EXPLORING BARRIERS AFFECTING LOW ACCESS AND UTILIZATION OF HIV RELATED SERVICES BY MEN-WHO-HAVE-SEX WITH MEN IN GHANA

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Ghana

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EXPLORING BARRIERS AFFECTING LOW ACCESS AND UTILIZATION OF HIV RELATED SERVICES BY MEN-WHO-HAVE-SEX WITH MEN IN GHANA

A thesis submitted in partial fulfillment of the requirement for the degree in Master of Public Health

By;

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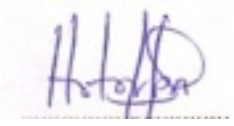
Declaration:
Where other peoples work has been used (either from printed source, internet source or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

This thesis: ***Exploring Barriers Affecting Low Access and Utilization of HIV Related Services by Men-Who-Have-Sex with Men in Ghana*** is my own work.

Signature 

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I cannot be able to convey the full extent of all your support which strengthened me to pass through this course successfully;

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Abstract

Background: Ghana has over the years experienced a stable generalized HIV epidemic until recently when emerging data indicates concentration among Key Populations at higher risk including MSM, IDUs and FSW. Among these groups, MSM are found to be disproportionately affected yet with low uptake of HIV related services.

Objective: This paper aimed to critically assess various barriers affecting low access and utilization of HIV related services by MSM to aid in making recommendations to Ghana AIDs Commission to improve uptake of HIV Services.

Method: Conducted critical analysis of reviewed literature pertaining to uptake of HIV services among MSM with guidance from the adapted Health Belief Model by Wirtz et al., 2014.

Study Results:

Study Results: Broad spectrum of studies from Africa suggest MSM engage in high risk behaviours such as transactional sex, unprotected anal sex, group sex, anal fisting and overlapping behaviours including the use of party drugs and alcohol. Such risk behaviours also have been reported in Ghana accounting for a high rate of new infections compared to other key populations at higher risk. Major concern on Health system factors regarding inadequate privacy, confidentiality, discriminatory attitudes, knowledge and skills of Health workers was found to significantly affect uptake. Nonetheless fear, social norms, political support and criminalization of MSM was very much outstanding as structural barriers accounting for the continuous low uptake to HIV services by MSM.

Conclusion: The continuous low uptake of HIV Services by MSM as suggested by this paper is greatly affected by the numerous barriers existing. There is urgent need to deal with these barriers by improving the Health system factors, targeting MSM with Interventions, revising current HIV, STI Policy and Training Curriculum to include MSM whiles advocating for repealing of laws criminalizing MSM to improve service provision and increase utilization.

Key words: *Men-who-have-sex with Men (MSM), Health, Access, Utilization, HIV and AIDS, Ghana, sub-Sahara Africa.*

Word Count: 12,599

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
BCC	Behavior Change Communication
CBOs	Community Based Organizations
CCM	Country Coordinating Mechanism
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DICs	Drop-In-centers
FHI 360	Family Health International 360
FSWs	Female Sex Workers
GAC	Ghana AIDS Commission
GHS	Ghana Health Service
GIZ	German Development Cooperation
GRID	Gay Related Immune Deficiency
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling

IBBSS	Integrated Biological and Behavioral Surveillance Survey
ICT	Information Communication Technology
IEC	Information, Education, and Communication
M&E	Monitoring and Evaluation
MARP	Most-at-Risk-Populations
MoH	Ministry of Health
MSM	Men who have Sex with Men
NACP	National AIDS and STI Control Program
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NSP	National Strategic Plan
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
IDU	Injecting Drug Users
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations

UNAIDS	Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WAPCAS	West Africa Project to Combat HIV and STI
WHO	World Health Organization

GLOSSARY OF TERMS

Anal sex: The Oxford Dictionary defines anal sex as an insertion of erected penis into a person's anus or rectum for sexual pleasure.

Drop In Center**:** A space intended as a welcoming place for MSM which can protect them against violation of human rights and as well offer them access to services like HIV Testing, BCC, Water based lubricants and STI screening.

MSM**:** MSM is a term created in 1994 in order to reduce stigma against gay, bisexual, transgender people and self-identified heterosexual men who engage in anal sex with other men, by describing behaviors rather than social or cultural identities (Young, 2005).

Sabin et al.s, 2013 definition in Ghana of the following terms were employed;

Bisexuals: Refers to men that have sex with both males and females or assume the role of either the male or female in a relationship and are known as '50 - 50'.

Commercial sex worker: *It is used to* refer to a man who has sex with other men in exchange for money. Commercial sex workers include both masculine and feminine gays.

Feminine Gay: A man who have sex with men but display some form of feminine features.

Masculine Gay: It is term is used to describe a man who has sex with other men, and who displays no obvious external feminine features suggestive of homosexuality.

Male pimp: A man who arranges meetings for men to have sex with other men. He essentially brokers transactional sex between men and other men for a fee.

Drag queen: This refers to an MSM who sometime dresses like a woman for show at parties, carnivals, and other events.

Married man: This is a man who is married to a woman, and also has sex with other men.

Transactional Sex: Transactional sex is defined as male sex with another male in exchange for money, gifts, or favors.

Other definitions according to the UNAIDS Terminology Guidelines, 2011;

Heterosexual: The term ‘heterosexual’ is used to refer to people who have sex with and/or are attracted to people of the opposite sex.

Homophobia: Homophobia is defined as fear, rejection, or aversion, often in the form of stigmatizing attitudes or discriminatory behavior, towards homosexuals and/or homosexuality.

Homosexual/homosexuality: The word homosexual is derived from the Greek word ‘homos’, meaning ‘same’. It refers to people who have sex with and/or sexual attraction to or desires for people of the same sex.

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CHAPTER 1: INTRODUCTION

Introduction

"MSM from low- and middle-income countries are in urgent need of HIV prevention and care, and appear to be both understudied anunderserved"
(Baral et al. 2007).

As a young Social Worker, I found myself after graduation in 2009 to be involved in HIV Prevention services targeting marginalized populations such as Female Sex Workers (FSW), and Men who have sex with Men (MSM). Around this time it was identified the HIV epidemic was concentrated among FSW, MSM and IDUs as Key Populations at higher risk (KPs). To date, only few MSM Access and Utilize HIV related services in Ghana although they are indeed considered at higher risk to HIV. The West Africa modes of transmission report in 2009 draw attention of the country on the high rate of infection originating from MSM population. In view of this, the AIDS Commission in 2010 led a robust movement to develop ''Most at Risk Population (MARPS) Strategic Plan'' now known as ''Key population at higher risk Strategic Plan'' to mobilize resources in addressing the increasing epidemic among KPs.

Three years on, some progress has been made in terms of utilization of preventive services by other KPs compared to MSM. For example, the Ghana AIDS Commission suggested a continuous low uptake of HIV services by MSM in their 2013 Mid Term evaluation report. I decided on this thesis topic with respect to my personal curiosity as an NGO worker involved in HIV preventive services to MSM in order to learn and understand more the target group I work with.

BACKGROUND INFORMATION

1.1 Geography

Ghana is located in West Africa and situated just above the Equator. The country lies between latitude 4 degrees and longitude 1 degree. The Greenwich Meridian passes through its industrial city, Tema, located in the Greater Accra region of the country (GSS et al., 2009a). Ghana shares border with Togo in the East, Ivory Coast to the West, Burkina Faso to the North and the Gulf of Guinea is located in the south (GSS, 2010b).

1.2 Demographic Characteristics

The population of Ghana is about 25million, representing an increase of 30.4% compared to the previous census data of 19million. The population by sex is 1male:2females. The growth rate stands at 2.5%, which means it will take about 28yrs for Ghana's population to double. The life expectancy in Ghana at birth is 55.0 for males and 59.2 for females (MOH, 2013). Over 51% of the populations reside in the urban and 49% also in the rural areas. The population is considered as very young, thus, 38.3% of the population is below 15years (GSS, 2010).

1.3 Political Profile

Ghana became the first Sub Saharan African country to gain independence in 1957. Since then, series of coup d etat led to deferment from the 1981 constitution until a new constitution was approved to restore the multiparty Politics system in 1992. The 1992 Constitution has since been reviewed only once (MOJAG, 2013). The country is subdivided into 10 administrative regions and currently has 216 districts (LGRD, 2012).

1.4 Socio-Cultural Situation

Over 100 languages exist in Ghana but the most dominant ones are Twi, Ewe, Dagbani and Ga. The Larger proportion (72%) of the population are Christians, 17% are Moslems, 5.2% adhere to traditional religion and 5.3% do not profess any form of religion. The predominant ethnic group is the Akans constituting 47.5% of the population, followed by Dagbani 16.6%, Ewe 13.9% and Ga 7.4%. All ethnic groups have their cultural beliefs, values and practices but with vast similarities (GSS, 2010b). The use of health service is seen to be affected by these different cultural beliefs and practices (Saleh, 2013). Literacy rate is 67% and in terms of education 23.4% of the population has never been to school (GSS, 2010b).

1.5 Health System

The country is experiencing an epidemiological transition which has lead to double burden of disease due to the increasing reports of non- communicable disease (39%) and communicable (53%) accounting for a large proportion morbidities and mortalities (WHO, 2011). Ghana Health Service (GHS) was established under as an agency to the Ministry of Health (MOH) to bring quality healthcare to every Ghanaian (GHS, 2007a).Health service delivery is carried out through decentralized structures. A detailed data-base has been established by Ghana Health Service to monitor activities of Private health care services (MOH, 2010).Out of 165 Public Health facilities 34.% have Quality Assurance team in place(GHS, 2011b).

In health care financing, the total health expenditure is 5.2% of Gross Domestic Product (GDP) and Out of pocket payments is 66.4%. The Health sector still face major challenges such as weak management of Health system, information system, shortage, inequitable distribution of facilities, health workers(GHS, 2011b). Also the estimated number of doctors, nurses and midwifes per 10,000 populations is still 1 as shown below in the case of Ghana and other countries in Sub Sahara Africa.

Table 1.1: Health Worker per Population in Ghana and selected Countries

Country	Doctors	Nurses	Pharmacist
Uganda	1:20,000	1:20,000	1:2000
Togo	1:16,667	1:5,887	1:3333
Ghana	1:10,700	1: 1,587	1:14,6

Source: (GHS, 2011)

1.6 Global HIV Response

The first AIDS cases reported in 1981 was identified among gay men in the U.S.A. AIDS then became known as Gay related immune deficiency referred to as 'GRID'(Altman et. al 2012). In 2012 prevalence among MSM ranged between 1%-57% in all member states with the highest median prevalence in Central and Western Africa. In the Global AIDS response, Sub Sahara Africa (SSA) remains more affected than other regions. In 2012 out of about 1.6 million new infections occurred in sub Sahara Africa (UNAIDS, 2013)

Current global estimates indicate 38million people are living with HIV (UNAIDS, 2013), and over 9.7 million on life saving Antiretroviral. The key points of WHO shows that Treatment gains are not reaching Key populations at higher risk (KPs) and therefore emphasized the need for improving access for them to benefit equitably from ART (WHO, 2013).

