 7 to 10 years without treatment, although this varies among individuals. (National Institutes of Health, 2021).

HIV is transmitted through various bodily fluids, with sexual contact being the primary mode of transmission (National Institutes of Health, 2021). In terms of the route with the highest risk, unprotected sexual intercourse, particularly anal sex, presents the most risk due to potential mucosal damage that allows the virus to enter the body (Cachay, 2024). Beyond sexual transmission, the virus can spread through shared needles among drug users, creating significant public health challenges in regions like Eastern Europe and Central Asia. Mother-to-child transmission is another pathway for HIV spread, occurring during pregnancy, childbirth, or through breastfeeding (WHO, 2023). Without proper medical intervention, mothers can transmit the virus to their children at rates of 20-40%, though modern medical treatments have dramatically reduced this risk (Hill et al., 2015).

Certain populations face disproportionately higher HIV infection risks. Men who have sex with men are approximately 26 times more likely to acquire HIV compared to heterosexual men (WHO, 2023). Sex workers, transgender individuals, and people who inject drugs are particularly vulnerable. Transgender women, for instance, have a global HIV prevalence rate exceeding 19% (Beyrer et al., 2012). Young people aged 15-24 are also significantly affected, accounting for approximately 34% of new infections in 2020 (UNAIDS, 2021).

While blood transfusions once posed a significant infection risk, comprehensive screening processes in many countries have substantially mitigated this transmission route (Cachay, 2024). The global landscape of HIV transmission is shaped by complex social, behavioral, and medical factors, with ongoing efforts focused on prevention, education, and reducing systemic barriers to healthcare access.

The response to HIV/AIDS has made significant progress the world over since the first AIDS case was reported in the early 1980s (UNAIDS, 2023). Globally, Eswatini, together with Switzerland, became the first countries to achieve the '95-95-95' global HIV target, where 95% of people living with HIV in Eswatini knew their status, 95% of people who knew their HIV-positive status were accessing treatment and 95% of people on treatment had a suppressed viral load. (Global Fund, 2020).

In Sub-Saharan Africa, significant progress has been made in the global response to HIV/AIDS since the early days of the epidemic (UNAIDS, 2024). For instance, among adults in Botswana living with HIV, 95 percent were aware of their status, 98 percent of those aware of their status were on antiretroviral therapy (ART), and 98 percent of those on ART achieved viral load suppression in 2021. (U.S Embassy Gaborone, 2022) . As compared to Ghana, as of 2020, 63% of the individuals infected knew their HIV status, 95% were on ART, and 73% achieved viral suppression. (Boakye & Adjorlolo, 2023).

However, this progress is not uniform across different populations and regions. Research by Mahy et al. (2021) indicates that certain demographics, such as children and men, have experienced slower improvements in testing and treatment outcomes compared to other groups. In India, despite an overall adult HIV prevalence of 1.6%, the prevalence among MSM is alarmingly high at 18.1%, highlighting this group's vulnerability to HIV infection (Kushwaha et al., 2017). In Ghana, there are notable gaps in HIV data, particularly concerning men who have sex with men (MSM), who face unique challenges that require urgent attention (Ogunbajo et al., 2017).

2.2.2 Sexual Minorities

Sexual minorities refer to individuals whose gender and sexual identities and expressions deviate from dominant cultural norms (Rodrigues et al., 2017). While sexual minorities typically

encompass lesbian, gay, bisexual, and transgender (LGBT) individuals, the definition has expanded to include non-binary, intersex, and other gender-variant individuals. This conceptual evolution, which began in the late 1960s, reflects a broader challenge to traditional heteronormative frameworks and a recognition of diverse identities beyond the binary heterosexual/homosexual dichotomy (Hagai & Zurbriggen, 2022).

The emergence of diverse sexual and gender identities is attributed to multiple interrelated factors. Research indicates that same-sex and related behaviors stem from complex influences including peer pressure, cultural practices, socioeconomic circumstances, personal identity exploration, limited sexual health literacy, and hereditary factors (Abu-Ba'are et al., 2023). Understanding these multifaceted origins is essential for moving beyond stigmatizing narratives and recognizing sexual minorities as a heterogeneous population with varied experiences and needs.

2.2.3 Access to Healthcare

Access to healthcare is a fundamental component of public health, significantly influencing individuals' quality of life and improving the performance of health systems (Dassah et al., 2018). It includes the ability to obtain necessary medical services without barriers related to payment, distance, or social class. Poor access to healthcare worsens health inequities, particularly along the lines of ethnicity, geography, and socioeconomic status (Meyer et al., 2013). As outlined by the CDC, access to healthcare includes several dimensions: availability of medical facilities and professionals, affordability of services, physical accessibility, acceptability of care, and awareness of available services (CDC, 2023).

Availability refers to the presence of sufficient healthcare resources in a given area. In many communities, particularly those that are under-resourced, there is often a shortage of primary care providers and facilities. This lack of availability can lead to increased wait times for

appointments and delayed care, which are detrimental to health outcomes (CDC, 2023). Furthermore, the geographic distribution of healthcare resources can create significant barriers for individuals living in rural areas where access to specialized medical services may be limited (Rural Health Information Hub, 2024).

Affordability is another critical aspect of healthcare access. High out-of-pocket costs can deter individuals from seeking necessary care, leading to untreated health conditions and worsening health disparities (Sirag & Mohamed Nor, 2021). Even with insurance coverage, many individuals face financial hardships due to high deductibles and copayments. For instance, the CDC notes that nearly one-quarter of low-income Americans with cardiovascular disease remain uninsured, highlighting the ongoing challenges related to healthcare affordability (CDC, 2023).

Accessibility involves not only physical proximity to healthcare facilities but also the means by which individuals can reach these services. (CDC, 2023). According to Hu et al. (2022), transportation issues for instance can significantly hinder access; individuals without reliable transportation may struggle to attend appointments, be late or obtain medications. Additionally, other factors such as work commitments and childcare responsibilities further complicate access for many people.

Acceptability pertains to the cultural competence and respectfulness of the healthcare services provided (Jongen et al., 2019). Individuals may avoid seeking care if they anticipate discrimination or lack understanding from healthcare providers regarding their specific needs (University of Southern California, 2023). This is particularly relevant for marginalized groups who may have experienced bias in previous interactions with the healthcare system.

Awareness relates to the knowledge individuals have about available services and preventive health measures. (Alissa & Alwargash, 2024). Health literacy plays a crucial role in

this dimension; those with lower health literacy may not fully understand their health conditions or treatment options, leading to poorer health outcomes (Coughlin et al., 2021). Efforts must be made to enhance public education regarding available healthcare resources and preventive measures.

2.2.4 Barriers to Healthcare

Access to healthcare is a critical determinant of health outcomes, particularly for populations disproportionately affected by HIV, such as sexual minorities (UNAIDS, 2022). However, several barriers hinder this population from accessing adequate care, often increasing their vulnerability to poor health outcomes. As reported in the study of Abu-Ba'are et al. (2023), these barriers can be broadly categorized into stigma and discrimination, socioeconomic challenges, legal and policy barriers, cultural and religious influences, and healthcare system inefficiencies.

2.2.4.1 Stigma and Discrimination

Stigma and discrimination remain significant barriers to healthcare access for sexual minorities living with HIV. Discrimination in healthcare settings often manifests as negative attitudes, denial of care, or breaches of confidentiality by healthcare providers (Logie et al., 2018). Internalized stigma, which occurs when individuals accept negative societal attitudes about their sexual orientation or HIV status, further deters them from seeking care (Turan et al., 2017). Anticipated stigma the fear of being judged or mistreated also contributes to delayed or avoided healthcare utilization (UNAIDS, 2020). Discrimination is particularly pronounced in regions where same-sex relationships are criminalized, such as Ghana. Studies indicate that fear of legal repercussions and public shaming forces many sexual minorities to conceal their identities,

preventing them from accessing HIV services (Kushwaha et al., 2017). This intersection of stigma related to HIV and sexual orientation compounds the barriers to care.

Research shows that sexual minorities often encounter heteronormative assumptions and prejudice from healthcare professionals, leading to negative healthcare experiences and reluctance to seek care (Meads et al., 2024). For instance, a systematic review found that one in seven LGBT individuals in the UK avoided seeking healthcare due to fear of discrimination from staff, while nearly one in four reported experiencing negative remarks from healthcare providers (Meads et al., 2024). These experiences contribute to a pervasive sense of distrust towards the healthcare system among sexual minorities, further exacerbating health disparities.

Moreover, the lack of cultural competence among healthcare providers can significantly hinder the quality of care received by sexual minorities (Nair & Adetayo, 2019). Many providers lack the training necessary to address the unique health needs of these populations, which can lead to feelings of exclusion and discrimination (Gonzales & Henning-Smith, 2017). This lack of understanding can result in missed opportunities for preventive care and treatment, as healthcare providers may overlook important health risks associated with sexual minority identities.

The intersectionality of identities also plays a crucial role in shaping healthcare access for sexual minorities. For example, nonwhite sexual minority individuals often face additional barriers due to systemic racism and discrimination within the healthcare system (Fay et al., 2021). This compounded discrimination can lead to even poorer health outcomes for those who belong to multiple marginalized groups.

In regions where same-sex relationships are criminalized, such as Ghana, the stakes are even higher. The legal environment creates an atmosphere of fear that discourages individuals from accessing necessary health services. Research indicates that many sexual minorities in these

regions conceal their identities due to fear of persecution, which directly impacts their ability to seek HIV services (Kushwaha et al., 2017). This fear is not unfounded; individuals have reported experiences of violence and discrimination when attempting to access care.

To address these multifaceted barriers, comprehensive strategies are needed. Initiatives should focus on improving provider education regarding LGBTQ+ health issues and fostering an inclusive healthcare environment (Yu et al., 2024). Training programs aimed at enhancing cultural competence among healthcare providers can help reduce instances of discrimination and improve patient-provider interactions (Gonzales & Henning-Smith, 2017). Additionally, policies that enforce non-discrimination protections in healthcare settings are essential for ensuring that all individuals receive equitable treatment.

2.2.4.2 Socioeconomic Factors

According to Haire et al. (2019), socioeconomic factors, including poverty, unemployment, and lack of education, significantly limit access to healthcare for sexual minorities living with HIV. Economic constraints often hinder individuals from affording treatment, transportation to healthcare facilities, or the time off work needed for regular medical visits. For instance, as reported by McMaughan et al. (2020), individuals in lower socioeconomic strata may struggle to cover the costs associated with healthcare services, leading to delayed treatment or avoidance of care altogether. This economic burden is particularly acute for sexual minorities, who may already face discrimination in employment settings, further exacerbating their financial challenges.

Additionally, lower levels of education among some populations correlate with a lack of awareness about available services and the importance of early care. Education is a critical social determinant of health; those with higher educational attainment are generally more informed about

health issues and have better health outcomes (CDC, 2023). For example, Dworkin et al. (2020) found that many men who have sex with men (MSM) in sub-Saharan Africa were unaware of pre-exposure prophylaxis (PrEP) as an HIV prevention tool, partly due to educational disparities. This lack of awareness can lead to higher rates of HIV transmission within these communities.

