

**PERCEPTIONS AND EXPERIENCES OF YOUNG KEY POPULATIONS ON
PROVISION OF RESPONSIVE SERVICES FOR MEN WHO HAVE SEX WITH
MEN & FEMALE SEX WORKERS:**

A CASE OF PASADA PROJECT, DAR ES SALAAM TANZANIA

**PERCEPTIONS AND EXPERIENCES OF YOUNG KEY POPULATIONS ON
PROVISION OF RESPONSIVE SERVICES FOR MEN WHO HAVE SEX WITH
MEN & FEMALE SEX WORKERS:
A CASE OF PASADA PROJECT, DAR ES SALAAM TANZANIA**

By

John Ambrose Shayo

**A Dissertation Submitted in Partial Fulfillment of the Requirements for Degree of
Master of Science in Health Monitoring and Evaluation (MSc. HME) of Mzumbe
University**

2016

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **Perceptions and Experiences of Young Key Populations on the Provision of Responsive Services for MSM & FSWs: A Case of PASADA Project, Dar Es Salaam, Tanzania**, in partial fulfillment of the requirements for award of the degree of Master of Science in Health Monitoring and Evaluation of Mzumbe University.

Major Supervisor

Internal Examiner

External Examiner

Accepted for the Board of Faculty of Public Administration and Management

.....
DEAN, SOPAM

DECLARATION AND COPYRIGHT

I, John Ambrose Shayo, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for similar or any other degree award.

Signature_____

Date_____

©

This dissertation is a copyright material protected under the Berne Convention, the Copyright Act 1999 and other international and national enactments, in that behalf, on intellectual property. It may not be reproduced by any means in full or in part, except for short extracts in fair dealings, for research or private study, critical scholarly review or discourse with an acknowledgment, without the written permission of Mzumbe University, on behalf of the author.

AKNOWLEDGEMENT

This work is a result of various inputs from different individuals. I am thankful to everyone who in one way or the other contributed to the completion of this work. However, I would like to mention a few individuals whose contribution amounted to the production of this report.

With sincere appreciation to everyone, and in no particular order, I would like to mention these few on behalf of the rest: 1) Prof. Angwara Kiwara, Lecturer at Muhimbili University of Health and Social Sciences and my major supervisor, for his regular guiding comments throughout the entire period of the study 2) Dr. Noel Mwambuga, Assistant Clinical in-charge for accepting my request for field attachment at PASADA and for his support in accessing different data in his office during my field attachment 3) Special thanks are due to Mr. Mac Sawaya and all participants, who devoted their valuable time to participate in this study.

DEDICATION

I hereby dedicate this work to my family: My beloved wife Hellen, PHEDES staff (Joan Nkya, Josephat Thadeo and Clara Nyange). I appreciate their moral support that motivated me towards the accomplishment of this important task. May God bless them!

LIST OF ABBREVIATIONS AND ACRONYM

AIDS	-	Acquired Immune Deficiency Syndrome
BCC	-	Behaviour Change Communication
CBOs	-	Community Based Organizations
CHESA	-	Community Health Education Services & Advocacy
FGD	-	Focused Group Discussion
FSWs	-	Female Sex Workers
HIV	-	Human immunodeficiency Virus
IEC	-	Information Educations Communications
KPs	-	Key Populations
MAT	-	Medication Assisted Treatment
MDGs	-	Millennium Development Goals
MOHSW	-	Ministry of Health and Social Welfare
MSM	-	Men Who have Sex with Men
MU	-	Mzumbe University
NACP	-	National Aids Control Program
NGO	-	Non-Governmental Organization
NMPS	-	National Multisectoral HIV Prevention Strategy
PASADA	-	Pastoral Activities and Services for People with AIDS Dar es Salaam Archdiocese
PEPFAR	-	Presidents Emergency Plan for AIDS Reliefs
PMTCT	-	Prevention of Mother-To-Child Transmission
PSI	-	Population Services International
PWID	-	People who Inject Drugs
SANA	-	Stay Awake Network Activities, Tanzania
SRH	-	Sexual Reproductive Health
STI	-	Sexual Transmitted Infection
TACAIDS	-	Tanzania Commission for AIDS
TB	-	Tuberculosis

UNDP	-	United Nation Development Programme
UNFPA	-	United Nation Population Funds
UNGASS	-	United Nations General Assembly Special Session
YKPs	-	Young Key Populations

ABSTRACT

Present disparities in access to HIV services among KPs are significant. Stigma and discrimination, violence, disciplinary harassment by police and social environments are major issues which fuel increased HIV vulnerability among KPs, thus availability, access, and uptake of HIV prevention, treatment, care, and support for MSM, sex workers and their clients are limited.

In response to the problem both local and international NGOs collaborated in initiating and implementing a responsive programme for KPs in Dar Es Salaam, Tanzania. PASADA, PSI and the Government of Tanzania implement a programme with a focus on providing care and treatment services to MSM and FSWs in Dar Es Salaam. A descriptive qualitative study using in depth interviews and focus group discussions were employed. Seven KPs (Four MSM, three FSWs) were enrolled for in depth interviews and one FGD conducted with peers of KPs. Three service providers were recruited for in-depth interviews from PASADA clinic centre.

We used Andersen's Behavioral Models for vulnerable populations and a framework for Monitoring and Evaluation for marginalized populations as a framework to interpret on the perceptions and experiences on health seeking and influences on the provision of services by health providers for KPs

The results highlight on the concerns of service providers lack of skills and low motivation related to the provision of services to KPs. KPs demonstrated awareness and knowledge of the comprehensive responsive services and issues which hinder accessibility. There was general unawareness of Hepatitis B and C, vaccination and appropriate prevention information among the group.

The qualitative study underscores the significance of information on both HIV risks and acceptable, effective HIV prevention options for MSM and FSWs. Learning and skills development should be available to the wider KPs community. Drop-centre interventions may be excellence sites to address health problems experienced by MSM and FSWs.

TABLE OF CONTENTS

CERTIFICATION	i
DECLARATION AND COPYRIGHT	ii
ACKNOWLEDGEMENT	iii
DEDICATION	iv
LIST OF ABBREVIATIONS AND ACRONYM.....	v
ABSTRACT	vii
TABLE OF CONTENTS.....	viii
LIST OF FIGURES	xi
 CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Background	1
1.2 Program Goal	3
1.3Major strategies.....	3
1.3.1Mapping of hot zones and hotspots.....	3
1.4 Program activities.....	3
1.5 Program logical Model.....	4
1.6 Stakeholder analysis.....	6
1.7 Statement of the Problem	6
1.8 Evaluation questions	7
1.9 Objectives of the study.....	7
1.10 Significance of the evaluation.....	8
 CHAPTER TWO	9
LITERATURE REVIEW.....	9
2.1 Knowledge and awareness of sexual health needs of KPs.....	9
2.2 Policy.....	10
2.3 The Responsive Services for Key Populations.....	11

2.4 Components of Responsive Services for Key Populations	12
2.4.1 Resources	12
2.4.2 Training of Health Service Providers.....	12
2.4.3 Linkages and Enrolment in care.....	13
2.4.4 Monitoring and Evaluation Framework for KPs.....	14
CHAPTER THREE	16
METHODOLOGY.....	16
3.1 Introduction	16
3.2 Study area.....	16
3.3 Evaluation period	16
3.4 Evaluation approach.....	17
3.5 Evaluation design	17
3.6 Evaluation framework.....	17
3.7 Qualitative method.....	19
3.7.1 Sampling and Selection of Interviewees	19
3.7.2 Data collection	20
3.7.3 Data management and analysis	21
3.8 Ethical issues	22
CHAPTER FOUR.....	24
PRESENTATION OF FINDINGS	24
4.1 Introduction	24
4.1.1 Respondents Characteristics.....	25
4.2 Knowledge and awareness of sexual health needs.....	25
4.2.1 Health policy	26
4.2.2 Training and Staff Motivation.....	27
4.3 Barriers/issues encountered in accessing services	28
4.3.1 Social-economic issues	28
4.3.2 Stigma and discrimination	28

4.3.3 Pasada Tradition and norms	29
4.3.4 Legal matters	29
4.4 Linkage and enrollment of care.....	30
4.5 Suggestions to improve the services/program.....	30
4.5.1 Accessibility and acceptability of the services.....	30
4.5.2 Targeting of programmes.....	32
4.5.3 Linkages with other services.....	32
4.5.4 Involvement of community stakeholders	32
CHAPTER FIVE.....	33
DISCUSSION OF FINDINGS	33
5.1 Introduction	33
5.2 Knowledge and awareness of sexual health care needs	33
5.3 Barriers/issues encountered in accessing responsive services	34
5.4 Suggestions for Effective response services	36
5.4.1 Accessibility and Acceptability of responsive services	36
5.4.2 Targeting Responsive services	36
5.4.3 Linkages and enrollment of care	37
5.4.4 Stakeholder Involvement	37
CHAPTER SIX	39
SUMMARY, CONCLUSSIONS AND IMPLICATIONS.....	39
6.1 Summary of key findings	39
6.2 Conclusions	39
6.2.1 Policy implications.....	40
6.3 Limitations of the study	41
6.4 Areas for further evaluation	41
REFERENCE	42
APPENDICES	47

LIST OF FIGURES

Figure 1.1: Logic Model for Implementation of Responsive Services for KPs.....	5
Figure 3.1: Operational Framework of the study.	18
Figure 3.2: Ten steps model for qualitative data analysis.....	22

CHAPTER ONE

INTRODUCTION

1.1 Background

Present disparities in access to HIV services among KPs are significant (UNAIDS, 2013). Stigma and discrimination, violence, disciplinary harassment by police and social environments are major issues which fuel increased HIV vulnerability among MSM, FSWs.