1.7 HIV Response in Ghana

Ghana's epidemic is reported to be a generalized epidemic although concentrated among Key Populations at higher risk (KPs). National prevalence stands at 1.37% and 1.9% in 2012 and 2013 respectively (NACP, 2014). In rural settings HIV prevalence is 0.2% and 11.6% in urban areas. About 224,488 people are living with HIV, 7812 new infections and death related to AIDs was 10,074 in 2013(NACP, 2014) The HIV response in Ghana is organized through existing decentralized structures (Regional and District AIDS Committee) and coordinated by the Ghana AIDS Commission (GAC) under the Office of the President. GAC provides national leadership in a multi-sectoral response. It coordinates the HIV response through active involvement of all state ministries, the private sector, NGOs, traditional and religious leaders and civil society organizations. The National AIDS Control Program (NACP) on the other hand is responsible for the formulation and implementation of clinical policies and guidelines (GAC, 2004).

CHAPTER 2: PROBLEM STATEMENT AND METHODOLOGY

This chapter presents in the sections below the problem statement, justification, study objectives and the methodology.

2.1 Problem Statement

According to WHO, comprehensive HIV service package for MSM include HIV Testing and Counselling (HTC), behavioural change communication provision condom and water based lubricants, treatment, care and support for PLHIV, and STI management (WHO, 2011). Comprehensive HIV prevention coverage for MSM globally was 52% in 2009 and 54% in 2012 (UNAIDS, 2013). Access by MSM to these services are different in various regions, thus, 12% in Africa and 43% in Latin America (UNAIDS, 2008).The global estimation report shows Africa, where Ghana is located, has the lowest HIV service coverage as for MSM.

Available estimates also show MSM are 19.3 times more susceptible to HIV compared to the general population (Baral et al. 2007). In Ghana very little research has been done on MSM especially in areas of HIV treatment, care and support services. The available data is limited to only preventive services such as Condom provision, BCC, STI and HTC. A critical step to HIV Prevention and Treatment is HIV Testing and Counselling (WHO, 2013). A recent survey in five regions in Ghana suggest over 70% (N=1302) of MSM have never been tested for HIV (IBBSS, 2011). Majority of MSM in Ghana also have low access to basic information on HIV and AIDs. Another survey conducted around the same time among MSM also found over 90% of MSM knew of a place to access HIV services but 9% (13,500) utilized these services(AED, 2008). The Ghana AIDs Commission has attributed the low uptake in part to stigma, discrimination and unfavourable legal environment and has called for further research to better understand the HIV epidemic among MSM (GAC, 2013).

The average HIV prevalence among MSM is 17.5% (GAC, 2013) against 1.9% in the general population (NACP, 2014). Also, it is reported that seven (7) categories of MSM in Ghana as explained by them exist: this include masculine gays, feminine gays, bisexuals, commercial sex workers, drag queens, male pimps and married men. The size estimation of MSM in Ghana is about 30,000 in 2011, thus, 13,500 reached with information on HIV prevention through one-on one peer led and about others through social media including Face book, Badoo and Whatsapp (GAC, 2013).All MSM are identified in Ghana as Key populations at higher risk (KPs) together with IDUs and FSW (GAC, 2011).

Among high risk groups, MSM seem to be neglected in terms of access to Intervention programs. In 2013 over half of FSW identified were reached by Peers with information on prevention services such as HIV Testing and Counselling (HTC),BCC, STI, Condom and Lubricant use compared to less than a third of MSM who were reached that year (FHI, 2013).

The lessons learnt from the West Africa Modes of Transmission (2009) as report by Bosu and Yeboah, (2010), revealed that key populations at higher risk (KPs) and their partners in Ghana contribute 41% (N=13,437) of all new HIV infections with 7.9% attributed to MSM and their partners. Also, the graph below show MSM contribution is high compared with FSW and IDUs. The low risk heterosexual population is still the largest source of infection followed by partners of clients of sex workers as reported below in 2009:

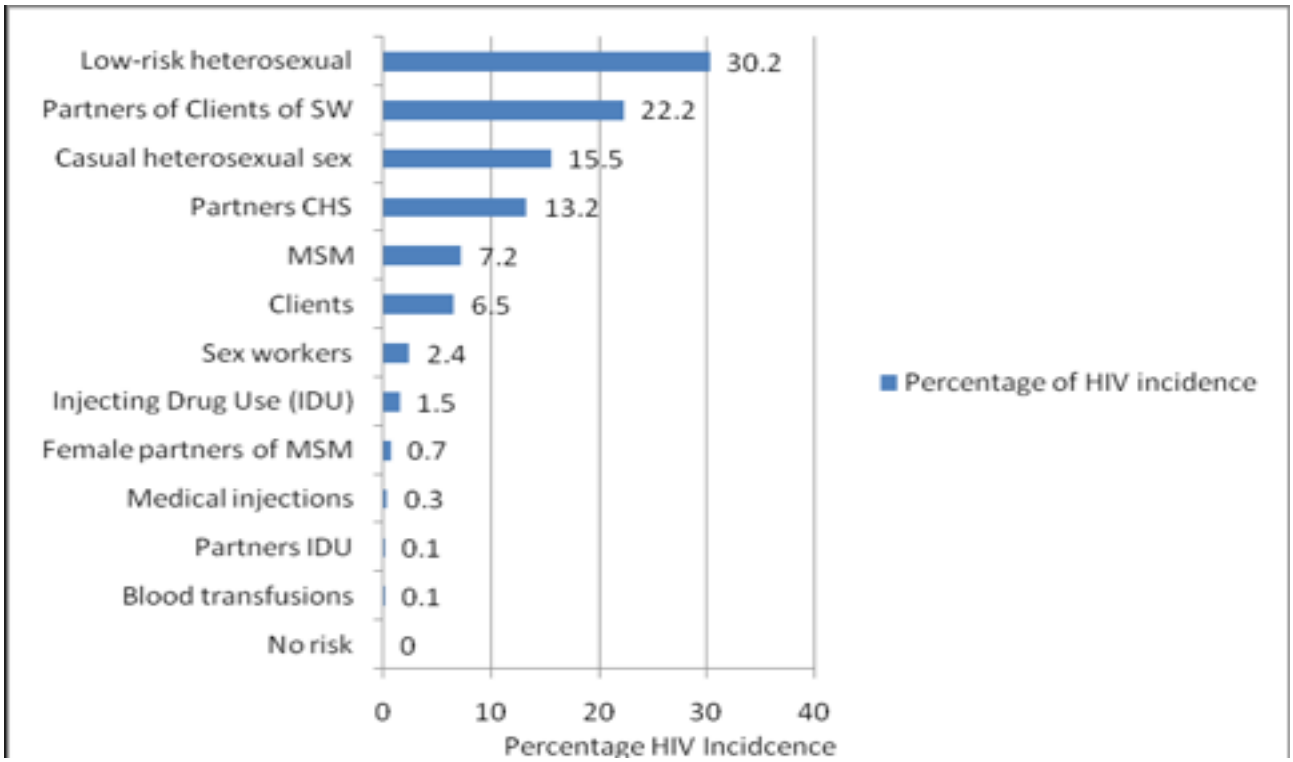


Figure 1.2: *Percentage of HIV new infections by MARPS and Population Source: Bosu and Yeboah, 2010.*

Reducing new infections among KPs is a major goal for the Ghana AIDS Commission (GAC) and the AIDS Control Program (GAC, 2011). In 2012, more than 50% of MSM reached by Family Health International (FHI) had never received any form of HIV prevention services (FHI, 2013). Projections from the

Global HIV Epidemic suggest an increase in coverage of MSM specific intervention may change the trajectory of HIV epidemic (Beyrer et al., 2011).

As reported earlier by IBBSS, only 20% of MSM have ever tested for HIV. This figure is far below the national target set by Ghana AIDS Commission to provide 80% of MSM with comprehensive HIV Services (GAC, 2011). If the progress of this indicator continues at this pace the intended target of reaching 60,000 MSM Test for HIV by the end of 2015 may not be realized. It is estimated that 25% (N=13500) of MSM are living with HIV but currently, the country does not collect information on ARV Treatment among MSM as mentioned earlier. However, in 2011 out of the estimated 113,475 Persons living with HIV (PLHIV) eligible for ART, only 56,050 (49%) received treatment services (GAC, 2013). Since MSM is seen a taboo, criminalized with issues on stigma and discrimination, the utilization of HIV related services as seen is apparently far low compared to the general population as suggested by GAC.

2.2 Justification

Increasing MSM access to HIV related services is an urgent priority area for global health (WHO, 2013). The international review on MSM from 20 countries shows fewer than one out of 10 MSM has ever received information on HIV prevention although evidence show MSM contribute to the largest source of new infections (UNAIDS, 2013). As mentioned in the problem statement, MSM are key to the HIV epidemic in Ghana, they have the highest prevalence compared to other populations at higher risk and their access and utilization of HIV preventive service is very low. The significant low uptake of HIV related services coupled with increased risk of HIV among MSM is an important Public Health issue as there is the possibility of further transmission among MSM network to the general population (GAC, 2013). In Egypt MSM are reported as bridge group to spread of HIV among general population as suggested by study respondents demographics which reported most MSM had sexual relations with women in general population(IBBSS, 2010). Attention therefore is needed to reduce new infections among MSM for the benefit of not the high risk group but as public health benefit.

There is no study in Ghana exploring factors affecting low access and utilization of HIV related services among MSM in Ghana which is why I intend to focus on this topic to understand how this high target of reaching 80% of MSM will be reached because the coverage is still low and would need to be

expanded in order to provide an effective contribution to reduce the HIV epidemic in Ghana.

Also, my interactions with most of the about 1,200 MSM we serve claim NGO services are ''stigma free'' most of them prefer utilizing services provided by NGOs compared to Public Health Services which is meant for everyone. Unfortunately, NGO services are not always available due to inadequate funding support. The question behind this is 'why are MSM not utilizing public health services' and 'what are the barriers affecting MSM to access community clinics and hospitals' who are to provide HIV services to everyone. The consequences of MSM not utilizing HIV related services will result in high burden of new infections and increase cost on the health system. It is therefore relevant to explore and deal with barriers affecting access and utilization of HIV related services among MSM in Ghana.

2.3 Study Objectives

Overall Objective

This research will explore barriers affecting Access and Utilization of HIV related services among MSM in order to make recommendations to Ghana AIDS Commission to deal with these barriers to improve service provision.