Moreover, education plays a vital role in empowering individuals to make informed health decisions. As highlighted in various studies, individuals with limited education often struggle to navigate the healthcare system effectively, which can lead to poorer health outcomes (Rashdi et al., 2025). The relationship between education and health is well-documented; those with less formal education are more likely to experience chronic health issues and have lower life expectancies compared to their more educated counterparts (McMaughan et al., 2020).

Healthcare awareness is another crucial aspect influenced by socioeconomic factors. Individuals from lower socioeconomic backgrounds may not have access to information about preventive services or treatment options available for HIV. According to Hamed & Talaat (2024), community-based education initiatives can help bridge this gap by providing targeted outreach and resources that inform sexual minorities about their healthcare options. Such programs are essential for promoting early detection and treatment adherence among vulnerable populations.

2.2.4. 3 Legal and Policy Barriers

The criminalization of same-sex relationships perpetuates fear, driving sexual minorities away from formal healthcare systems (UNAIDS, 2020). This legal context fosters institutionalized discrimination, where policies fail to protect LGBTQ+ individuals or explicitly exclude them from targeted healthcare interventions. Moreover, the lack of legal protections against discrimination in healthcare settings further marginalizes sexual minorities. As a result, many prefer to rely on

informal networks or delay seeking care until emergencies arise, compromising their health outcomes (Poteat et al., 2016).

2.2.4.4 Cultural and Religious Influences

Cultural norms and religious beliefs heavily influence attitudes toward sexual minorities, particularly in socially conservative regions. In many African contexts, homosexuality is viewed as immoral or unnatural, often reinforced by religious teachings (Giwa & Greensmith, 2012). These cultural attitudes contribute to widespread social exclusion and discrimination in healthcare settings, deterring individuals from seeking care. Research indicates that negative perceptions of homosexuality are often rooted in traditional beliefs and reinforced by religious doctrines, leading to significant barriers for sexual minorities in accessing healthcare services (Albuquerque et al., 2016).

Religious-based organizations, which often provide a significant portion of healthcare services in Ghana, may also perpetuate discriminatory practices. Many faith-based healthcare providers adhere strictly to conservative interpretations of religious texts that condemn homosexuality, resulting in judgmental attitudes toward LGBTQ+ individuals seeking care (Poteat et al., 2021). Studies show that sexual minorities frequently encounter healthcare workers who hold biases influenced by their religious or cultural backgrounds, which can lead to suboptimal care delivery (Poteat et al., 2021). This discrimination not only affects the quality of care but also discourages individuals from utilizing available health services due to fear of being judged or mistreated.

Moreover, the intersection of cultural norms and religious beliefs can create an environment where sexual minorities feel compelled to hide their identities (Saalim et al., 2023). In regions where homosexuality is criminalized or stigmatized, individuals may avoid disclosing

their sexual orientation to healthcare providers, fearing repercussions or discrimination (Giwa & Greensmith, 2012). This concealment can lead to delays in seeking treatment for HIV and other health issues, ultimately worsening health outcomes among sexual minorities.

The impact of cultural and religious beliefs extends beyond individual attitudes; they can also shape public policy and community responses to sexual minorities (Dreier et al., 2020; Gyamfi et al., 2024; Kim, 2024). In many cases, conservative religious groups actively lobby against LGBTQ+ rights, reinforcing discriminatory laws and practices that further marginalize these communities (Adamczyk & Pitt, 2019). This systemic discrimination creates a cycle of exclusion that limits access to essential health services and perpetuates health disparities.

Conversely, it is worth noting that not all religious interpretations foster negative attitudes toward sexual and gender diversity. Some religious communities advocate for inclusivity and acceptance of LGBTQ+ individuals. For instance, certain branches of Buddhism, progressive Christianity, and reformist sects within Islam actively promote equal rights for all individuals regardless of sexual orientation (Cheng, 2011; Hidayatullah, 2014; Nanda, 2014).

2.2.4.5 Healthcare System Challenges

The healthcare system itself presents structural barriers that hinder access to care for sexual minorities living with HIV. Some studies have reported that many healthcare providers lack the training or cultural competence to address the specific needs of sexual minorities. As noted in the study by Reisner et al. (2019), inadequate knowledge about LGBTQ+ health issues can lead to insensitive care or outright refusal of services. This lack of training among healthcare providers often results in negative experiences for sexual minorities, who may encounter biases or misunderstandings regarding their health needs, leading to avoidance of necessary medical care.

Additionally, specialized services catering to the needs of sexual minorities are often unavailable or concentrated in urban areas, making them inaccessible to those in rural or peri-urban regions (Poteat et al., 2016). This geographical disparity creates significant challenges for individuals seeking care, as those living in remote areas may have to travel long distances to access appropriate healthcare services.

Fear of disclosing personal information also plays a critical role in discouraging sexual minorities from seeking care. A study conducted by Chan & Laster (2020) reported that concerns about confidentiality and the potential for personal information to be disclosed without consent can lead individuals to avoid healthcare settings altogether. Also, in communities where social stigma is prevalent, the risk of being outed can deter individuals from accessing essential services, particularly when healthcare staff are familiar with community members (Turan et al. 2017). This fear is compounded by experiences of discrimination and mistreatment in healthcare settings, which can create an environment of distrust.

Moreover, systemic issues within the healthcare infrastructure contribute to these barriers. Many healthcare systems lack policies that explicitly protect sexual minorities from discrimination and provide guidelines for culturally competent care (Ayhan et al., 2020). This absence of protective measures can result in a lack of accountability for providers who engage in discriminatory practices, perpetuating a cycle of exclusion and poor health outcomes for sexual minorities.

Research has shown that experiences of discrimination in healthcare settings are not uncommon among sexual minorities. A systematic review found that individuals identifying as sexual minorities often report higher rates of mistreatment and denial of care compared to their

heterosexual counterparts (Balik Ayhan et al., 2020). Such experiences can lead to a reluctance to seek care, further exacerbating health disparities within these populations.

Addressing the structural barriers within the healthcare system is essential for improving access to care for sexual minorities living with HIV.

2.2.5 Facilitators to Accessing Care

Facilitators are conditions or factors that enhance access to healthcare, especially for marginalized populations like sexual minorities living with HIV. These facilitators can be categorized into structural, interpersonal, and individual levels.

At the structural level, organizational policies and healthcare systems play a critical role in facilitating access to care (George et al., 2023). For instance, supportive policies that promote inclusivity and cultural competence within healthcare institutions can significantly enhance the experiences of sexual minorities. Research indicates that when healthcare organizations implement policies that prioritize training on LGBTQ+ health issues, the quality of care improves (Ayhan et al., 2020). Such policies create an environment where healthcare providers are better equipped to understand and address the unique needs of sexual minorities, fostering a more welcoming atmosphere for patients. Also, the availability of specialized services is another crucial structural facilitator (Beach et al., 2018). Specialized clinics that focus on LGBTQ+ health often provide tailored services, including mental health support and sexual health education. However, these services are frequently concentrated in urban areas, leaving rural populations with limited access (Poteat et al., 2016). Expanding these services into underserved regions is essential for ensuring that all individuals have access to appropriate care.

At the interpersonal level, the relationships between healthcare providers and patients significantly influence access to care (Ogunbajo et al., 2017). Positive interactions characterized

by respect, empathy, and understanding can encourage sexual minorities to seek necessary medical attention. Studies have shown that when healthcare providers demonstrate cultural competence and actively listen to their patients' concerns, it fosters trust and encourages individuals to disclose their sexual orientation or gender identity (McCann & Sharek, 2014). This trust is vital for effective communication and for ensuring that patients feel comfortable discussing their health needs.

Moreover, community support networks also play a pivotal role in facilitating access to care. Peer support groups and community organizations can provide valuable resources, including information about available services and assistance navigating the healthcare system (Poteat et al., 2021). These networks not only offer emotional support but also empower individuals by connecting them with healthcare resources tailored to their specific needs. On an individual level, personal factors such as knowledge about available services and self-advocacy skills are crucial facilitators (Arora et al., 2021) . Education plays a significant role in promoting health equity among sexual minorities. Programs aimed at increasing awareness of HIV prevention methods, such as pre-exposure prophylaxis (PrEP), are essential for empowering individuals to take charge of their health (Dworkin et al., 2020). Furthermore, individuals who are well-informed about their rights within the healthcare system are more likely to advocate for themselves and seek out necessary care.

Additionally, resilience and coping strategies among sexual minorities can facilitate access to care. Research has shown that individuals who possess strong coping mechanisms are better equipped to navigate the challenges posed by stigma and discrimination in healthcare settings (Rosenqvist & Saye, 2017). Building resilience through community support and educational initiatives can help mitigate the negative impact of societal pressures on health-seeking behaviors.

2.3 Summary of Review

The literature review focused on discussing theoretical and empirical issues including the overview of HIV tracing the historical events, trends in the HIV response strategy and the concerns about sexual minorities. Sexual minorities are among key populations contributing to HIV infection and outcomes for agenda 95-95-95. Access to care for sexual minorities remain a challenge due to barriers such as stigma, socio-economic factors, policies and legislations, impact of culture and religion and the gaps in the healthcare systems. The World Health Organisations policy on Universal Health Coverage and Sustainable Development Goal 3 is threatened if MSM access to care services is poor. This study sought to understand these factors situating it within the Anderson's behavioural model

CHAPTER THREE

METHODOLOGY

This chapter outlines the systematic methods employed in the data collection process. It is organized into several key sub-sections, including the research design, study site, target population, sampling technique, data collection instruments, data collection procedure, data analysis, inclusion and exclusion criteria, and ethical considerations. Each sub-section is described in detail to provide a comprehensive understanding of the methodological approach adopted for the study.

3.1 Research Design

This study adopted a qualitative descriptive exploratory design. The design was chosen because it allows for in-depth exploration of human experiences in their natural context (Sandelowski, 2000). Given the sensitive nature of sexual minority identities in Ghana, this approach was appropriate for capturing participants' perceptions and experiences in their own words.

The philosophical underpinning of this study was interpretivism, which assumes that reality is socially constructed and best understood through participants' subjective meanings (Creswell & Poth, 2018). Within this paradigm, knowledge is co-created between the researcher and participants, making it particularly suitable for exploring how men who have sex with men (MSM) interpret and navigate barriers in accessing HIV care. This design was preferred because it provided flexibility in data collection and analysis, allowing themes to emerge organically while maintaining the context and authenticity of participant narratives (Nowell et al., 2017).

3.2 Setting of the study

The study was conducted at a private facility within the Ga East Community. The clinic provides a range of essential services including outpatient care, sexually transmitted infection

(STI) management, ultrasound scans, and Antiretroviral Therapy (ART). It caters to various patient demographics, notably men who have sex with men (MSM), female sex workers (FSW), and the general public (WAAF, 2024). The facility distinguishes itself through its innovative healthcare delivery strategy that fosters a culture of competence and inclusivity, which is often lacking in conventional healthcare settings. This model promotes gender-affirmative care, ensuring that MSM patients can access services without fear of judgment. As a result, the clinic has witnessed significantly improved attendance rates compared to similar facilities, reflecting its success in creating a welcoming environment for marginalized groups.