Punitive environments have been shown to limit the availability, access, and uptake of HIV prevention, treatment, care, and support for sex workers and their clients (Scheibe, Drame & Shannon, K. (2012).

The world may fail to claim an AIDS free future without targeting intervention approaches to key populations. Key Populations are disproportionately infected with the Human Immunodeficiency Virus (HIV) compared to the general populations (Beryer et al, 2012). Indulgence of risky sexual behavior leads the key populations to infections with HIV, STI and sexual health related problems. Organized interventions can relieve them from the menace and restore responsibility towards better life styles.

In samples from low- and middle-income countries in the Americas, Asia, and Africa MSM and FSWs have a markedly greater risk of infection with HIV compared with the general population. KPs from these countries are in urgent need of prevention and care, and appear to be both understudied and underserved (Baral,Sifakis,Cleghorn,& Beyrer(2007).

Addressing the specific needs of key populations (KPs), UNDP and UNFPA have supported some programs that achieved results such as improving health-services delivery, addressing stigma, discrimination, and establishment of a more favorable legal framework. Besides, these programmes accounts for approximately 4% of HIV expenditure globally (UNAIDS 2014).

Sub-Saharan Africa, is home to the majority of the world's generalized HIV epidemic, with an estimated 22.9 million people currently living with HIV/AIDS (UNAIDS, 2010). In contrast to concentrated epidemics, in which the burden of HIV-infection is primarily carried by key populations such as female sex workers and men who have sex with men, epidemics are characterized by a population-wide HIV-prevalence of greater than 1% (UNAIDS/WHO, 2000). An analysis of 16 countries in sub-Saharan Africa in 2012 showed a pooled prevalence of more than 37% among key populations. These countries have reported decrease in the new HIV infection among adult heterosexuals, but the situation is different among MSM and FSWs, this is evident through surveys done to assess the magnitude of the disease among these groups. In Kenya, the HIV prevalence among MSM was 24.6% in 2005 (Sanders *et al.*, 2007) while that of the general population in the same period was 6.7% (WHO, 2005).

In Cape Town, South Africa, the HIV prevalence was 30.9% among MSM while that of the national general population was 16% (UNAIDS/WHO, 2009). In Zambia, 33% of the MSM survey participants reported to have HIV infection compared to the national adult HIV prevalence of 15.2% (Zulu *et al.*, 2006). In Senegal, where the national HIV prevalence is an estimated 1%, 22% of MSM surveyed were HIV positive (Wade *et al.*, 2005).

In Tanzania, according to a 2010 regional study through blood samples and vaginal swabs, estimated HIV and STI prevalence at 31.4 % and 27.3 %, respectively (NACP, 2011). In 2013, estimated HIV prevalence among FSWs in Dar Es Salaam was stable at 32 percent. Overall, estimated HIV prevalence ranged from 14 percent in Tabora to 37.5 percent in Shinyanga (NACP, 2013).

The overall prevalence of HIV among MSM in Dar Es Salaam was 22.2% and varied according to sexual position during anal sex. It was higher among receptive partners (46.5%) and lower among assertive partners (10.5%). Those who practiced both positions had a prevalence of 21.2 percent (Leshabari *et al.*, 2013). HIV prevalence was highest among the men in the 25–34 age groups. Another study with a prevalence

estimate was for Unguja Island in Zanzibar, where HIV prevalence of 12.3 percent (8.7–16.3%) was estimated among MSM (Dahoma et al., 2009).

To respond to the magnitude of HIV prevalence among KPs, several initiatives have been undertaken, including development of consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. The Guidelines focus on five key populations: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers; and transgender people (MOHSW, 2014).

On the other hand, local NGOs in partnerships with international NGOs are implementing programs to respond to KPs health problems. The PASADA, Population Services International (PSI) in collaboration with the government of Tanzania, implements a program with a focus of providing care and treatment services to MSM and FSWs in the community in Dar Es Salaam.

1.2 Program Goal

The PASADA program aims at contributing in the reduction of HIV incidence in Tanzania by preventing HIV transmission between KPs and their sexual partners through increased behavior changes of KPs and their sexual partner and increased access by key population to high quality medical and non-medical support and services.

1.3 Major strategies

- 1.3.1 Mapping of hot zones and hotspots
- 1.3.2 Implementing Behavior Change Communication activities
- 1.3.3 Collaborate with Regional and District AIDS control, coordination services
- 1.3.4 Ensure continuation of care among key population

1.4 Program activities

- 1.4.1 Searching for MSM and FSWs in their respective hangouts and residences in all 84 wards of Dar es Salaam.

1.4.2 Conduct Community based HIV Counseling and testing, TB screening, syphilis testing and other STI screening

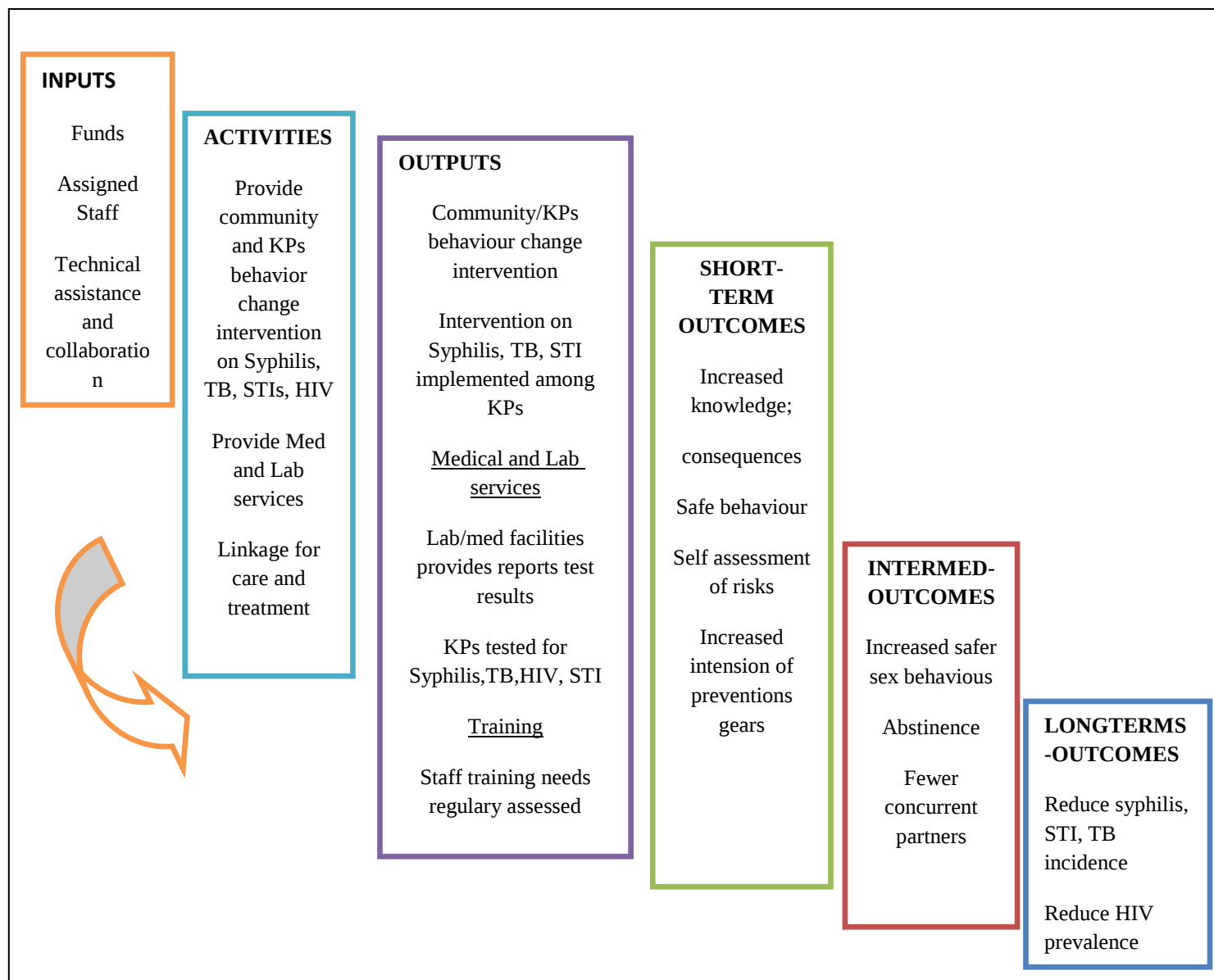
1.4.3 Linkage for care and treatment for those found to be positive for HIV, TB and syphilis and others STIs

1.4.4 Raise Community awareness on HIV and other STIs and TB

1.5 Program logical Model

This is a pictorial logical path showing how the components of the intervention were interlinked to bring about the intended results. The components include the resources required as inputs into the intervention, activities that were implemented, outputs, outcome and expected long term outcomes of the intervention. **See Figure 1.1.**

Figure 1.1: Logic Model for Implementation of Responsive Services for KPs



1.6 Stakeholder analysis

The program worked in collaboration with peers, MSM and FSWs groups, and organizations like SANA, CHESA and WAREMBO FORUMs. The role of each stakeholder perspective, participation, and ways of communication are described in **appendix 1**.

