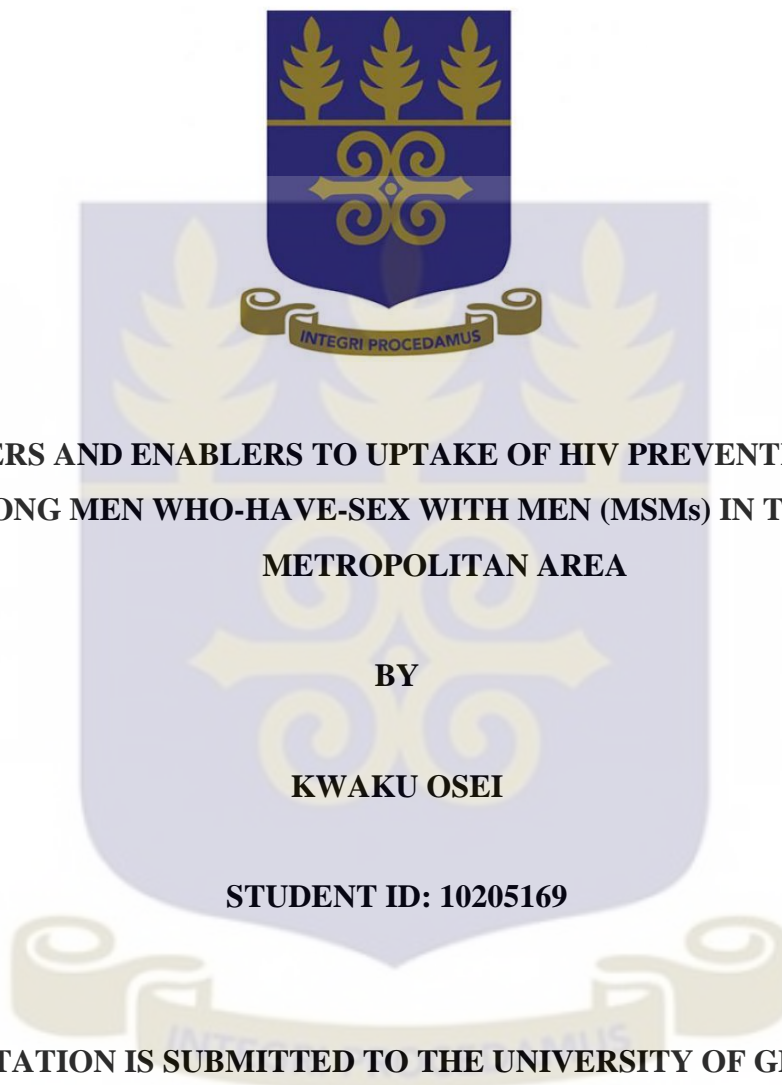


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**BARRIERS AND ENABLERS TO UPTAKE OF HIV PREVENTION SERVICES
AMONG MEN WHO-HAVE-SEX WITH MEN (MSMs) IN THE ACCRA
METROPOLITAN AREA**

BY

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE
MASTER OF PUBLIC HEALTH (MPH) DEGREE**

JULY, 2019

DECLARATION

I, KWAKU OSEI, hereby declare that except for references made to other people's work which I have duly acknowledged, this proposal is the result of my own research done under supervision and that it has neither in part nor in whole or concurrently been presented for another degree elsewhere.

.....

Date

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(Student)

.....

Date

Dr. Genevieve C. Aryeetey

(Supervisor)

DEDICATION

I dedicate this study to my parents, Mr. Andrew Osei and Mrs. Mary Osei for their unflinching support and prayers throughout the course of my study. To my wife, Anita Akumiah and son, Ohene Kyei Kwame Osei who supported me in diverse ways, I appreciate you and God bless you.

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I am most grateful to the Almighty God for His guidance and strength throughout my programme. My sincere appreciation to my supervisor, Dr. Genevieve C. Aryeetey for her leadership and constructive comments, which has guided me to the successful completion of this dissertation.

To the lecturers at the School of Public Health who taught and mentored me to this successful end, I am grateful.

My immense appreciation to the management of the Centre for Popular Education, Human Rights Ghana for allowing me to use their Office premise for my data collection. They provided a safe space for the peer educators to feel comfortable to share and actively participate in the study.

Finally, I thank the peer educators who are working in the communities to support ongoing efforts to provide HIV prevention services to Men who-have-sex with Men in the communities, your efforts are commendable. I appreciate the time you took to avail yourself to actively participate in the study.

ABSTRACT

Introduction: Populations considered as having a high risk to HIV infection are known as key populations (KPs). There has been substantial funding for HIV programmes for Men who-have-sex with Men (MSM), however, the prevalence of MSM in Ghana increased from 17.1% in 2011 to 18% in 2017 which is higher than the HIV prevalence among the general population which is 1.67%. This is also coupled with low uptake of HIV prevention services. It is therefore important to explore what could be enabling and hindering their uptake of available HIV prevention services to guide future policies and plans targeting them.

Objective: To explore predisposing factors that influence uptake of HIV prevention services among MSM, to examine enabling factors that influence uptake of HIV prevention services among MSM and identify need factors that influence uptake of HIV prevention services among MSM in the Accra Metropolitan Area.

Methods: The study adopted an exploratory qualitative research approach and study population consisted of 15 MSM peer educators directly involved in HIV prevention services and a management staff of Centre for Popular Education and Human Rights Ghana.

Results: The study showed the importance of peer educators in supporting uptake of HIV prevention services in the community. However, some factors such as low knowledge about prevention services, unfriendly legal environment and negative attitudes of community members affected the uptake of HIV prevention services among MSM.

Conclusion: The study results identified some barriers to uptake of HIV prevention services by MSM as low level of education of MSM, income levels of MSM and negative attitudes of health workers. Some enablers included the presence of peer educators, and formation of support groups. It is important that these factors identified are urgently addressed to improve uptake of HIV prevention services among MSM.

Keywords: HIV, testing, uptake, prevention, peer educators, barriers, enablers, MSM, Accra

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMA	Accra Metropolitan Area
ANC	Ante Natal Clinics
ARV	Antiretroviral Drugs
CBVCT	Community-based Voluntary Counselling and Testing
CEPEHRG	Centre for Popular Education, Human Rights Ghana
CSE	Comprehensive Sexuality Education
EPP	Estimation and Projection Package Modelling
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GDHS	Ghana Demographic Health Survey
HIV	Human Immune-deficiency Virus
HSS	HIV Sentinel Survey
IBBSS	Integrated Bio-Behavioural Surveillance Survey
IEC	Information Education and Communication
JHS	Junior High School
KP	Key Populations
LGB	Lesbian, Gay and Bisexual
LMIC	Lower Middle Income Country
MDG	Millennium Development Goals
MSM	Men who-have-sex with Men
NACA	National Commission on AIDS
NHIS	National Health Insurance Scheme
PLHIV	Persons Living with HIV

SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SHS	Senior High School
SSA	Sub-Saharan Africa
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, HIV remains a major public health concern resulting in the loss of lives of more than 35 million since the first case was reported and 1 million lives by the end of 2016. Currently, the number of people living with HIV is 36.7 million with an estimated 1.8 million being newly infected with the virus (UNAIDS, 2017). Although HIV is mainly transmitted through unprotected anal and vaginal sexual intercourse with an infected person, other modes of transmission include transfusion of infected blood, using infected needles, syringes and other sharp equipment and vertical transmission from an HIV infected mother to her child while she is pregnant, in labour and delivery or post-natal via breastfeeding (Pinsky & Paul, 2009).

Across sub-Saharan Africa (SSA), HIV disproportionately affects men-who-have-sex-with-men (MSM) compared to other men of the same age group in the general population (Ghana AIDS Commission, 2011). MSM have a higher chance of getting infected with HIV especially in low and middle income countries (LMICs) such as Asia, Africa, Latin America and the Caribbean, and in Eastern Europe and Central Asia. Available evidence from these countries suggests that structural risks—social, economic, political, or legal factors—and individual-level risk contribute to shaping uptake of HIV services for these men. Data shows that regarding coverage and access to HIV and AIDS prevention, treatment, and care services, it is limited for MSM and some studies estimate that fewer than 1 in 10 MSM globally are able to have access to the most basic package of preventive services (Chris Beyrer, Andrea L. Wirtz, Damian Walker & Frangiscos Sifakis, 2011).

There has been considerable progress made in providing HIV prevention services and behaviour change activities to MSM globally especially through the use of peer to peer

approach through peer educators. However, there is still evidence of high disease burden among this group in many sub-Saharan countries including Ghana. In Ghana, for example, the HIV prevalence for MSM is 18.1% (Ghana AIDS Commission, 2018) compared to the current HIV prevalence of the general population, which is 1.69%. The findings from the 2014 Modes of Transmission study provides evidence that there is an urgent need to provide HIV prevention services for KPs including MSM as they are considered a bridging population and their activities could consequently result in an increase in the HIV prevalence of the general population in Ghana overtime (Laar & Debruin, 2017).

1.2 Statement of the Problem

Ensuring universal access to HIV prevention, treatment, care and support services has been a major underlying feature towards ending AIDS by 2030 (UNAIDS, 2016). This desire has been made prominent in the United Nation's Millennium Development Goals (MDG 2000-2015) and the Sustainable Development Goals (SDGs 2016-2030). The goal of universal access is to ensure that irrespective of factors such as age, sex, race, religious beliefs and sexual orientation, every individual must be provided with HIV services to achieve the global target to end AIDS by 2030 (UNAIDS, 2016b).

Ghanaian laws are developed to protect the citizens from all forms of discrimination. However, there are no laws that protect the human rights of MSM, thereby fuelling stigma and discrimination towards them. The sexual preference of MSM is considered as unnatural carnal knowledge, which is, sexual intercourse with a person in an unnatural manner or with an animal (The Republic of Ghana, 1960). In addition to constitutional provisions, cultural values and norms proscribes the activities of MSM which results in violence meted out to them in the community (Lithur, 2010). This position of the country about activities of MSMs affects HIV programming for this sub-group as they become "hard to reach" because they do

not want to make their sexual orientation known to access HIV services nor contribute to policy or programme development that will guide provision of targeted interventions for them.

Based on the fact that MSM engage in risky sexual behaviour and some also engage in heterosexual sex which places the general population at risk of HIV infection, the Ghana AIDS Commission, in collaboration with its stakeholders developed the first most-at-risk population (now Key Population) Strategic Plan 2011-2015 (Ghana AIDS Commission, 2011). The Plan was to ensure that those that are most vulnerable to the HIV epidemic including MSMs are reached with targeted HIV prevention, treatment, care and support services.

Also, the National AIDS spending assessment shows that majority of funding for HIV programmes in Ghana is directed at key population interventions which includes MSM (Ghana AIDS Commission, 2017). The decision to increase funding for MSM is based on guidance that with adequate financing in HIV prevention, there will be an improvement in quality of programmes for key populations which could result in 40–50% decline in new infections (UNAIDS, 2016c).

The prioritization of funding for key population interventions in Ghana has resulted in the reduction of HIV prevalence among Female Sex Workers (FSW) from 11.1% in 2011 to 7.1% currently. However, the HIV prevalence of the MSM population has increased from 17.1% in 2011 to 18% in 2017 (IBBSS, 2017). With the huge investments in HIV prevention programming among MSM in-country, there remains a high burden of HIV in this population with a relatively low uptake of HIV prevention services (Ghana AIDS Commission, 2018). It is therefore important to explore the reasons that could be enabling and hindering the uptake of available HIV prevention services among MSMs in the country despite the huge funding being used to implement key population activities.

1.3 Narrative to the conceptual framework

The Andersen behavioural model for health services utilization has been adapted to explain factors influencing the uptake of HIV prevention services by MSMs. This model was developed by Ronald M. Andersen, to ascertain factors that facilitate or impede utilization of health services by individuals (Anderson, 1968). It is a product of predisposing, enabling and need factors (Gupta et al., 2014).

Predisposing factors such as knowledge of HIV prevention services (e.g. IEC materials, education, condom use, HIV testing services), educational status and being a member of social network can influence uptake of HIV services by the MSM population.

The enabling factors such as the existing policy/legal environment, level of income, proximity to HIV prevention services and disclosure of sexual orientation point can positively or negatively affect their uptake to HIV prevention services. In addition, attitudes of community members, capacity/skills of peer educator and availability of HIV prevention commodities can influence uptake of HIV prevention services.

Finally, the need factors encompass the MSM's decision to seek or not to seek HIV prevention services and the level of training they have received to empower them to demand services can positively or undesirably affect uptake of HIV prevention services.