Geographically, the Ga East Municipality is bordered to the north by the Akuapim South District and to the west by the Ga West District. The region presents an urban landscape characterized by high population density, which complicates healthcare delivery. This context underscores the importance of IHCC's role in providing accessible health services amidst these challenges (WAAF, 2024).

3.3 Target Population and Eligibility Criteria

The study population included all MSM attending clinic at the Ga East Municipality

3.3.1 Inclusion

1. MSM who were 18 years and above living with HIV
2. MSM who were on antiretroviral medications
3. MSM who were consented to partake in the research
4. MSM who could speak English and Twi
5. MSM who were vocal and ready to share their experience

3.3.2 Exclusion Criteria

1. MSM who were mentally impaired

2. MSM who were HIV negative and are on PrEP.
3. MSM who were less than 18 years of age
4. MSM who were not willing to let their status be known

3.4 Sampling and Sample size

Sampling is the selection of a subset of the population of interest in a research study (Turner, 2020). In this study, a purposive sampling strategy was used to identify participants who met the inclusion criteria and could provide rich, relevant data on the topic. Purposive sampling is a non-probability sampling method which is commonly employed in qualitative research to select participants based on their experience and ability to articulate their perspectives (Palinkas et al., 2015). The sample size consisted of eleven (11) participants, determined by the principle of data saturation, where additional interviews yielded no new information or themes (Guest et al., 2020). Recruitment was facilitated by a clinician at the WAAF Clinic, who discreetly introduced potential participants to the researcher to maintain confidentiality. Given the sensitive nature of MSM identity in Ghana, this approach ensured trust and voluntary participation.

3.5 Pre-testing of Data Collection Tool and Procedure

A pilot test of the interview guide was conducted with two participants who shared similar characteristics with the main study population but were excluded from the final sample. With support from an ART nurse, MSM attending the clinic for sexual health services were pre-informed about the study and invited to participate in the pilot. The pre-test took place at a nearby facility, Ga East Hospital ART Clinic, where the research team assessed question clarity, cultural sensitivity, and recording equipment functionality. Based on participant feedback, minor revisions were made to question phrasing and sequencing to improve clarity and conversational flow. This pilot testing process was essential for ensuring that the interview guide effectively captured

participants' lived experiences while maintaining ethical sensitivity throughout data collection (Hurst et al., 2015).

3.6 Data collection tool

The study used a semi-structured interview guide to collect data through in-person interviews, focusing on factors affecting access to antiretroviral therapy (ART) among Men who have Sex with Men (MSM). The interview guide was developed based on the study's theoretical framework, addressing healthcare access disparities in marginalized populations. Open-ended questions allowed participants to share detailed experiences, while ensuring key themes were covered consistently. The guide explored several domains, including; Healthcare accessibility, Barriers and facilitators to accessing ART services, social and cultural factors, Stigma, discrimination, and social support, economic factors, and healthcare system factors.

Other tools used were the field notes and a tape recorder to record all the interview for transcription and data analysis. Field notes were kept by writing all observations that were made during interviews in a notebook. The field notes included observations such as the gestures, temperament and the general appearance of the participants during the interview.

3.7 Data collection procedure

Data collection occurred in September 2024, using interviews. The researcher obtained informed consent and conducted interviews in a comfortable, private, well-lit room at the facility, scheduling sessions at participants' convenience. To establish rapport and reduce anxiety, the researcher began with an open-ended question: "Tell me about your experiences in receiving care at the health facility." This approach encouraged participants to share freely and ask questions

about the study. Demographic information was collected informally, with participants given opportunities to clarify any uncertainties before and during the interview.

3.8 Data Management

The interviews were audio-recorded using a tape recorder, with additional observations of participants' gestures and appearance documented in a notebook. To maintain confidentiality, participants were assigned pseudo codes from 001 to 011, preventing direct identification. Data collected were transcribed verbatim as soon as possible before the next interview to ensure improvement in the line of questioning in the subsequent interviews. The audiotape was replayed several times to ensure correct transcription and reduce errors and omissions as much as possible. Each transcription was kept as a different file and put in a folder with special identification. The transcribed recording was kept in a file cabinet that is accessible to just the researcher and supervisors.

The researcher kept the interview material under lock and key for safekeeping. The data is intended to be kept for about five years after the study and thereafter destroyed according to the IRB's regulation. Demographic data of respondents were separated from the interview data and care was taken to ensure that no linkages were established between them. The electronic copies of the interview transcriptions were saved in a folder on a password protected computer hard drive to ensure that data was secure and safe.

3.9 Data Analysis

Data were analyzed using thematic analysis as described by (Mwita & Mwilongo, 2025) which provides a flexible yet systematic approach to identifying, analyzing, and reporting patterns

within qualitative data. The analysis began with a process of familiarization, during which the researcher was immersed in the data by repeatedly reading and listening to the interview recordings to gain a holistic understanding of participants' narratives. Each transcript was then transcribed verbatim and manually reviewed alongside field notes to ensure completeness and accuracy. Following this, initial codes were generated by highlighting significant statements and phrases that reflected key ideas related to the research objectives. Coding was both deductive, drawing on the constructs of Andersen's Behavioral Model, and inductive, allowing new insights to emerge directly from participants' accounts. The generated codes were systematically compared and grouped to form subthemes, which were later refined and clustered into broader themes that captured the essence of participants' experiences.

To enhance the analytical rigor, constant comparison was employed across all transcripts to identify similarities and differences, ensuring that emerging patterns were grounded in the data. The researcher continuously revisited the transcripts during the analysis to verify that the themes accurately represented participants' perspectives. NVivo version 12 software was used to organize and manage the data, facilitating efficient retrieval of coded segments during theme development. The final themes were defined, named, and supported with illustrative quotations to reflect the participants' voices authentically. To ensure accuracy and credibility, the researcher engaged in peer debriefing with the academic supervisor and conducted member checking with selected participants to validate the interpretations and confirm that the findings accurately reflected their lived experiences.

3.10 Methodological Rigor

To ensure the trustworthiness and quality of the study findings, methodological rigor was maintained throughout the research process guided the pillars of credibility, dependability, confirmability, and transferability (Ahmed, 2024). Credibility was established through prolonged engagement with participants, which allowed the researcher to build rapport and gain a deep understanding of their experiences. Each interview transcript was returned to participants for member checking, ensuring that their views were accurately represented, while peer debriefing sessions with the academic supervisor helped refine interpretations and minimize researcher bias. Dependability was achieved by maintaining a detailed audit trail that documented all stages of the research process from data collection to coding decisions and theme development, allowing the study to be replicated under similar conditions. To promote confirmability, the researcher engaged in continuous reflexivity, keeping a reflective journal to acknowledge personal assumptions, biases, and emotional responses that could influence the analysis. This reflexive process ensured that findings were grounded in participants' narratives rather than the researcher's preconceptions. Finally, transferability was enhanced by providing rich, thick descriptions of the research context, participants, and data collection procedures, enabling readers to assess the applicability of the findings to similar settings. These combined strategies reinforced the integrity, transparency, and trustworthiness of the study, ensuring that its conclusions authentically represented the lived experiences of sexual minorities accessing HIV care in the Ga East Municipality.

3.11 Ethical considerations

In order to protect participant rights and prevent ethical violations, institutional approval was sought from the West Africa AIDS Foundation, and permission sought from the head of the

clinic to engage clients. An extensive explanation was given to participants by the researcher in a language that was best understood by the participants in view of objectives, future benefits, purpose and risks of the study. Participants were given sufficient time to make decision on their participation in the research. Participants were made aware that interviews would be recorded on a voice recorder. Those who met the inclusion criteria were given a consent form to sign after the explanation of the study.Participants were informed of their right to evacuate from the study at any time even after signing the consent form. Participant were made aware that withdrawing from the study will not affect the service they receive from the clinic.

Participants were in the known that, consent form, data, transcripts, audio records and all documents obtain during the study would be kept safely for at least five years after the research. Participants were informed that ethical clearance would be sought out if the data would be used for any motive in the future. Participant were informed that data would be used for the purpose and it will only be accessible to the researcher and her supervisor. The study findings were shared with participants through discussion sessions, aimed at both informing and motivating them. The study was conducted in a peaceful environment where privacy was ensured.

CHAPTER FOUR

FINDINGS OF THE STUDY

This chapter presents the findings of the study, which explored the factors influencing access to HIV care among sexual minorities, particularly men who have sex with men (MSM), in the Ga East Municipality of Ghana. The findings are organized according to major themes and subthemes

that emerged from the analysis of interviews with eleven participants. The presentation of findings is guided by the study objectives and interpreted within the framework of Andersen's Behavioural Model of Health Service Use. To preserve confidentiality, participant IDs (e.g., PM001, PT002, etc.) are used throughout the narrative. This chapter begins with the demographic profile of participants and an organisation of themes and subthemes.

4.1 Socio-demographic characteristics of participants

Eleven (11) participants were interviewed, guided by a semi-structured interview guide. Participants involved in this study were all Ghanaians. Their ages ranged from 22 to 39 with an average age of thirty-one (31) years. Participants spoke a minimum of one (1) language and maximum of three (3). Nine (9) participants spoke English and two (2) spoke Twi. Their education level ranges from Junior high, secondary and tertiary. Eight (8) of the participants were Christians, one Muslim whilst the remaining two (2) were non-religious persons. Only one (1) participant is unemployed, while 10 are employed. The duration of living with HIV ranged from 2 to 10 years and duration of been an MSM ranging 6 to 26 years. Additionally, some participants identify as versatile, playing both male and female roles in their sexual relationships.

4.1.2 Participants profile

The participants' profile includes key characteristics of each sexual minority living with HIV. This profile comprises the following elements: participant identification code, age, self-

identification, religion, level of education, nationality, and occupation. Below is the table detailing the participants' profiles.