1.7 Statement of the Problem

Key Populations particularly young people face a number of problems, especially high rate of HIV infections, SRH challenges, stigma and discrimination compared to the general population Chandra-Mouli et al. (2015). From this perspective, interventions for KPs need to be comprehensive and appropriate to their health needs.

In Tanzania, the Government through its agencies, the National AIDS Control Programme (NACP) and the Tanzania Commission for AIDS (TACAIDS), had formulated policies and strategies in multi-sectoral response services to combat HIV and AIDS. NACP as well as TACAIDS has made great strides and progress to put structures and operational environments at the national, regional and district levels, for a meaningful HIV and AIDS multi-sectoral response (Kiondo & Kiondo, 2011)

Collaborative actions of NGOs and CBOs designed projects and programmes to address HIV AIDS and SRH issues specific to target audiences,—the programmes vested on knowing the local epidemic dynamics; the characteristics of the populations affected; the physical, social, and political environments that influence risk and vulnerability; their needs and barriers to address these needs; the health systems and community infrastructure. With this information in hand, an evidence-based plan can be developed and implemented (WHO, 2014).

Attention to the perceptions and needs of young people is essential, along with the development of policies, services, and programs that address those needs, particularly the youth-friendly approach to service delivery (Braeken & Rondinelli, 2012) The

expectations of these programmes is to reduce infections and the impacts of AIDS and SRH in the target populations. Some programmes have shown effectiveness of the interventions among the addressed populations (Kesterton & Cabral de Mello, 2010).

Some programmes and interventions are ongoing and others have ended. Monitoring and evaluation reports from organizers show success. Little is known on the impact of the responsive services that caused behavioural change to recipients. The effectiveness of some of the programmes have not been investigated. Owing to this and since there is an increasing number of problems, that young people face in modern society, the researcher felt compelled to investigate the effectiveness of the project/ intervention services. The researcher seeks to evaluate whether the responsive services, in interventions/projects effectively address behavioural change among KPs problems.

1.8 Evaluation questions

The main evaluation question was to evaluate the awareness and the knowledge of care satisfaction and their recommendations for improving the responsive services. Evaluation questions are narrated in appendix IV, V & VI

1.9 Objectives of the study

The objectives of the study were as follows:

- 1.9.1 To assess the perceptions and experiences of MSM and FSWs aged 19-24 with regards to the provision of responsive services addressing the needs
- 1.9.2 Provide recommendations on what to integrate in design of effective responsive services in mainstream programmes.

1.10 Significance of the evaluation

The study highlights significant concerns of service providers and the beneficiaries of the interventions. The findings will be useful for program improvements, used as base for revising policy and guideline framework for Key Populations. Furthermore the knowledge generated through this study will be shared among the evaluators and other stakeholders.

Besides, the findings of this study will be a vital tool for planning comprehensive responsive services targeting KPs. They will also increase the need of safety uptake and provision of KPs, in results will reduce criminalization and stigma.

CHAPTER TWO

LITERATURE REVIEW

2.1 Knowledge and awareness of sexual health needs of KPs

According to WHO (2012) Global estimation shows, about half of the people currently living with HIV do not know their HIV status. Few individuals among the key populations, access HIV Testing and Counseling services, making them less informed about their HIV status. Key populations, individuals often test late and often fail to associate HIV Testing and Counseling to care and access to ART. Thus, many start treatment when already significantly immune-compromised.

The African continent is the most affected by the global HIV-1 epidemic, with East and Southern Africa in general more severely affected than West and Central Africa (Ogunbodede, 2004). Differences in the spread of the epidemic can be accounted for by a complex interplay of sexual behaviour and biological factors that affect the probability of HIV-1 transmission per sex act Buvé, Bishikwabo-Nsarhaza, & Mutangadura (2002). Men having sex with men and Female sex workers are more affected with the burden. Several factors may contribute to the magnitude of the problem within the group: Violence, lack of community empowerment, community-wide awareness and knowledge are among the factors which limit the overall effectiveness of interventions to reduce HIV risks (WHO, 2014).

Urgent preventive efforts are required to rescue the population from violence and new HIV infections. Efforts to prevent violence can be promoted through advocacy for law and policy reforms, that protect the rights and safety of key populations, thereby increasing awareness of reporting mechanisms and disciplinary action; by conducting sensitization workshops for people with pivotal roles in the community (e.g. Government officials, police, media, health-care workers and religious leaders), through the creation of safe spaces, and by creating early warning and rapid response mechanisms with the involvement of key population community members, health

workers and law enforcement officials. Integrating community representatives into these efforts also helps to create channels of communication among key populations, civic officials, and police.

To reduce HIV new infections, efforts are required to provide a comprehensive package of evidence-based HIV-related recommendations for all key populations; increase awareness of the needs of and issues important to key populations; improve access, coverage and uptake of effective and acceptable services; and catalyze greater national and global commitment to adequate funding and services. Comprehensive information of condoms and lubricants use, sensitization and awareness of hepatitis C and B prevention should be undertaken with all KPs and health workers Beyrer et al.(2012)

2.2 Policy

Globally, in 2014 WHO produced the consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. The Guidelines focus on five key populations: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers; and transgender people.

They present an opportunity for civil society; including networks of key populations and people living with HIV, to work with their governments to meaningfully involve KPs in national policymaking and begin investing in their specific needs.(Reynolds, 2010)

The Guidelines also offer an opening for dialogue and action on harmful laws, policies, and societal norms that result in the denial and violation of human rights for key populations. The Guidelines based on the following principles, the human rights of members of the key populations must be protected, the right to access quality healthcare, free from discrimination, access to justice and intervention to reduce the burden of HIV among key populations that must be respectful and acceptable and affordable.

Other principles, including that the treatment must be accurate to enable key population decision-making. Lastly, integrated service provision needs to meet the multiple co-

morbidities and poor social situations experienced by people from key populations (World Health Organization, 2014).

In sub-Saharan Africa, several countries have endorsed several global commitments and the respective plans of actions, including MDGs; the UNGASS declaration; the Abuja High-Level Partner Forum on PMTCT (2005) among others, committed to improving the quality of life and achieve the elimination of new HIV infections in the general population especially where new infections are concentrated (Dzokoto, 2006).

Given the disproportionate burden of the HIV epidemic among the specific population groups in Tanzania, much is needed on addressing the HIV prevention, diagnosis, care and treatment for KPs. In 2014, the MOHCDGEC developed National Guidelines, which will guide and standardize the implementation of a comprehensive package of HIV and Health Interventions for the KPs who are at high risk for HIV.

2.3 The Responsive Services for Key Populations

International responsive services on AIDS/SRH targeting a young people population, are services that address their concerns regarding their personal- health, social, educational and career development (Braeken, D., & Rondinelli, I., 2012). Programmes to reach KPs account for approximately 4% of HIV expenditure globally (UNAIDS, 2014). Global-World bank with UN agencies have joined their effort to develop guidance documents to evidence informed national policies and program.

The Tanzania Commission for AIDS in collaboration with other stakeholders developed the National Multisectoral HIV Prevention Strategy (NMPS, 2009-12) and revised version of 2014-17 as a major national milestone in response against the epidemic. Various prevention interventions are integrated into existing systems and structures to enhance compliance on implementation. In reducing the proportion of youth engaging in cross-generational sex and delay of early sexual debut, the National Behaviour Change Communication (BCC) guideline and communication package for young people has been developed.

According to MOHCDGEC (2014), National Guidelines for comprehensive HIV intervention for KPs has been developed. The aim of the Guideline were to; provide a comprehensive package of evidence-based HIV-related recommendations for all key populations; increase awareness of the needs of and issues important to key populations; improve access, coverage, and uptake of effective and acceptable services.

2.4 Components of Responsive Services for Key Populations

2.4.1 Resources

The KPs responsive services become effective only if project administrators support the implementing team by providing resources. For example, sufficient budget enough to carry the activities through; provision of adequate time; information and educational books; allowing time for uninterrupted psychosocial counseling activities, and providing space for confidential treatment, care and support services (WHO, 2014). Lack of resources can negatively affect the KPs responsive services.

2.4.2 Training of Health Service Providers

Sub-Saharan Africa has a very high burden of HIV-1 infection, of which a substantial proportion occurs among populations reporting high-risk sexual behaviour such as transactional sex and anal intercourse Beyrer et al.(2010). Healthcare workers (HCWs) typically receive little or no training in the healthcare needs of men who have sex with men (MSM) and FSWs, limiting the effectiveness and reach of population-based HIV control measures among this group Van der Elst et al.(2013).

Training is a key factor to effective KPs responsive services implementation. International literature shows that training of personnel not that well prepared to offer KPs services Rispel et al.(2011). Lack of trained man power for psychosocio-counselling and provision of appropriate services acts as a drawback to the effective implementation of services Renton et al.(1996).