1.3.1 Conceptual Framework

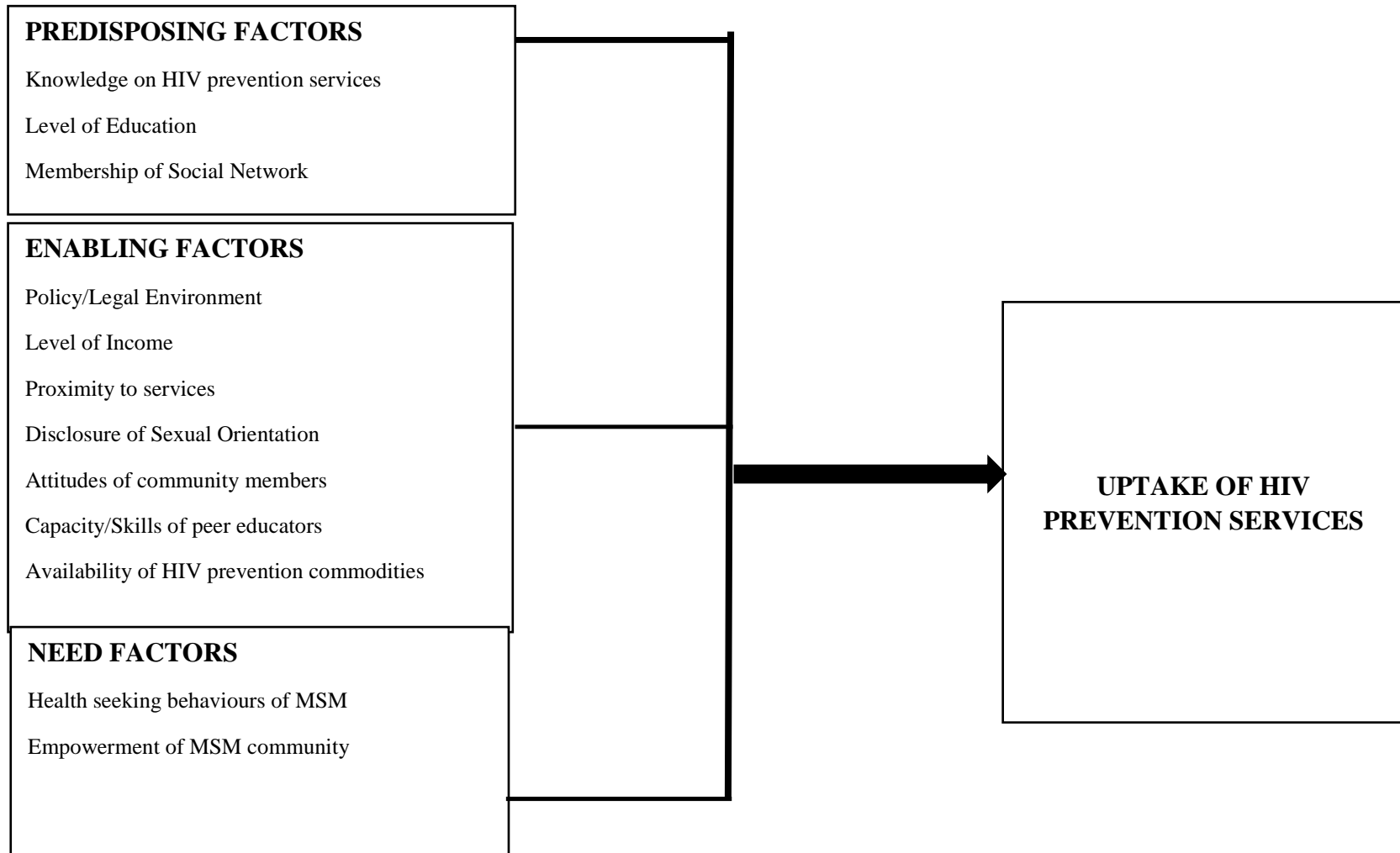


Figure 1 : Conceptual Framework on uptake to HIV prevention services adapted from the Andersen RM 1995

1.4 Justification of Study

Ghana like many other UN countries have committed to achieving the Sustainable Development Goals (SDGs) especially Goal 3 which aims to ensure healthy lives and promote wellbeing for all at all ages (Singh, 2015) which is also interpreted to include the well-being of KPs. In Ghana, among the group considered as KPs are Female Sex workers (FSW) and Men who have sex with Men (MSM) (Ghana AIDS Commission, 2016b). This means that these groups must be provided HIV prevention, treatment, care and support services irrespective of sexual orientation. Given this global policy, GAC in partnership with stakeholders has employed a public health approach to provide targeted HIV services to KPs. As a result of adopting a public health approach, there has been a reduction in HIV prevalence in FSWs from 11.1% in 2011 to 7.1% (IBBSS, 2016). However, with the MSM population, it has increased from 17.1% in 2011 to 18% in 2017 (Men's Study, 2017). This means, there is still a significant proportion of the MSM population with a high HIV burden. This is also against the background that the current national HIV prevalence is 1.67% among the general population.

Since HIV prevention is the first action in the quest to prevent HIV infection and there has been a lot of investment in preventing HIV infection among this sub-population, it is important to ascertain whether this sub-population are accessing available HIV prevention services, whether these services are tailor-fit to serve their needs and what possible barriers or enablers exist to uptake of these prevention services. Finding answers to these questions will ensure the provision of targeted HIV prevention solutions for the group, without which there could be an increase in HIV infection thereby contributing to the burden of the virus among them overtime.

1.5 Objectives

1.5.1 General objective

To explore barriers and enablers to the uptake of HIV prevention services among MSMs in the Accra Metropolitan Area from the perspective of peer educators who are also MSM.

1.5.2 Specific objectives

1. To explore predisposing factors that influence uptake of HIV prevention services among MSM
2. To examine enabling factors (including barriers) that influence uptake of HIV prevention services among MSM
3. To identify need factors that influence uptake of HIV prevention services among MSM

1.6 Research Questions

1. What are the factors that influence the uptake of HIV prevention services among Men who-have-sex with Men within the Accra Metropolitan Assembly?
2. What are MSM's perceptions, demographic and other factors that influence their uptake of HIV prevention services?
3. What are the perspectives of an MSM-focused NGO on factors that hinder or enable uptake of HIV prevention services among MSM?

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter is to review existing literature on works done on HIV in general and its mode of transmission. It provides literature on the HIV situation in the country, as well as, global and national policy provisions about providing HIV prevention services to key population including MSM. This chapter also reviews existing literature on factors that influence uptake of HIV prevention services at the global, regional and national level.

2.2 Human Immunodeficiency Virus

HIV is an abbreviation for Human Immunodeficiency Virus (HIV), a virus that infects certain types of white blood cells of the immune system, specifically the CD4 cells, impairing their function and rendering them incapable of fighting off infections and diseases in the body (WHO, 2017). Progressive deterioration of the immune system due to lack of treatment can lead to a state of immune deficiency referred to as Acquired Immunodeficiency Syndrome (AIDS). This state is characterised by the manifestation of opportunistic infections and other HIV related cancers resulting from the deterioration of their immune system. (Pinsky & Paul, 2009; WHO, 2017)

2.2.1 Stages of HIV

Stage 1: Acute HIV infection

Acute HIV Infection is the earliest stage of infection which occurs within 2 to 4 weeks after a person is infected. It is characterised by flu-like symptoms, such as fever, headache, rash sore throat, stomach upsets, joint and muscle pains. (Avert, 2017). Several changes occur in the immune system during this stage, including rapid deterioration of CD4 cells, production of anti-HIV antibodies, and cytotoxic CD8+ lymphocytes destroy HIV-infected cells (Carpenter,

2017). HIV progresses faster at this stage, thus early diagnosis and treatment is critical at this stage to limit viral replication in the body. The risk of HIV transmission is also at its greatest during this period, especially in pregnant mothers and accounts for vertical transmission (Padian et al., 2011).

Stage 2: Chronic Infection

The second stage of HIV infection is Chronic HIV infection also called asymptomatic HIV infection. There is continual viral replication and HIV progression with CD4 cell counts declining rapidly at an average rate of approximately 50 cells/ μ L/y. Often, people at this stage may show no signs of HIV-related symptoms up to about 10 to 15 years. The absence of treatment and appropriate interventions during this stage will lead to acquisition of AIDS (Avert, 2017; Carpenter, 2017)

Stage 3: Acquired Immunodeficiency Syndrome

AIDS is the most advanced stage of HIV infection (WHO, 2017). The infected person exhibits symptoms such as weight loss, chronic diarrhoea, feverishness, persistent cough and severe illnesses. This stage is also characterised by an absolute CD4 cell count of less than 200 cells/ μ L, the presence of over 20 opportunistic infections and other HIV-related cancers in infected persons. In the absence of treatment, people living with HIV will survive for 3 years (Carpenter, 2017).

2.2.2 Modes of Transmission

HIV cannot be transmitted via casual contact, the virus is present in blood, semen, vaginal fluid, pre-seminal fluid, breast milk and other fluids of the infected person, thus can only be transmitted through direct contact of mucous membranes with these fluids (Wilton James, 2011; Catie, 2014). Modes of transmission include having unprotected anal and vaginal sexual intercourse with an infected person, receiving blood from an infected person through blood transfusion, sharing of contaminated needles, syringes, surgical and other sharp

equipment. The virus may also be transmitted vertically from an infected mother to her baby during pregnancy, at the point of labour, delivery and also during breastfeeding (WHO, 2017).

Estimates of HIV prevalence among MSM have been reported to be higher than prevalence of the disease in the general population (Baral, Sifakis, Cleghorn, & Beyrer, 2007; Oster et al., 2014). There is an increased risk of getting infected with HIV virus during anal sex than vaginal sex (Valleroy et al., 2000). This risk is predominantly highest among the receptive partners, and this is because the lining of the rectum is thin and may allow HIV to enter the body during anal sex (Beyrer et al., 2012).

2.3 National Response to HIV

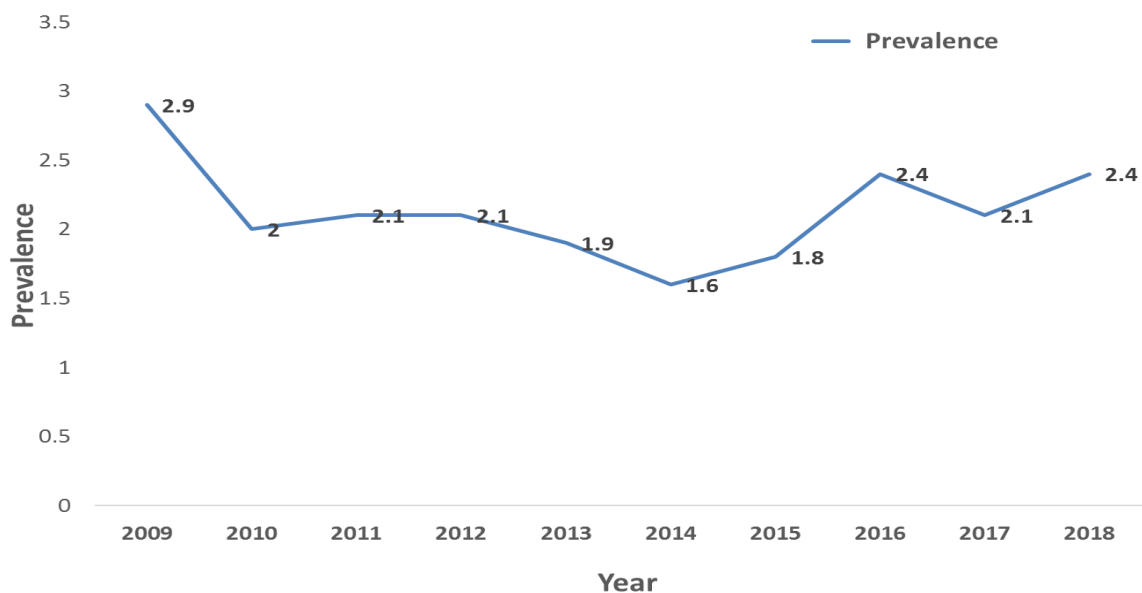
The first 42 cases of HIV and AIDS in Ghana was recorded in 1986 mainly among women who had travelled outside the country. The response to HIV and AIDS was first managed as a disease rather than a development issue. Before the first case was recorded, Ghana established the National Advisory Commission on AIDS (NACA) in 1985 to advise Government on HIV and AIDS issues (Ghana AIDS Commission, 2001).

Overtime, the country begun to realize that addressing HIV and AIDS will not be achieved through using only a health-centred approach, as a result, the Ghana AIDS Commission was formed in the year 2000. The Ghana AIDS Commission (GAC) is a supra-ministerial and multi-sectoral body that has His Excellency, the President of the Republic of Ghana as its Chair and was accented by an Act of Parliament, Act 613 in 2002. Its mandate is to provide support, guidance and leadership for the national response to the HIV and AIDS epidemic. The GAC also has responsibility for coordinating both health and non-health planning and implementation of HIV programmes (Ghana AIDS Commission, 2002). The Ghana AIDS Commission Act 613 was further revised in 2016 based on global targets and goals in

addition to the changing dynamics of the national HIV response. The new Act (Ghana AIDS Commission Act 938) in addition to the roles specified in Act 613 provides for the establishment of an HIV Fund, the protection of human rights of persons living with HIV or AIDS and streamlining the administrative structure of the Ghana AIDS Commission (Ghana AIDS Commission, 2016).

Since the year 2000, the first population-based survey on HIV prevalence in Ghana was undertaken by the Ghana Demographic Health Survey (GDHS) published in 2003. Results of the survey indicated that the percentage of adults aged 15-49 years who were HIV positive was 2%. Following this survey, the mode of estimating HIV prevalence in Ghana has been modified and upgraded using sentinel surveillance of pregnant women attending Ante Natal Clinics (ANC) and the Estimation and Projection Package (EPP) Modelling. The estimated median HIV prevalence from 2009 to 2018 is shown in Figure 2.

Median HIV Prevalence 2009- 2018



Source: HIV Sentinel Surveillance Report, 2018

From Figure 2, the HIV prevalence among antenatal clients for 2018 was 2.4% (C.I 2.18 - 2.62) which was an increase from the 2017 prevalence of 2.1%. Despite the increase

observed between 2017 and 2018, HIV prevalence among antenatal clients since 2010 has been below 3%. Again, Figure 2 also shows a nationwide decline despite recent increases in the last five years. Efforts are still ongoing to sustain the reduction of prevalence through a scale-up of HIV prevention and control interventions.