Table 1: Participants Profile

ID	Age	Self-identification (Gender)	Duration of living with HIV (years)	Duration of been an MSM (years)	Religion	Level of education	Nationality	Occupation
PM001	34	Male	3	10	Christian	Tertiary	Ghanaian	Security
PM002	22	Male	2	6	Muslim	Tertiary	Ghanaian	Student
PM003	30	Male	6	9	Christian	Tertiary	Ghanaian	Social worker
PV 004	29	Male	3	11	Christian	Tertiary	Ghanaian	Communication consultant
PT005	32	Transgender	5	15	Christian	Senior high	Ghanaian	Chef
PM006	24	Male	4	14	Christian	Tertiary	Ghanaian	Educator
PM007	36	Male	10	16	Christian	Junior High School	Ghanaian	Unemployed
PM008	35	Male	4	26	None	Tertiary	Ghanaian	Chef
PV009	24	Male	6	8	Christian	Tertiary	Ghanaian	Fuel Attendant

PM010	24	Male	3	6	Christian	Tertiary	Ghanaian	Student
PM011	39	Male	11	18	None	Tertiary	Ghanaian	Development worker

Organization of Themes

Analysis of the qualitative data revealed a total of five major themes and fourteen subthemes that capture the experiences of men who have sex with men (MSM) in accessing HIV care within the Ga East Municipality. The first theme, individual experience in accessing HIV care and service, comprised three subthemes: healthcare providers' relationship, impact of anti-LGBTQ+ legislation, and satisfaction with services. The second theme, healthcare access and support systems, included two subthemes: financial support and medication accessibility, and confidentiality concerns. The third theme, peer and family support of sexual minority living with HIV, included four subthemes: stigma, discrimination, family dynamics, and peer and community support. The fourth theme, individual experiences of sexual minority living with HIV, had three subthemes: reaction to diagnosis, anti-retroviral medicine, and personal history. The fifth theme, coping mechanisms and adaptive strategies, comprised two subthemes: religious and spiritual coping, and psychological adaptation to treatment. Collectively, these five themes and fourteen subthemes provide a nuanced understanding of the complex interplay between social context, healthcare systems, and individual agency in shaping access to HIV care among sexual minorities in the study setting.

Table 2: Themes and Sub-themes from Transcribed Data

Themes	**Sub-themes**

Individual experience in accessing HIV care and service.	• Health care providers' relationship • Impact of Anti-LGBTQ+ Legislation • Satisfaction with services
Healthcare access	• Financial support and medication accessibility • Confidentiality concerns
Peer and family support	• Stigma • Family dynamics • Peer and community support • Discrimination
Individual experiences	• Reaction to diagnosis • The anti-retroviral medicine • Personal history
Coping mechanisms and adaptive strategies	• Religious and spiritual coping • Psychological adaptation to treatment

Beneath each major theme, several sub-themes emerged, each corresponding to its respective theme. These sub-themes were supported by direct quotes from participants, which were presented in coded form to ensure confidentiality.

4.2 Individual experience in accessing HIV care and service.

This theme detailed the experiences of sexual minorities in utilizing the healthcare system. Some participants expressed positive relationships with their healthcare providers, highlighting instances of effective communication and understanding. However, the majority reported negative

experiences in Antiretroviral Therapy (ART) clinics at most government hospitals compared to private facilities. Three sub-themes are examined under this overarching theme: first, the relationship between healthcare providers and patients, which reflects the importance of trust and communication in healthcare settings; second, policies within the healthcare system that may affect access and quality of care; and third, overall satisfaction with services received.

4.2.1 Healthcare provider's relationship

It was recognized from the interviews that some participants were gratified with the services they received. Participants expressed pride and happiness when accessing ART care as gay men because their healthcare providers related to them very well, and the environment was welcoming. They reported not being subjected to stigma and expressed satisfaction with the services received. Sexual minorities living with HIV described their healthcare providers as patient, loving, and kind. Other participants were satisfied with the support they received from donors to help cover their medical expenses through their hospitals, as well as the use of the National Health Insurance Scheme (NHIS) and partner involvement in their treatment journey. They expressed appreciation for being able to pick up medication on any day, including weekends, and noted that healthcare providers were understanding and non-judgmental.

Participants were happy because they had people they could always talk to whenever they visited their clinics and during counseling sessions. However, some clients expressed that the attitude of healthcare providers in the public sector was very poor, leading them to transfer to private hospitals where they faced little to no stigma. Additionally, some participants reported not receiving any form of support aside from their antiretroviral therapy (ARVs). A participant expresses how comfortable it feels to access healthcare

> "*Since I was diagnosed in clinic A, I know that is community-friendly with regards to this sexuality. So, I don't go anywhere else for medication, it's just there. So far everybody I have interacted here has been very helpful and it's been great. I haven't had any bad experience*" ***(PM002)***.

Similarly, another participant expressed that;

> "*My experiences are not varied because I have only access from a few, specifically HIV services. Currently the facility I use is okay and is the one I have been going to since 2020 and the services there is great*" ***(PM006)***.

In contrast, one participant expressed how unfriendly the healthcare environment was and how bad treatment the treatment he received was.

> "*With me, transgender, I'm a bit girly so when they saw me, they were like this your people are here again. One nurse was calling the other person and I felt it was stigmatizing and when I realized, I was positive. I was asked to go for counselling and some of the words was discouraging*" ***(PT005)***.

Another also shared a similar experience;

> "*She took a blood sample and took it to a different room. She sat with me and started to say a lot of things, saying my life has ended because I have HIV. She said because of the lifestyle that I'm living that this punishment is coming to me. She kept on and on about it looking for a reply from me but I kept nodding my head. The senior nurse came in whiles she was saying that, and she also said when I came, she had an aura about me and it has to do with a lot of sexual promiscuity so it's necessary we pray about it" **(PM006)**.*

These contrasting experiences highlight the critical role that healthcare provider attitudes and behaviors play in shaping the experiences of sexual minorities within the healthcare system. While positive interactions can enhance care-seeking behavior and foster trust, negative encounters can lead to avoidance of necessary medical services.

4.2.2 Impact of Anti-LGBTQ+ Legislation

Participants' discussions revealed that, rather than focusing on formal healthcare policies or standard operating procedures, their experiences were shaped largely by the prevailing socio-political climate and societal attitudes toward sexual minorities. Many described how fear, stigma, and discrimination particularly linked to the proposed anti-LGBTQ+ bill, created significant barriers to seeking or continuing HIV care. These negative perceptions within the broader community and even among healthcare providers led to mistrust and feelings of vulnerability among key populations. As a result, participants emphasized how their sexual orientation and the hostile legal environment deeply influenced their comfort, willingness, and ability to engage with HIV services. One participant had this to share in this regard;

> "*When I realised, I was positive I was asked to go for counselling and some of the words were discouraging, I felt very bad and I didn't want to continue treatment and all that. So, my sexual orientation affected me because our society frowns at this key population thing and LGBTQ+ and all these things, so it affected me badly at times I asked myself why am I this way and why are people not accepting me*" ***(PTM005)***.

Another participant shared a similar sentiment and described;

> "*My last words, the LGBTQ+ bill, whatever bill or whatever has affected our way of coming for services because we are now scared. Who knows one-day we come and the*

*police will just arrive and say they are taking us to the police headquarters. Today we can't trust anybody even those who are well trained in the HIV services and among the LGBTQ+ community. The bill has affected me, even hearing it, other things in it makes us feel vulnerable and we are not in okay in the society" (**PT005**).*

4.2.3 Satisfaction with services

Satisfaction with services includes aspects of quality care as defined both in traditional terms by health professionals and as perceived by the community. It is a metric that measures how well a company's products, services, and customer experience meet customer expectations, particularly among sexual minorities. Some participants expressed satisfaction with the service they received, while others voiced their displeasure. One participant narrated:

"*With hospital B, I felt at home. They were accommodating, even how the doctors and nurses care about humans, especially in my situation. I was welcomed well. No bullying or stigmatization over there, I was okay. They all give me hope" (**PM006**).*

Another participant narrated:

"*My first time when I realised, I was positive, there is this woman who made everything easy. She was open. I will say, there is no way she showed any form of hatred. She was always welcoming." (**PM008**).*

Participant from the study shared;

"*When I go to the hospital sometimes the doctors and nurses, when they see that I am gay, they tend to like me a lot, I get close to them and they show interest because they want to know what's going on in my head and the problems I am going through. It makes me happy and I wonder isn't it me the gay? With me that I have contracted the sickness yet I go to*

this hospital and the nurses treat me so well and have a conservation with me. Sometimes the way the doctors' advices me and show me things to do and what not to do that will help me" ***(PM007)***.

4.3 Healthcare access and support systems

This theme captures the practical dimensions of accessing HIV care, including the financial and logistical barriers that sexual minorities face, as well as concerns about privacy and confidentiality in healthcare settings. Two sub-themes emerged that reflect these structural challenges to consistent engagement with HIV services.

4.3.1 Financial support and medication accessibility

Access to medication and the financial capacity to maintain treatment adherence emerged as critical factors influencing participants' engagement with HIV care. Participants highlighted both the barriers they faced and the resources that facilitated their access to medications. Some expressed gratitude for external support systems such as donor assistance and insurance schemes that reduced financial strain, while also emphasizing the importance of practical accessibility features such as flexible clinic hours and the ability to collect medications conveniently.

One participant expressed appreciation for the financial support they received:

"I was satisfied with the support I received from the project the clinic was running and that helped to conduct some baseline laboratory tests, as well as the use of my work medical issurance too" ***(PM011)***

However, financial constraints remained a concern for some. One participant reflected on the challenges:

> *"I find it difficult to buy some medications at the clinic and do some other assessments. And it has been very difficult for me because I do not have the money, unless I call my friends to help me. And even that one is not always because they always give me excuses and I feel like I am begging too much".* ***(PM007)***

The availability of flexible medication pickup and weekend access represented a significant facilitator for consistent treatment adherence among participants who had access to these services.

4.3.2 Confidentiality concerns

Confidentiality and privacy fears emerged as a significant barrier to consistent healthcare engagement. Participants expressed anxiety about encountering people they knew at healthcare facilities, fearing that their HIV status and sexual orientation would be exposed to their social networks. These concerns about breach of confidentiality deterred some participants from seeking care regularly or from accessing certain facilities altogether, highlighting the intersection between individual stigma fears and systemic confidentiality failures.

One participant narrated their experience:

> *"The only problem I had was when started seeing people I know at the facility. I wasn't feeling comfortable I got scared when I started to see people I know because I didn't know what they would say. I have actually worked in the showbiz before so I got scared, you know it is easy when you are in the industry, things will just escalate"* ***(PM008).***

4.4 Peer and family support of sexual minority living with HIV

Peer and family support encompass the assistance individuals receive from their social networks. It comes in various forms, including psychological, financial, and mutual support, all of which help alleviate individual burdens and provide emotional relief to some extent. This theme captures how social connections or their absence profoundly influence the lived experiences of sexual minorities living with HIV, including experiences of stigma, discrimination, family dynamics, and direct support from trusted networks.

4.4.1 Stigma

Stigma is a mark of shame, disgrace, or disapproval that leads to individuals being rejected and excluded from various areas of society. It manifests in several forms, including labeling, structural stigma, perceived stigma, self-stigma, and public stigma. Sexual minorities experience significant stigma, which is exacerbated by conditions such as HIV.

A Participant narrated:

> "*The only problem I had was when started seeing people I know at the facility. I wasn't feeling comfortable I got scared when I started to see people I know because I didn't know what they would say. I have actually worked in the showbiz before so I got scared, you know it is easy when you are in the industry, things will just escalate*" ***(PM008)***.