In general, some personnel are appointed and given sketchy in-service training for provision of the necessary services. The service providers are not competent. As a result, the beneficiaries are inadequately informed and educated of the services rendered to them. The impact is seldom achieved.

2.4.3 Linkages and Enrolment in care

Community-based HIV testing and counseling for key populations, with linkage to prevention, care and treatment services, in addition to provider-initiated testing and counseling is strongly recommended.

Several interventions reviewed, highlights the importance of interventions that could reduce transport difficulties for KPs. Decentralization, task shifting and integration of services need to be expedited to alleviate health system barriers. It suggests a combination of interventions to retain specific groups at risk for attrition such as workplace programmes for employed patients, dedicated clinic and support programmes for men and younger individuals. (Govindasamy & Kranzer,2012).

A positive HIV diagnosis without linkage to HIV prevention, care and treatment confers limited benefits. Ensuring that people are linked to and enrolled in HIV clinic care is necessary to realize the full health and prevention benefits of ART. Unfortunately, substantial losses occur at every step of the HIV care continuum. These losses can be particularly great among peoples from KPs Sorensen et al.(2012).

Multiple reasons hindering linkage to care include psychological and social barriers, economic constraints, and health system factors. Key operational issues need to be considered and addressed in order to improve linkage to care, including better partnerships between community and clinical provider and increased efforts to improve the quality of services Travis et al.(2004).

2.4.4 Monitoring and Evaluation Framework for KPs

A Joint United Nations Programme on HIV/AIDS (2008) in a framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations highlighted the crucial components of comprehensive intervention target to Key Populations as follows:

- i. Acceptability of programme services – this could be impacted by experiences of stigma and discrimination, perceptions of privacy and confidentiality, appropriateness and relevancy of interpersonal communication and printed materials, involvement in programme planning and implementation, positive and negative experiences, and overall satisfaction.
- ii. Access to programme services – including distance to and location of project sites, opening hours, waiting times, cost, and police presence.
- iii. Targeting of programmes – whether programmes are reaching particular networks of most-at-risk populations and excluding others that may be less visible or more highly affected by HIV.
- iv. Linkages with other services – as individual programmes cannot be expected to meet all the needs of most-at-risk populations, organizations need to link effectively with others providing complementary services. These include other prevention services as well as treatment, care, support, human rights, and life or vocational skills training.
- v. Involvement of community stakeholders – programmes targeting most-at-risk populations are unlikely to be successful without the simultaneous involvement of those individuals who also influence their vulnerability to HIV. They are specific to local contexts and can include sex industry gatekeepers (e.g. ‘madams,’ ‘pimps’), sexual partners, police and local authorities, or influential individuals.

These individuals directly influence the success of interventions, and process evaluations commonly explore their attitudes towards, and interactions with, programmes

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter gives details of the methods used to conduct the study. One method employed in the study (qualitative method) is explained under this chapter detailing sampling techniques, data collection tools, data management process, analysis techniques, and presentation of findings.

3.2 Study area

The study was conducted at PASADA in Temeke District, Tanzania. The faith based NGO in collaboration with Population Services International (PSI-TZ) with support from the Ministry of Health, Gender, Community Development, Elderly and Children (MoHCDEC) and through USAID support and Global Fund. The program targets four key populations (Female Sex Workers (FSWs); Women Engaging in Transactional Sex (WETS); Men having Sex with Men (MSM) and Potential Clients of FSWs. This is a five years program from April 2011 to March 2016 being implemented in 10 regions of Tanzania Mainland (Dar Es salaam, Iringa, Mbeya, Mwanza, Tabora Shinyanga, Mara, Dodoma, Tanga and Mtwara. The program is extended for one more year to end in 2017 March.

3.3 Evaluation period

Data were collected from 12th to 26th Feb 2016. The Gant chart, Appendix 2 summarizes different activities and the time frame planned for each activity that was carried out in the whole process. The activities in the Gant chart include proposal development, data collection, data analysis, report writing, and dissemination of findings.

3.4 Evaluation approach

A formative approach was employed to evaluate the community based HIV care program for Men having Sex with Men and Female Sex workers. Approach informs about the effectiveness of responsive services among target groups.

3.5 Evaluation design

A cross sectional study design was employed. This design was appropriate because the evaluator wanted to collect the data at once and assess the current situation of the program implementation. The study intended to study the perception and experiences of the target group in term of effectiveness relating to their needs.

3.6 Evaluation framework

The study used Andersen's Behavioral Model for Vulnerable Populations (Gelberg et al.2000) to assess the effectiveness response services among key populations at PASADA in Dar es Salaam. The model suggests that health care utilization is a function of three components: a predisposition by people to use health services, factors that enable or impede use, and people's urgency for care. Each component is divided into traditional and vulnerable domains that are especially important to examine in understanding the health needs and behaviors of vulnerable populations. This Evaluation, integrated the framework for M&E of marginalized groups for effective intervention which suggests five components: Acceptability of programme services, Access to programme services, Targeting of programmes, Linkages with other services, Involvement of community stakeholders as major components of effective response services. Using these models, Andersen's Behavioral Model for Vulnerable Populations and Framework for M&E for marginalized populations, we assessed the perceptions and experiences among KPs, examined barriers to health care, accessibility and utilization among them at PASADA in Dar es Salaam. The logical framework for the study is summarized in **Figure 3.1**.

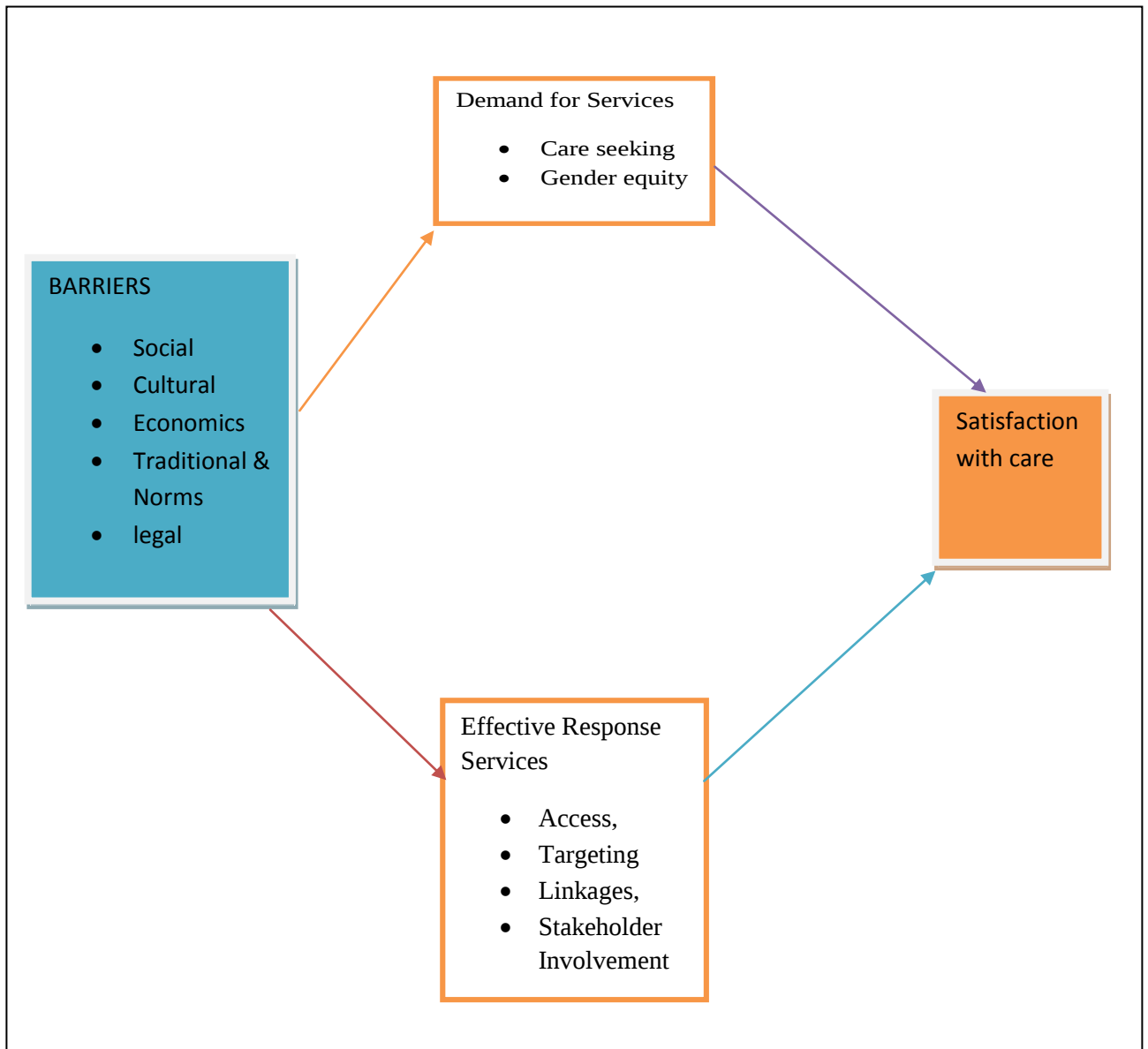


Figure 3.1: Operational Framework of the study (John, 2016 adopted from Gelberg, Andersen, & Leake (2000) & Joint United Nations Programme on HIV/AIDS. (2014).