Specific Objectives;

- Explore Individual barriers affecting low access and utilization of HIV services by MSM.
- Describe the kind of HIV related services available.
- Critically analyze the factors in the health system affecting MSM from accessing and utilizing the available HIV services.
- To identify and discuss evidence from other settings that have shown to be effective and appropriate to improve access and utilization of HIV services by MSM.
- Make recommendations to AIDS Commission to improve service provision among MSM.

2.4 METHODOLOGY

2.4.1 Search Strategy

A literature study was done to identify relevant publications on Barriers affecting Access and Utilization of HIV Services by MSM. To achieve this objective, I borrowed from Muthuri (2013) and Zoogah and Nkomo's (2013) methodology of literature review which centers on reviewing published scholarly articles on major online databases and journals. The online search and review focused on key phrases such as *'Men-who-have-sex with Men (MSM), Health, Access, Utilization, HIV and AIDS, Ghana, in sub-Saharan Africa'* were included. The variety and combinations of words employed was meant to ensure that all relevant published work was included. Mainly four (4) electronic databases including MEDLINE, PUBMED, LANCET and COCHRANE were searched. Organizational websites such as WHO, UNAIDS, Ghana AIDS Commission and Ghana Health Service were also included. The search was conducted through the VU University online library. Inclusion criteria was based on context similarities, international best practices not much attention was paid to the timeframe but majority of the search covered work from 1970 to present. It is however important that while every effort was made to do a comprehensive search, it is possible that some relevant research was overlooked.

2.4.2 Conceptual Framework

To be able to articulate the findings in this study 'factors affecting access and utilization of HIV related services by MSM' in a more systematic and organized structure, I searched various literatures for the ideal framework to guide the study. During the search I came across frameworks including analyzing policy and program for sexual minorities by Rispel et al., 2011 and Obrist et al., (2007). I also found the Andersen's Behavioural Model, 1995, explaining Health Service Utilization as well as the adapted Health belief model by Wirtz et al., (2014). Haven carefully looked at all these frameworks I chose for this paper the adapted Health Belief Model (HBM) adapted by Wirtz et al., (2014). I decided on this model because it was used to analyse HIV service utilization among MSM in Malawi which is the same topic this paper intends to explore. Apart from the major similarities in the context it was applied, it also portrays current issues specific to MSM compared other frameworks which seem generic and outdated.

The adapted Health Belief model has three broad dimensions namely 'Individual Perceptions', 'Modifying Factors' and 'Likelihood for Action' (Wirtz et al., 2014). It is further explained that all these dimensions in most instances

trigger decision making process and influence utilization of services (Rosenstock, 1974). For example 'Individual Perception' such as perceived susceptibility, threat and severity of HIV may be influenced by modifying factors such as criminalization, social norms, and cues to action (Wirtz et al., 2014). The model suggests, before MSM can confidently take up services, it is important to overcome Perceived barriers such as fear of disclosure, stigma in health facilities, health provider's fears on legal repercussions and all forms of significant barriers. These perceived barriers is said to determine the 'Likelihood of Action' to bring about 'Desired Behaviours' including MSM seeking health services, health workers providing services to MSM and also discussing sexual risk (Wirtz et al, 2014).

The adapted Health Belief Model will also help to critically analyze the specific objectives of this study with regards to the uptake of HIV related Services by MSM in Ghana. This is because it has broad dimensions to cover both health system factors which was not found in the original Health Belief model. The original model as developed in the 1950s explains health behaviours by focusing on beliefs and attitudes of only the individuals (Rosenstock, 1974). However, since Wirtz et al. (2014) borrowed heavily on the original ideas of the authors, there were references made to these authors to better understand the model. Half-way through application of the adapted Health Belief Model by Wirtz et al. (2014), I found out Perceived Susceptibility and Perceived Threat were actually overlapping which added no value as separate boxes and so was combined. After this further adaption, the model almost came close to the Anderson Behavioural model although significant differences specific to MSM still existed between the two models.

2.4.3 Limitation of Study

The study has several limitations. First, with the literature review, literature was severely limited to this topic in Ghana: biases is likely to occur as only the available study were used whiles majority of such studies were based on convenience sampling. Second generalizations cannot be drawn from the results as almost all studies were qualitative and the opinions of MSM expressed in the studies are subjective which cannot be the case for every MSM in Ghana. Finally, the language of the author presented a barrier in reviewing literatures found in French and other languages.

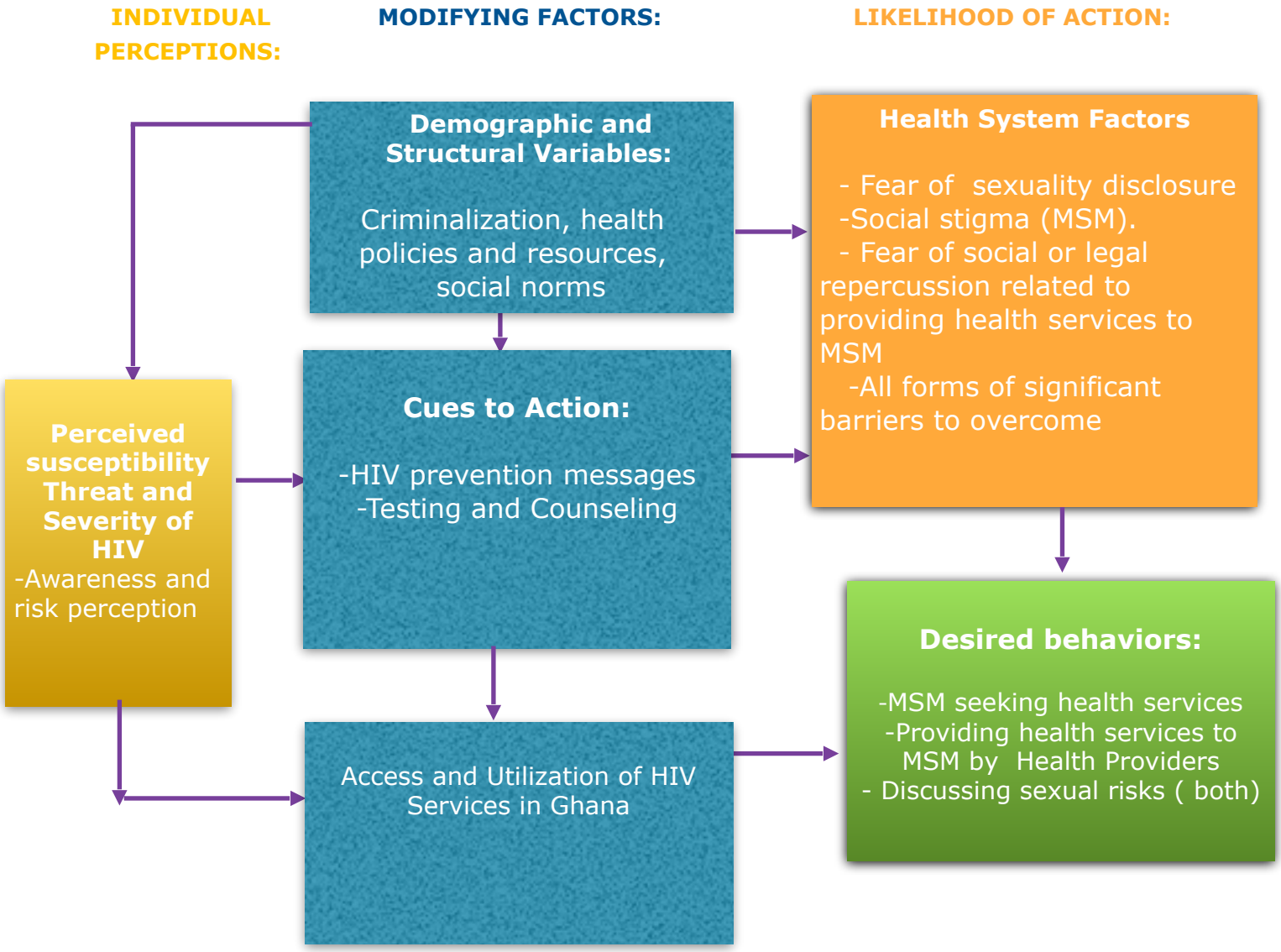
2.4.4 Defining 'Access' and 'Utilization'

According to W.H.O, access is crucial to prevent health problems and its related morbidities and mortalities (WHO, 2000). Many scholars have worked hard to make clear this concept of Access in association with health outcomes. Penchansky et al.,(1981) explain Access as the provider's ability to supply

services of general interest and on the other hand the client's ability to use these services. This paper deems fit Peters et al., 2007, definition of Access as the use of services on time in accordance with the individual's need. Utilization is defined by the Oxford Dictionary as "making practical and effective use". Most often than not, utilization is used as a proxy to measure access without considering quality or whether people needed the service or not (Penchansky et al. 1981).

The adapted Health Belief Model gave four distinct dimensions for service utilization. This includes perceived susceptibility, perceived threat, perceived barriers, and perceived benefits (Wirtz et al., 2014). According to Janz et al. (1984) 29 were reviewed and perceived barriers (Likelihood of Action) came as the most powerful determinant in influencing the use of health services. Perceived susceptibility (Individual Perceptions) was also found as a strong contributor to use of recommended preventive behaviour.

Figure 1.3: *The Adapted Health Belief Model as applied to Access and Utilization of HIV related Services.*



Source: Adapted from Wirtz et al. 2014

CHAPTER 3: STUDY RESULTS-FACTORS AFFECTING ACCESS AND UTILIZATION OF HIV SERVICES BY MSM IN GHANA

This chapter brings the study results or findings from the various scientific papers reviewed on factors affecting access and utilization of HIV Services by MSM. The conceptual framework will be use to organize the findings in a more logical way. Study results are presented under sub sections.

3.1 INDIVIDUAL PERCEPTIONS[1]

This section will focus on awareness of MSM and Health Providers regarding risk of HIV transmission among MSM community in Ghana.

3.2.1 Perceived Susceptibility, Threat and Severity of HIV

Perceived susceptibility is defined as the individual's level of awareness of risk to develop a health problem and the awareness of potential consequences of the health problem (Janz et al. 1984). Sex among MSM involves anal intercourse and if unprotected, it carries a high risk of HIV transmission for both the receptive and insertive partner (Oluyemisi et al. 2013).The risk associated with receptive anal intercourse is high than MSM who engage in insertive (Baral et al. 2007). As introduced in the problem statement, evidence shows MSM are 19.3 times more susceptible to HIV compared to general population. This notwithstanding, results from a qualitative study conducted in Accra, Ghana on low utilization of condom among MSM found about 80% of MSM were engaged in high risk behaviours such as: sex work(transactional sex), anal fisting, oral sex multiple sex partners, alcohol and use of 'Party drugs'. Overwhelmingly, they did not perceive these behaviours as increasing their risk to HIV, (Drah et al. 2009). In effect, inconsistent condom use among MSM ranged between 50-70% (N=1302) as reported in the Ghana Men's Study (IBBSS, 2011).