Another participant also narrated:

> "*There was a particular nurse that I knew, but anytime I don't meet her the other nurses will behave in a certain way towards me. There has been instance where they call the nurse and say 'wo nipa no aba ooh' every nurse in the unit is trained provide services but, in the*

end, they will say that. They don't want to associate with you because they know who you are and that is very stigmatizing" ***(PM011)***.

4.4.2 Discrimination

Discrimination refers to the unfair or prejudiced treatment of individuals and groups based on characteristics such as gender, age, race, or sexual orientation. It is described as treating someone unfairly because of one of their protected personal characteristics. Participants have reported experiencing discrimination in various forms, including from family, friends, and the healthcare system. One participant narrated:

"*My family accept me for who I am. They know who I am so they sometimes make you feel inferior. Honestly, I mentioned nurse A, that woman needs to be applauded. The way she treats people with HIV is different, I don't know about other facilities, but here and that place. Nurse A is unique. She will make you feel at home and understand what you have contracted and what you need to do to be able to stay alive. She is a mother*" ***(PM008)***.

Another participant also shared

"*I quite remember I went to the health centre because I had genital warts, it was little so I wanted to get rid of it once and for all, I went there and the woman who was supposed to examine me asked me to go and stand at a corner and bend down. She was looking from a distance; she didn't even try to come close. She just didn't touch it. I told her it could be haemorrhoid because I have had it since I was a child. They don't want to touch an HIV patient. She told me she has been working for long and when she sees haemorrhoid she will know it. And I later found out it was haemorrhoid. She gave me something to apply on it and that area became so fragile*" ***(PM010)***.

Another participant narrated:

> "*On that day even when I was walking out of the room to the hostel they opened the door, I didn't touch it. They opened and sanitized it and they came out to see me off and they were giggling. Some people had to come and ask them what's going on. I felt very bad*" ***(PM006)***.

4.4.3 Family dynamics

Family relationships represent a complex dimension of support and rejection for sexual minorities living with HIV. While some participants experienced familial acceptance of their sexual orientation, this acceptance did not necessarily translate into unconditional emotional support for their HIV status or overall well-being. In other cases, families actively rejected participants, creating environments of shame and inferiority. These family dynamics significantly shaped participants' emotional well-being and their willingness to disclose their status to extended family networks.

One participant reflected on mixed family experiences:

> *"My family accept me for who I am. They know who I am so they sometimes make you feel inferior and I think a lot sometimes about if they discuss me with their friends and other distant family members that are not aware but I know I can't do anything about it and they are my family so I have to accept it"* ***(PM008).***

Another participant highlighted broader family rejection based on sexual orientation:

> "*A lot of people think if you are gay, they don't need you in their premise especially people with Islamic background. Sometimes too among friends, families don't want to involve you in certain things because of the orientation*" ***(PM006)***.

4.4.4 Peer and community support

Beyond experiences of stigma, discrimination, and family challenges, participants also highlighted the profound importance of positive peer relationships and community organizations in sustaining their engagement with HIV care and in their overall well-being. Support from trusted friends and community-based organizations provided emotional sustenance, practical assistance, and opportunities for mutual understanding that enhanced participants' ability to manage their health and maintain psychological well-being.

A participant stated:

> "*I think the best support I have had are some of my friends, thankfully I have friends in good places so I am able to speak to one or two and have matters solved. I did benefit from a teaching by PORSH. It connected me to people and made me understand the challenge other people face in the healthcare system. I think is one of the pivotal engagement I have received in my life that has broadened my mind to the fact that are a lot of in-balances in the healthcare delivering system especially when it comes to people living with HIV*" ***(PM009)***.

4.5 Individual experience of sexual minority living with HIV

This theme discusses the experiences and reactions of sexual minority after being diagnosed as HIV positive client. The social, mental and emotional effect both positive and negative experience and how they managed it. There were three sub-themes under this (1) Reaction to diagnosis, (2) The anti-retro viral medicine, (3) personal history.

4.5.1 Reaction to diagnosis

Reactions to diagnosis describe what participants felt and the emotions they expressed towards their HIV diagnosis. Their reactions after receiving the news and the different ways they adapted to the changes in their lives varied. Some participants were neither sick nor showed any symptoms of HIV before they got tested, while others were ill, which prompted them to take the test. In either case, their healthcare providers requested testing for some of them. In this regard, some participants narrated:

> "I *was one-day taking my shower and all of a sudden, I realized I had red spots in my palm and under my foot so I just googled to see and it out as syphilis and the following week I started getting some rashes on my face and I decided to check what it is. I came here to run some tests and it came out as positive. I wasn't scared, I was just disappointed because I got to know that, it is not curable and it won't kill you if you do what is right. I was disappointed because I felt like I should know better and a little bit responsible*" ***(PM002)***.

> "*I went to the hospital, I was very sick but the doctor tested me and found my status, when he told me, on the first day! I was very sad but the doctor was a very good person so he gave a good advice that even though I have the disease if I take my medication well, I can be health. I can live long*" ***(PM007)***.

Another participant narrated:

> "*I found out about my HIV status about fourteen (14) years ago and it's not been easy. I was asked to test for HIV, I had very limited opportunity, so I had to test. Unfortunately, there was no counselling, absolutely nothing so I was just tested and the news was broken*

to me. It took me by surprise. It was very difficult to accept the results. I was very confused and didn't know whether I have accepted the results or not" ***(PM011)***.

4.5.2 The anti- retro viral medication (ARVs)

Medicines are substances used to treat, prevent, or manage disease. Anti-retroviral medications (ARVs) are medicines used to manage HIV patients and consist of a combination of three drugs, which come in different forms, either as fixed doses or separately. Participants expressed their experiences with taking remedies and coping strategies related to their medications, including both the physical and psychological effects of treatment. Managing side effects and adapting to long-term medication use represented significant challenges for many participants.

A participant shared his experience below:

"*Initially the drugs that we were taking it was in a bottle of which I can't recall the name. They later brought the one in the blue bottle, but before that, the one in the white bottle. When I take it, I sweat, I can't sleep so I would say it took about a year and a half. Almost two years and then, you go and they tell you that is part of the drugs*" ***(PM004)***.

Another participant narrated:

"*I was given septrin to start with because they said my immune system was quite stronger. I went and every time I took the drug, I didn't feel good about it. Sometimes feel sores in my mouth. I had to go to this Prophet who gave me three pure water, prayed over it and told me that I should drink it and asked me to put money in the graphic and burn it around 2am. I did all these with the hope that the results will be reversed. I have been able to stay on treatment because the environment is free, friendly and supportive*" ***(PM011)***.

4.5.3 Personal history

Personal history is data gathered from an individual's past medical history, including allergies, physical examinations, and surgeries. It also encompasses individuals' understanding of their sexual identity and the timeline of their self-discovery. Participants shared their medical and personal histories, including how they came to understand their sexual identity and its intersection with their HIV diagnosis. These personal trajectories reveal diverse pathways to sexual identity awareness, ranging from early childhood recognition to late adolescent or early adult self-discovery.

One participant narrated:

> "*I have been in the community since I was born, I wasn't introduced, right from primary I had feelings for my male friends. As at eight (8) years. I started the penetration. My first time it was painful! Honestly but I was eager to know what is in so I didn't complain much*" ***(PM008)***.

Another participant narrated similar to the above with some differences in his case:

> "*When I was young, I used to have a feeling, I was gay but I didn't put much attention in it. It was just recently like four years; I was introduced on social media. I met a friend who asked me a question like what is my role and I didn't understand what he meant by that. I met a guy who was also girly. I went to school with and after school he said he is in my area so I should visit him. He started touching and kissing me. I gave in and got interested in it.*" ***(PM009)***.

Another participant shared his:

"*I have known about my sexuality a long time. I knew it since I was ten (10) years. But I came to terms with it when I was in my 20s. I had a problem with my stomach, I was running. The doctor didn't have a good idea what it was. He was very screwed to my sex life and whether I am sexually active which didn't make any sense to me. He made me run some test and for the last test he added a retro. Now that I know it is an HIV test*" ***(PM006)***.

4.6 Coping mechanisms and adaptive strategies

This theme captures how participants managed the multifaceted challenges of living with HIV as sexual minorities. Rather than remaining passive in the face of stigma, discrimination, and healthcare barriers, many participants developed specific strategies to cope with their circumstances. These coping mechanisms, both religious/spiritual and psychological reflect the active ways in which participants adapted to their diagnosis and navigated their care journeys.

4.6.1 Religious and spiritual coping

Some participants employed religious and spiritual practices as a means of coping with the psychological and emotional challenges associated with HIV diagnosis and treatment. These coping strategies reveal how participants drew upon their spiritual beliefs to manage anxiety, process their illness, and seek meaning in their experiences. In some cases, spiritual practices were reported alongside conventional medical treatment, suggesting participants' efforts to integrate multiple healing paradigms.

One participant described their spiritual coping approach:

"I was given septrin to start with because they said my immune system was quite stronger. I went and every time I took the drug, I didn't feel good about it. Sometimes feel sores in my mouth. I had to go to this Prophet who gave me three pure water, prayed over it and

told me that I should drink it and asked me to put money in the graphic and burn it around 2am. I did all these with the hope that the results will be reversed." ***(PM011).***

4.6.2 Psychological adaptation to treatment

Participants demonstrated psychological resilience in adapting to the demands of long-term antiretroviral treatment. Many learned to normalize medication side effects, accepted the chronic nature of their condition, and gradually integrated medication management into their daily routines. This psychological adaptation represented an important shift from initial shock and denial toward active engagement with their treatment regimen and a commitment to maintaining their health despite the challenges they faced.

One participant reflected on their adaptive journey:

"Initially the drugs that we were taking it was in a bottle of which I can't recall the name. They later brought the one in the blue bottle, but before that, the one in the white bottle. When I take it, I sweat, I can't sleep so I would say it took about a year and a half. Almost two years and then, you go and they tell you that is part of the drugs" ***(PM004).***

Another participant emphasized the role of environmental support in facilitating adaptation:

"I have been able to stay on treatment because the environment is free, friendly and supportive" (PM011).

4.7 Summary of Findings

In summary, this chapter described the findings from the collected data from eleven sexual minority participants. The data from the participants' experiences produced five major themes and fourteen sub-themes that provide a comprehensive framework for understanding their multifaceted experiences in accessing and managing HIV care.

Participants shared diverse experiences in navigating the healthcare system for HIV care. The findings indicated that many participants faced challenges related to stigma and discrimination, which impacted their willingness to seek treatment. Additionally, the socio-political climate surrounding anti-LGBTQ+ legislation created substantial barriers to care engagement. Some reported feeling unsupported by healthcare providers, while others highlighted the importance of empathetic and knowledgeable staff in facilitating their access to care. These disparities underscore the critical role that individual healthcare provider attitudes play in either facilitating or hindering care-seeking behaviours among sexual minorities.

Practical barriers to care, including financial constraints and confidentiality concerns, emerged as significant factors limiting healthcare engagement. While some participants benefited from financial support mechanisms and convenient medication access, others remained burdened by economic constraints and privacy fears that deterred them from seeking care. The breach of confidentiality, whether actual or feared, represented a profound vulnerability for participants who worried about unintended exposure of their HIV status and sexual orientation to their social networks.