3.7 Qualitative methods

Qualitative method was employed to explore in-depth information about the community based HIV care program for Men who have Sex with Men and Female Sex workers. This method was applied purposely to capture the perception and experiences of the beneficiaries of the program and the health service providers of the program.

3.7.1 Sampling and Selection of Interviewees

This study was conducted with Service providers whom are providing services at PASADA health centre and MSM and FSWs attending clinic at the centre. More than two thousand KPs have registered for ARV clinics in this centre and they are received at a rate of ten new clients every week. Program is led by the Clinical Medical Officer, and managed by a doctor, social worker, and counselors. For data collection, doctor in charge introduced us to KPs (we were told they are MSM and FSWs) whom were seated at the waiting place. Evaluator conveniently approached them before they get to meet the doctor for their routine check-up.

The evaluator in Kiswahili language read out the informed consent form verbatim. The consent form included a brief description of the project, purpose study, and expected results and how the findings would help health educators. The specific procedure of how the interview or group discussion would be conducted was explained, and potential time taken for each interview or discussion was mentioned.

Health service providers were purposively sampled with an attempt to recruit staff from centre. Eligibility criteria for these interviews included being aged 18 years or older, having worked in the specific KPs intervention, and providing informed verbal consent to participate. A total of three participants were recruited. Their inputs were important to understand the experiences of service providers and how interventions may be implemented to enable them to provide quality care to KPs. The interviews were conducted in one of the counselors' room within the clinic premises.

3.7.2 Data collection

Data was collected through in-depth interviews (IDIs), lasting 15 minutes on average, with 10 respondents (Seven of them are KPs and three are Services provider) and one focus group discussions (FGDs), lasting approximately 25 minutes with six respondents. Individual interviews were more pragmatic in this study setting because the KPs had limited time and preferred privacy. However, for purposes of this study where we wanted to seek data completeness and confirmation, we had to request peer (case managers) to give us time for the focus group discussions. Individual interviews and focus group discussions have been combined for the purpose of data completion and confirmation (Adami, 2005; Halcomb and Andrew, 2005; Lambert and Loiselle, 2008). Individual interviews were used to explore personal experiences and focus group discussions helped examine beliefs about the condition or phenomenon (Molzahn et al., 2005). However, the evaluators conducted observation to confirm the input given with the KPs and the service providers. Thus, each method may provide different views of the same problem and thus create a more comprehensive understanding (Lambert and Loiselle, 2008).

The specific interview guide used to explore KP's perceptions and practices related to the provision of responsive services for MSM and FSWs comprised four sections:

- i. Knowledge and awareness of sexual health needs.
- ii. Barriers/issues encounter to access of the services
- iii. Linkage and enrollment of care
- iv. Suggestions to improve the service/program

Audio and note taking as methods of recording data were used concurrently for individual interview, however audio recording of FGD could not be carried out because case managers (Peers) were uncomfortable with this method. Hence, the use of note-taking as a method of recording data was a pragmatic consideration. In order to

compensate for the challenges of note-taking during a focus group discussions were facilitated by two investigators.

The senior field-evaluator played the role of moderator, asked the questions, and held the conversation while the junior person assumed the role of assistant moderator taking notes and responses verbatim. The assistant was experienced person in public health and trained to take notes in a manner, which indicated clearly if something was a direct quote and if some comment had been paraphrased. The moderator also simultaneously took notes.

At the start of all IDIs and FGDs, the assistant moderator filled out a social demographic survey form that captured each respondent's age, education level, occupation and the place of living. Five IDIs were conducted at first, all ideas emerging from them, were tested in the following days in the one FGDs to confirm conceptual representativeness of concepts. Also specify the conditions under which these perceptions existed (Strauss and Corbin, 1990).

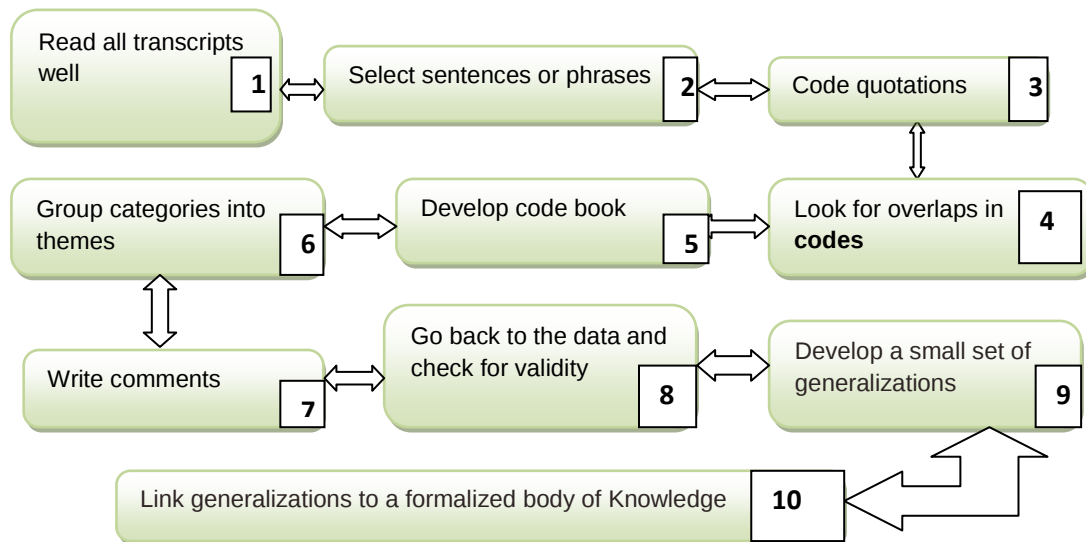
Data collection ended after conducting the second set of five IDI's as the evaluator reached a point where no new themes emerged and the data did not add to the overall frame-work of analysis. The last five IDIs further enriched the conceptualization and helped identify individual and contextual circumstances around the phenomenon. This sequence added value to the interpretation process and enhanced trustworthiness of the findings (Lambert and Loiselle, 2008).

3.7.3 Data management and analysis

Audio data for each in-depth interview was labeled and appropriately saved after each session. Since the interviews were conducted in Swahili, and the research language is English, data were transcribed verbatim and then translated into English. Data from FGD were also translated into English to form one transcript. Data were organized using ATLAS.ti.7 software to facilitate analysis process.

Analysis adopted the “ten steps cyclic model” of Qualitative Data Analysis (QDA) as proposed by Dey, 1993 –Figure 3.2. Transcripts in word documents were uploaded into ATLAS. ti software, followed by reading and re-reading the transcripts to really know the contents. Quotations were identified and coded to give them labels relevant to the information contained in the quotations. Content analysis was done to come up with main themes. An output of all codes with quotations organized into themes was produced, and this output was used for report writing. Figure 3.2 shows the ten-step cyclic model for qualitative data analysis.

Figure 3.2: Ten steps model for qualitative data analysis



Source: Dey, (1993)

3.8 Ethical issues

The evaluator obtained a permit from Mzumbe University to conduct the study following approval of the research proposal. Permission was also granted by the Director of Pasada to conduct the study in the organization. Participants signed a consent form to participate in the study. Through this form, the evaluator reassured the participants on

confidentiality that their responses would be used only for the purpose of this study. Data collected is used only for the purpose of this study and not otherwise.

During the interview, the participant was told how confidentiality would be maintained. The voluntary nature of participation was clearly explained by telling the participant she/he was free to withdraw from the research at any time without giving a reason; clear information was provided that the participant had the right to refuse participation (or to ask for cancellation from the study) if she felt uncomfortable, and that this will not affect any other aspect of the client's care-getting process.

The name of a contact person for further questions was also provided. The participants were informed that they would not receive any compensation. After reading the complete form slowly and clearly, the interviewer asked the participant if she had understood the objectives and process; only when the respondent gave verbal consent, the evaluator signed the form and proceeded with the interview questions. This procedure was followed in both the focus group discussions and in-depth interviews. Client who agreed to participate were interviewed in a small side-room provided by the centre authorities. Evaluator was experienced in conducting interviews with KPs both female and male.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the themes that emerged during qualitative data analysis. The findings provide in-depth information from KPs about their perception on the provision of responsive services for MSM& FSWS implemented by PASADA. Seven in-depth interviews were conducted with KPs and one FGD is involving peers of KPs. Three in-depth interviews with key informants (services providers) were conducted. Four major themes emerged during these sessions, which are : 1) Knowledge and awareness of sexual health needs 2) Barriers/issues encounter to access of the services 3) Linkage and enrollment of care 4) Suggestions to improve the services/program.

The evaluation framework of *Joint United Nations Programme on HIV/AIDS. (2014)* was useful to guide the conceptualisation of the study. However, following my own initial formative assessment of PASADA clients, before the designing of the tools, learnt that there are issues that confronted to be participants. The themes thus presented are a result of this process, which informed the interview guide.