Another qualitative study exploring attitudes, beliefs and behaviours of MSM in Kumasi, Ghana reported most participants saw transactional sex as acceptable and considered it as just another job to earn money. However, only 6 out of the 99 participants believe transactional sex increases risk of HIV since it promotes unprotected sex and few also felt it was shameful to receive something in return for sex but found the rewards too hard to resist (Sabin et al, 2013a). The above findings are almost in agreement with results of previous studies;

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[1] With regards to risk perception on anal sex, another interesting finding in Ghana but not related to this topic was 7.3% of Female Sex Worker were reported to engaging in unprotected anal sex but did not see their behaviors as high risk to HIV (IBBSS, 2011)

1. In Dela Attipoe's qualitative research on MSM vulnerability in Ghana, over 50% of MSM demonstrated no knowledge on risk of HIV in anal sex, limiting their uptake of services. They hold the belief that HIV and other Sexually Transmitted Infection cannot be transmitted through anal sex (Attipoe, 2005).

2. Another study in South Africa found MSM involved in risk behaviours including multiple sex partners, sex work, alcohol and drug use before sex but less than 1% perceived their behaviours as high risk to HIV (Lane et al., 2011).

3. A cross sectional study among 601 MSM in Cote d' Ivoire indicated high risk behaviours including sex work, low condom and lubricant use etcetera, were associated with self perception of low risk among others. The study also suggest Inconsistent condom use during the last anal sex was at 66% (Aho et al. 2014) against 50-70% (N=1302) in Ghana (IBBSS, 2011).

4. Findings in Malawi shows 80% of MSM still hold the belief transmission of HIV was only possible through unprotected vaginal sex and were unaware of the risk of HIV associated with anal sex. The few who were aware said they learn about such risk through participation in research studies (Wirtz et al. 2014).

Many of the studies in Africa do not differentiate the perceptions of risk among various categories of MSM. But in the case of Australia, studies show the risk behaviours of MSM increase due to ''treatment optimism'' referring to reduction in fear of HIV/AIDs (Ven et al., 2000). In other cases (Peru, Ecuador, South Africa, Brazil, Thailand, and United States), sexual risk behaviours reduced among participants after study results in a cohort which followed 2,499 HIV positive MSM for almost 2 years showed 44% efficacy in Post Exposure Prophylaxis and Pre Exposure Prophylaxis(Liu et al. 2010). However, the 2013 COCHRANE review on 237 studies on ART as prevention in HIV discordant couples found ART was significantly associated with decrease risk but efficacy is dependent on control of STI, condom use, viral load , and potency of ART (Anglemyer et al. 2013). The WHO has therefore recommended immediate start of ART for discordant couples (WHO, 2013). This means- risk perception may not be the same for all categories of MSM as clustered in the study in Ghana and other SSA countries and this requires more research to better understand the various aspects.

3.2.2 HIV Awareness among MSM

A program in Ghana named MARP orientated new innovations for research' (MONITOR) conducted a study among older MSM (above 30 years). Their findings on HIV awareness show about 95% (N=44) had secondary education but exhibited 'less than complete knowledge' on HIV. Also, 40% (N=44) were unable to mention any preventive method and reoccurring knowledge gab reported was lubricant use alone can prevent HIV. Knowledge on treatment was reported to be low: only 3 out of 44 participants knew about Anti-retroviral said they were not aware but also have faith they will remain uninfected (Sabin et al., 2013b).

Awareness on transmission, prevention and treatment is key to utilization of HIV services and this is imperative to knowledge on where these services are provided. According to Sabin et al., (2013a) in their study on adolescent MSM in Kumasi, lack of knowledge on locations HIV service facilities was identified as major barrier limiting uptake these of these services. In the study, 30% (N=99) had no idea on where to access HIV Testing services whiles 20% were aware such places existed but did not know their names and locations (Sabin et al., 2013b). The relevance of the knowledge of service location is arguable using findings from a survey exploring beliefs and attitudes of MSM which found over 90% of MSM knew of a place to access HIV services but only 26% (N=385) utilize these services (AED, 2005). This means awareness as important as it may seem may not always affect uptake. This variation may also be attributed to the clustering of the categories of MSM by various studies in sub-Saharan Africa.

3.2.3 Some views of MSM in Ghana on Risk Behaviors

A. Group sex

''Group sex occurs once in a while. Sometimes two groups of 6 may meet and will be moving from one person to the other. I have experience (d) it before and I enjoyed it'' –FGD participant, aged 16 years (Sabin et al, 2013b).

''I have group sex with my French guys. I was linked to them by a friend and we meet at Vienna in Accra. We are four in a group. We do not drink but smoke marijuana at times before having sex''. –FGD participant (Sabin et al, 2013b).

B. Transactional Sex

''[It is] very common especially (among) students''. –FGD participant, aged 16 years.

''I do that [have sex] for money and favours and am sure that is the reason why most of us are involved. So it happens most often''. –FGD participant, aged 16 years (Sabin et al., 2013).

''One partner told me he prefers raw sex and if I allowed him he would give me enough money. I accepted it and we had raw sex''. –IDI participant, aged 17 years (Sabin, 2013).

C. Knowledge Gap on Condom and Lubricants use

> *'In a situation where it is difficult to use a condom, I always have lubrications as a back up because it can also prevent bacterial infection. Personally I believe that in situations when a condom is not available… lubricants can be used as a substitute*.' –IDI participant, aged 37 years. (Sabin et al, 2013b)

3.2.4 Health Providers Awareness of HIV Risk among MSM

There is no study exploring level of awareness of HCPs in Ghana, available studies focused heavily on MSM experiences. However the below findings in Kenya and Uganda is more telling on the situation of Ghana given major context similarities:

1. Elst and colleagues conducted an 'online facilitated' MSM sensitivity program among (74) Kenyan Health Care Providers (HCP) including Nurses, Clinicians and Administrators. At baseline, level of awareness was assessed: only 8 percent has ever received some form of sensitization on counselling MSM and 7percent also on anal sex practices. At the end of the program, 49% against 13% of HCP at baseline showed sophisticated awareness on risk by explaining MSM risk behaviours, the process unprotected anal sex contribute to HIV and STI and ways condom and lubricants can be used for risk reduction (van der Elst et al., 2013).
2. In the case of Uganda, a study was conducted in Kampala national referral hospital among 477 nurses and midwives. The study result show, one third scored below average on modes of HIV transmission among Key population at higher risk although the average work experience among participants was 15years (Walusimbi et. al., 2004).

This means in Ghana awareness level among Health Care Providers (HCP) will equally be low if not worse given the similarity in context to both countries. Awareness creation among HCP is seen as relevant regardless of their work

experience but essential to understand risk behaviours and available risk reduction strategies they can promote among MSM depending on the clients situation.

3.3 MODIFYING FACTORS

Modifying factors are an important aspect of the HBM and mainly include demographic or structural variables, perceived threat and cues to action which together is said to affect individual's health seeking behaviours. These variables include criminalization, social stigma, health policy, resources, awareness of MSM population, and cues to action (Wirtz et al., 2014). I discuss these factors below as they apply in the Ghanaian context.

3.3.1 Structural Variables

Criminalization of MSM

Thirty-eight of Africa's 53 countries have laws criminalizing homosexuals with punishment ranging from harsh jail sentence, (14 years in Kenya) life imprisonment (for "aggravated homosexuality" in Uganda) and as worse as death penalty (in the case of Sudan, Mauritania and parts of Nigeria) (Rupar 2014; Itaborahy 2012). In some of these countries such as Mozambique and Mauritania the laws date as far back as the colonial period of 1954 and 1984 respectively. In others, such as Uganda and Nigeria, leaders have recently sign into law bills that officially criminalize homosexuals (Landau et al., 2014).

Indeed only 6 countries (Gabon, Sao Tome and Principe, Mauritius, Central Africa Republic, Cape Verde, and Guinea Bissau) from the continent signed the December 2008 UN Assembly Declaration to decriminalize MSM activities (Mawuli, 2011).
In Ghana specifically, although the law is not explicit on the homosexuals, Act 29 of the 1960 Criminal Code as amended in 2003, Section 104 states;

(1) Whoever has unnatural carnal knowledge—

(a) of any person of the age of sixteen years or over without his consent shall be guilty of a first degree felony and shall be liable on conviction to imprisonment for a term of not less than five years and not more than twenty-five years; or

(b) of any person of sixteen years or over with his consent is guilty of a misdemeanour; or

(c) of any animal is guilty of a misdemeanour.

(2) Unnatural carnal knowledge is sexual intercourse with a person in an unnatural manner or with an animal.

Consequently, male-to-male sex is viewed as "unnatural" and therefore illegal (Sabin et al., 2013a), though the law is silent on lesbians. But beyond this ambiguous law, more explicit political statements from influential politicians showing strong aversion to homosexuality in recent times is even more telling on the the status of MSM's in Ghana and their ability to access health services.

In 2011, the then Western regional minister of the country, Paul Evans Aidoo reacting to reports that 8,000 gay people in the Western Region had registered with Aids charities, issued a directive that gays be placed under arrest in order to "get rid of" them (BBC, 2011). He further called landlords and tenants to come forward if they suspected someone was gay. Even more authoritative was Ghana's late President John Atta Mills rejection of the UK's threat to cut aid if he refuses to legalize homosexuality in 2011. The President is reported to have said «I, as president, will never initiate or support any attempt to legalize homosexuality in Ghana,"(BBC, 2011).

Available literature on homosexuals and health services reveal that there seems not to be enough scientific studies on the role of the criminal code/ political statements on the uptake of HIV services among MSM's. Nevertheless, there have been widespread suggestions that the criminal code and influential politicians' positions such as the one by the President create social and institutional barriers that hinder accessibility and utilization of HIV services (Mawuli, 2011). The Ghana Centre for Popular Education and Human Rights for instance has noted that MrAidoo's comments could endanger the nation's underground gay community (BBC, 2011). MacDarling Cobbinah of Coalition against Homophobia argues that Mr Aidoo's comments "has brought about a lot of fear and stigma for the people. It is difficult to organize programs for counselling, safer sex, and other needs of LGBTs and other MSMs. It is very difficult for people to walk freely on the street" (Melloy, 2011, p. 2). He argues that the call for arrest has really pushed down people and that a side effect of such stigmatization is that the very people who most need fact-based health information and the means to protect themselves and others, such as condoms, are far less likely to receive those things in a climate where homosexuality is criminalized.

The Ghana Aids Commission in its *Mid-Term Evaluation Report of the National HIV and Aids Strategic Plan 2011-2015*, also noted that "stigma, criminalization and gender-based violence reported by MSM have compelled some to go underground, hence making them difficult to reach with interventions."(p. 34). Generally therefore, it appears that Ghana MSM's

community, without official programs targeting them (Lago, et al., 2010) are unable to access regular services (HIV prevention, HIV screening, prevention for positives, etc) like their heterosexual counterparts partly as result of their illegal status.