The role of peer and family support emerged as a critical factor in helping participants cope with their diagnosis and navigate healthcare systems. Many found strength in sharing their experiences with others who understood their struggles, and community organizations such as PORSH provided pivotal support that broadened participants' understanding of systemic challenges and fostered a sense of community and belonging. Conversely, some participants reported feelings of isolation due to unsupportive family dynamics or societal stigma. Family relationships presented a complex picture, with acceptance of sexual orientation not necessarily translating into support

for HIV status. The presence of supportive networks was shown to significantly enhance emotional well-being and facilitate better adherence to treatment regimens.

Participants articulated a range of personal narratives that reflected the complexities of living with HIV as a sexual minority. Many described the emotional turmoil following their diagnosis, characterized by feelings of sadness, fear, anxiety, and disappointment about their future and relationships. The experience of managing anti-retroviral medication brought both physical and psychological dimensions to their care journey, with side effects and the psychological meaning of ongoing treatment shaping their engagement with healthcare. Participants developed active coping strategies including religious and spiritual practices and psychological adaptation to manage the multifaceted challenges they faced. Understanding these personal histories and trajectories of sexual identity development is essential to grasping how participants' current experiences with HIV care are shaped by their broader life contexts and social positioning. The intersectionality of sexual orientation and HIV status contributed to compounded stigma, influencing how individuals perceived themselves and interacted with society, yet many participants demonstrated remarkable resilience in navigating these complex terrains. The findings are discussed and compared with the existing literature in the next chapter.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter highlights the findings of the study on the experiences of sexual minorities living with HIV, specifically focusing on factors affecting their access to care, individual experiences in accessing HIV care, and the support systems they rely on. Below is a summary of the key points and themes discussed:

5.1 Demographic Profile of Participants

The study involved eleven (11) men who have sex with men (MSM) living with HIV, all of whom were Ghanaian nationals accessing care at the International Health Care Centre (IHCC) in the Ga East Municipality. Participants ranged in age from 22 to 39 years, with a mean age of 31 years, representing a relatively young adult population. This age profile is consistent with Sub-Saharan African epidemiological patterns where younger adults (18-39 years) represent a substantial proportion of the population engaged in HIV care (UNAIDS, 2022). The concentration in this age group is significant because these individuals simultaneously navigate HIV disease management, sexual minority identity consolidation, and normative developmental tasks in a context of legal criminalization and cultural hostility toward same-sex relationships. This convergence of challenges represents what Sevelius et al. (2016) term "compounded marginalization."

Educationally, the sample demonstrates relatively high formal education attainment. Nine participants (81.8%) had attained tertiary education, while two (18.2%) completed secondary education. This exceeds Ghana's national tertiary education completion rates and likely reflects how education facilitates access to urban centers, affirming environments, and formal healthcare systems (Baral et al., 2013). However, a critical finding is that high educational attainment did not protect participants from stigma, discrimination, or barriers to care. This directly challenges health

literacy models suggesting that education alone overcomes access barriers. Braveman and Gottlieb (2014) distinguish between individual-level factors (education) and structural-level factors (discrimination, institutional practices), demonstrating that structural stigma operates independently of individual advantages. Furthermore, one tertiary-educated participant was unemployed, and another with only junior high school education was also unemployed, suggesting that educational credentials alone do not guarantee economic stability, particularly for sexual minorities facing workplace discrimination.

Regarding religious affiliation, eight participants (72.7%) identified as Christians, one (9.1%) as Muslim, and two (18.2%) reported no religious affiliation. This composition reflects Ghana's Christian-majority context and is analytically significant given religion's role in shaping societal attitudes toward sexual minorities. Christian institutions in Ghana have been documented as centers of anti-LGBTQ+ advocacy, creating sociocultural contexts in which religious teachings are weaponized against sexual minorities and people living with HIV (Epprecht, 2008; Albuquerque et al., 2016). Multiple participants reported that healthcare workers invoked religious frameworks to condemn them, reflecting what Botnick et al. (2002) term "moral theology of illness," where HIV is portrayed as divine punishment. For Christian participants, this created what Williamson et al. (2015) describe as "layered stigma" convergence of sexual orientation stigma, HIV stigma, and religious condemnation creating particularly toxic psychological environments. Yet participants continued engaging with religious institutions despite experiencing religious stigma, reflecting "selective spirituality," where individuals maintain spiritual connections while rejecting institutional teachings condemning their sexuality (Williamson et al., 2013). In Ghana's context, where religion is deeply embedded in social and family structures, complete religious disaffiliation may increase social isolation and family estrangement.

Occupationally, ten participants (90.9%) were employed in diverse fields including security, education, social work, communication, hospitality, and development work, while one (9.1%) was unemployed. The 90.9% employment rate is notably high compared to Ghana's general unemployment rates (11-13%) and substantially higher than unemployment rates documented among sexual minorities in global settings (Badgett et al., 2007). This suggests the sample may skew toward individuals with moderate socioeconomic stability, potentially underrepresenting highly marginalized sexual minorities engaged in informal economies, experiencing housing instability, or unable to work due to illness. Employment status is a critical enabling factor in the Andersen Behavioral Model, as financial stability influences access to transportation, capacity to afford ancillary healthcare costs not covered by national insurance, flexibility to attend appointments, and economic security to sustain treatment engagement (Anderson, 1995; Travers et al., 2020). The notably unemployed participant had experienced 10 years of HIV duration and only junior high school education, illustrating how employment, education, and health duration interact over time.

5.2 Factors affecting access to care by sexual minority living with HIV

This study revealed that several factors hinder access to HIV care among sexual minorities, including knowledge gaps, stigma, unethical testing practices, and lack of counselling. While some participants voluntarily tested for HIV, others lacked knowledge about the symptoms and relied on traditional remedies before seeking formal care. Similar to the findings of Bekker et al. (2023), this reflects persistent gaps in health literacy among key populations. However, unlike in other settings where community-led education has improved HIV awareness, participants in this study

showed limited understanding of the signs and symptoms of HIV. This suggests that in Ghana, community sensitization and outreach to sexual minorities remain inadequate.

The study also found that some individuals were tested without informed consent or proper counselling, highlighting ethical lapses within health facilities. This finding supports Robert et al. (2020), who observed that violations of confidentiality and autonomy discourage individuals from accessing HIV services. However, in contrast to settings where counselling services have become integral to HIV testing, this study shows that such support is often inconsistent, contributing to mistrust and fear of the healthcare system.

Participants' experiences of discrimination during testing and treatment were associated with non-adherence, social isolation, and emotional distress. This aligns with Adia et al. (2019), who noted that stigmatizing attitudes from healthcare workers drive treatment avoidance. Nonetheless, while previous studies have suggested improvements in stigma reduction due to provider training, this study demonstrates that discrimination remains pervasive in Ghanaian healthcare settings. These findings imply that structural stigma continues to undermine health outcomes and the quality of life of sexual minorities living with HIV. Strengthening ethical standards, enhancing provider training, and promoting patient-centered care are therefore critical to improving access and trust in the system

5.3 Individual experience in accessing HIV care

Participants reported both positive and negative experiences when accessing HIV care. On the positive side, they appreciated the calm and supportive environment in some facilities, the counselling provided by empathetic health workers, and the free supply of ARVs. These findings

are consistent with Moyo et al. (2021), who emphasized that compassionate provider–client relationships enhance treatment adherence and satisfaction. Participants also highlighted that private ART clinics offered more privacy, flexibility, and respectful treatment compared to public facilities. This observation supports Hassan and Tucker (2021), who found that privatized clinics often deliver more individualized and non-judgmental care. However, this contrasts with studies where no significant difference was found between public and private facilities, suggesting that the Ghanaian context presents greater disparities in provider attitudes and service delivery.

Differentiated service delivery (DSD) models, particularly weekend and after-work medication pickups, were viewed as convenient and beneficial, echoing Suen et al. (2022), who found that DSD enhances adherence and retention in care. Yet, unlike in settings where DSD also strengthens peer and provider support networks, participants in this study viewed it primarily as a logistical convenience rather than a psychosocial support mechanism. This highlights the need to expand DSD in Ghana beyond structural efficiency to include peer-led and community-based support components.

Despite these positives, many participants encountered discriminatory treatment such as verbal abuse, avoidance, and moral judgment by healthcare workers. Some were even subjected to demeaning actions like being avoided or asked to seek spiritual deliverance. These experiences corroborate Sallam et al. (2022) and Adia et al. (2019), who reported similar acts of stigma among healthcare professionals. However, this study found that such discrimination is particularly severe in public hospitals, contrasting with research from other African countries where public-sector reforms have somewhat improved inclusivity. Furthermore, while policies such as the Patient's Charter exist to protect patients' rights, most participants were unaware of them, confirming

Igihozo et al. (2022) who noted limited patient empowerment. This gap between policy and practice leaves sexual minorities vulnerable and underscores the need for health worker sensitization and policy enforcement.

5.4 Peer and family support of sexual minority living with HIV

Peer and family support were found to be limited due to fear of stigma, financial insecurity, and social rejection. These findings are consistent with Berg et al. (2021), who reported that fear of discrimination leads many PLHIV to conceal their status or disclose only to peers in similar situations. However, while previous studies observed that disclosure to peers often results in acceptance and emotional relief, participants in this study sometimes experienced further stigma even within their social circles. This contrast may be due to the highly conservative sociocultural and legal environment in Ghana, which reinforces negative perceptions of sexual minorities.

Family rejection, verbal abuse, and name-calling were commonly reported, aligning with Igihozo et al. (2022), who described similar experiences of shame and discomfort in family settings. This finding is similar to that which was observed by Konlan et. al (2025) where families usually rejected members who identified as part of the LGBTQ community. Yet, unlike in contexts where improved HIV literacy has enhanced family support, participants in this study indicated that ignorance and moral judgment remain widespread. Interestingly, participants were more comfortable disclosing their status to healthcare providers than to family members. This finding contrasts with Moyo et al. (2021), who found that clients were often more fearful of healthcare professionals than family. This reversal suggests that some Ghanaian healthcare providers are beginning to offer more non-judgmental spaces for clients, even as family and community environments remain hostile.

The implications of these findings are significant. Limited family and peer support not only exacerbate emotional distress but also affect treatment adherence and quality of life. Programs targeting sexual minorities should therefore focus on community sensitization, family engagement, and financial empowerment to reduce stigma and promote acceptance.

5.5 Emotional and Psychological Experiences of Sexual Minorities Living with HIV

Participants' emotional experiences were characterized by guilt, depression, suicidal ideation, and self-blame. These feelings stemmed from both HIV-related stigma and sexual identity stigma. The findings correspond with Ford et al. (2018), who identified internalized stigma as a key driver of psychological distress among sexual minorities living with HIV. However, unlike studies that reported gradual acceptance of HIV as a manageable condition, participants in this study continued to view HIV as a moral punishment or divine retribution. This contrast highlights the strong influence of religious and cultural beliefs in shaping perceptions of illness in Ghana.