4.1.1 Respondents Characteristics

M/S	Category	Sub Category	Number IDI	FGD
A.	Sex	Female	4	3
		Male	6	5
	Total		10	8
B	Age in Years	18-24	7	8
		25-50	3	-
	Total		10	8
C	Marital Status	Single	16	-
		Married	2	-
		Widowed	0	-
		Divorced	0	-
	Total		18	
D	Education	Non	0	-
		Primary	2	-
		Secondary	12	-
		Above secondary	4	-
	Total		18	-
E	HIV status(Positive)	Female	1	
		Male	2	
	Total		3	-
F	Residential	Male(4)	Homeless	

4.2 Knowledge and awareness of sexual health needs

The respondents were aware about the services provided by the program, were able to mention and narrate the services. For those initiated with the ARV were aware with their clinic schedule, contact person and the place. When they were asked, what services are provided at the centre, the respondents cited the test for HIV and treatment for sexually transmitted diseases and i quote:

“We are tested HIV, malaria, gonorrhea UTI and also they cut the genital warts” Genital warts are part of STI , these are herpes, which specially develop in the anus and often for older people and also to young people who practice homosexuality also female who practices anal sex” MSM#1

We are comfortable with the way they treat us here, I am HIV positive, I tested here, I collect my ARV here and also they check my CD4,we normally take a very short time. They give us advices and counseling as well to stop sex business. I love them and I like their services FSW#1

The service provided for KPs is well known and understood by the staff and other adults served at the centre. The program is separated from other services provided by PASADA including CTC for adults. The service providers have been well oriented on how to offer the health services to KPs at the centre and brothel. *“We had oriented two staff for KPs services, but these are absolutely not enough...we strategically plan to train more staff to improve our program.”*....The Clinical in Charge responded

4.2.1 Health policy

The program implemented according to the stipulated National Guidelines for Comprehensive Package of HIV interventions for Key Populations.

“We follow the Ministry of Health guidelines, issued specifically for KPs by the NACP. The guidelines have demonstrated the model of implementation of KPs program and standard should be maintained”. The clinical in charge

However, there is a need of revising the Guidelines for KPs or pre-test them for improvements. Service providers were asked to share their experiences based on the guidelines and the actual needs of KPs if they were fulfilled.

I can say it is 50 %, the guidelines are good. If you read them, it shows the focus, and aim of helping KP but only theoretically. If you go after them, the ministries are doing just because they want people to do of course. Sometimes they say it is because of the pressure of donors.

In the implementation process, several issues are raised, that should be solved with the Ministry but no-action has been taken. These include technical and administrative concerns as narrated here.

Current data for KPs from NACP we doubt if are good data .It revealed that no mechanism set in place to regulate the implementers in Tanzania. Therefore, the rate of duplication of data is alarming in this field. For example, former NGO dealing with KPs was two, but for now we are more than twelve when KPs are the same number..Those NGOs you will find here, you will meet them also at SANA, PSI and also Jhapaigo. Clinical officer in charge.

Another issue emerged was the police harassments. Brothels are illegal in Tanzania, therefore MSMs and FSWs have been apprehended by the police and are harassed. As a result, rate of adherence has decreased because some clients are hiding because of the police harassment and others are in prisons. Regardless of the efforts taken to discuss with the Ministry of Health, community Development, Gender, Elderly and Children but no solution reached.

"We are scared of the police, we cannot get out, looking for our stuffs, and they will take us to prisons" msm#3

It is noted that the rate of KPs accessing the services including ARV has been dropping down from day to day. Recruiting of new clients in the program has been so difficult because KPs are so scared. They don't trust the service providers.

"We are harassed! We are harassed by police, our clients do not trust us anymore! Because they thought that we made plans with the police to catch them".

4.2.2 Training and Staff Motivation

The service providers articulated the need of Training and motivation among service providers and case manager (peer) for better improvement of the program. They discussed the critical role of training for staff. One respondent recounted her frustration with low rate paid for mapping and resolved to reform the payment scheme to have frequent training and good payment for efficiency and effectiveness of the program.

"What we are paid ...and what we are doing is not the same, however, we need strategies on how we will reach our clients and protect ourselves from diseases like Hepatitis. Training is important to us". Peer

An emphasis on training and promotions was common in in-depth interview for services provider. *If you are working in KPs program, you are finished! No incentives as our fellow staff are getting from PMCT and CTC, they are enjoying promotionwe need promotion if we need changes. Nurse*

4.3 Barriers/issues encountered in accessing services

Participants discussed/informed on critical issues/concerns encountered in accessing the services. They highlight common concerns such as, social-economical, cultural, traditional and legal matters.

4.3.1 Social-economic issues

Most respondents informed on great distances between homes and the centre, unreliable transport and fare as factors hindering them to attend regular services

. “I stay with my friends at Mbezi and Pasada is very far from my place, but I have to come here whenever I have bus fare. I used to collect my ARV here, but sometimes I missed them because of transport” MSM #2

Service providers have also noted transport for KPs as accessibility barrier. The adherence rate for ARV clinic among KPs is very low. One of the factor influenced the adherence is the transport cost for KPs *“I have to give them my money for transport for the coming clinic, if you won’t give them you will not find them.” Doctor of the clinic*

Most of KPs both MSM and FSWs are reluctant to disclose their health status to their parents, relatives and sexual partners, one respondent share his experience.

“I have friends of mine, who were my school mates, we are all gays, but my friends never came here for services because they fear their parents and relatives. They don’t want them to know they are gay.” Myself, I was like them, but soon I left my parents, I joined the program, and tested HIV positive”.

For MSM, top (one inserting penis) they don’t want at all to be known. They are reluctant to look for KPs services. Some of them are in the same age as bottom and others are married adults.

4.3.2 Stigma and discrimination

Stigma and discrimination were also found to be issues hindering accessibility of the services. It has been a critical problem in the early stage of the project. It was not an

easy task for staff of PASADA to provide services for KP. Besides the Pasada centre is a very busy place with a school, a church and CTC services. KPs, MSM in particular fear of being judged by people who interact with them at the centre. One of services providers for KPs shared his experience about stigma at the centre

“KPs fear to be judged and discriminated, thus some of them end at the gate without getting services. Although we strive to counsel them not to posture as they grow up in the street..., we try also to educate them to dress smartly so as to appear smart..”Nurse

4.3.3 Pasada Tradition and norms

Pasada is a faith based organization they don't offer condoms and lubricants (jelly) for KPs. This is an obstacle for MSM in particular, Condoms and lubricants are essential services to KPs for HIV prevention. *“ I cannot sex without condom and unfortunately, they are not available here at the centre, so I have to go somewhere else.”It cost us much MSM#3*

The peers complained about the condom and lubricants not being available at Pasada. Due to this it is difficult to impress their clients when they are doing the mapping in the brothels. Condom availability is a vital component for any HIV program and Sexual reproductive health. A comprehensive program for KPs should include condoms and lubricants.

4.3.4 Legal matters

All participants, including peers and service providers condemn police harassment. One of the providers expressed how the program has been affected by police harassment. The client number has dropped, they used to test for more than 60 FSWs in one night in one brothel but for now they manage half the way. One participant from the FGD narrated that MSM are discriminated by police when they are looking for police support....They are often tortured. They cannot call for police help whenever they have problems, they are scared of them”.

Another respondent narrated how he has been treated by the police and criminalized

I don't have an Idea how many times I have been in prisons,...we don't have our rights here Tanzania, am about to die soon...when you are in prison and they find out you are gay...you are forced to do sex in prison. Tanzania criminalizes homosexuality. It has nevertheless started to implement different harm-reduction, HIV interventions for key populations.MSM#4

4.4 Linkage and enrollment of care

We centralized our services, the clinical in-charge informed that their services are provided in one centre, they only link their clients to other NGOs for services which are not available at the center.

“HIV testing and counseling, treatment and care we provide them here. We are reluctant to link our clients to other care and treatment services. We don't know which organization offer care and treatments specific for KPs....However, we don't have enough space and staff to offer efficient services.”..... “We know condoms are significant to our clients but we don't offer them here we direct them to other places including those organizations we worked with”. Clinical-incharge.

4.5 Suggestions to improve the service/program

Several suggestions emerged during the analysis of this sessions to improve the services. In depth interviews and FGDs were asked to share their suggestions to improve the program, and here the suggestions provided: accessibility of the services, the target group, linkages with other services and stakeholder involvement as major components of effective response services.

4.5.1 Accessibility and acceptability of the services

The respondents both MSM FSWs and service providers strongly recommend the need of program to be scaled-up to all districts and wards to increase the accessibility.

Imagine how far we are coming from. It would be better if they will scale-up the services and group them, young people, women, and men. But now they have grouped us together we are not comfortable.

The participants suggest, the police should be involved so that they will reduce harassment, training more staff to reduce stigma and discrimination. The opening time of the centre, waiting time and location of the centre should be observed.

The program of KP is implemented within Pasada premises in one small room with two tables and one files board. It is a very busy room with three staff, one Doctor, social worker and an internship student. Outside the room, there is a waiting place for the clients outside the room. The Program focuses both adult and young people. Two respondents share their experiences

“As you see our clients coming in, they have been waiting in that open place. If the program would consider differentiating the group it would be possible to reduce stigma .Because they will meet themselves.” Services provider

I am tired of that waiting area; there is no privacy at all, better if they could find somewhere else so that we can have our own business. The room is so small, sometimes you may find some people inside, even we don't know them “wanatuchora tuu” FSWs.

The absence of condoms and lubricants for KPs has been strongly condemned by the respondents. In fact, it has been so cumbersome to service providers and peers in implementing their normal routine tasks.