Social Norms

Social norms are standards of appropriate behaviour for actors with a given identity (Finnemore & Sikkink 1998). Generally, social norms are made up of culture, beliefs, customs and common practices among a particular group. They consist of *values* (a sense of what is good or bad), *prescription* (what one ought to do or not) and *sanction*, a reward (positive sanction) or punishment (negative sanction). In the HBM, social norms are considered s modifying factor.

Currently in Ghana, same-sex practice is considered non-normative sexual behavior meriting general social condemnation. For instance in giving a reason why he (former President) will not support decriminalization of homosexuality in Ghana, Former President Mills in 2011 argued that, the UK could not impose its values on Ghana. He categorically said "Ghana's "societal norms" were different from those in the UK."(BBC, 2011), suggesting that same-sex may be an acceptable norm in the UK but cannot be the case in Ghana. Studies support the president's view. Owusu et al., (2013) in their study on 'Attitudes and views on same-sex sexual behaviour in Ghana' revealed that all 120 respondents interviewed affirmed that "the only sexual practices that are permitted involve the opposite sex, the man and the woman who are recognized as husbands and wives." (p. 180). The result of this widespread norm is prejudice of MSM's (Swim et al., 1999). It also leads to fear of association with persons who exhibit such non-normative sexual behaviours not only by majority of the population but even health care providers. Consider this illustrative statement by a MSM interviewed by Sabin et al., (2013a) in Kumasi (Ghana); "It is very difficult to discuss your issues with anyone. Even the nurses are not reliable". (p. 47).

Financial Barrier to Access

In 2004, user fees at health facilities was thought as worsening the inequities existing between the poor and rich so the National Health Insurance Scheme (NHIS) was established. To enrol on NHIS, payments of premiums are required yearly. The NHIS was seen as a move to address the fearsome financial barrier to access health service but payment of the premium is still a challenge to most Ghanaians (NHIA, 2003).

Studies have shown costs, infrastructure and other constraints in the health system provision affect MSM attitude towards health seeking. Sabin et al.,

(2013a) report that, obtaining treatment without health insurance, long queues at facilities, accessing hospital services without a referral were identified among older MSM as barriers to obtaining services. Among younger MSM the same authors found out that insufficient funds and no health insurance was a major barrier most of them as captured by this 28 year old MSM; "My only problem is that some of the prescribed drugs are very expensive and it becomes more challenging if you don't have the National Health Insurance Scheme card." (Sabin et al., 2013a p.42). Infrastructure in terms of space was found in a study among MSM in Dar es Salaam, Tanzania, which attributed overcrowding in health facilities to increasing fear of disclosure as there is limited confidentiality and privacy (Magesa et al 2013).

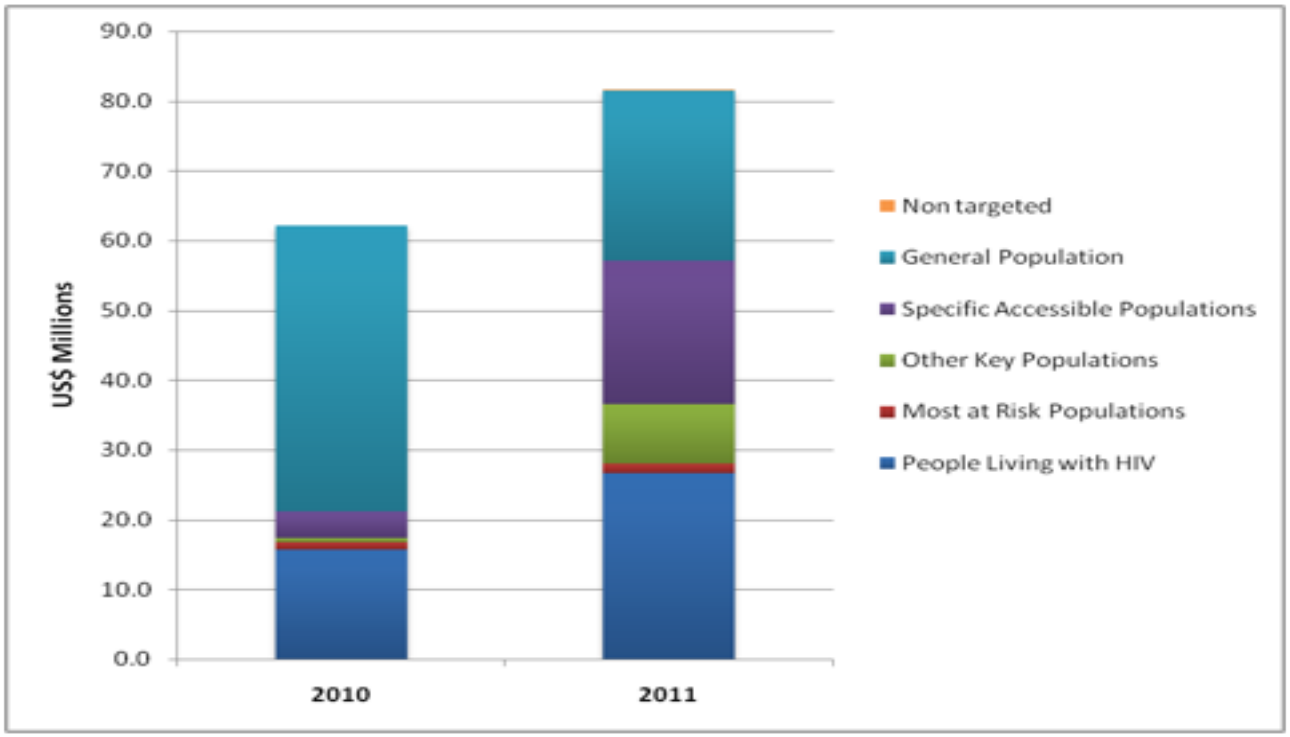
Health Policies

Ghana's current HIV and AIDS policy was guided by various international agreements Ghana has signed such as UNGASS, the Ghana Poverty Reduction Strategy and the African Charter on Human Rights (GAC, 2004).The Policy has since been reviewed once to include only FSW (GAC, 2007). Notably, the HIV and AIDS policy has no specific provision on MSM. However, the AIDS Commission in 2010 managed to come out with an ambitious Strategic Plan for Key Population at higher risk to meet donor requirement. Among the objectives of the Plan was to ensure universal access by reaching 80% of all MSM with HIV Services (GAC, 2010). Notably, the Strategic Plan was not borne out of the National HIV and AIDS policy. Hence no financial provision was made with regard to the objective of reaching MSM which has hampered implementation. Thus as Lago et al.'s (2010) review of the Plan showed, different aspects of HIV and AIDS such as 'Mother to child Transmission' and 'Workplace HIV and AIDS' have been prioritized with specific policy guidelines ahead of issues of MSM. For example, when the National Monitoring Report of the Reproductive and Child Unit discontinued HTC service due to shortage of test kits, the government intervene to reserve test kits for pregnant women (due to their priority status) which was not the case for MSM, HTC was discontinued and projections are shortage of test kits will last till 2015(GAC, 2013).

Generally, there is limited funding support from government in the implementation of the Strategic Plan on Key Populations at higher risk and this is evidence from the report on the National AIDS spending Account (NASA). Funding mainly comes from the International Community accounting for 74% (US$60.81 million)of total expenditure in 2011 with a decrease of 3% from the previous(GAC, 2013).

The funding support for newly identified Specific Accessible Populations such as healthcare workers, factory workers, uniform services, and students increased from increased from 6% to 25% whiles KPs increased by only 1%. In the graph below the proportion of total funds spent on Key Populations at higher risk (KPs) remained low in 2010 and 2011 compared to other beneficiary groups as seen in figure 1.4 below:

Figure 1.4: Spending by Beneficiary Group in 2010 and 2011



3.3.2 Cues to Action

In the HBM, Cues to Action add up to the modifying factors to promote utilization of services. It comprises internal (symptoms) and external prompts such as availability of information and services to encourage health seeking and providing expected behaviour (Wirtz et al., 2014). In the sections below, the kind of HIV services available (external prompts) in Ghana that 'may' or 'may not' encourage service utilization among MSM will be described.

Available HIV Services in Ghana

According Obrist et al. (2007), availability is defined as meeting clients needs with existing health services.

Anti Retroviral Therapy (ART)

MSM in Ghana have no specific Public Health HIV service targeting them apart from those provided by NGOs and CBOs. MSM utilize ART service under the national ART program. The so called scaled up ART program is still low in coverage. Currently the number of ART site is 157 as of 2012 located in only regional and district hospitals. Additionally, 205 CD4 machines, 8 PCR, DNA are available and functioning in Teaching hospitals in only 8 out of the 10 regional/ district facilities. Almost all ART sites have the capacity to provide pre and post exposure prophylaxis services either for occupational incidents among health workers, discordant couples and survivors of rape or defilement (GAC, 2013). However, from the health facility 2013 monitoring report, the service in recent times has encountered problems such as frequent shortage of test kits, lack of reagents for CD4 testing, broken down and malfunctioning CD4 machines and inadequate furniture for clients (RCH, 2013).

Primary Health Care facilities which are the first point of care only provide HIV Testing and Counselling (HTC) and refer clients to regional and district ART facilities (RCD, 2013). This uneven distribution of ART sites and its concentration in urban areas means MSM in rural areas would face geographical difficulty in accessing them. Although the number of MSM accessing ART in Ghana is not reported, a review on AIDS Control Program (NACP), ART service provision in a study on utilization of ART found the number of males accessing ART had declined from 30.1% in 2008 to 27.6% in 2010. The reason for decline was attributed to gender based inequities between men and women *(*Gyeke et al*. 2012).*

HIV Services offered by CBOs/NGOs

Apart from ART services, NGOs and CBOs provide comprehensive HIV prevention package including behaviour change communication (BCC), HTC, diagnosis and management of STI, promotion of condom and water based lubricant, Peer lead referrals to Drop-in-Centers. Clients who test positive are linked or referred by DIC Nurses to the national ART program. In 2012, HTC programs were experiencing severe shortages of first response test kits for HIV and the quantity of the ''Know Your Status programs'' were reduced (NACP, 2013).

Recently an NGO named FHI adopted the use of Interpersonal Communication Technology (ICT) including telephone help- lines, bulk messaging on healthy living and life line for PLHIV on ART adherence and innovative use of social media to reach middle class MSM who are often hard to reach through

traditional peer education approaches (GAC, 2013). Below is a developed BCC material distributed by NGOs to Peer Educators for outreach work.

Figure 1.5: Pocket-size folded brochure on HIV prevention (BCC Material on Key HIV prevention behaviours used by PEs)

Source: Rebertson, 2010.