Participants' reliance on herbal and spiritual treatments before diagnosis further reflects the role of traditional beliefs in healthcare decision-making, consistent with Kigombola et al. (2023). Nonetheless, while Kigombola et al. found a decline in the use of alternative medicine due to growing ART awareness, this study suggests that such reliance persists among Ghanaian sexual minorities. This persistence may indicate deep-rooted mistrust of healthcare providers and the ongoing influence of faith-based interpretations of illness.

In terms of social support, participants described isolation and limited assistance from family or peers, which mirrors findings by Bekker et al. (2023). Yet, in contrast to contexts where

strong community networks have improved psychosocial well-being, this study found a lack of organized community groups supporting sexual minorities in Ghana. This absence contributes to prolonged loneliness and psychological vulnerability. The compounded effects of stigma, isolation, and fear have significant implications for the quality of life of sexual minorities living with HIV, as emotional distress can weaken adherence, reduce self-esteem, and hinder social reintegration

5.6 Application of model to study

The findings of this study align with Andersen's Behavioural Model which explains how individual, enabling, and need factors influence access to healthcare. The study revealed that sexual minorities living with HIV face substantial barriers within each component of the model.

The study showed that many participants had limited knowledge about HIV prior to their diagnosis. Some did not experience any symptoms but voluntarily decided to test, while others lacked awareness of early signs and risk factors. Participants also reported pervasive stigma and discrimination from various sources, including healthcare providers, family members, and the general public. These experiences often led to emotional distress, with a few participants expressing suicidal thoughts before developing self-acceptance and coping strategies. Some created peer support groups for encouragement, while others adopted personal strategies such as self-motivation and adjusting to their new reality. These findings are consistent with those of Afulani et al. (2021) and Ogunbajo et al. (2020), who reported that limited knowledge and high stigma among key populations hinder healthcare utilization. However, unlike Chinouya et al. (2022), who found that most participants sought information about HIV proactively, this study suggests a more reactive approach, as many participants only learned about HIV after diagnosis.

The enabling factors in Andersen's model relate to the resources and conditions that facilitate or hinder access to care. In this study, limited awareness of HIV-related policies and the absence of supportive institutional frameworks emerged as major barriers. Participants revealed that Standard Operating Procedures (SOPs) for key populations were not recognized or applied by most healthcare providers. Some healthcare workers exhibited discriminatory behavior, such as verbal or non-verbal abuse, moral judgment, or failure to obtain informed consent before testing. Misdiagnosis was also reported, reflecting gaps in provider training and sensitivity. These findings resonate with Klein et al. (2023), who observed similar neglect of sexual minority guidelines in healthcare settings, and Makofane et al. (2020), who highlighted structural discrimination as a barrier to HIV service access. Despite these challenges, a few participants identified organizations and private clinics that were welcoming and provided continuous support, which kept them engaged in care. Some appreciated flexible service hours that allowed them to pick up medication on weekends. This aligns with Logie et al. (2021), who emphasized the importance of safe and affirming spaces for sexual minorities in improving adherence and retention in care. However, unlike Mabaso et al. (2022), who found widespread institutional support for sexual minorities in South Africa, this study indicates that such supportive structures are still limited in Ghana.

The final component of the behavioural model, the need factors, encompasses perceived and evaluated health needs that influence healthcare utilization. Peer and family support were identified as critical determinants in this study. Many participants were reluctant to disclose their HIV status or sexual orientation to family members due to fear of stigma and rejection. Those who disclosed often faced social exclusion, verbal abuse, and pressure to conform to societal norms such as heterosexual marriage. These experiences mirror findings from Zhang et al. (2019), who reported that disclosure often results in strained family relationships and psychological distress.

Nonetheless, some participants found strength in peer support networks and friendships with other HIV-positive individuals. These groups provided emotional encouragement, education, and financial assistance. A few participants became peer educators and case managers, which improved their self-esteem and financial independence. This observation is consistent with Poteat et al. (2020), who found that peer involvement enhances treatment adherence and emotional well-being among sexual minorities. However, this study contrasts with Musheke et al. (2019), where family support was the main source of resilience; here, peer networks played a more dominant role.

This study confirms the usefulness of Andersen's Behavioural Model as a guiding framework but suggests certain modifications to enhance its relevance to sexual minorities living with HIV in Ghana. Specifically, the predisposing factors should explicitly incorporate stigma and discrimination as distinct sub-constructs. The enabling and need factors should also be modified to include peer and family relationships as well as intimate partner violence, which strongly influence care-seeking behaviors and retention in treatment among sexual minorities.

CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

This chapter provides a summary of the study, implications, limitations and conclusion drawn from the findings. The section also provides recommendations based on the findings of the study. The objective of the study was to:

1. describe the barriers that MSM living with HIV face in accessing HIV care and treatment services in the Ga East Municipality.
2. examine the facilitators that enable MSM living with HIV to access HIV care and treatment services in the Ga East Municipality.
3. explore the personal health practices and coping strategies of MSM living with HIV who are receiving care in the Ga East Municipality.

6.1 Summary of the study

The study investigated the factors influencing access to HIV care for HIV positive sexual minorities with the objective of identifying barriers and proposing solutions. A qualitative research design was employed, using an interpretive descriptive approach guided by the Andersen Behavioural Model. Data were collected through face-to-face interviews with 11 participants aged 22 to 39 years. The interviews were audio-recorded, transcribed verbatim, and analysed using a thematic approach. Three main themes emerged: individual experiences of sexual minorities living with HIV, peer and family relations, and experiences accessing HIV care, analysed in line with the behavioural model. The study revealed that participants had varied individual experiences with

HIV. Some initially experienced symptoms such as rashes and diarrhoea, which led them to seek medical intervention and received a diagnosis, while others were asymptomatic before diagnosis. Participants reported emotional struggles following their diagnosis, including guilt, shame, internalized stigma, self-blame, and difficulty accepting their condition. Over time, most participants adjusted to their new reality. Some initially sought alternative treatments, such as herbal medicine or spiritual healing, but later adhered to antiretroviral therapy (ART), often after experiencing the loss of loved ones or receiving counselling from models of hope. While some participants experienced challenges with adherence, including defaulting on treatment, others remained self-motivated and committed to avoiding relapse. ART side effects were also a common concern. Participants frequently faced depression and suicidal ideation early in their journey, but many gradually built self-confidence. Discrimination and stigma were prominent, with participants reporting workplace exclusion, relationship breakdowns, and other forms of marginalization. Despite these challenges, some participants found support through NGOs, healthcare providers, friends, and financial assistance, which helped them cope with their condition.

Peer and family relations played a significant role in shaping participants' experiences. While some participants received emotional and financial support from their families and peers, others faced rejection and isolation. Peer networks and community groups often provided vital assistance, offering practical and emotional support in the face of stigma.

Participants' experiences in accessing HIV care were diverse. Some encountered stigma and discrimination from healthcare providers, including inadequate examinations, misdiagnoses, and judgmental attitudes related to their sexual orientation. Instances of participants being preached to or subjected to prayers for their orientation were reported. Others mentioned enforcement of restrictive policies, such as limiting clinic visits for ART pickup to specific days, and imposed

unnecessary infection prevention measures, which created additional barriers. On the other hand, some participants described welcoming healthcare environments characterized by compassion, kindness, and strong interpersonal relationships with providers. Certain facilities went beyond medical care, providing assistance such as covering laboratory fees, facilitating national health insurance enrolment, and offering food supplies.

The study also found that participants had limited awareness of policies related to HIV care and the rights of sexual minorities. Most had little to no knowledge of the Patient's Charter, highlighting the need for improved education and empowerment for this population. Overall, the findings underscore the importance of addressing stigma, enhancing provider-patient relationships, and ensuring equitable access to HIV care and support services for sexual minorities.

6.2 Reflexivity and insight gained

Reflexivity involves examining one's own beliefs, judgments, and practices throughout the research process, recognizing how these may influence the study. It helps to identify and reduce bias, enhance credibility, and improve the trustworthiness of both the study and the researcher. Reflexivity also provides clarity around decision-making processes (Olmos-Vega et al., 2023).

The researcher is a registered general nurse with nine years of professional experience, including seven years of caring for people living with HIV. Working at the West Africa AIDS Foundation & International Healthcare Centre (WAAF & IHCC), a facility recognized for being sexual-minority-friendly and the first private hospital to offer antiretroviral therapy in Ghana, has significantly influenced the researcher's perspective on factors affecting access to care for sexual minorities living with HIV. This professional background shaped the researcher's approach and understanding of the challenges faced by participants in accessing HIV care.

Conducting this research provided valuable insights, as the researcher gained an in-depth understanding of participants' experiences and challenges. Data collection was carried out solely by the researcher, and systematic coding was employed during analysis to ensure rigor. However, the study faced challenges due to the sensitive nature of the subject, especially in the context of the anti-LGBTQ bill. This legislation caused many potential participants to withdraw from the study, while others were hesitant to express themselves freely due to fear and anxiety.

Despite these challenges, the researcher gained significant skills and knowledge through the research process. These included learning how to conduct interviews effectively, explaining the research process to participants, and systematically transcribing, coding, and analysing data. The experience enhanced the researcher's confidence and deepened their understanding of managing sexual minorities living with HIV.

6.3 Implications

The implications of the study were discussed in all the areas of nursing such as nursing practice, education, research, and policy.

6.3.1 Nursing practice

Nurses working in the ART clinic should be equipped with the requisite knowledge on SOPs of Sexual minority to help identify their essential and unique needs. Nurses should be more oriented on cultural competency to accommodate sexual minority living with HIV. HIV health education should be intensified at all service delivery point to avoid the negative attitude some ART nurses show towards HIV positive sexual minority. HIV health education should be intensified and sexual minority centred approach to encourage their frequent usage of the various ART clinics.

6.3.2 Nursing Education

Continuous education program including in-house trainings and short courses should be developed on cultural competency for sexual minority. This will help nurses to provide more client centred care.

6.3.3 Nursing Research

Further research should be conducted to explore the specific needs of sexual minorities living with HIV and how these can be effectively integrated into existing HIV care and support services. Future studies should also examine the syndemic factors influencing access to HIV care and treatment adherence among sexual minorities and identify strategies for addressing these barriers.

Quantitative research is recommended to measure the relationships among constructs of Andersen's Behavioural Model, providing empirical evidence to support or refine the model within the Ghanaian context. In addition, other theoretical frameworks could be applied to gain a broader understanding of the determinants of healthcare access among sexual minorities living with HIV.

There is also a need to develop a practical assessment tool to guide healthcare professionals in identifying and addressing the unique factors that hinder access to care for HIV-positive sexual minorities. Lastly, future quantitative studies should evaluate the quality of life of sexual minorities living with HIV to inform the design of holistic and inclusive nursing interventions

6.3.4 Policy Formulation

The Ghana AIDS Commission (GAC) and the National AIDS Control Programme (NACP) should integrate stigma reduction strategies into the HIV management Standard Operating Procedures (SOPs) for sexual minorities. Policy makers should ensure the active involvement of

sexual minorities in the formulation of policies and programs to create comprehensive service packages that reflect their specific health and social needs.