We also visit our clients in brothels, their priority is condoms and lubricants, but the organization does not allow us to distribute, we are facing a difficult situation with our clients. They do not understood us if our intention is to protect them and treat them.
Service provider

During FGD with peers, the topic of condoms and lubricant dominated the discussion, condoms and lubricants are significant items to KPs, it has been used as a tool to build the rapport between KPs and peers or service provider. Discussions in one word, strongly recommend the program should take urgent actions regarding condoms and lubricants.

4.5.2 Targeting of programmes

The participants suggest the program should reach particular networks of most at risk populations including those who are in schools and not only those who are at brothels. They strongly advise that the programme should be extended to their partners in particular the “tops” who are less visible and more highly affected by HIV.

4.5.3 Linkages with other services

The participants narrate on the necessity to link them to different service providers

“I need to go for tailoring course, but am scared, I am wondering if we could have the centre offer such service to us, it could be better” .One service provider expressed her experience

“our young sisters and brothers need our help but it is difficult to offer all their needs, we need a network where we can link them, example, human rights, VETA and treatment including Hepatitis B and C.”

4.5.4 Involvement of community stakeholders

The participants strongly recommend that the involvement of parents and community is important .The peers state MSM are experiencing difficult life because they are homeless, if the program involved parents and other relatives we could have better results. Important stakeholders like parents, police, and community and service providers should share stakes, hence the program will be successful.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

Based on the findings as presented in chapter four, this chapter presents a detailed discussion of the findings in relation to the themes emerged, which are: 1) Knowledge and awareness of health care needs . 2) Barriers/issues encounter to access of the responsive services. 3) Linkages and enrollment of care and 4) Suggestions to improve the responsive services for KPs.

5.2 Knowledge and awareness of sexual health care needs

This qualitative study with MSM and FSWs including service providers found that although almost all respondents had knowledge and awareness of responsive services such as, HIV test and STI, TB and screening for cancer, which are common to KPs, most were unaware of Hepatitis B and C, vaccination, appropriate prevention, causes and treatments. Knowledge of condom use is not comprehensively known among the KPs interviewed.

According to National Guidelines for a comprehensive package of HIV intervention for Key Populations (2014) sensitivity and awareness of hepatitis of hepatitis C and B, prevention should be undertaken with all KP and health workers. Key population with active HBV or HCV infection should receive treatment according to available and affordable treatment regimes. The guidelines direct rapid HBV vaccination shall be offered to KP at risk of HBV infection and vaccine should be offered to any KP who has experienced sexual violence within 14 days of the event.

For comprehensive, responsive services for KP, MSM should have access to basic HIV-related services, including condoms, lubricant, HIV testing, and antiretroviral therapy. This measurable success will be achieved by raising the awareness Beyrer et al.(2012).

The staffs are few; they are not enough to offer efficient services. Inadequate staffing and poor attitudes of healthcare staff is among health system factors affecting the efficiency of the program particularly for KPs. Besides, the findings show that, the service providers are lowly motivated and lack enough competence to offer a comprehensive service. Healthcare workers (HCWs) typically receive little or no training in the healthcare needs of men who have sex with men (MSM), limiting the effectiveness and reach of population-based HIV control measures among this group Van der Elst et al.(2013).

The program used the National guidelines for implementation, however, only half of the guides are used.

“I can say it at fifty percent, the guide is good, if you read it, it shows the focus, and aim of helping KP but only theoretically. If you go after them, the ministries are doing just because they want people to do of course. Sometimes they say it is because of the pressure of donors”. Incharge

We didn't find if the guidelines have been evaluated, Furthermore, there is no monitoring and evaluation framework to assist the evaluation.

5.3 Barriers/issues encountered in accessing responsive services

We used Andersen's Behavioral Model for Vulnerable Populations and framework for M&E for marginalized adopted in this study to discuss this section.. The model highlights the issues encountered in health care utilization, including social, cultural, economical, traditional &, legal and environmental.

(Gelberg et al.2000) to assess the effectiveness of response services among key populations at PASADA in Dar Es Salaam. The model suggests that health care utilization is a function of three components: a predisposition by people to use health services. Participants in this session described several common issues encountered in services utilization including .Transport, social matters, stigma, discrimination, and lack of condoms and lubricants. These factors are similar to those discussed in other

literature on barriers encountered by MSM and FSWs to access health services Risher et al. (2013).

One service provider was of the view that culture and faith could be the major issue promoting low utilization of the services at the centre. Restrictions of provision of condoms and lubricants are going against the national guidelines which enforce that wide accessibility, availability and affordability of male and female condoms together with non-oil based lubricants should be ensured (MOHCDGEC,2014). Service providers suggest that the issues of condoms and lubricants should be included their package so that they can reach the target of attain zero new infections.

The findings revealed that stigma also exists among the service providers themselves,s as expressed by health in-charge *“even our staff here they show tendencies discriminate the KPs. They are requesting high payment to work for KPs we have only two staff a doctor and one nurse at this centre”*

The study suggests the national guidelines should be obeyed as stipulated in tackling the issues encountered by KP in accessing the health services. The health provider should provide non-judgmental and non-discriminatory services to KPs. Condoms and lubricants are essential components therefore must distribute to KP and their sexual partner.

Homelessness was noted as a predisposing factor, which hinder the utilization of health services. All responding MSM were homeless and financially poor, and experienced transport problems.

One provider narrated the social and economical difficulties KP goes through regardless of services being free *Our clients particularly MSM are homeless some stayed in Kariako and others in brothels, they are financially in in bad status, particularly those with HIV infections, personally am forced to give them money for transport so that they can attend their clinics.*

From FGDs, criminalization and low motivation for health providers were identified as factors which fuel, low utilization of the services for KP. These findings proved in another study(Ref..) which documents that criminalization of KP also serve as a negative factor in the provision of, access to or utilization of services. Besides services provider should be individually motivated to provide services for KPs.

According to the national guidelines (2014) A combination of stigma, discrimination and criminalization limits KPS to access available services.

5.4 Suggestions for Effective response services

Through the framework adopted from Andersen's Behavioral Model for KPs these results highlight the accessibility of the services, the targeting group, linkages with other services and stakeholder involvement as major components of effective response services.

5.4.1 Accessibility and Acceptability of responsive services

The respondents both MSM FSWs and service providers strongly recommend the need of program to be scaled-up to all districts and wards to increase the accessibility. Similar recommendations quoted from national guidelines that scale-up of appropriate, culturally relevant and sensitive, low threshold [ensures that implementation setting facilitates easier access to services through specific locations – such as drop-in centre- with appropriate opening hours suited to KPs and high impact services and programmes while maintaining quality and sustainability. The health information and health services should be accessible.

5.4.2 Targeting Responsive services

Respondents reflected on their comprehensive needs, KPs on what they should receive and providers on what they should provide for KPs. Two providers explicitly acknowledge that the services being provided are comprehensive to the targeted group, however, they are only complying with National guidance only at fifty percentage. The

guidelines recommended the package of intervention for KPs to include HIV diagnosis, treatment and care (ART, PMTCT, drug-drug interactions, nutrition, PEP). Prevention of sexual transmission (which includes comprehensive condom and lubricant programming), interventions aimed at reducing harm due to substance abuse (NSP, OST, other drug dependence treatment, opioid overdose management), behavioural interventions, sexual and reproductive health (STI management, contraception, conception and pregnancy, cervical screening, voluntary medical male circumcision) and prevention and management of co-infections and co-morbidities like tuberculosis, viral hepatitis mental health.

Age category also found to be essential components in providing comprehensive services. The study revealed that, program was provided to all people (adults and young people) with similar staff share one room founded at the centre. Although we are intervene KPs but they needs they differ depend on their ages. According to Andersen's Behavioral Model for Vulnerable Populations (2000), age is among the predisposition component for health care utilization.

5.4.3 Linkages and enrollment of care

More emphasis on linkages of program and other services including, vaccination of hepatitis B and C, distribution of condoms and lubricants as well non-health services as entrepreneurs development skills. According WHO (2014) linkages of KPs intervention, reduce age and gender related barriers to access health services. Linkage is an essential component in comprehensive HIV Testing and Counseling (MOHSW, 2014).

5.4.4 Stakeholder Involvement

Involvement of parents and community was central to provider's recommendations for improving responsive services to KPs These recommendations included orient KPs parents or guardian in the program and raise awareness to the community.

Parents and the community at large are important stakeholders to be involved in our program.....will reduce homelessness and loss to follow-up of our clients and also will increase accessibility of the services.

The involvement of supportive parents or guardians can be beneficial, especially for those requiring ongoing treatment and care. It is important, however, to have the adolescent's express permission before contacting parents or care-givers.

Participants expressed training for service providers as core and critical enablers for key populations. One provider narrated that more skills are required in their professional to provide quality responsive services to KPs.

...The way we can deliver non-discriminatory services, non- coercive care with confidence, the training is important even to sensitize and educate health workers on issues specific to key populations. .., creating inclusive health services requires sensitizing and educating providers and other staff members in health care and social services.

In line with this, they emphasized on orientation sessions on how to use the National guidelines on provision of friendly responsive services to KPs.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND IMPLICATIONS

6.1 Summary of key findings

Summing up the key findings in chapter four through the framework adopted from Andersen's Behavioral Model for KPs the knowledge about the needs among the KPs is high, although most were unaware of Hepatitis B and C, vaccination, prevention causes, and treatments. Knowledge of condom use is not comprehensively understood among the KPs.