Media sensitization program

There are currently 34 radio and TV stations with anti-stigma and discrimination messages. Several other BCC messages are aired through the mass media. Major HIV prevention media campaigns include: '*Protect the Goal'* condom use campaign; *Be Bold* (HIV Testing and Counselling) and Anti-stigma campaign *'It could be me, it could be you'*. (GAC, 2013). None of the above program focuses on MSM but rather on the heterosexual community. For example, a case study by two CBOs, CEPHERG and MARITIME who work with MSM in Accra and Takoradi found that the media and most HIV prevention programming in the region consistently describe HIV vulnerability in terms of heterosexual risk with no attention to MSM. The very few programs targeting them is also said to face significant challenges in reaching MSM to access these information and services as it is based on only Peer Education (Robertson, 2011). This means the lack of such information can severely limit uptake of available services as there are no prompts or reminders to encourage MSM.

3.4 LIKELIHOOD OF ACTION

This component of the adapted Health Believe Model estimates the possibility that the use of a recommended action or behavior will prevent illness as expected (Janz et al., 1984). According to Wirtz et al. 2014, the likelihood of MSM taking up a recommended behavior is minimal, unless all the below forms of perceived barriers are removed. Examples include social stigma, fear of disclosure and fear of sexuality disclosure.

Social Stigma

MSM are particularly a stigmatized population in Ghana, in part because male-to-male sex has traditionally been viewed as illegal, making them a difficult yet critical to reach population with HIV and AIDS-related services (Sabin et al., 2013).The Ghanaian society believe MSM are ''intentionally going out on their way to look for the virus by their sexual behaviours'' (Nzambi et al., 2011). Social stigma therefore presents a significant barrier for MSM to seek health care and also access HIV related services in Ghana (CCG, 2010).

For example the German BACKUP Initiative together with Ghana AIDs Commission (GAC) conducted a study on stigma and discriminatory attitudes towards Key Populations at higher risk (KPs). The study found HIV stigma and discrimination was seriously against MSM because of deep rooted social norms and values prohibiting same sex practices. It was also reported, 69.1% (N=4,689) of Ghanaians knowingly would not welcome MSM into their home and 54.8% agree MSM should be socially excluded from the community. Strikingly, 69.7% (4,689) showed concern about their health and are in agreement that MSM should have access to medical care in community health facilities (Nzambi et al., 2011).

In such context it is not surprising the results from MARPS Oriented New Innovations program found half (N=99) of their study subjects reported fear of community stigma drove them away from accessing HIV services: in response to challenges they face staying healthy (Sabin et al., 2013b). Similar results reported in a study on sexual stigma among 323 MSM in Swaziland indicated a strong association between uptake of HIV services and fear of stigma at health facilities as suggested by 61.7% of respondents (Risher et al. 2013).

Fear of Sexuality Disclosure

MSMS are confronted with making decision to disclose their sexual orientation and to seek care. As reported by W.H.O, MSM may be less likely to disclose their sexuality together with other related behaviours in health care settings

and this hinder discussion between them and Providers to inform subsequent clinical decision making (WHO, 2011).

The study among 537 MSM from Namibia, Botswana and Malawi found only 17% of participants have ever disclose same sex behaviour and 19% were afraid to disclose their sexuality and take up HIV Services. This study also found 21% were blackmailed and 5% denied treatment upon disclosing sexual orientation (Fay et al. 2011).

Also, a study among MSM in Dar es Salaam, Tanzania, attributed the fear of disclosure to lack of confidentiality and privacy due to overcrowding in health facilities. In this study, participants also mentioned the fear of HIV positive test results and inconvenience they face to visit facilities (Magesa et al., 2013). Findings in a cross sectional study in Lesotho also pointed out negative experiences when MSM disclose their sexuality in health facilities. This includes police discrimination (36/219), verbal/physical harassment (140/234) and beating 43 out of 228 ((Baral et al. 2011b).

Equally in Ghana a 28 year-old IDI participant highlighted his experience:*" ...sometimes you do not get your privacy, the Nurses would be around whilst you are accessing treatment"* (Sabin et al., 2013a)*.*This means the likelihood for MSM to withhold information on their sexuality may be high especially when the environment does not promote them privacy. As suggested by WHO, (2011), this may affect the quality of service they receive as Providers may not be adequately informed to make subsequent clinical decisions. This shows how privacy and confidentiality is of utmost importance to MSM to disclose their sexuality to Health providers and take up services without fear of negative consequences.

Perceived or Enacted Stigma

Long standing evidence exists showing MSM may delay access to health care as a result of perceived stigma (WHO, 2011). The thought of violence and stigma against same sex practice often lead to internalized homophobia which is known as shame or self-hatred (Voison et al., 2012), and this as a result prevent them to access HIV services (Aho et al., 2014). For instance, a survey conducted in Lagos and Ibadan, Nigeria, assessed the level of internalized homophobia among 1,125 MSM and found one third of participants reported internalized homophobia: MSM PLHIV and bisexuals were reported to be two times more likely to report homophobia compared to negative MSM. This study suggests the internalized homophobia in bisexual's results from the dual lives they live due to cultural norms attached to marriage between men and women (Adebajo et al., 2012). The story in Ghana is somehow similar as documented

in Nigeria, when explained by an MSM from Kumasi, Ghana: *"I am not able to go to the hospital because I'm shy and I fear that I will be stigmatized."*–IDI participant, aged 32 years (Sabin et al., 2013b). P

Fear of Social or Legal Repercussion

Some service providers are reported to perceive legal and social repercussions on providing services to MSM and so fear to do so (Wirtz et al., 2014). For example, a study in Malawi exploring health seeking behaviour in MSM also recruited five Health Providers from local STI Clinics, District and regional Hospitals and HIV prevention Organizations. The study findings show providers claim they have their own fears in providing services to MSM. A Service Provider in this study explained: *''….knowing that MSM in Malawi are kind of criminalized if people know that we are treating them may be we will be in trouble…..''* (Wirtz et al., 2014).

Somehow similar to the above, is a study in Senegal on risk of HIV among 46 MSM, which also recruited 14 Key informants. There was also five (5) Health providers who were part of the Key informants, they reported the fear of arrest pushed them to suspend their HIV prevention programs to MSM because of recent arrest of nine (9) other HIV prevention workers (Poteat et al. 2011). According to Wirtz et al., (2014), barriers that are perceived by both MSM and Service Providers need to be overcome for the provision of service and uptake of services to be realized. This means utilization of HIV services by MSM can happen if the so called fear in both the service provider and MSM are dealt with. Given that MSM practice is a taboo and also criminalized in Malawi (Wirtz et al., 2014) and Senegal (Drame et al., 2012), the study findings will probably be similar in Ghana. This means in Ghana it is apparent for fear of legal repercussion to trigger Health providers to shun provision of services to MSM.

Attitudes of Health Care Providers

Evidence shows MSM face significant barriers to access healthcare as a result of widespread stigma which is against homosexuality in mainstream society and health systems (WHO, 2011). For example some MSM in the MONITOR program in Ghana explained how difficult it is for them to access services. According to one MSM *"Because I do not want these service providers to annoy me with their unnecessary comments I don't attend clinic at all. It is not easy at all. The way and manner a certain nurse talked to us, it was embarrassing so we felt uncomfortable. Because of that we left the hospital and went to a drug store for drugs".* –FGD participant, aged 29 years (Sabin et al., 2013a). The findings of this study are partly consistent with Dela Attipoe's research paper also in Ghana on risk of HIV among MSM also in Ghana on risk of HIV among MSM, where a participant was reported to have said *"I will better stay*

indoors and die than to suffer humiliation in the hands of health workers" (Attipoe, 2005).

Similarly, a study in Dar es Salaam, Tanzania on barriers impeding Utilization of HIV related services among 50 MSM found similar to the situation in Ghana. In this study MSM complained on mistreatment by Health providers, a 22yr narrated *"……I disclosed my sexual orientation to the Doctor who then started to tell me that homosexuality is sinful and I will go to hell. He was very angry and refused to provide me the services I was looking for''*. Attitudes of health providers towards MSM were noted in the study as causing a lot of difficulties when they want to seek HIV related services (Magesa et al., 2014). Lane et al., (2008), suggest these negative experiences MSM go through in health facilities because of their sexuality were perceived as a norm to avoid seeking health care and results in poor sexual health among them.

On the other hand, particular narrations from Ghana's MONITOR program, suggested attitudes of some providers were observed as MSM friendly. In this study, MSM who had utilized HTC in those facilities emphasized the need for their peers to first get a contact (bridge builder) in the health facility before even going. It was explained: *I know Suntreso Hospital..... Previously, it was very difficult to go to the hospital but now, we go to the 2 nurses who have been trained for men who have sex with men. The nurses have been introduced to us, so we know them and are comfortable with them."* –FGD participant, aged 31 years (Sabin et al., 2013a).

Technical Knowledge and Skills of Health Providers

It is suggested that Health Workers in Public Health Facilities in Africa have limited or no evidence based or culturally adapted training on MSM and this affect reaching MSM with population based HIV related services (Halperin, 1999). Evidence from Kenya revealed that Health Care Workers have no guideline and training on MSM as some were quoted to have said: *"We don't have a guideline, yet we see them daily. We have no idea on how to manage infections affecting men who have sex with other men".* (van der Elst et al., 2013 p.3). In Ghana Sabin et al., 2013 found that the quality of services given by nurses motivated MSM to take up services. They report that almost all interviewed MSM who were satisfied with health services attributed it to helpful, friendly and skilled nurses and providers who cared for them in the institutions they visit. This means efforts is required to improve technical competencies of Health providers the optimum level of services to attract MSM in accessing HIV Services from public facilities.

CHAPTER 4: INTERVENTIONS FROM CAMEROON AND SOUTH AFRICA THAT AIM TO IMPROVE ACCESS AND UTILIZATION OF HIV SERVICES AMONG MSM

In this chapter, I present some Interventions targeted at Men who have Sex with Men (MSM) and the lessons learnt. Appropriate recommendations (context specific) will be made to the Ghana AIDs Commission based on the lessons learned. All over sub-Saharan Africa, there is serious lack of Interventions, prevention and treatment of diseases transmitted by anal sex for MSM (Eduard et al., 2007). In effect, inclusion criteria was broadened to Africa, type of HIV epidemic and issues related to stigma. I discuss these Interventions as identified in Cameroon and South Africa in the subsequent sections below.

4.1 ALTERNATIVES-CAMEROON INITIATIVE

MSM in Cameroon is illegal, stigmatized and referred as 'unCameroonian'. The HIV epidemic in Cameroon is a generalized epidemic with prevalence estimated at 4.5% but concentrated among MSM with prevalence of about 18.42% (UNAIDS, 2014).