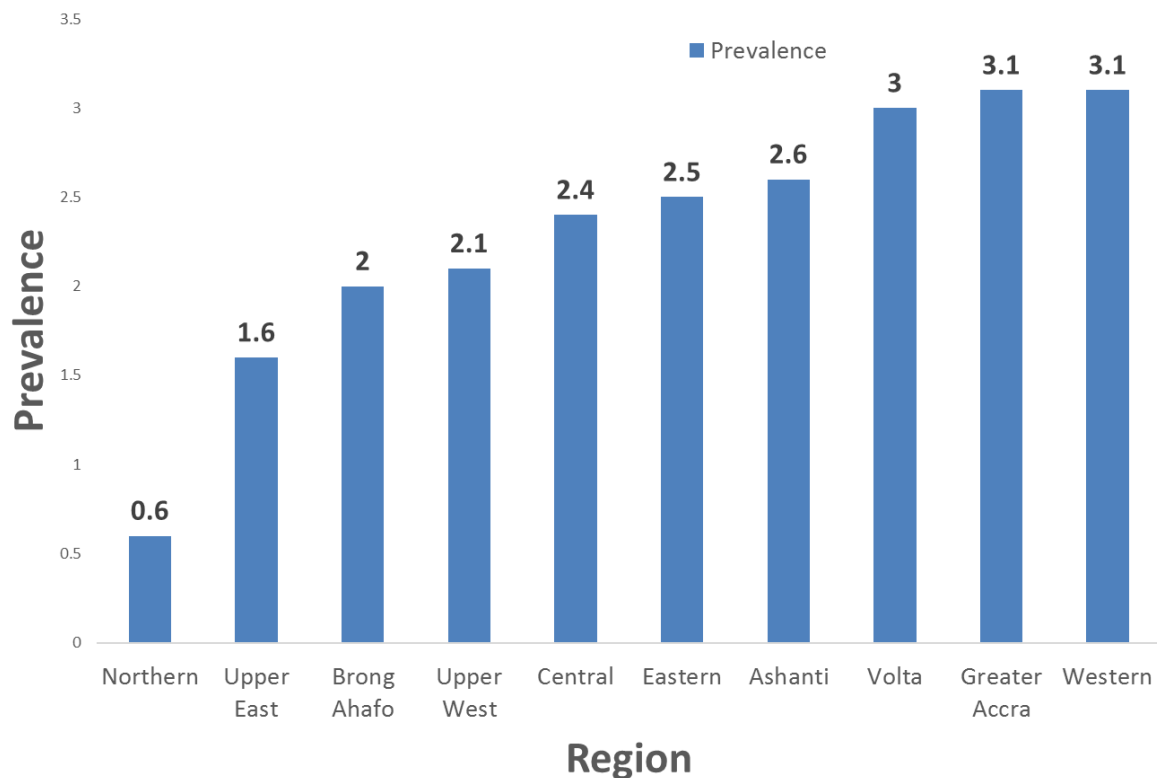


Figure 3: 2018 HIV prevalence by Region

According to the 2018 HIV Sentinel Survey Report, five regions recorded prevalence above the national median prevalence of 2.4% with significant increases in the Upper West and Western Regions from 1.3% in 2017 to 2.1% and 2.4% in 2017 to 3.1% respectively. Greater Accra was the region with the highest prevalence of HIV in the country for the year 2018. The Northern region characteristically recorded the lowest prevalence below 1% (0.6%). For three conservative years, there have been major swings in prevalence in all regions except the

Northern and Upper East regions. The Western region has in the last three years steadily increased its prevalence to one of the regions with the highest prevalence in 2018. The unstable variations in regional prevalence over the years therefore calls for targeted interventions across all regions aimed at achieving stability across board.

In the same year, the highest age group prevalence was recorded within the 35-39-year group (3.4%) and the lowest (0.9%) was within the 15-19-year age group. The 15 to 19 years' group has consistently remained the age group with the lowest mean prevalence since 2012. HIV prevalence in the young population (15-24) remained same as the previous year's prevalence of 1.5%. This sustained lowest prevalence among the young population (the proxy for new infections) is very positive and must encourage an intensification of HIV prevention interventions amongst them.

Ghana's HIV epidemic is firmly established as higher in urban sites compared to rural sites. However, in 2018, the gap is closing as median HIV Prevalence is 2.6% among urban sites and 2.2% for rural sites. This finding is affirming the fact that rural HIV prevalence is catching up with urban sites. However, this increase could be due to the fact that most of rural sites in Ghana have upgraded to urban sites based on the operational definition of a rural site. Hence there is the need to reassess rural sites for reclassification.

In 2017, the national HIV prevalence was 1.67%. This was made up of an estimated 313,063 Persons Living with HIV, with adults totalling 284,860 and children totalling 28,203. There were 19,101 new infections, with 3,422 being children between the ages of 0 and 14 years and 15,679 being adults. There were 15,694 deaths attributed to AIDS with 2,902 being children aged 0-14 years, and 12,792 being adults. In the same year, it was estimated that about 312,597 people needed access to the antiretroviral therapy (a combination of antiretroviral drugs used to treat HIV) out of which an estimated 284,860 were adults and

27,737 were children. An estimated 18,263 mothers needed Prevention of Mother-to-Child Transmission (PMTCT) services (National AIDS/STI Control Programme, 2018).

2.3.1 HIV Prevention Efforts

Studies conducted show that the best way to curb the spread of HIV is focusing on behavioural strategies. However, evidence shows that global prevention efforts are woefully inadequate to meet existing needs and this is further emphasized by the fact that less than 10% of individuals at risk globally are reached with major prevention services (Merson, Malley, Serwadda, & Apisuk, 2008). Despite the availability of tried and tested HIV prevention approaches and a scale-up of HIV treatment in recent years, new infections among adults globally have not reduced sufficiently. UNAIDS has cited key reasons to explain why there has not been much progress in the attempt to scale up HIV prevention programmes globally: lack of political will and as a result, inadequate investments; reluctance to target interventions that address the needs of young people, low focus on KPs and harm reduction; and a lack of systematic prevention implementation, even where policy environments permit it (UNAIDS, 2019).

In 2017, a global coalition of United Nations Member States, donors, civil society organizations and implementers was established to support global efforts to accelerate HIV prevention. Membership includes among others, the 25 highest HIV burden countries including Ghana. The overarching goal of the Global HIV Prevention Coalition is to get the buy-in of the holders of political power to prioritize prevention of HIV by developing a roadmap that has been agreed upon by key policy-makers, funders and programme implementers. In addition, the coalition must support the achievement of the 2016 United Nations Political Declaration on the Ending AIDS target which is to reduce new HIV

infections to less than 500,000 by 2020, from more than 1.8 million in 2016 in the respective states (UNAIDS, 2017a).

A major group that contributes substantially to new HIV infections is MSM. Over thirty (30) years into implementing HIV activities globally, evidence shows that MSM are the most vulnerable to HIV infection as they are 19 times more likely to be infected by HIV than the general population of reproductive age and have an overall HIV prevalence of 12% (AIDSFree and PEPFAR, n.d.). Research shows that MSM bear a disproportionate burden of HIV and are at increased risk of HIV infection especially in sub-Saharan Africa (SSA). As a result, it is globally recommended that the response to the HIV epidemic in SSA requires a non-discriminatory human rights approach to all at-risk groups, including MSM and to ensure that all populations in SSA, including MSM, have access to the full range of rights that help ensure equal opportunities for health and wellness (Abara & Garba 2017).

2.3.2 Epidemiology of HIV among MSM

In lower prevalence settings such as Ghana, the majority of HIV infections occur among key populations—people who inject drugs, sex workers, transgender people, prisoners, gays and other MSMs—and their sexual partners (UNAIDS, 2017b). Countries have in their own way employed quite a number of approaches to address this issue by providing key populations with HIV prevention commodities such as HIV testing services, condoms, pre-exposure prophylaxis, needles and syringes (UNAIDS, 2016a). In 20 countries where studies were conducted in 2009 and 2013, findings revealed that there was a decline in the percentage of MSMs reached with HIV prevention programmes from 59% to 40%. However, access varied greatly between regions and within countries (AVERT, 2019).

Results from recent studies, indicate the widespread existence of MSM groups across Africa with high rates of HIV infection through engaging in risky sexual behaviour, and evidence of behavioural links between MSM and heterosexual networks have been reported (LANCET,

2009). Data from 2017, showed that MSM were responsible for 57% of new HIV infections in Western Europe and North America, 41% in Latin America and the Caribbean, 25% in Asia and the Pacific and the Caribbean, 20% in Eastern Europe and Central Asia and the Middle East and North Africa. Data also shows that in the same year, they also accounted for an estimated 12% of new HIV infections in western and central Africa and in Mauritania, 45% of new HIV infections (AVERT, 2019). Homosexuals in sub-Saharan Africa have little or no access to HIV/AIDS information, preventive services as well as treatment (Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). It is for these reasons that regional hubs have recognised the importance of having specific interventions to prevent HIV among MSM especially since they act as a bridging population to the general population.

2.4 Factors Influencing risk of HIV among MSM

The high number of MSMs living with HIV across the world gives a clear indication of certain challenges that hamper the comprehensive provision of HIV services among this group. The factors that put MSMs at a high risk of getting infected with HIV can be classified under biological, behavioural and socio-cultural factors.

2.4.1 Biological Factors

MSM are highly prone to HIV infection by virtue of the fact that when they engage in unprotected anal sex, there is a higher risk of HIV transmission compared to unprotected vaginal sex. This is because, the walls of the anus are thin and more easily torn, creating an entry point for HIV into the bloodstream (AVERT, 2019). Another biological factor that has been identified is known as the “topping” or “bottoming” preference of the MSM. Insertive sex is when the male takes the “top” position (i.e., inserts penis into partner’s rectum) and receptive sex is when the male takes the “bottom” position (i.e., partner puts penis into man’s rectum) (Ghana AIDS Commission, 2011). If an HIV-negative person has insertive anal sex

with an HIV-positive partner, rectal fluid containing HIV can come into contact with the urethra and/or the penis foreskin which are vulnerable to HIV infection (Wilton, 2014).

2.4.2 Behavioural Factors

Many countries especially in sub-Saharan Africa consider the activities of MSM as illegal. As a result, this group becomes “hard to reach” with HIV prevention services. This is because their activities are not done overtly and therefore makes it difficult to plan targeted programmes for them. This therefore has implication on their knowledge about HIV prevention to be better able to protect themselves. For example, in Ghana, accurate knowledge about HIV, including being able to identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission, ranges from 50% to 65% amongst MSM (Ghana AIDS Commission, 2011) which is higher than the national estimate of 34% for men (Ghana Statistical Services, 2014b).

There is evidence to show that the knowledge gap that exist among MSM contribute to their low use of available HIV prevention services. For example, it was reported that in 2018, less than 60% of MSMs reported use of condom during last anal sex in 33 of the 87 countries that reported data to UNAIDS and only 15 countries had rates higher than 80% (UNAIDS, 2018). In Ghana, regarding HIV prevention seeking behaviour among MSM, including STI testing and results return, HIV testing and results return, being reached through peer outreach, or having visited a drop-in clinic, overall levels of use are low, with less than half of MSM in all sites having received any HIV prevention intervention (Ghana AIDS Commission, 2011).

2.4.3 Sociocultural Factors

Resulting from the values and norms that exist in many countries, the activities of MSMs are met with homophobia, stigma, discrimination and in worst cases, violence. As a response to these negative treatment, MSMs prefer not to make their sexual orientation openly known for fear of stigma and discrimination (AVERT, 2019). The situation of stigma and discrimination

related to HIV in Ghana is very high with just 8% of women and 14% of men within the age of 15 to 49 showing accepting attitudes on all four indicators of stigma associated with HIV/AIDS (Ghana Statistical Services, 2014b). Reports also indicate that stigma is highest among PLHIVs who are members of key populations than other PLHIV (Ghana AIDS Commission, 2014c). The pervasive nature of stigma and discrimination against PLHIV and by extension KPs including MSM makes them go into hiding and therefore do not benefit from the available HIV services. Even healthcare workers who declare neutrality and acceptance toward homosexuality have been known to display homophobic attitudes when providing healthcare services, breaching ethics standards and compromising effective delivery of care for sexual minorities (The Global Forum on MSM and HIV, 2010).

2.5 Predisposing factors to uptake of HIV prevention

2.5.1 Knowledge on HIV prevention services

Knowledge on HIV prevention services has been identified as central to the reduction of HIV infection. HIV prevention services include the provision of education about how to prevent HIV through the ABC model (abstinence, be faithful and use condoms) (Ghana AIDS Commission, 2014a). It also includes the provision of HIV prevention commodities such as distribution of condoms and access to stigma- and discrimination-free HIV testing services and referral to treatment (UNAIDS, 2016d).

Generally, there has been an increase in the knowledge about HIV prevention if one compares the 2014 Ghana Demographic and Health Survey to the 2008 Ghana Demographic and Health Survey. However, there are still gaps in comprehensive knowledge about HIV with persons still believing that someone who looks healthy cannot be infected with HIV, that a mosquito bite can transmit HIV, that HIV is caused from a supernatural source, and that sharing food with an HIV-positive person can cause one to become positive (Ghana

Statistical Service, 2014). Although knowledge might not be sufficiently protective in and of itself, having accurate and comprehensive information about HIV may benefit sexual health by impacting health promoting attitudes necessary for successful engagement in healthcare-seeking behaviour (Swenson, 2010).

2.5.2. Level of education

Evidence available suggest that the higher the level of education, the more likely one will engage in safer sex behaviours that prevent them from being infected with HIV. It is important therefore that education is prioritized towards ending the HIV and AIDS epidemic based on the fact that it is controllable, manageable and preventable, all of which can be realized through formal education (Mwamwenda, 2014). Lack of education is likely to result in low assertiveness and low self-esteem which increases the difficulty of accessing available services. (Paphassarang et al.2002).