In collaboration with the World Health Organization (WHO), GAC should develop context-specific HIV treatment protocols that are tailored to the Ghanaian setting and responsive to the realities of sexual minorities. Furthermore, policy makers should strengthen and institutionalize a well-structured Differentiated Service Delivery (DSD) model that addresses the unique barriers faced by sexual minorities in accessing HIV care.

Finally, there is a need to expand and enhance Drop-in Centres (DICs) within safe and confidential spaces to promote service utilization and reduce healthcare avoidance. Well-equipped DICs can provide integrated HIV prevention, treatment, and psychosocial support services, thereby improving health outcomes and overall quality of life among sexual minorities living with HIV.

6.4 Limitations of the study

This study was conducted exclusively within the Greater Accra Region, which limits the generalizability of the findings to sexual minorities living with HIV in other parts of Ghana. However, the qualitative design allowed for an in-depth exploration of participants' lived experiences, providing rich insights that may inform understanding in similar contexts.

The study focused primarily on sexual minorities, particularly men who have sex with men (MSM), and did not include other subgroups such as bisexual women, transgender individuals, or heterosexual men living with HIV. This narrow focus may have excluded other perspectives within the broader key population. Accessing participants was also challenging due to the sensitive nature of sexual orientation and the prevailing socio-legal climate, including the ongoing debates around

the Anti-LGBTQ bill. Some participants expressed fear of exposure, which may have influenced the depth of disclosure during interviews.

Another limitation relates to the mental health status of certain participants during data collection. A few individuals showed signs of psychological distress, requiring pauses or follow-up interviews to ensure their comfort. Although the study provided a supportive interview environment, immediate psychological therapy could not be offered to participants who might have required such assistance.

Lastly, the study's geographic and demographic scope underscores the need for further research across different regions and among diverse sexual minority subgroups, including adolescents and transgender persons. Future studies should also integrate mental health assessments and provide psychosocial support for participants to ensure their well-being during data collection. These efforts will help build a more comprehensive and inclusive understanding of the barriers and facilitators to HIV care among sexual minorities living with HIV in Ghana

6.5 Conclusion

The study concludes that the experiences of sexual minorities living with HIV in Ghana are deeply shaped by stigma, discrimination, and structural inequalities within the healthcare system. While biomedical services such as ART are available, access is constrained by socio-cultural attitudes, legal restrictions, and limited institutional responsiveness to the needs of sexual minorities. The findings affirm Andersen's Behavioural Model but suggest that the model should be expanded to include stigma, discrimination, and social identity as core determinants of health-seeking behaviour for key populations.

The study further concludes that enabling factors such as the availability of friendly healthcare providers, flexible clinic schedules, and support from community-based organizations improve adherence and treatment continuity. Conversely, lack of confidentiality, judgmental attitudes, and limited awareness of patients' rights hinder service utilization. The absence of supportive family structures exacerbates emotional and psychological distress, underscoring the importance of peer networks as vital sources of resilience.

Overall, improving access to HIV care among sexual minorities requires a shift from solely biomedical approaches to more inclusive, rights-based, and psychosocially supportive interventions. Addressing stigma at all levels; individual, institutional, and societal is critical to ensuring equitable healthcare delivery and improving the quality of life of sexual minorities living with HIV.

6.6 Recommendations

Based on the findings of the study, below are suggested recommendations

6.6.1 Recommendations to the Ministry of Health

1. Integrate mental health services into HIV services.
2. Promote more awareness creation on HIV combination prevention strategies (e.g., PEP, condoms, and PrEP) to the general public to address myths, misunderstandings, and misconceptions surrounding HIV.
3. Encourage comprehensive virtual HIV interventions to enhance access, such as online consultations and delivery of essential commodities like HIVST kits, condoms, lubricants, PEP, and PrEP services.

6.6.2 Recommendations to the Ghana Health Service (GHS)

1. Intensify in-service training on stigma reduction for all health workers.
2. Provide more drop-in centers (DIC) at safe spaces for sexual minorities living with HIV.
3. Advise policymakers on the potential negative implications of the anti-LGBTQ bill for sexual minorities in accessing HIV care and achieving the 95-95-95 goals.

6.6.3 Recommendations to Nursing and Midwifery

1. The Nursing and Midwifery Council should incorporate compassionate care for gender and sexual minorities, as well as other vulnerable populations, into the nursing curriculum at training colleges.
2. Hospital heads should encourage step-down training to cascade knowledge and skills from external training programs to all staff.

6.6.4 Recommendations to West Africa AIDS Foundation (WAAF) Clinic

1. Establish peer support systems for HIV-positive sexual minorities, in collaboration with GAC and NACP.
2. Integrate mental health support into HIV care services provided by the clinic.

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APPENDICES

Appendix A: Introductory Letter

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

August 23, 2024

Medical Officer In-Charge

International Healthcare Centre (WAAF Clinic)

Ecomog-Haatso

Dear Sir/Madam,

PERMISSION FOR RESEARCH STUDY

I write to introduce to you Ms. Priscilla Affum, a Master of Science in Nursing student at the College of Health Sciences, School of Nursing and Midwifery, University of Ghana, Legon.

As part of the requirements of the Msc. programme, the student is to undertake a research study, and she intends to use your institution as the main study site for the research. The title of her research is "Factors affecting access to care by sexual minorities living with Human Immune Deficiency Virus at the Ga-East Municipality."

I write to seek your permission to enable her to undertake this necessary assignment.

Thank you.

Yours faithfully,

Dr. Gladys Dzansi

Appendix B: Interview Guide

Interview Guide

Introduction

Introduce yourself, purpose of the study, ensure confidentiality, and obtain consent to start recording.

Part I

1. Can you briefly tell me about yourself?

Probe

(Age, Sexual Orientation, Level Education, Employment status and duration of living with HIV etc.)

Part II

2. Can you describe your experience accessing HIV treatment services at the hospital environment?

Probe

a) Tell me how comfortable you are accessing care and treatment at the facility.
b) Please explain the challenges you face/faced trying to access or use HIV treatment services
c) Can you share any specific example of a time you were faced with such challenges?

Part III

3. Tell me the effect your background has had on your ability to access and use care at the hospital.

Probe

a) How has your educational level, social status, sexual orientation etc. affected your ability to access care. Elaborate on the positive or negative experiences.
b) Tell me about any time you were stigmatized due to your background? Verbal / Non-Verbal cues? Please elaborate with specific examples of instance(s).

Part IV

4. Can you describe your relationship with your healthcare providers?

Probe

a) Tell me about the way doctors, nurses or other workers in the hospital relate to you. Can you elaborate?
b) Please share any positive or negative experiences you have had with your healthcare providers. (An example of a time you had such an experience)

Part V

5. Tell me about the strategies you usually use to cope with the challenges you have mentioned earlier.

Probe

a) What do you do when you experience the challenges you mentioned? Kindly elaborate.
b) Are there support systems (friends, family, community organizations or personal strategies) that have been most helpful to you?

Part VI

6. Tell me about what you think should be done to improve the way HCPs provide care to you?

Probe

a) *How can healthcare providers better support individuals like yourself in accessing and using care?*

Part VII

- Is there anything else you would like to share?

End of Interview

Thank you for your time.

Appendix C: Consent Form

Consent Form

Title of Study: Exploring Factors Affecting Access to Care by Sexual Minority Living Men with Human Immune Deficiency Virus

Principal Investigator: Priscilla Affum
Address: University of Ghana
College of Health Sciences
School of Nursing and Midwifery

Purpose of the Study

You are being invited to participate in a research study that aims to explore the factors affecting access to care by Sexual Minority Men Living With HIV. The study will identify barriers and facilitators to access to care as well as coping strategies that you might have used in your care and treatment.

Participation Details

Duration: The interview will last approximately 60 to 90 minutes.
Location: Interviews will be conducted in a private office/space to ensure confidentiality.

Voluntary Participation

Your participation in this study is completely voluntary. You may refuse to participate or withdraw at any time without any consequences.

Confidentiality

All information you provide will be treated confidentially. Your identity will remain anonymous in any reports or publications resulting from this study. Data will be stored securely and only accessible to the research team.

Risks and Benefits

There are minimal risks associated with participating in this study, including potential emotional discomfort when discussing sensitive topics. However, your participation may help improve understanding and access to care for sexual minorities living with HIV, potentially leading to better health outcomes.

Consent to Record

Consent Form Cont'd

I agree to my interview being audio-recorded for research purposes.

Right to Withdraw

You have the right to withdraw your consent to use your data up to two weeks after the interview, after which your data will be deleted.

Contact Information

If you have any questions about the study, your participation or have not been treated fairly by the researcher, you may contact:

Dr. Gladys Dzansi
School of Nursing and Midwifery
gdzansi@ug.edu.gh

Agreement

By signing below, you acknowledge that you have read and understood the information provided, and you consent to participate in this study.

Participant's Name: _____

Participant's Signature: _____

Date: _____

Researcher's Signature: _____

Date: _____

Appendix D: Information Sheet

Recruitment Script

My name is Priscilla Affum, an MSc Nursing student at the University of Ghana, School of Nursing and Midwifery. I appreciate your interest in participating in this important research study. This study focuses on exploring factors affecting care access and utilization by Sexual Minority Men Living With HIV.

Study Objectives

The study specifically aims at;

1. Describing the barriers and facilitators that MSM living with HIV face in accessing and utilizing HIV treatment services in the Ga East Municipality.
2. Describing the predisposing factors that enable MSM living with HIV to access HIV care and treatment services in the Ga East Municipality.
3. Describing the need for care factors that influence access to care and use in the Ga East Municipality.
4. Exploring the personal health practices of MSM living with HIV who are receiving care in the Ga East Municipality.

Participation Details

I would like to invite you to participate in a one-on-one interview about your experiences related to access to care and your experiences receiving treatment. Your insights are invaluable, and the interview will last approximately 60 to 90 minutes.

Eligibility Criteria

To participate, you must meet the following criteria:

- Assigned male at birth and have sex with men.
- Confirmed HIV-positive status.
- Aged 18 years or older.
- Residing in the Greater Accra Region.
- Willing to participate in the study.

Importance of Your Participation

Your participation will contribute significantly to improving our understanding of the care and treatment needs of marginalized groups like MSM living with HIV in Ghana. The findings will help develop interventions aimed at enhancing care and treatment outcomes for individuals in your community.

Voluntary Participation

Please remember that your participation is entirely voluntary. If you have any questions or need more information, feel free to ask.

If you need more time to think about it, that's completely fine. You can reach out to me later with any questions.

Confidentiality

Your confidentiality is assured as your personal information will not be accessible to anyone aside the researcher.

Thank you for considering this opportunity to share your experiences and contribute to this important research.