Alternatives-Cameroon is an MSM community support group established in 2006 and it is the only organization openly providing HIV Services to MSM in Cameroon. Its mission is to ''fight for respect of Human Rights''. The organization uses Human Rights approach as an 'umbrella' to threats emanating from social stigma and legal status of MSM. Likewise, the WHO Intervention guideline for MSM, place emphasis on the principle of respect and protection of Human Rights as key to all programs targeting MSM (WHO, 2011).

Funding support for *Alternatives-Cameroon* is from different external sources including France, Europe and the United States. *Alternatives-Cameroon* comprises of 30 members and operates in three locations and is being managed by (5) Administrators, a Secretary and (4) Unit heads. It has established a health facility known as 'Access Centre' situated in the downtown (Douala). The centre is easily accessible by MSM and it is designed carefully to maintain a high level of privacy. Additionally, the 'Access Centre' has formed strong partnership with a local community health facility where the president of Alternative-Cameroon support group happens to be the Medical Officer in charge. He provides free consultations for MSM unwilling to go to 'Access Centre' (Kalamar et al. 2011).

Alternatives-Cameroon has also established Sexual Health and HIV Prevention Unit (SHPU). The SHPU undertakes HIV Prevention activities called ''Proximity Approach to HIV Prevention through community mobilization activities to serve

all MSM especially those discriminated against on the basis of sexual orientation. Intervention activities include Peer Educators monthly outreach in bars and Cafe's, sensation and outreach through dating websites: during which willing MSM network host education programs in their homes for 10-15 friends. A current strategy is also being implemented through Peer Educators (PEs) who are trained to reach out to 'hidden' MSM in their social networks (Kalamar et al. 2011).. During all these programs, HIV services such as provision of information on HIV risk behaviours, protection strategies against HIV and STI, countering myths on anal sex, HIV and VCT. Other services include medical options for Treatment, Psychosocial support by referring MSM to Alternatives-Cameroon support group. Also, free water based lubricants and condoms are distributed by Peer Educators during face to face outreaches (Kalamar et al. 2011).

For quality assurance purposes, the Sexual Health and HIV Prevention Unit conduct monitoring activities. Adjustments are made thereof to improve service provision and increase access by MSM. This is done through monthly field visits to program sites and educational workshops with Peer Educators at the 'Access Centre'. Some implementation challenges discussed include financial burden, fear of arrest and harassment. Though there has not been an extensive study on real impacts of Alternatives-Cameroon, generally, it has been deemed successful. For instance amFar (2014) writes on its website that, the online surfing of various websites by PEs has increased uptake of Alternatives-Cameroon's primary health services. Also testimonies showed MSM are gaining new awareness about the health needs.

***Lessons Learnt**:* The interventions were adjusted around the need of each beneficiary as a result of reports from outreach workers. The Content was reviewed to focus more on protection strategies such as condom and lubricant use, VCT etcetera rather than fidelity, abstinence or partner reductions because from the reports of PEs it is not worth promoting among Cameroonian MSM. A Peer Educator explained: *''We met people who had already had one hundred partners. . . . So it is just not worth it to tell someone to abstain. It is better to say to him, when you want to have a one-night stand, remember to take your condoms and your lubricant'' PE- Serge, age 29.*(Kalamar et al. 2011)*.*

Alternatives-Cameroon also considers courage and dedication by PEs as vital for implementation but the law against same sex practice ''sits at the heart of the problem'' and limiting their efforts. A Peer Educator asked rhetorically: *''How can we effectively intervene in the area of public health with a law hanging over our heads? . . . This law, it must go! (Patrick, age 27)''.* Also, as

part of its intervention, they are engaged in Advocacy works towards repealing of the law against MSM in Cameroon (Kalamar et al. 2011).

4.2 ANOVA 'HEALTH 4 MEN' INITIATIVE

South Africa is also experiencing a generalized epidemic with major concentration among MSM (NSP, 2012). Same sex practice is deemed legal in South Africa since 1994 (SANAC, 2012) nonetheless, MSM still mark mainstream health facilities as unfriendly (Rebe et al, 2013) and stigmatizing (Lane et al., 2011). Healthcare to MSM in South Africa were ignored until recently when the Sexual Health Clinic was launched and has since attracted MSM in care. The *ANOVA* Health Institute in collaboration with South African National Department of Health has launched (6) Sexual Health Clinics for MSM: one (1) located in central Johannesburg, two (2) in Cape Town and three (3) in Soweto. Funding support was from USAID (United States Agency for International Development) and PEPFAR (US President's Emergency Plan for AIDs).

HIV Services provided include: HIV Testing and counselling, treatment, information on sexuality, sensitization on HIV, harm reduction for MSM who use drugs, research participation, STI screening and Management. An essential tool developed was the Prevention and Treatment Guidelines for intensive training of Health Care providers and service delivery in Clinics (Lane et al, 2008). Peer Educators outreach intervention is also used as a linkage to the MSM community through referrals made to Clinics. Comprehensive M&E framework has also been developed to monitor various activities in Clinics and Peer outreach activities. Peer Educators (PEs) affiliated to ANOVA from time to time exchange ideas to expand their network. They do this through partnership with PEs from Desmond Tutu HIV Foundation who are also involved in research, advocacy and MSM peer-led community outreach but only in greater Cape Town. So far, since the inception of the program, it has reached about 3,800 MSM with services (Rebe et al, 2013).Consequently it seem the impact assessment of the program on uptake by MSM is yet to be done since the literature did not include such results but only the number of MSM reached with HIV Services.

***Lessons Learnt**:* In service delivery, the (6) Clinics are marketed as 'Sexual Health Clinic for Men' and anonymity is assured at all stages, reducing fears of being an MSM or HIV positive. Also, Training package for Health Care Providers has improve their attitudes and skills to deliver services in a non-judgmental way even in cases where their beliefs contradict diverse Male identities and behaviors (Rebe at al., 2013).

4.3 ADAPTING THE INTERVENTIONS FOR GHANA

Both Interventions reviewed appear promising to improve service provision to MSM and increase access and utilization of available HIV Services although information of rate in uptake was not reported but from the success stories, and lessons learnt can be drawn upon. The fidelity of these Interventions in the Ghanaian context is much more questioning rather than a solution because of variables like differences in values, societal norms, language and religion. However, strong similarities also exist including cultural acceptability, community stigma, type of epidemic and more strongly in Cameroon the criminalization of MSM. Contextualizing these Interventions is very much needed so the UNAIDS Guideline will be used in order to realize its benefits in Ghana as seen in Cameroon and South Africa. For example the ANOVA Initiative (South Africa) has open display of risk reduction messages on MSM ''Getting to know each other campaign'' (Rebe et al. 2013) may help to reach more MSM but threatens the legal status of MSM in the Ghana situation. Such component of the Intervention requires modification by restricting it only within MSM networks.

Alternatives-Cameroon has been designed much more to protect MSM and Care providers against existing legal implications. This is key to be considered by the Ghana AIDs Commission to avoid arrest and harassment of MSM and Health Care providers. Construction of MSM friendly facility is feasible although it comes with financial implications but can be doable provided donor agencies intensify their support. As seen earlier the International support has decreased by 3% from 2010 t0 2011. Local mobilization of resources therefore is needed to support Interventions. For the time being peer led Intervention as seen in the two programs, is more appropriate and worth expanding coverage. The approach is convenient for the country since MSM are still a hard to reach group and also taken into consideration the situation of resource constraint in the health system.

Both Interventions were spearheaded by civil society organizations which means much of the attention have to go into identifying and collaborating with these organizations already involved in service provision to MSM. Three major CBOs including FHI, MARITIME and CEPERG are already into HIV prevention activities and STI screening for MSM. These services are mainly provided at Drop in centres. However, intensive technical organizational training is required to equip these organizations to adequately implement these Intervention design. Although some of the CBOs may already have capacity to implement such Intervention designs, refresher training is required to facilitate adaptation

and quality in service delivery. By reaching out to MSM the country can also have accurate size estimation data through mapping up of NGO outreach sites to inform future Interventions and research to improve service provision.

CHAPTER 5: DISCUSSION

In this chapter, I analyze and discuss the reviewed literature and findings using the study objectives and the Framework.

My discussion below reflected holistically on the model but not looking at only the outcomes as I did in the previous chapter but on how the various aspects of the model interrelates to each other. The adapted Health Belief by wirtz et., 2014 was useful in identifying crosscutting issues such as, legal repercussion, training and knowledge gap among health care providers and MSM respectively. I discuss below arguments, counter arguments and supportive opinions.

Factors Affecting Access and Utilization of HIV Services by MSM

This paper found both perception of HIV risk among MSM and Health Providers was low and much more MSM attributing risk to heterosexual community and saw no need to take up HIV services. Perception however was found not as an independent variable, but subjective to the individual's situation and also modification by the existing socio-political environment. As the study findings show in Ghana, there are structural barriers that influence perception of HIV risk, severity and threat by MSM and Health Providers. Particularly, criminalization and strong societal aversion towards MSM push them underground, disrupting efforts and attempts at provision and uptake of HIV prevention, care and treatment services.

The portrayed dislike of MSM was found to be borne out of the country's societal norms and the belief by majority of Ghanaians and some influential political leaders that MSM is a sexual behavior that is 'foreign and unacceptable' in the Ghanaian society although MSM activities exist. For example the German Backup Initiative in collaboration with AIDS Commission in their study suggest over 60% of Ghanaians agreed on social exclusion of MSM from the rest of the community. The hostile socio-political environment was in part also found to explain the lack of specific national policy and evidence informed interventions. This has led to severe lack of Cues of Action, thus, information and messaging on MSM that serve as prompts and reminders on risk behaviours and available HIV services.

Indeed, except for STI management, there exist several free HIV related services including ART, BCC, Post Exposure Prophylaxis etcetera which are rather designed to meet only the needs of heterosexual community. In effect, there are no particular national program targeting MSM except for the ones provided by NGOs and CBOs which are limited in coverage (Robertson, 2010). This suggests that NGO initiatives should be more encouraged, supported and service coverage expanded to provide comprehensive HIV service as was the case in both identified interventions in this paper.

Yet, as reported in Alternatives-Cameroon Initiative, promising NGO activities may be seriously hampered by the general hostile, legal and political environment (e.g. as fear of arrest). Consequently, efforts at improving access and uptake of services among MSM in Ghana in the long term may need to address structural factors including decriminalizing same-sex practice to promote the rights of MSM to freely access services.

In the current socio-political and legal environment, the likelihood of MSM to take up services is contingent on their ability to overcome barriers and weigh benefits against the fear of seeking care. Equally, health care provider's willingness to provide services is based on their ability to overcome their personal, systemic barriers and resource gaps including unfavourable opening hours of health facilities, long queues, and unfriendly attitudes of health providers. Also, they particular face barriers such as fear of legal repercussion as mentioned earlier and social stigma.