Higher education levels are also clearly correlated with delayed sexual debut, greater HIV awareness and knowledge about HIV testing sites, fewer sexual partners, higher rates of condom use, and greater communication about HIV prevention between partners – all factors that substantially lower HIV risk (The Global Coalition on Women and Girls, 2011). Studies also suggest that educational level increases response to condom promotion and recommends the need for special efforts to reach men and women with low educational attainment with HIV prevention services (Lagarde, Carae, Glynn, & Kanhonou, 2001).

2.5.3. Membership of Social Network

A support group is a group of people who come together to discuss issues, experiences and/or roles that they have in common without being judged, blamed, stigmatised or isolated (Fanelli & Moyo, 2008). In the global HIV response, implementing support groups as a programme is expected to ensure that AIDS-related deaths are reduced, retention in care

improved and a moderate impact on mortality and quality of life of PLHIV (Bateganya, Amanyeiwe, & Dong, 2016). In Kenya, for example, there is a recognition that support groups provide an avenue where MSM can be easily reached and provided HIV prevention services. MSM support groups offers an opportunity for organizations to reach MSM with accurate health information, provision of safe sex lubricants, condoms and other health and social services (Okall et al., 2018). The establishment of self-help and support groups for MSM allows for easy access and the provision of information on SRH, including HIV/STI prevention, drug use, and referrals to services (USAID & Khmer HIV/AIDS NGO Alliance, 2008).

2.6. Enabling factors to uptake of HIV prevention

2.6.1. Policy/Legal Environment

Most countries in the world and in particular Africa consider the activities of MSM as illegal. It is reported that there are currently 67 countries that criminalise same-sex activities in 2019 thus infringing on the human rights of MSMs and other members of the LGBTQ community (AVERT, 2019). There are currently 13 countries that met out death sentences to persons that are homosexual such as Iran, Sudan, Saudi Arabia, Yemen and parts of Nigeria and Somalia (Carroll, 2016). In Ghana, the Constitution criminalises activities of MSM. The Criminal Offences Act proscribes the “unnatural carnal knowledge” of another person (s.104), where unnatural carnal knowledge is defined as “sexual intercourse with a person in an unnatural manner or with an animal” in s.104 (2) (Lithur, 2010). As a way to contain the activities of MSM, there are a reported 41 countries that have passed laws to restrict non-government organisations (NGOs) from working on LGBTQ issues (Mendos, 2019). Based on these realities, it is very difficult for MSM to be open about their sexuality and access HIV services for fear of discrimination or worse, imprisonment or death. Countries like Ghana have

developed HIV policies and plans (i.e. the National HIV and AIDS Strategic Plan 2016-2020) approved through national consultation and consensus building platforms to guide the provision of HIV services to MSMs using the public health approach.

2.6.2. Level of Income

The world spends a lot of money to ensure that its inhabitants have access to health care irrespective of income levels (Ghebreyesus, 2019). When people have to pay out of pocket for the cost for health services, the poor and vulnerable are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness (World Health Organization, 2019). To ensure equity and equality in accessing health services, countries are advised to adopt various forms of health insurance approaches which pools together resources for the benefit of the public (World Bank & International International Finance Corporation, 2014).

In Ghana, the Act that was passed to implement the NHIS started in 2003 to establish a National Health Insurance Authority; to implement a National Health Insurance Scheme; establish a National Health Insurance Fund to pay for the cost of health care services to members of the Scheme; establish private health insurance schemes and to provide for related matters (Government of Ghana, 2012). Despite the government's efforts to minimize financial barriers to health services, assuring that the NHIS is financially sustainable continues to pose a serious challenge and runs the risk of collapsing the scheme which will in-turn heavily burden those with low incomes.

2.6.3. Proximity to services

Proximity to services is crucial to uptake of service. This is even more true when it comes to populations in the rural areas as compared to the urban areas (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). In South Africa, even when health services are provided free of charge, monetary and time costs of travel to a local clinic pose a major obstacle for vulnerable sub-

groups of the society, leading to overall poorer health (McLaren, Ardington, & Leibbrandt, 2013). There are studies that support existing views that geographical proximity remains a strong catalyst for health care seeking (Al-mandhari, Al-adawi, Al-zakwani, Al-shafae, & Eloul, 2008).

Other studies indicate that distance impacts choice of a health facility, cost of health services, frequency of clinic attendance, and mode of transport from home to the health facility (Mwaura, Wandibba, & Olungah, 2017). This situation is also the same for MSM as studies conducted show the need to recognize the existence of LGBT (Lesbian, Gay and Bisexual and Transgender) and their diverse sexual and mental health needs, and the need to provide them appropriate health care and psycho-social services including HIV and AIDS prevention and treatment directly to them (Tadele & Amde, 2019).

2.6.4. Disclosure of sexual orientation

There are privacy and confidentiality policies that exist within Ghana that prevent disclosing a person's health status without their consent (Ghana Health Service, 2017). These policies are intended to allow the patient to comfortably share any information without fear of it being disclosed. However, in Ghana, there is evidence to show that disclosure as MSM or the perceived notion of one being MSM by health workers in some facilities is spread among health workers which in-turn results in stigma and discrimination (PEPFAR, Ghana AIDS Commission, & Health Policy Plus, 2018). To avoid this, MSM prefer not to disclose their sexual orientation which is a major obstacle to serving the unique needs of MSM in clinical settings. It is for this reason why using peer educators in the provision of certain health services is being adopted currently as they represent a decreased level of threat and facilitate uptake of services (Western Australian Centre for Health Promotion Research, 2010).

2.6.5 Attitude of community members

Homophobia has been reported as one of the key forces driving Africa's epidemic because stigma and discrimination makes MSM a hard-to-reach group for the provision of HIV prevention and early treatment services (UNAIDS, 2019). Studies on MSMs in Ghana show that they face violence in the communities they live. MSMs are abused physically and emotionally through insults by members of the community because their lifestyles are contrary to what society expects from men (Lithur, 2010). In other countries, MSMs are reported to be experiencing a high frequency of harassment, violence, and extortion, particularly from male sex partners met online and police (Li et al., 2018). Violence against MSM by community members can be effectively addressed if national governments are committed to address their issues, even in an environment where MSM behaviours are criminalized. Creating an enabling environment to promote wellbeing and safety for MSM is a critical enabler for HIV prevention programmes to achieve 90- 90- 90 goals (Bhattacharjee et al., 2018).

2.6.6 Capacity/skills of peer educators

There has been global recommendations for Men's health groups and organizations of MSM and transgender people to be seen as key partners that can be engaged based on their ability to facilitate interaction with sexually diverse communities and because they have a greater understanding of their emotional, health and social needs, and the cost of inaction (World Health Organization, 2011). In countries like Peru, MSM are purposefully engaged to lead HIV prevention activities that aim to encourage gay men to test for HIV through social media (Menacho, Galea, & Young, 2016). This approach led to an increase in proportion of MSMs who were able to use social media to discuss about sexual partners and about STIs. In order to promote the agenda of building capacity of MSM peer educators to provide HIV prevention interventions, there has been training manuals and modules developed. Globally,

organizations such as the International HIV/AIDS Alliance have developed a manual that is intended to train MSM to be actively involved in the provision of HIV prevention services (International HIV/AIDS Alliance, 2016). In Ghana, for example, there exists a standard operating procedure (SOP) that details the minimum package of prevention services that must be provided for MSM (Ghana AIDS Commission, 2014a). The SOP also provides standard guidelines for HIV and AIDS prevention programs targeting KP to ensure consistent quality of services within the national framework (Ghana AIDS Commission, 2014b). This SOP is used in the training of MSM who work in the community to ensure standardization of HIV services provision.

2.6.7 Availability of HIV prevention commodities

Central to undertaking health interventions is the provision of its related commodities. The same applies in HIV prevention. It is not possible to undertake HIV prevention interventions if there are no condoms, test kits and information, education and communication materials. To achieve the 90-90-90 treatment targets by 2020, there must be continuous availability of HIV commodities (UNAIDS, 2014). This therefore means that there has to be a constant supply of test kits, antiretroviral therapy and equipment to confirm viral suppression. To ensure that there is constant supply of commodities, Ghana has set up the health commodity security supply chain in all the regions. Drugs and supplies, including contraceptives, are managed through this supply chain to health facilities throughout the country (Manso, Annan, & Anane, 2013).

2.7 Need factors to uptake of HIV prevention

2.7.1 Health seeking behaviours of MSMs

General health seeking behaviour of Ghanaians is low. A number of initiatives have been instituted by Ghana to increase health seeking behaviours. The most prominent of such

initiatives is the National Health Insurance Scheme (NHIS). Although the NHIS is supposed to increase health seeking behaviours of Ghanaians, segments of the population especially the poor are less likely to utilize health services, suggesting that the NHIS has not succeeded in bridging inequalities in health services utilization between the poor and rich (Kuuire, Bisung, Rishworth, Dixon, & Luginaah, 2015). Health seeking behaviour of MSM in Sub-Saharan Africa is low. For example, MSM in Tanzania have reported stigma and discrimination, lack of confidentiality and privacy, lack of availability and MSM friendly HIV related health services, financial challenges, poor practices and negative attitudes directed towards them by health workers, fears and lack of HIV knowledge among them as barriers for them to access these available services (Magesa, Mtui, Abdul, Kayange, & Chiduo, 2014).

2.7.2. Empowerment of MSM community

Studies done on empowerment has led to a number of definitions for the term. However, for the purpose of this study, empowerment is defined as a progression that helps people gain control over their own lives and increases the capacity of people to act on issues that they themselves define as important (Luttrell, Quiroz, Scrutton, & Bird, 2009).

Empowerment of MSM is crucial to their uptake of HIV services. This is because they will be better placed and informed to insist on the provision of services and speak out against any form of stigma and discrimination that is meted out to them in the course of receiving HIV services. For example, many community-based voluntary counselling and testing (CBVCT) services for MSM have been initiated by the affected population themselves because they have been empowered and work collaboration with the other stakeholders (EURO HIV EDAT, 2019). It is therefore important that intentional efforts are made to empower MSM by creating avenues for trainings and public discussions on HIV prevention, treatment, care and research literacy for them (Durueke, Ukpong, Audu, Amuamuziam, & Adaranijo, 2011).

2.8 Conclusion

Based on the review of relevant literature, it is clear that there are a number of challenges in the provision of HIV prevention services to MSM. These challenges act as a barrier and causes low uptake HIV prevention services even if they is available. However, literature also shows how some countries have been able to address these barriers through the implementation of global policies and the recognition that prioritizing MSM HIV prevention interventions is crucial to reduce the HIV prevalence of the general population in the long term. It is therefore important to conduct a similar study to ascertain factors that could be enabling and hindering uptake of HIV prevention services among MSM in Ghana particularly Accra Metropolitan Area.

CHAPTER THREE

METHODS

3.1 Introduction

This chapter presents detailed description of methods applied in conducting the study. They include study design, study area, study population, inclusion and exclusion criteria, sampling methods, study variables, data collection tools and methods, data quality and analysis and ethical consideration or issues.

3.2 Study design

This is an exploratory research and employing qualitative techniques to collect and analyse data. Focus group discussions (FGDs) were conducted for peer educators who agreed to participate in the study. An in-depth interview was also conducted with a management staff of CEPEHRG upon agreement to participate. The study consisted of a total of 15 peer educators who are MSM and an executive member of CEPEHRG. This was because CEPEHRG currently has 15 peer educators who provide HIV prevention services to MSM in the Accra Metropolitan Area of the Greater Accra Region. Two separate focus group discussions were conducted, with the first group made up of seven (7) participants and the second group made up of (8) participants.

Focus Group discussions was used with the peer educators because it is useful to obtain detailed information about personal and group feelings, perceptions and opinions about a matter. It also saved time as many respondents views can be solicited and provides an avenue for the peer educators to seek clarification. However, in-depth interview was used for the management staff of CEPEHRG to acquire detailed information stemming from on the wealth of knowledge about the barriers and enablers to HIV prevention services among MSM within the Ghanaian context and particularly within the study area.

All the peer educators that participated in the study had a minimum of a year's experience in providing HIV prevention services to MSM and were willing to participate in the study. In the case of selecting the management staff, it was based on the length of time (a minimum of five years) the individual had held an executive position in the Organization and their willingness to participate in the study.

3.3 Study area

The study was conducted in the Accra Metropolitan Area of the Greater Accra Region. The Greater Accra Region is one of the sixteen administrative regions in Ghana. The region is divided into 10 administrative areas namely Ga South Municipal, Ga West Municipal, Ga East Municipal, Accra Metropolitan Area, Adenta Municipal, Ledzokuku Krowor Municipal, Ashiaman Municipal, Tema Metropolis, Dangme West District and Dangme East District (Ghana Statistical Service, 2013).

The Greater Accra Region has the second highest population after the Ashanti Region, with a population of 4,010,054 (1,938,225 Males and 2,071,829 Females) per the 2010 Population and Housing Census, accounting for 15.4 per cent of the country's total population (Ghana Statistical Service, 2013). The reason for this can be attributed to the fact that the Greater Accra has the highest growth rate of 3.1%. This is also because the region has the highest immigration rate in the country. The attraction of Accra as the capital of Ghana continues to put the capital at the receiving end of a steady migration of people and influence of external cultures from other parts of the country, neighbouring African Countries and European Countries.