Similarly, MSM also face social stigma, but typically fear most disclosing their Sexuality and positive HIV test results which was attributed to uncertainties on issues on privacy, confidentiality and stigma at health settings. Social stigma particularly presents a significant barrier for MSM in Ghana to accessing available HIV services in public health facilities (CCG, 2010), just as it present a major challenge in other countries such as Swaziland (Nzambi et al., 2011) Malawi (Wirtz et al., 2014), Namibia and Botswana (Fay et (Activities & Sciences 2014). From my personal experience, 'fear of the unknown' at public health facilities is a major obstacle for MSM to take up HIV treatment services when referred by Peer Educators. Additionally, W.H.O has observed that failure to disclose sexuality hinder service providers to be informed on subsequent clinical decision making (WHO, 2011). Training Health Providers to improve their knowledge and skills to deal with such cases in this sense is crucial. As shown in the best practice of Alternatives-Cameroon, attitudes and skills of care providers improved after they are trained and they deliver MSM friendly services even in cases where their values or beliefs contradicts diverse male identities. In Ghana's context, study participants referred to some nurses

trained by NGOs as 'MSM friendly' (Sabin et al., 2013a) suggesting non-discrimination and relatively increased knowledge on MSM.

Unfortunately, knowledge gaps on MSM are not addressed in the clinical curriculum of Nurses, Physicians and other Health Care Providers (HCP) in low and middle income countries (WHO, 2011). Efforts on building competencies among care providers thus need to be intensified. Evidently, qualitative insight from studies on technical competency of Health Providers in Kenya, Uganda and Malawi suggests only few health care providers have ever receive some form of training on risk reduction, counselling for MSM and anal sex practices (Elst et al., 2013). This is also the case in Ghana as studies have documented from experiences of some MSM the negative behaviours HCP shown towards them. Comprehensive training package is urgently required to improve service provision to MSM as shown in the two Intervention program.

Finally, research needs such as size estimation of MSM, understanding risk perception among various categories of MSM instead of the usual cluster of these groups and assessing how knowledge of HIV service location can affect utilization by MSM are also deem necessary to deal with barriers affecting access and utilization.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

In this final chapter, I draw conclusions and make recommendations based on the analysis and discussions.

6.1 Conclusion

Low Access and Utilization of HIV related Services by MSM in Ghana pose a great public health concern since this group is marginalized and at higher risk to HIV. This paper has provided insight to Individual and Health system factors that affect uptake of HIV related services. Variables explored included the Individual Perception on risk, modifying and Health System factors.

Regarding the Individual perception, most MSM associated risk of HIV with vaginal sex whiles perceiving anal sex as safer. Modifying factors including criminalization, resources, social norm and availability of HIV services was found as the stronghold for the low uptake of HIV Services as many Service providers and MSM fear legal repercussions. Modifying factors was also found to generate stigma and discrimination, unfriendly attitude of Service Providers among other significant barriers prevented the 'Likelihood of action' or uptake.

This paper is unclear about how knowledge on available HIV service location affected utilization. Although two out of three studies suggest no link between knowledge and uptake, the other found significant association, thus comes as an important area for further research detailing the relative impact on utilization given the level of knowledge on service locations amidst numerous barriers.

It is therefore critical at this time for Ghana AIDS Commission to deal with barriers and also consider drawing lessons from other countries in Africa (e.g. South Africa and Cameroon) with evidence of effective intervention which aimed to improve access and utilization of HIV services by MSM. Neglect and exclusion of MSM who are higher risk to HIV in national programming undermines the potential of any response to be effective (DTFD, 2011). The AIDS Commission as the supra ministerial authority in the HIV response in Ghana has a big job ahead if the goal of 'ending the AIDs Epidemic' will be realized in Ghana, considering the present low uptake of HIV preventive services by MSM coupled with numerous barriers identified in this paper.

6.2 Recommendations

Based on the results of this paper the appropriate recommendations are made below to improve provision of HIV related Services to MSM in Ghana.

Policy Issues

- The AIDS Commission and the National AIDS Control Program need to revise HIV and STI Policy and guidelines to include MSM in order to address program implementation barriers affecting Utilization of HIV services among MSM and also ;
- Advocate based on strategic information and field experiences for repealing of laws that criminalize MSM to promote their right and equally access available HIV services without fear.

Health Facility Level

- The AIDS Commission should support Ministry of Health and Ghana Health Service to establish MSM Friendly facilities to provide comprehensive HIV related services to MSM.

- The Ministry of Health need to strengthen its coordination with the Education Ministry to revise the curriculum of Health Providers and ;
- Train current providers to expand competencies and awareness on HIV Services for MSM including professional standards on human rights and patient care with regards to: duty to treat, confidentiality, privacy, stigma and non discriminatory attitudes.
- Train members of the Organizations working with MSM to self assess their weakness for effective implementation of Interventions.

Community Level

- The AIDS Commission need to form strong collaboration with local NGOs, CBOs and civil society organizations already working with MSM to advocate for equitable and non discriminatory Services.
- Adapt the right based approach to HIV Prevention activities to address community stigma, discrimination and violence rather than focusing only on risk behaviours which throws the problem back to MSM.

Meaningful Involvement of MSM

- Put best efforts into mobilization of volunteers from MSM community as Peer Educators to reach their peers with information on HIV through face to face and involve them at all stages of the implementation.
- Including MSM in all stages of Intervention planning, design, and implementation phase to create community ownership to the program.

Research Needs

- AIDS Commission would have to establish a national HIV epidemiological surveillance to understand the needs, size and lived realities of MSM for designing evidence informed Interventions;
- Conduct research on clinical dimensions on risk perceptions among all the (7) categories of MSM to better understand their needs. How knowledge on HIV service location by MSM can affect utilization.

Monitoring and Evaluation

- AIDS Commission, AIDS Control Program and Ministry of Health need to develop a national reporting tool on specific indicators for monitoring Access and Utilization of comprehensive HIV Services by MSM.

Sustainability Issues

- As the current funding stream for MSM Interventions are tied to donor agencies, and with the current decline in donor funds, the AIDS Commission should intensify efforts in mobilizing resources locally to support intervention programs to widen up the coverage.

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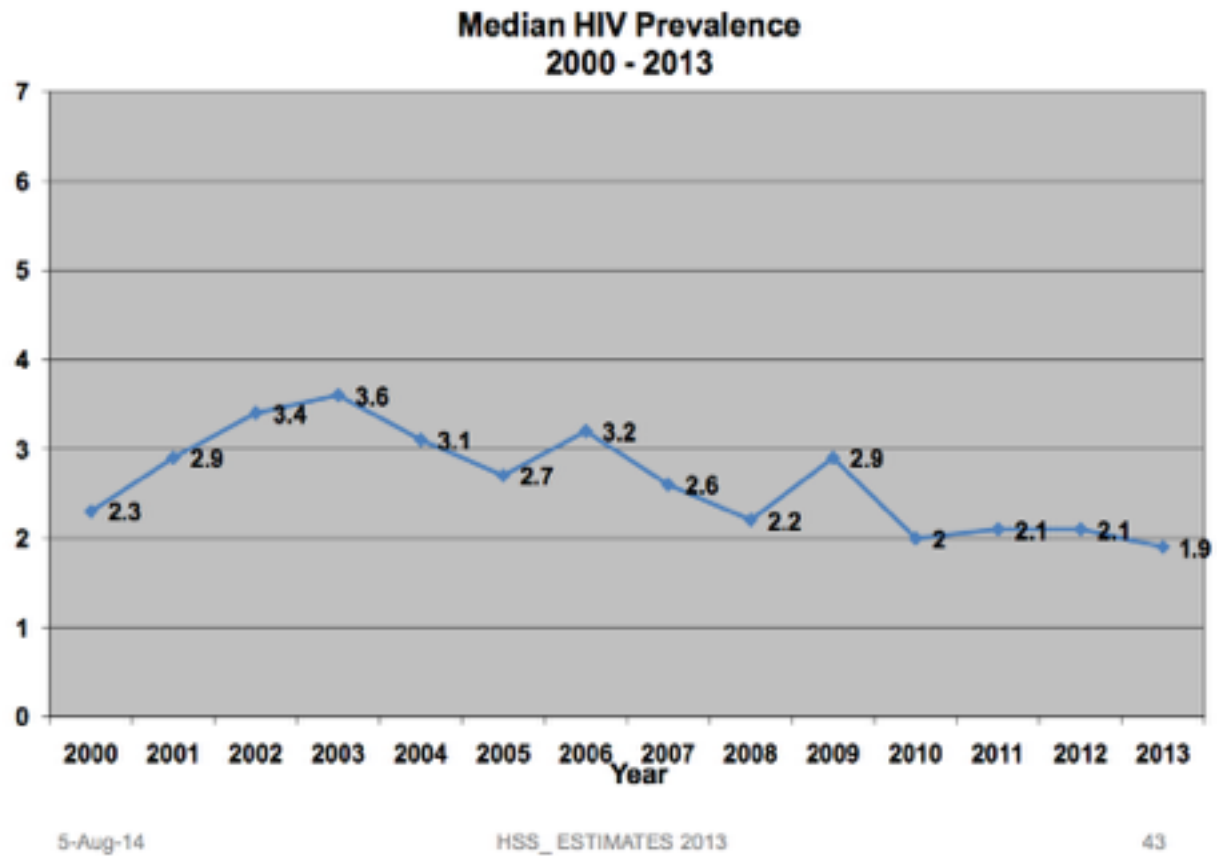
APPENDICES

Figure 1.1: Ghana Map

Source: BBC Africa, Ghana Profile, 2014.

HIV Trend in Ghana from 2000 to 2013



Source: NACP, 2014.

Table 1.3: **Examples of interventions for preventing HIV among MSM (ANOVA Initiative)**

Psychosocial	Increased HCT and early detection of positives
Reducing number of sex partners	
Reducing alcohol and recreational drug use	Male and female condoms
Increasing condom use for risky sexual behaviours	Condom-compatible sexual lubricant
Increasing the use of condom-compatible lubricant	Early ART
Sero-sorting	PEP
Sero-positioning	STI screening and treatment
Motivational counselling	PrEP (refer to SA guidelines)
Couples' services including targeted counselling	Microbicides (undergoing research)
Combating societal homoprejudice and increasing access to non-judgemental healthcare services	HIV vaccines (undergoing research)

Screening and management of depression and other mental health disorders	Harm-reduction programmes for drug users includes safe injection technique, clean injecting equipment (needles), treatment of soft-tissue abscesses, IEC materials, education about overdoses and linkage to rehabilitation programmes for those who want to stop drug use
Development and dissemination of appropriate healthcare and risk-reduction messages that address the specific sexual health needs of MSM	Medical male circumcision; does not provide the same risk reduction as for heterosexual men but might protect bisexual men and those who exclusively adopt the penetrative role in anal sex