The Accra Metropolitan Area which is the study area is one of the 260 Metropolitan, Municipal and District Assemblies (MMDAs) in Ghana, among the 16 MMDAs in the Greater Accra Region. It was established by the Local Government Act, 1993, (Act 462) and

Legislative Instrument 1615 which also established the Six (6) Sub-Metropolitan District Councils in 1898. Having gone through a number of changes in terms of size and number of Sub Metros, the AMA as it exists now was established in 2012 with L.I. 2034 following the creation of the La Dadekotopon Municipal Area (Ghana Statistical Service, 2013).

According to the HIV Sentinel Survey (HSS) Report, the HIV prevalence of the region has seen an increase from 2.1% in 2017 to 3.1% in 2018 (NACP, 2018). The 2017 Mapping and Population Size Estimation (MPSE) and Integrated Bio-Behavioural Surveillance Survey among MSMs in Ghana - GMS II showed that 35.3% and 36.9% of MSM in the Greater Accra Region had two or more male insertive sexual partners and two or more male receptive partners respectively. Approximately, fifty-seven (57%) of MSM in the Greater Accra region used condom at last sex with a man or a woman (bisexuals) and the highest HIV prevalence among MSM was in the Greater Accra Region (42.2%); followed by 25.4% in the Ashanti Region.

3.3.1 Centre for Popular Education and Human Rights, Ghana

CEPEHRG is a civil society organization that has been implementing MSM HIV prevention and education programmes in Ghana since March 2003. As a civil society organization, CEPEHRG was key in the development of the Most-At-Risk Population (MARP) Strategic Plan 2011-2015 (the first ever strategy targeting KPs in the country) in 2011 and continue to implement HIV prevention programmes targeting MSM till date. CEPEHRG was established to improve and promote the provision of HIV prevention services, human rights and social justice for sexual minorities through information sharing, education and empowerment. CEPEHRG provides human rights and HIV prevention education to reach their target populations which includes Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) community members. CEPEHRG's strength lies in the use of competent and well-trained

outreach staff/peer educators to reach their constituents and involving them in the design, implementation and monitoring of program activities.

3.4 Study population

The study population involved two set of respondents. They were, peer educators who are MSM and had been engaged by CEPEHRG and a management staff of CEPEHRG. The peer educators had been trained to provide HIV prevention services to their constituents within the Accra Metropolitan Area. For the purpose of this study, peer educators who are MSM were used because they are easier to reach, open about their sexuality and oversee a large number of MSMs within the Assembly. As a result, they were able to bring their personal experiences to bear, in addition to articulating the views of the MSM they provide services to (who may not want to participate in the study as a result of fear or perceived stigma about their sexual orientation) within the community. A management staff of CEPEHRG was interviewed, as they have the advantage of institutional memory and can provide some historical perspective on the barriers and enablers to uptake of HIV prevention services among MSM.

3.5 Inclusion criteria

Eligible study participants included the following

- Peer educators who are MSM and engaged by CEPEHRG
- Peer educators who have a minimum of one-year experience providing HIV prevention services to MSM and willing to participate in the study.
- An executive member of CEPEHRG with a minimum of five years' experience in that position and willing to participate in the study.

3.6 Exclusion criteria

Ineligible study participants included the following:

- Peer educators and executive member of CEPEHRG who refused to participate in the study
- Peer educators with less than a year's experience
- An executive member of CEPEHRG with less than five years' experience in that position

3.7 Data collection techniques and tools

The study tool used were interview guides to extract relevant information from the peer educators and the management staff of CEPEHRG during focus group discussions and in-depth interviews respectively. Inductive qualitative analysis was used for the study. The interview guide looked into the demographics of the MSM peer educators and sought their personal insights, as well, their perspectives on barriers and enablers to uptake of HIV prevention services by MSMs based on their experience working in the area they serve. In addition, the guide was used during the in-depth interview with the management staff of CEPEHRG. Perspectives from respondents received were audio recorded in addition to interviewer notes taken during interview sessions. Based on the feedback received from the respondents, codes and themes were identified to guide discussions and make conclusion and recommendation.

3.8 Quality control

To guarantee quality of study outcome, all data collection tools were pre-tested in Tema metropolitan area. A Research Assistant was trained prior to the commencement of study. All audio interviews and transcripts were cross checked with the written notes taken to ensure that no relevant information was lost.

3.9 Data processing and analysis

Based on the objectives of this study, the data collected provided information on whether predisposing factors such as knowledge, education and membership of a social network influences uptake of HIV service. It also provided information on how the policy environment, income, proximity, disclosure issues, attitudes of community members and availability of prevention commodities could affect uptake of HIV services. Finally, data on need factors such as health seeking behaviours of MSMs and empowerment of the MSM community were also collected.

All audio recorded interviews were transcribed verbatim and typed out using Microsoft word. Data from the transcripts were analysed to include but not limited to the following broad themes obtained from the objectives of the study; predisposing factors, enabling factors and need factors influencing uptake of HIV prevention services among MSM. Sub-themes were developed from the data collected to elaborate on the identified broad themes. A coding book was used to organize coding in NVIVO Version 11.

3.10 Pre-testing of interview guides

The interview guides were pre-tested among twelve (12) peer educators of CEPEHRG working in Tema Metropolitan Area. The purpose of pre-testing was to test clarity of the questions and to by similar study participants and to identify the lapses in the questions and assist in determining the duration of time required to administer the questions.

3.10 Ethical considerations

Ethical clearance

Ethical clearance was sought from the Ghana Health Service Ethics Review Committee of Research and Development Division in Accra.

Approval

Approval was received from CEPEHRG prior to commencement of data collection.

Consenting procedure

An informed consent form was given to participants prior to commencement of study. This informed consent form comprised a participant information sheet highlighting the principal investigator's background, contact information, purpose of the study, procedures, confidentiality, risks, voluntary participation and benefits of participating in the study.

The informed consent form was given to the proposed participants to read. Those who required clarification were given the opportunity to ask further questions to inform their decision. Upon agreement to participate in study, participants were asked to sign consent forms after which a copy of the information sheet was given to them.

Potential risk

There was no foreseeable risk to study participants as their anonymity was protected throughout the study. The interviews were held at the Office of CEPEHRG, as it provided a safe space for the MSM peer educators to congregate in their numbers. Participants were also given ample periodic breaks as and when they require to make them feel comfortable. In addition, there was transport arrangements made for peer educators who are unable to come to the interview site due to financial reasons.

Privacy and confidentiality

Focus Group Discussions were held in a private room in the office of CEPEHRG. This is because, the peer educators are comfortable with the surroundings of CEPEHRG and were more likely to be at ease to respond to questions comprehensively. To safeguard identity, names of participants were not collected to ensure anonymity. Only the PI and his academic supervisor had access to the data collected.

Voluntary consent and withdrawal

Participants were informed that involvement in study is voluntary and withdrawal at any point during data collection process was permissible. Respondents were also informed that they could choose not to answer questions they felt were uncomfortable.

CHAPTER FOUR

RESULTS

4.1. Introduction

This chapter presents results on the characteristics of the study participants and themes that emerged from the focus group discussions (FGDs) and key informant interview (KII) conducted. This chapter also presents findings on the socio-demographic characteristics of study participants, predisposing factors, enabling factors and need factors influencing uptake of HIV prevention services among MSM. Emergent themes included knowledge on HIV prevention, education levels, membership of social network, empowerment of MSM, income levels of MSM, policy/legal environment, attitudes of community members, capacity and skills of peer educators, health seeking behaviour of MSM and availability of HIV commodities.

4.2. Socio-demographic characteristics of study participants

In all, fifteen (15) peer educators who are directly involved in the delivery of HIV prevention services to MSMs in the Accra metropolitan area participated in focus group discussions. Two separate focus group discussions were conducted, with the first group made up of seven (7) participants and the second group made up of (8) participants. All the participants of the FGDs were MSMs trained as peer educators to embark on HIV prevention activities targeting MSM in the Accra Metropolitan Area.

There was a mix of peer educators that had different levels of experience providing HIV prevention services to MSM in the communities. The peer educators had between one year and the maximum of twelve years of experience in this field. Ages ranged from twenty-three (23) to above forty (40) years with most eight (8) in the 26 - 30 age category. In terms of educational qualification, four (4) had attained tertiary education, one (1) had received

vocational education, eight (8) had received education to the Senior High School level and two (2) had attained primary school education.

Table 1: Characteristics of peer educators involved in the focus group discussions

	Characteristics	Frequency
Age	23 – 25 years	5
	26 – 30 years	8
	40 + years	2
Highest level of education	Primary	2
	SHS	8
	Vocational	1
	Tertiary	4
Duration as peer educator	1 – 2 years	3
	3 – 5 years	7
	6 – 10 years	3
	Over 10 years	2

The management staff of CEPEHRG interviewed was 37 years old, had held the position for 7 years and holds a Master’s Degree.

4.3 Predisposing factors influencing the uptake of HIV prevention services among MSMs

Predisposing factors focuses on issues related to MSMs knowledge of HIV prevention services, educational status, membership of a social network, and how these factors influence uptake to HIV prevention services among them.

4.3.1 Knowledge on HIV prevention services

Peer educators must be from the MSM community as a pre-requisite to being selected. Prior to engaging MSMs in the communities, the peer educators are trained by the Ghana AIDS Commission and its partners to understand basic information about HIV including modes of transmission, engaging in safer sex and current prevention methods and services being implemented and provided in-country respectively. They are also trained in community entry approaches and psychosocial support to help MSMs who are HIV positive and those that suffer violence in the communities. There are also conscious efforts to link the peer educators to certain persons within the health facilities (i.e. MSM friendly facilities) and within the police service so that they can refer their clients when they have HIV- specific needs and suffer human rights abuses in the communities. The combination of training and linking peer educators to friendly partners in the police service and health facilities complements their work in ensuring the provision of comprehensive HIV prevention services. The quotes below are responses received from respondents showing how MSMs are selected, trainings they receive and their knowledge about HIV prevention.

“Before one can be a peer educator, he must be in the MSM community. Mostly we rely on networks. So, using the snowball strategy which is me knowing you, you knowing me and you knowing others and knowing your friends. That's the strategy we use. Through this snowball strategy where a community member refers another community member, we also meet these people and have an interview with them with some few questions which will let us know whether you are part of the community or not”.

(KII, Deputy Executive Director, CEPEHRG)

“If it was not from the training we got from GAC and partners, we will have not been able to perform our duties well. Our link to friendly health workers and the police gives confidence to our clients that we know what we are about”.

(27-year-old, SHS, peer educator for 9 years)

“The trainings we get is very important because it has helped a lot of people. An example is that now most people know their status and those who test positive have been enrolled and those who are not positive have been assured on protecting themselves by the use of condoms in order not to be affected by HIV. We know this because we were taught during the trainings”.

(40-year-old, primary, peer educator for 12 years)

“To add to that is the A, B, C model that we use: A- abstinence, you know we are human and we cannot abstain, not everyone can abstain. So, if you can't abstain you use Condom (C), correct and consistent use of condom. B- being faithful to your partner, delay sex, desist from sharing sharp objects”.

(27 years old, SHS, peer educator for 2 years)

However, feedback received from peer educators was that many of the MSM's in the community do not have adequate knowledge about HIV and prevention methods, and as a result, are not in the best position to adequately protect themselves from getting infected with HIV. Hence the presence and activities of peer educators brings HIV information and prevention commodities to their doorsteps. Using the peer educators' approach, the MSMs in the community are able to seek clarifications on issues about HIV that are alien to them and get practical demonstration on how to use HIV prevention commodities (example condoms) efficiently and effectively so they are fully protected from getting infected with HIV. MSM's are also given prevention information, education and communication materials so that they can share with other members in the community. In addition to HIV education, the peer educators also use the opportunity to educate the MSMs about other sexually transmitted infections.

“Our people do not have much knowledge about prevention methods that are around to protect them from HIV. Their knowledge is very low. We educate our peers about condom use and also for them to know their HIV status in life. We also educate them on STIs and others like gonorrhoea and tuberculosis”.

(25-year-old, primary, peer educator for 5 years)

“Because their knowledge is low about HIV, we give them more information about condom usage and how to have sex without breaking the condom or contracting sexually transmitted infections”.

(27-year-old, SHS, peer educator for 4 years)

4.3.2 Educational level of MSM

The peer educators interviewed mentioned that the level of education of an MSM has an impact on uptake to HIV prevention services. They attribute lack of education as a barrier as it prevents uneducated MSM from being able to read the predominantly English IEC materials to understand how to adequately protect themselves from getting infected with HIV. In addition, lack of education results in a lack of confidence in MSM to insist that their rights to services are upheld.

“I think the level of education too counts because the booklets and flipchart we use are written in English. If the person can’t read, then you have given it to him in vain. He will take it home and probably put it somewhere. He will not be able to benefit from the information written in the booklet”.

(27-year-old, SHS, peer educator for 4 years)

“To add to what he is saying, people that don’t know the law about stigma go to the clinic and a nurse may shout on them. They will then feel down because they don’t know their rights. There is no way I will be positive and go to the hospital and a nurse will shout on me because I am educated and know my rights. So, illiteracy really makes people stay away from services because they do not have confidence and maybe because a nurse shouted on them and they did not have confidence to argue their case, they wouldn’t go again. It makes them default or not go at all”.

(30-year-old, tertiary, peer educator for 9 years)

4.3.3 Formation of support groups

The study found that one of the major ways for information sharing and providing psychosocial support to each other is through the formation of support groups. Through the support groups they are able to discuss issues related to HIV prevention and learn from each

other. In addition, it provides an avenue for MSMs who are living with HIV to meet other persons living with HIV to be able to cope with their status.

“I think it’s good because it’s not all the time about talking about sex in the meeting. We can do other things for people to learn about HIV so we are well informed. When we face abuse in the communities and find out we are HIV positive, we need someone to talk to so we do not commit suicide and support groups help us. We learn from each other about how to protect ourselves and how to protect ourselves for HIV”.

(24-year-old, vocational, peer educator for 2 years)

Being a member of a support group provides emotional support to the MSM. It provides them the opportunity to meet and interact with people who share the same sexual orientation and deal with the same issues they face. A support group ensures that an MSM has someone to talk to or ask for help should they be faced with any issue either health or non-health related. It acts as a safe-haven for MSM where they know they will not be judged on the basis of their sexuality.

“I think support groups is important because it helps people feel that I’m not alone and that there are others who are like me and going through what I am going through so there is hope for me. Because of the challenges we face, it helps that support groups are around so we can help each other on not only HIV issues but personal stuff”.

(29-year-old, vocational, peer educator for 3 years)

4.4 Enabling Factors influencing the uptake of HIV prevention services among MSMs

Enabling factors focuses on getting the perspective of the respondents on issues related to existing policy/legal environment, level of income, Proximity to services, disclosure of sexual orientation, attitude of community members, capacity/skills of peer educator and availability of HIV prevention commodities and explore how these factors influence uptake of HIV prevention services among the MSM population.

4.4.1 Policy/Legal environment

Feedback received indicates that the current legal environment makes it difficult for MSM to uptake available HIV prevention services. The current laws in the country criminalizes the activities of the MSM thereby having a negative ripple effect on accessing available HIV services.

“Actually, the legal policy environment is a little bit complicated. Generally, homosexuality is not accepted in our country so that is one of the biggest challenges to MSM going for HIV services. Then all kinds of criminalizing stuff through section 104 of the constitution which causes stigma and discrimination against them will not make them go for services”.

(KII, Deputy Executive Director, CEPEHRG)

However, there is a window of opportunity that exists within the legal environment. This is the presence of HIV policies and plans developed by the Ghana AIDS Commission that have been endorsed by His Excellency, the President of the Republic of Ghana and provide provisions that create an enabling environment for the provision of HIV services to MSM even in the midst of the general legal framework.

“For now, with the help of Ghana AIDS Commission we have some few policies and plans which are a little favourable to the MSM population and we use that to provide services to MSM. The good thing is that the current HIV strategic plan from 2016-2020 which provides strategies for engaging MSM is signed by the President”.

(KII, Deputy Executive Director, CEPEHRG)

4.4.2 Attitude of community members

Being openly gay or a homosexual is frowned upon in Ghana. It is culturally and religiously unacceptable. This reflects in the general attitudes of Ghanaians about activities of MSM. Derogatory comments are passed by people claiming that peer educators are encouraging homosexuality, thus brainwashing people to engage in homosexuality.

“I have a friend who anytime I try to mobilize peers for education he will go like: “As for you people, the thing that destroyed Sodom and Gomorrah that we are being advised to stop, you are going around gathering people and encouraging them to do it, you should rather go and seek after God”.

(30-year-old, tertiary, peer educator for 9 years)

Some family members voice out their displeasure about peer educators associating with their wards.

“I went to call one of my peers for a group discussion and his mother said: “Don’t drag my son into those things that you people are doing”. It was as if I was initiating her son into something but her son already knows everything and I am rather giving him education”.

(27-year-old, SHS, peer educator for 4 years)

Identified MSMs in the community are sometimes physically assaulted. These actions against MSMs deters them from accessing available HIV preventive services for fear of being recognized or identified.

“Just this year (2019) there was an attack on a peer educator in Kumasi who had gone on his normal education. When he was educating his peers, some guys were outside listening to him. After he had finished and was leaving, they asked him whether he was the one fuelling homosexuality in the community. He was attacked and had bruises on him”.

(KII, Deputy Executive Director, CEPEHRG)

These assaults towards MSM by community members deters peer educators from going into some communities and providing HIV preventive services to their colleagues who need them.

“We know our own people in the community are those a high risk of HIV and you want to help them. But there are sometimes you go to the communities and realize they need help but you can't go there because you may be attacked by community members. They will abuse you just like that”.

(29-year-old, tertiary, peer educator for 3 years)

4.4.3 Income level of MSM

Peer educators indicated that level of income act as a barrier to uptake of HIV services. They admitted that lack of money prevents some clients from benefiting from HIV prevention services as many are unable to pay for transport to the service centres. They mentioned that when there are training opportunities in HIV prevention education and per diems are not added, most of the clients are unable to attend due to financial challenges thereby missing out on important information required to protect oneself from being HIV positive.

“At my level, sometimes you ask them to participate in a training or education training, they tell you they don’t have transportation. They miss out on a lot of training when we tell them there is no money to be given when we finish the programme”.

(24-year-old, vocational, peer educator for 2 years)

Other peer educators added that their clients know that being on anti-retroviral drugs when you find out you are HIV positive require that you maintain good nutritional habits to ensure that the medication works. However, many of them are unable to afford this so prefer not to test to know their HIV status so they are not saddled with the additional financial burden associated with knowing one is positive.

“Our people know that after taking the HIV drugs for some time you will need to eat well and buy good food for the drugs to work. Since they do not have money they say that knowing their status will bring them cost so they will rather not know so they will not test at all”.

(25-year-old, SHS, peer educator for 4 years)

4.4.4 Proximity to services

Access to condoms, lubricants and HIV information, education and communication materials have been made easier through the activities of peer educators. This has resulted in improved usage of HIV prevention commodities among MSMs. This is because, not only are the commodities cheaper from the peer educators as compared to market prices, but during community outreaches programmes, they are also given out to MSM free of charge. For example, public health condoms that are given out by the Ghana Health Service to civil society organizations including CEPEHRG are sold at a very low cost i.e. 10 pesewas for a strip of three or given out for free during outreaches in the communities. These affordable prices are to encourage patronage and use of condoms during risky sexual encounters. Ghana AIDS Commission has also made condom vending machines available in the communities to increase access to the communities and address the issues of stigma related to the purchase of condoms at pharmacies.

“Most people don’t know how to use their condoms and they are shy to visit the drug stores for them. But being a peer educator, your role is to provide them condoms and lubricants sometimes as low as ten pesewas per 3 strip. This has helped us deliver condoms to our clients without them going to the pharmacy and has improved their uptake of other prevention services too. The placement of the condom vending machines at vantage areas in the communities by the Ghana AIDS Commission has helped make condoms accessible”.

(24-year-old, vocational, peer educator for 2 years)

4.4.5. Disclosure of sexual orientation

The disclosure or suspicion of one's sexual orientation as an MSM results in discriminatory, judgemental, rude and sometimes violent attitudes from health workers working in the facilities. This behaviour by health workers act as a barrier to uptake of HIV prevention services. MSMs disclose their sexual orientation to health workers to assist them to understand the health problems they have so they can get the requisite treatment and care. However, the mere suspicion or sometimes disclosure of one's sexual orientation results in stigma and discrimination by the health workers. Hence, MSMs are not too enthused about seeking health care services in general. This defeats the efforts to provide comprehensive HIV services to MSM and in-turn affects the country's achievement of reducing new HIV infections.

“So, they face stigma and discrimination at some point during service delivery. For example, you refer a client to a health facility and the client may have problems at the anal region. The nurses tend to ask that you are a man and what happened that you have a problem at the anal region. Then the conversation starts and that's where the stigma also starts and you see people gossiping and telling others that person who came here is this and that”.

(KII, Deputy Executive Director, CEPEHRG)

“It is when you share your problem that you will get a solution to it. You cannot tell a nurse that you have anal wart and then when she asks you whether you have anal sex you say no. There is a reason why nurses take patients medical history. It helps them know where to start the medication from. If you tell the nurse that you have anal sex, she will know the right medication to give you. But most people cannot disclose their sexual orientation to the health workers and it is affecting uptake of services”.

(27-year-old, SHS, peer educator for 4 years)

“If you disclose your sexual orientation, some of the nurses will quickly change their facial expressions. They will stigmatize you so some of the clients don’t want to go to the hospital”.

(30-year-old, tertiary, peer educator for 9 years)

“With the public facilities, immediately you tell them you are MSM, the way they will even look at you or the comments they will make will make you feel bad. Some will take you to a small room, take a bible and start preaching to you”

(27-year-old, SHS, peer educator for 4 years)

4.4.6. Capacity/skills of peer educators

One of the efforts that government institutions such as the Ghana AIDS Commission and the National AIDS/STI Control Programme have been implementing through civil society organizations (CSOs) to improve the uptake of HIV prevention services in the communities is through the formation and training of peer educators. These peer educators are chosen from the community based on their understanding of the context of the environment and their familiarity with members in a community. This opportunity is leveraged upon to provide a wide array of HIV prevention services to the community. This approach is also used for MSMs to ensure they are not left behind in the provision of HIV prevention activities. These peer educators are recruited and trained to help improve access to HIV preventive services amongst their peers and colleagues. Below is a quote from the deputy executive director of CEPEHRG detailing their role in building capacity of peer educators and how the peer educators use these skills to provide HIV prevention services.

“In terms of HIV prevention services, we do what we call the peer education outreach where we train people to go into the community and educate their peers on HIV prevention messages. We ensure they are well equipped for this task. We also distribute condoms and water-based lubricants through these peer educators to educate and give to their clients for them to live positively in order to avoid HIV and other sexually transmitted infections. We train the peer educators to do referrals where we refer our clients to health facilities to go and seek further health services. Then we also do STI treatments at our drop-in centres and health facilities also. We also offer the HIV testing services for community members through outreaches and other mediums based on mobilization by peer educators”.

(KII, Deputy Executive Director, CEPEHRG)

Peer educators indicated that they were trained on the HIV continuum commencing from the HIV education, importance of knowing one's HIV status and staying on treatment once testing positive.

“Hmmm, we learnt that if you don't get adequate education on HIV and you engage yourself in risky behaviours, you will contract HIV. We also learnt that there is life after HIV. If you go for an HIV test and you are reactive, there is the need for you to be enrolled on treatment. And once you are in care, you must be monitored to make sure that you are going to the health facility for your treatment. Once you are taking your medication and visiting the clinic when you are supposed to, you will get viral suppression. This means that the mode of transmission is reduced and your viral load comes down”.

(30 years old, SHS graduate, peer educator for 4 years)

They are also educated on the rights of MSMs as patients or clients when they seek health care and the responsibility of not having unprotected sex with others if they know they are HIV positive as this is criminal and they can be prosecuted.

“To add to all that, we were also told about the rights of patients or clients. As a person living with HIV or client, you shouldn't have unprotected sex with other people. If a person knows his status as positive and has unprotected sex with other, it is a crime. The person can be prosecuted if reported. We know that MSM has the right to seek healthcare and we educate our people as such”.

(30 years old, tertiary, peer educator for 9 years)

Peer educators also educate colleagues on the availability of treatment for persons living with HIV (PLHIV) and encourage them to know their HIV status. If the MSMs test negative, peer educators educate them on how to continue living without HIV. However, if they are reactive, peer educators will refer them to health facilities to be placed on life-saving antiretroviral drugs after a confirmatory test is done to confirm results. They also educated people on their right to health care as citizens of Ghana as guaranteed in the 1992 constitution

“Because we have skills and well informed, it has helped a lot of people in our community. An example is that now most people know their status and those who test positive have been enrolled on treatment and those who are not

positive have been given education and assured of protecting themselves by the use of condoms so they are not affected by HIV. They know this because we thought them from the skills we have acquired”

(40-year-old, primary, peer educator for 12 years)

4.4.7. Availability of HIV Prevention Commodities

The study showed that there tends to be intermittent shortages of HIV prevention commodities especially condoms and lubricants which are used together to prevent HIV infection. Globally, it is encouraged that condoms are used with lubricants to ensure that there is no tearing of the condom during anal sex. These shortages create a situation where MSMs are not able to be reached with condoms and lubricants thereby leading them to engage in unsafe sex.

“Yes, we face challenges. Mostly shortage of condoms and lubricants and we have to wait till some come in. The last time we distributed was in May. Since then we've not had supply of commodities so the few ones that are available are the ones we distribute to them. They are likely to engage in risky sex and get infected during this period because of access”.

(KII, Deputy Executive Director, CEPEHRG)

“Sometimes the lubricants get short a lot and that's what we use most with the condoms. So, some people use their spit leading to condom breakages. This is because the lubricants at the pharmacies are expensive. This places them at high risk of getting the virus”.

(41-year-old, SHS, peer educator for 10 years)

4.5 Need factors influencing the uptake of HIV prevention services among MSMs

Need factors focuses on issues related to MSM's health seeking behaviour and the opportunities available to empower them to demand services and effect on uptake of HIV prevention services.

4.5.1. Health seeking behaviour of MSMs

Peer educators mentioned that the health seeking behaviour of MSM in the communities is heavily influenced by the real or perceived bad treatment they will receive from providers of

health services because of their sexuality. They mentioned that the stigma and discrimination some MSM have faced while trying to access HIV prevention services is communicated to other MSM within the community which in-turn results in low health seeking behaviour among MSM.

“I have my friend who was reporting to me always that when he goes, the nurse behaves some way towards them. So, when he himself is going to for the drugs (ARVs), he feels uncomfortable”. He also does not like encouraging other MSM to go the health facilities for HIV testing”.

(25-year-old, primary, peer educator for 5 years)

“The attitude of the nurses is also part of it. They shout at them and even though some clients know their rights, the negative attitudes still affect them. So, they prefer to stay at home and not go for services at the hospital. A few of them are even complaining about facility A and B (names withheld) because they have been abused a lot by the health workers”.

(30-year-old, tertiary, peer educator for 9 years)

The disbelief of the existence of HIV affects the health seeking behaviour of some MSMs. They refuse to test to know their HIV status and so cannot be immediately put on treatment if they test positive. For this group of MSMs, it is only when they start experiencing the onset of symptoms of HIV such as continuous illness, chronic fatigue, severe weight loss and persistent diarrhoea that they seek HIV services. However, at this stage, there is very little that can be done except to encourage the person to stay on treatment. Below is a quote detailing when some MSM seek health services.

“For some of them, they won’t believe when you tell them about HIV so they will not test. But when they become positive and the virus starts doing damage to the body. That’s when they’ll run to you”.

(29-year-old, tertiary, peer educator for 3 years)

Peer educators recounted instances where in their line of duty, they were told by other MSM that they cannot be infected by HIV. Study participants attributed this stance by members of the MSM community as the basis for many of them not utilizing available HIV services. This

in-turn translates into engaging in risky sexual behaviours that places them at risk of getting infected with HIV.

“Yes, because some people think they know too much. Sometimes if you want to educate them about HIV, they will tell you it doesn’t exist. So, you have to calm down and know how to talk to them”.

(40-year-old, peer educator for 12 years)

“There are MSM who think they cannot be infected so whatever you tell them, they will not use the prevention methods. There are others who still refuse to believe that the virus is real so they will not mind you when you talk to them”.

(29-year-old, tertiary, peer educator for 3 years)

4.5.2. Empowerment of MSM community

Study participants indicated that many MSMs are not empowered to make the right choices about safe sex and do not know where to go when they require HIV education. They attributed this lack of empowerment about sexual reproductive health and rights to the culture and values of the populace. Generally, there is stigma related to conversations around sexual reproductive health and rights issues such as safer sex education and utilizing HIV prevention commodities that can be linked to engaging in sex e.g. condoms and lubricants. Based on the fact that people are not empowered to demand HIV services because they are not aware of their availability or do not want to be stigmatized, it results in low uptake of services. In the case of MSM, this situation is even more complex. This is because, there are no fora or platforms where they can be educated and empowered about their specific sexual reproductive and rights. In addition, available educational materials to empower the populace is tailored to respond to the specific needs of heterosexuals and not homosexuals thereby placing them at a disadvantage. The peer educators indicated that this limited to no information or education about their specific HIV prevention needs made them engage in risky sex prior to becoming peer educators. They added that other MSMs who have not been

empowered like them because of the trainings they have received still engage in unsafe sex and do not utilize available HIV preventive services because they have not been empowered.

“But on a more serious note, irrespective of all these things, we are here in Ghana where parents hardly talk to their children about sexual practices and all that. You can’t even talk about your sexual orientation if you are MSM...you get me. So, it is very, very scary. I myself, when I learnt about these things, it was a little bit too late. You get me! And I wish I know that the whole time I was doing all the things that I was doing, I could be infected with HIV. I was just having sex with men and thinking it was just something. But I got informed and I felt like I needed if I was more empowered earlier I would have been careful. I wish I could turn back the hand of time so that I get more information. So, I think this information is very, very important”.

(24-year-old, SHS, peer educator for 4 years)

“Most importantly, people think having sex with a guy there will be no pregnancy so there is no need to use a condom. They think we use condom because we want to prevent pregnancy, not STI. So, people have unprotected sex with men because they feel that even if they “cum” in them there will be no pregnancy so I am safe, forgetting the aspect of STI and HIV. So I think that it is important for them to be empowered to know that having unprotected sex can generally cause harm”.

(30-year-old, tertiary, peer educator for 9 years)

There have been efforts made by the CHRAJ and the Ghana AIDS Commission to ensure that MSM are provided with up to date information to empower them to know their rights and report cases of human rights abuses they face for redress. Through platforms such as the CHRAJ online reporting system and through social media platforms like WhatsApp, MSM are able to report cases of human rights abuses they face for redress and provided up to date information on issues ranging from HIV to Sexual and Gender Based Violence (SGBV).

“Talking about rights, they have also enlightened us a lot on gender-based violence and how we can seek justice. We have also learn how to report when someone attacks you physically. We have the CHRAJ online reporting system and WhatsApp to help us communicate violence and abuse we face and also share information about SGBV and HIV”.

(27-year-old, SHS, peer educator for 4 years)

CHAPTER FIVE

DISCUSSION

5.1. Introduction

This chapter discusses the findings of the study in relation to existing literature to assess predisposing, enabling and need factors that influence uptake of HIV prevention services among MSM.

Those interviewed included peer educators who have been recruited by CEPEHRG to provide HIV prevention services to MSM. These peer educators are MSM that are based in the community they operate. The peer educators in this study had been at post from a minimum of a year to twelve (12) years with an age range of 23 years to above 40 years. The management staff interviewed on the other hand was the deputy executive director of CEPEHRG who had held that position for seven years.

5.2. Predisposing factors influencing the uptake of HIV prevention services among MSMs

The study found that the knowledge of peer educators about HIV, its mode of transmission and prevention approaches available was adequate. However, regarding other MSM in the communities under study, the peer educators indicated that they have low knowledge about HIV, its modes of transmission and prevention approaches. The study corroborates results from a Ghana AIDS Commission (2011) report which showed that in Ghana, accurate knowledge about HIV, including being able to both identify ways of preventing sexual transmission of HIV and refute the misconceptions about HIV transmission, ranges from 50% to 65% amongst MSM. This study also gave credence to the low knowledge about HIV among MSM when peer educators confirmed that many of their clients do not believe that HIV is real and as a result cannot be infected. The study further supports findings from

UNAIDS (2018), that the knowledge gap that exists among MSM about HIV contributes to their low usage of HIV prevention services which was echoed by the peer educators. The outcome of low knowledge by MSM in the community according to the peer educators supports findings from the Ghana AIDS Commission (2011) report which showed that in Ghana, accessing HIV prevention interventions including STI testing and results return, HIV testing and results return, being reached through peer outreach, having visited a drop-in clinic for prevention services are overall low. The study discovered that peer educators are an active partner in the provision and uptake of HIV services based on their unique role of being MSM and the trainings on HIV prevention approaches they receive prior to their commencement of their duties. Also, based on the fact that they are MSM, they are able to communicate and educate their clients based on their life experiences rather than being theory based.

The study supports findings from Paphassarang et al. (2012), that education level is important to MSMs uptake of HIV prevention services. Indeed, education provides MSM with confidence to insist their right to health care and services are upheld. In addition, education provides clients with the ability to read and comprehend the messages on the HIV prevention materials that are distributed during outreaches (which are mostly in English) unlike the uneducated ones.

This study showed that being part of a support group positively facilitates the uptake of HIV prevention services. The benefit of being a member of a support group in relation to uptake of HIV prevention services from this study is corroborated by the findings by Okall et al. (2018) and USAID & Khmer HIV/AIDS NGO Alliance (2008) in their study. The platform provided by a support group acts conduit for education on HIV prevention and the provision of HIV commodities especially condoms.

5.3. Enabling Factors influencing the uptake of HIV prevention services among MSMs

The study supported existing literature that the legal environment in Ghana is not favorable to activities of MSM and this results in stigma and discrimination against them. These findings from the study reinforces UNAIDS (2019) assertion that homophobia is one of the key factors that drive the HIV epidemic in Africa as it promotes stigma and discrimination. Also, feedback from the peer educators and management staff of CEPEHRG confirm findings from Lithur (2010) that the laws of Ghana criminalizes the activities of MSM in Ghana. The ripple effect of the legal environment is violence and abuse against MSM by community members. Findings from a study conducted by Li et al (2018) was corroborated by responses from peer educators when they indicated that they experience frequent harassment and violence from members of the community in the performance of their duty. The attitudes of community members are also consistent with findings by the Ghana Statistical Service (2014) which showed that less than 15% of men and women expressed accepting attitudes on all four indicators of stigma associated with HIV and AIDS. This implies that there is 85% of the population that still express negative attitudes of stigma associated with HIV. This therefore results in low uptake of services and must be addressed.

The study discovered that the combination of the legal environment and attitudes of community members act as a barrier to uptake of HIV services. This is because, they prevent peer educators from being able to provide HIV prevention services to MSMs at some areas in the Accra Metropolitan Area for fear of being met with violence from community members. Despite this, there exist a window of opportunity that allows CEPEHRG and by extension peer educators to perform their duties as Ghana does not have laws that restrict non-government organisations (NGOs) to work with MSM as compared to other countries per the findings of Mendos (2019). The presence of national HIV policies and plans that guide the

provision of HIV services to MSMs using the public health approach should be funded and comprehensively implemented to increase uptake of prevention services.

This study confirms the findings from a World Health Organization (2019) report that income levels have major impact on uptake of health services with those heavily burdened being the poor and marginalized in society. This study showed that limited to no resources prevented many MSM from benefitting from HIV available prevention services especially training opportunities where they will get access to HIV education. Based on this reality, the study supports the recommendations made the World Bank & International International Finance Corporation (2014) which calls for countries to adopt and sustain a form of health insurance approach which pools together resources for the benefit of the public. Through the comprehensive implementation of this recommendation, MSMs could be able to access some essential HIV prevention commodities free of charge with their health cards and this will facilitate equity and equality in accessing health services including HIV services. In Ghana, there has been some efforts made through the National Health Insurance Scheme (NHIS) to minimize financial barriers to access of HIV services but this should be scaled-up.

The study corroborates findings from a study conducted in South Africa which showed that even when health services are provided free of charge, monetary and time costs of travel (proximity) to a local clinic pose a major obstacle to uptake of HIV services (McLaren et al., 2013). The study reiterates the assertion that by Al-mandhari et al (2008) that geographical proximity remains a strong catalyst for health care seeking behaviours by individuals. The study discovered that the approach adopted by Ghana to deal with the challenges of proximity regarding MSM service provision is the deployment of peer educators into the community to provide prevention services directly to MSM.

This study supports the findings from PEPFAR, Ghana AIDS Commission, & Health Policy Plus (2018) on the negative attitudes that result from disclosing ones sexual orientation

especially from health workers. A study conducted by Western Australian Centre for Health Promotion Research (2010) indicated that one of the ways to mitigate the negative feedback received by MSM from providers of health and/or HIV prevention services upon disclosing their sexual orientation was through the introduction of peer educators, this study is in agreement with the study findings. This study findings also coincides with the results from AVERT (2018) study which showed that many MSMs experience homophobia, stigma, discrimination and violence, and as a result, hide their identity and sexual orientation. The outcome of this is that MSMs will go into hiding therefore making it difficult to identify them and provide them with available HIV prevention services.

The study discovered that MSM were trained by the Ghana AIDS Commission and its partners before they are given the peer educator role. This finding corroborates the provision from the Ghana AIDS Commission Standard Operating Procedure developed in 2014 that calls for the provision of a minimum standard package of services to be provided for KP including MSM. This study found out that when MSMs are trained on HIV prevention approaches, they in-turn provide HIV services to their constituents which leads to increase in uptake of prevention services. The study also discovered that without the training done for peer educators prior to their deployment into the community, the peer educators will not be able to deliver on their role effectively and efficiently.

This study showed that Ghana faces challenges in the achievement of the 90-90-90 treatment targets based on the reality of intermittent availability of HIV commodities. According to UNAIDS (2014), there must be a constant availability of HIV commodities as a pre-requisite to the achievement of the treatment targets. However, feedback from the peer educators and the management staff of CEPEHRG indicates that they face challenges with availability of HIV prevention commodities thereby hampering their ability to perform their duties and resulting in low uptake of HIV prevention services. The feedback also received from the

respondents about the intermittent shortages of commodities show a gap in the country's health commodity security supply chain. According to Manso, Annan, & Anane (2013), the health commodity security supply chain is to ensure the constant supply of health commodities but there clearly are reported shortages from beneficiaries. There must be priority placed on improving the health commodity security supply chain to ensure that MSM can uptake HIV prevention services whenever they need to do so.

5.4. Need Factors influencing the uptake of HIV prevention services among MSMs

The study was in agreement with the results from an analysis conducted by Magesa, Mtui, Abdul, Kayange, & Chiduo (2014) in Tanzania which showed that the health seeking behaviour of MSM is low because of the real or perceived stigma and discrimination they may face from health workers if they attempt to access services. This therefore creates a mistrust of the health system by MSM and will cause them avoid accessing available HIV services. Managing MSM cases must be intentionally integrated into the training curriculum of health personnel before they are officially deployed to a health facility. The early exposure and training of health workers about this sub-group will help them in dealing with them appropriately. This will create confidence and trust in the health system by MSM which will in-turn have a positive effect on uptake of HIV services. This study also corroborated available data that the general health seeking behaviour of Ghanaians is low (Kuuire, Bisung, Rishworth, Dixon, & Luginaah, 2015) which therefore explains in part, the low health seeking behaviour of MSMs in the country.

Focus group discussions with the peer educators showed that they were empowered per the definition expounded by Luttrell, Quiroz, Scrutton, & Bird (2009). They showed awareness about their requirements of their role as peer educators, as well as their rights as guaranteed by the constitution especially where it relates to health. The functions peer educators play in

the country is based on the exposure and opportunities provided them by the Ghana AIDS Commission and its partners through training. The role of peer educators in HIV prevention service delivery is similar to the roles that other empowered peer educators play in their communities around the world (EURO HIV EDAT, 2019). The empowerment of peer educators can be attributed to the presence of the national documents such as the National HIV and AIDS Policy and National HIV and AIDS Strategic Plan 2016-2020 which clearly recognises the presence of MSM and prescribes specific prevention interventions that should be provided to them. However, the study showed that not all MSMs are empowered like the peer educators so efforts need to be made to support them.

5.5. Study Limitations

1. The timeframe allotted by the University of Ghana for data collection and analysis was limited this therefore affected the duration of interviews with respondents and did not allow the PI to probe other aspects of the study.
2. Specifically, a focus group discussion with other MSM in the community (beneficiaries) who are not peer educators to get their views would have given a holistic perspective about the situation but time did not permit.
3. Conducting an in-depth interview for all peer educators would provide deeper insights and perspectives from them. However, due to inadequate time, FGD for them was used.
4. The study may be subject to social desirability bias due to the tendency of respondents to provide responses expected by the PI.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Introduction

This chapter provides conclusion to the study as well as practical recommendations based on the study findings and feasible suggestions from study participants. It also provides strength and limitations of the research and proposes areas for further studies.

6.2 Conclusion

Peer educators demonstrated adequate knowledge about HIV information, education and communication issues and commodities available based on their responses to questions related to modes of transmission of HIV, how HIV can be prevented and HIV prevention services available for the MSM sub-population. Similar to the peer educators, the management of CEPEHRG represented by the Deputy Executive Director showed adequate knowledge about the national HIV response and the policy landscape that exists to support the provision of HIV prevention services to MSM. All peer educators who participated in the study agreed that adopting a prevention approach is the way to prevent new HIV infections especially among MSM. They also attributed their knowledge on HIV prevention approaches to the Ghana AIDS Commission and its partners prior to commencing their duties which they mentioned was central to their performance as peer educators.

The study identified some factors which served as either barriers or enablers to uptake of HIV prevention services among MSM. Some barriers identified are low level of education and income levels of MSM, unfriendly legal/policy environment coupled with negative attitudes of community members, disclosure of sexual orientation, negative attitudes of health workers, low health seeking behaviour of MSM and intermittent shortages of HIV prevention commodities. Some enablers also identified was the presence of competent and empowered

peer educators, formation of support groups, improved access to HIV prevention education through peer educators, easy access and affordability of HIV preventive commodities through peers.

It is important that national policy makers and planners take note of the barriers identified to make a conscious effort to address them and improve upon the enablers to ensure that the gains and progress made are sustained and scaled-up. It is also important to recognise the importance of peer educators, a means to increase uptake of HIV prevention services amongst MSMs.

6.3 Recommendations

The following are proposed recommendations based on study findings and practical suggestions from study participants.

- A. The Ghana AIDS Commission should work closely with civil society organizations to train more MSM as peer educators so that HIV prevention services can be provided effectively to this sub-population. In order to prevent overburdening the current peer educators, efforts must be made to identify and train new peer educators in the Accra Metropolitan Area.
- B. The Ghana AIDS Commission and CEPEHRG should continue to intensify its community based approach. Community-based approach occurs when there is a shift from providing HIV services only at health facilities to the community. Adopting this approach will improve uptake of services especially among MSM as they face stigma and discrimination at health facility.
- C. CEPEHRG must strengthen support groups for MSM in the Accra Metropolitan Area. The peer educators cited support groups as crucial because it provides psycho-social support to them when they face issues of stigma and discrimination. It also provides

an avenue where they can learn from each other especially on HIV prevention. CEPEHRG must explore alternative sources of funding to ensure the continuation of the work of the support group.

- D. The Ghana AIDS Commission should work with CHRAJ to revamp the CHRAJ online reporting system to respond to current issues faced by MSM. There should be capacity building sessions organized for CHRAJ staff nationwide and MSMs once the reporting system is revamped. CHRAJ Staff must be trained on how to retrieve data from the reporting system and case management of MSM issues whereas MSM are trained on how to file a complaint using the system for redress.
- E. The Ghana Health Service must continue to make HIV prevention commodities especially condoms easily accessible and affordable to MSM in the communities. From the study, it is clear that CEPEHRG and the MSM population in the Accra Metropolitan Area rely heavily on these prevention commodities. Hence it is important they are readily available for use if any progress is to be made in the reduction of new HIV infection. In addition, the provision of these prevention commodities must be accompanied by training and demonstration on its use.

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APPENDIX 1A: INTERVIEW GUIDE FOR MANAGEMENT STAFF OF THE CENTRE FOR POPULAR EDUCATION AND HUMAN RIGHTS, GHANA

Background Information	
Age	
Sex	
Qualification	
Management Position Title	
Duration	

SECTION A

1. Provide a brief background to the establishment of your organization highlighting the human resource in-house?
2. What HIV prevention services does your Organization provide?
3. Does the current legal/policy environment prevent you from providing all the HIV prevention services available?
4. What criteria is used to select MSM peer educators to support your work? (age, education, income level)
5. Can you give an overview of the roles the peer educators perform in the Organization?
6. What training opportunities are available to these peer educators to make them effective in their service delivery before and after they start their community outreach?
7. What are the challenges faced by your peer educators in their work in the community?
8. How do you address the challenges faced by the peer educators?
9. Do you have support groups in the community for the MSM?
 - If yes, does being a member of a support group influence uptake to HIV services?
 - If no, why not?
10. Does your organization face challenges with supply of HIV prevention commodities? (shortage of test kits, lubricants, test kits and other prevention commodities)
11. Do you engage the community before deploying your peer educators to provide HIV prevention services? Explain your response.

12. What is the attitude of community members towards your peer educators and the MSM population?
13. Do you work with Government institutions?
 - If yes, describe how you collaborate with Government to undertake your work?
14. How involved is your organization in the development of national MSM studies, policies, plans and M&E?
15. Do you have recommendations to improve the current provision of HIV prevention services for MSM (If any)?

APPENDIX 1B: INTERVIEW GUIDE FOR PEER EDUCATORS

	Unique No: <input type="text"/>
Date	
Location	
Principal Investigator	

Background Information	
Age	
Highest educational level	
Duration as peer educator	

1. Were you trained on HIV prevention provided before you commenced your role?
 - a. If yes, by which organization
 - b. If yes, in what area of HIV prevention?
2. Are there other areas in HIV prevention that you that was not included in the training?
 - a. If yes, what are they?
3. What HIV prevention services do you provide as a peer educator in the community?
(explore their knowledge on importance and types of services provided)
4. Are there other HIV prevention services you are not providing?
 - a. If yes, what are they?
5. What are the modes of transmission of HIV?
6. How can HIV be prevented?
7. Is there any importance in the establishment of support groups in the provision of HIV prevention service?
8. Do you establish support groups in the communities for the MSMs you provide services?
 - a. If yes, are there any benefits?
 - b. If no, why not
9. Does a client's level of education influence their uptake of the HIV prevention services you offer?
 - a. Give reasons to your response.
10. Does a client's level of income influence their uptake of the HIV prevention services you offer?
 - a. Give reasons to your response.

11. Does the distance of the HIV prevention service to the client impact on their uptake?
12. Is there a relationship between disclosing your sexual orientation to uptake of HIV prevention services?
13. Does the legal environment affect your performance as a peer educator?
14. Does the legal environment prevent your clients in the community from accessing the services you provide?
15. Do you engage the community before you commence your work in the community?
 - a. Give reasons for your answer
16. Do you face any stigma as a result of your work from the community?
 - a. Explain your answer
17. Do your clients face any stigma when accessing HIV services from the community?
18. Do you face shortages of HIV prevention commodities in your work?
 - a. If yes, how are you able to continue your work effectively?
 - b. If yes, how long does it take before you receive new stock?
 - c. If yes, how often does it occur?
19. Does the availability of HIV prevention commodities affect uptake of services?
20. How involved are you in the development and implementation of national policies and plans?
21. What mechanism do you use to ensure that the information and decisions that are made at national level are transferred to your clients?
22. Do you use available platforms to insist on your right to access HIV prevention services?
 - a. Give reasons for your answer
23. Does knowledge and training on HIV prevention services affect uptake of services for the MSM community?
24. What is the attitude of your clients to accessing HIV prevention services from health facilities?
 - a. Give reasons for your answers
25. Do you refer your clients who test positive to the health facilities for treatment?
 - a. Give reasons for your answers

APPENDIX 2A: PARTICIPANT INFORMATION SHEET

- i. **Title of Study:** ASSESSING BARRIERS AND ENABLERS TO UPTAKE OF HIV PREVENTION SERVICES AMONG MEN WHO-HAVE-SEX WITH MEN IN THE ACCRA METROPOLITAN AREA

- ii. **Introduction:** I am Kwaku Osei, the Principal Investigator, and a Master of Public Health student in the Department of Health, Policy, Planning and Management of the School of Public Health, University of Ghana
Contact: 0244247277
Email: oseik15@live.com

- iii. **Background and Purpose of research:** This study seeks to study aimed assessing barriers and enablers to uptake of HIV Prevention services among Men who-have-sex with Men in the Accra Metropolitan Area

- iv. **Nature of research:** The study is a qualitative study and will take place at the Office of CEPEHRG. Focus group Discussions (FGDs) will be conducted for peer educators and an in-depth interview will also be conducted with the management staff of CEPEHRG. An audio recorder will be used during the FGD and in-depth interviews. Participants are required to share information on factors that enable or hinder your uptake of HIV prevention services by responding to questions. The study will consist of a total of 15 participants primarily consisting of peer educators and an executive member of CEPEHRG

- v. **Participants involvement:**
 - **Duration /what is involved:** Data will be collected from MSM peer educators and a management staff of CEPEHRG through focus group discussions and an in-depth interview respectively. Focus Group Discussions and in-depth interview will span for an average of 25 minutes and will be held at conducive environments within the office of CEPEHRG with the aim of ensuring utmost privacy

 - **Potential Risks:** The study will not pose any risk to you. However, in case of emotional trauma, you will be given periodic breaks to pull themselves together. In

severe instances where you may require further assistance, you will be referred to a professional counsellor for support.

- **Benefits:** Participating in the study will not yield any financial benefits to you, however findings from this study will contribute to improving uptake of HIV prevention services among MSM. Furthermore, findings will be beneficial to you as it will contribute to the development of targeted policies to ensure availability and accessibility of HIV services for your group. MSMs in areas within the Accra Metropolitan Area that do not access available HIV prevention services will be identified and relevant institutions notified to address the issue.
- **Costs:** You will not incur any cost if you agree to participate in the study, besides your time.
- **Compensation:** You will not receive any monetary or material compensation for participating in the study. However, the cost of transportation to the office of CEPEHRG from your residence will be borne by the Principal Investigator.
- **Confidentiality:** Your name and identity will not be recorded in this study. However, the information you are going to provide will be coded and will be treated strictly confidential. You are assured of total confidentiality to the information you will give. Apart from the Principal Investigator and Academic Supervisor, no one else will have access to information provided. Data will be collected using digital tape recorder and note pads. All paper records will be stored safely stored in cabinets under lock and key while audio recording will be stored in password protected folders. Paper and electronic records collected will be destroyed after a minimum of three years as per research protocol.
- **Voluntary participation/withdrawal:** Participation in this study is voluntary. You can choose to withdraw from the study or stop the interview at any time you want. You can also choose not to answer any question(s) you find uncomfortable about. You will not be penalized in any way for your refusal to participate in this study. However, you are encouraged to participate fully in this study to help improve uptake of HIV prevention services among MSMs.

- **Outcome and Feedback:** Findings and recommendations would be available at the School of Public Health and it will also be disseminated to various stakeholders at a meeting at the end of the study.
- **Feedback to participant:** Findings will be shared with participants at the end of the study.
- **Funding information:** The principal investigator will solely fund this study.
- **Sharing of participants Information/Data:** You are assured of total confidentiality to the information you will give. Apart from the Principal Investigator and Academic Supervisor, no one else will have access to information provided.

Provision of Information and Consent for participants

A copy of the Information sheet will be given to you after it has been signed or thumb-printed to keep.

Who to Contact for Further Clarification/Questions:

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APPENDIX 2B: CONSENT FORM FOR PEER EDUCATORS

Title of Study: ASSESSING BARRIERS AND ENABLERS TO UPTAKE OF HIV PREVENTION SERVICES AMONG MEN WHO-HAVE-SEX WITH MEN IN THE ACCRA METROPOLITAN AREA

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (English [] ,Ga[], Twi[], Ewe[] or Hausa[]). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I have agreed for the audio recorder to be used during this session YES [], NO []. I voluntarily agree to be part of this research.

Initials of Participant..... ID Co.....

Participants' Signature/Thumb-Print.....

Date:.....

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the English [] Ga[], Twi[], Ewe[] or Hausa[] language to his/her proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter.....

Date:.....

Contact Details:

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood English [] Ga[], Twi[] Ewe[] or Hausa[]

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name/Initials:

Signature/Thumb-print of participant:.....

Date:.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature

Date.....

APPENDIX 2C: CONSENT FORM FOR CEPEHRG MANAGEMENT STAFF

Title of Study: ASSESSING BARRIERS AND ENABLERS TO UPTAKE OF HIV PREVENTION SERVICES AMONG MEN WHO-HAVE-SEX WITH MEN IN THE ACCRA METROPOLITAN AREA’’

PARTICIPANTS’ STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants’ Information Sheet read and satisfactorily explained to me in a language I understand (English []). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I have agreed for the audio recorder to be used during this session YES [], NO []. I voluntarily agree to be part of this research.

Name or Initials of Participant..... ID Co.....

Participants’ Signature/Thumb-Print.....

Date:.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher’s name.....

Signature

Date.....


APPENDIX 3: GHANA HEALTH SERVICE ETHICAL CLEARANCE

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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

MyRef. GHS/RDD/ERC/Admin/App 19/181
Your Ref. No.

Kwaku Osei
University of Ghana
School of Public Health



Your Health Our Concern

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
7th May, 2019

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

GHS-ERC Number	GHS-ERC 022/04/19
Project Title	Barriers and Enablers to Uptake of HIV Prevention Services among Men Who-Have-Sex with Men in the Accra Metropolitan Area
Approval Date	7 th May, 2019
Expiry Date	6 th May, 2020
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

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

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

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

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