Several constraints that hinder responsive services utilization among KPs highlighted, these including social-economic, cultural traditions and norms, criminalization, stigma and discrimination. Transports, homeless among KPs lack of condoms and lubricants distributions, police catch-up, stigma and discrimination were common discussed with participants. For service providers' low motivation, lack of skills, and discrimination expressed.

For improvement responsive services, strongly recommend scale-up of the intervention down the ward level, the intervention should comply with the national guidelines. Linkages of program with other services and the involvement of other stakeholders, including parents and community were reported.

6.2 Conclusions

The Qualitative study underscores the significance of information on both HIV risks and acceptable, effective HIV prevention options for MSM and FSWs Hepatitis B and C in-particularly. Learning and skills development should be obtainable to the wider KPs community. Drop-centre interventions may be an excellent site to address health problems experienced by MSM and FSWs. Free criminalization and stigmatization of

the use of services among FSWs and same sex practices, there is need to increase the protection of use and provision of these services for MSM and FSWs.

6.2.1 Policy implications

In view of the findings of this study, some areas need to be addressed by stakeholders for future improvement of the program targeting KPs. The evaluator recommends as follows. Firstly, the Hepatitis B and C are provided in a very limited health centre like Mnazi mmoja. The recommendation is given to the ministry of health that **Laws, policies and practices** should be **reviewed** and, where necessary, revised by policymakers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations. The scale-up of hepatitis B and C services should be urgent. The services should be made available, accessible and acceptable to KPs based on the principles of the right to health and free of stigma and discrimination. The second study found that the repressive police practice against KPs including harassments, extortion and arbitrary arrest, hinder the effective responsive services among KPs, hence advocacy efforts with police should be undertaken to ensure KPs are protected against violence and the increasing behavioral risk of HIV. Through education and awareness-raising, responses should address the causes of stigma and discrimination, including irrational fears of infection and moral judgments.

Thirdly, the findings revealed that, the number of skilled and motivated staff implementing KPs responsive services is small. It is noted that, only one Dr and a nurse were specifically to provide services for more than two thousand KPs at the centre. We recommend that urgent efforts are needed to review national health frameworks and law enforcement practices to eliminate punitive policy frameworks which discourage NGOs from implementing responsive services to KPs. Insists education and sensitization programmes designed for health-care staff be nondiscriminatory and to ensure quality of comprehensive health care for KPs.

The goals of Zeroes, zero new HIV infections, zero discrimination and zero AIDS-related deaths In Tanzania will not be attained if policy and programmatic steps are not transformed to ensure that norms to prevent criminalization, stigma, and discrimination of KPs are minimized.

6.3 Limitations of the study

Sample sizes were low due to the challenges of recruiting this population; however, the repetition of themes heard across interviews with healthcare workers, MSM and FSWs suggest proximity to saturation. A second limitation is related to the use of the Andersen's Behavioral Model; this model is often used as a model for quantitative intervention research. Because this study was qualitative, the Andersen's Behavioral Model provides a framework for understanding provision and access to responsive services but quantitative, causal associations are limited somehow.

6.4 Areas for further evaluation

The focus of this study was on the effectiveness of responsive services of MSM and FSWs at PASADA centre. The result revealed low effectiveness of responsive services for study group.

It is high time now, to conduct a study that will assess the effectiveness of responsive services for implementers of responsive services to KPs but are non-faith based organizations.

REFERENCE

- AIDS UNICEF., Joint United Nations Programme on HIV/AIDS., & World Health Organization. (2002). *Young people and HIV/AIDS: Opportunity in crisis*.
- Akinyi, O. P. (2009). *Determinants of Utilization of Youth Friendly Reproductive Health Services among School and College Youth in Thika west district, Kiambu county, Kenya* (Doctoral dissertation, KENYATTA UNIVERSITY).
- Baral, S., Sifakis, F., Cleghorn, F., & Beyrer, C. (2007). Elevated risk for HIV infection among men who have sex with men in low-and middle-income countries 2000–2006: a systematic review.
- Beyrer, C., Baral, S. D., Walker, D., Wirtz, A. L., Johns, B., & Sifakis, F. (2010). The expanding epidemics of HIV type 1 among men who have sex with men in low-and middle-income countries: diversity and consistency. *Epidemiologic reviews*, mxq011.
- Beyrer, C., Sullivan, P. S., Sanchez, J., Dowdy, D., Altman, D., Trapence, G., ... & Mayer, K. H. (2012). A call to action for comprehensive HIV services for men who have sex with men. *The Lancet*, 380(9839), 424-438.
- Braeken, D. , & Rondinelli, I. (2012). Sexual and reproductive health needs of young people: matching needs with systems. *International Journal of Gynecology & Obstetrics*, 119, S60-S63.
- Buvé, A., Bishikwabo-Nsarhaza, K., & Mutangadura, G. (2002). The spread and effect of HIV-1 infection in sub-Saharan Africa. *The Lancet*, 359(9322), 2011-2017.
- Chandra-Mouli, V., Armstrong, A., Amin, A., & Ferguson, J. (2015). A pressing need to respond to the needs and sexual and reproductive health problems of adolescent girls living with HIV in low-and middle-income countries. *Journal of the International AIDS Society*, 18(6Suppl 5).
- Chandra-Mouli, V., Armstrong, A., Amin, A., & Ferguson, J. (2015). A pressing need to respond to the needs and sexual and reproductive health problems of adolescent girls living with HIV in low-and middle-income countries. *Journal of the International AIDS Society*, 18(6Suppl 5).
- Coates, T. J., Richter, L., & Caceres, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. *The Lancet*, 372(9639), 669-684.

- Djomand, G., Quaye, S., & Sullivan, P. S. (2014). HIV epidemic among key populations in west Africa. *Current Opinion in HIV and AIDS*, 9(5), 506-513.
- Druce, N., Dickinson, C., Attawell, K., Campbell White, A., & Standing, H. (2006). Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up. *London: DFID Health Resource Centre*.
- Dzokoto, A. (2006). National Report on the Progress of the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS. *Ghana. January*.
- Fay, H., Baral, S. D., Trapence, G., Motimedi, F., Umar, E., Ipinge, S., ... & Beyrer, C. (2011). Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. *AIDS and Behavior*, 15(6), 1088-1097.
- Figueroa, C., Johnson, C., Verster, A., & Baggaley, R. (2015). Attitudes and Acceptability on HIV Self-testing Among Key Populations: A Literature Review. *AIDS and Behavior*. <http://doi.org/10.1007/s10461-015-1097-8>
- Gouws, E., White, P. J., Stover, J., & Brown, T. (2006). Short term estimates of adult HIV incidence by mode of transmission: Kenya and Thailand as examples. *Sexually transmitted infections*, 82(suppl 3), iii51-iii55.
- Govindasamy, D., Ford, N., & Kranzer, K. (2012). Risk factors, barriers and facilitators for linkage to antiretroviral therapy care: a systematic review. *Aids*, 26(16), 2059-2067.
- Israel, E., Laudari, C., & Simonetti, C. (2008). HIV prevention among vulnerable populations: The Pathfinder International approach.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2014). The gap report. *Geneva: UNAIDS*.
- Joint United Nations Programme on HIV/AIDS. (2005). *The "Three Ones" in Action: Where We are and where We Go from Here*. World Health Organization.
- Joint United Nations Programme on HIV/AIDS. (2014). A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations.

- Kennedy, C. E., Spaulding, A. B., Brickley, D. B., Almers, L., Mirjahangir, J., Packel, L., ... & Osborne, K. (2010). Linking sexual and reproductive health and HIV interventions: a systematic review. *Journal of the International AIDS Society*, 13(1), 26.
- Magesa, D. J., Mtui, L. J., Abdul, M., Kayange, A., Chiduo, R., Leshabari, M. T., ... Tungaraza, D. (2014). Barriers to men who have sex with men attending HIV related health services in Dar es Salaam, Tanzania. *Tanzania Journal of Health Research*, 16(2), 1–10. <http://doi.org/10.4314/thrb.v16i2.8>
- Martin, P., Mathambo, V., & Richter, L. (2011). UNICEF OVC programme component evaluation.
- Mmbaga, E. J., & J. Dodo, M. (2012). Sexual Practices And Perceived Susceptibility To HIV Infection Among Men Who Have Sex With Men In Dar Es Salaam, Mainland Tanzania. *Journal of AIDS & Clinical Research*, 01(S1), 1–6. <http://doi.org/10.4172/2155-6113.S1-012>
- Needle, R., Fu, J., Beyrer, C., Loo, V., Abdul-Quader, A. S., McIntyre, J. A., ... & Pick, B. (2012). PEPFAR's evolving HIV prevention approaches for key populations—people who inject drugs, men who have sex with men, and sex workers: progress, challenges, and opportunities. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 60, S145-S151.
- Obel, J., Larsson, M., & Sodemann, M. (2014). Sexual and reproductive health and HIV in border districts affected by migration and poverty in Tanzania. *The European Journal of Contraception and Reproductive Health Care*, 19(6), 420-431.
- Ogunbodede, E. O. (2004). HIV/AIDS situation in Africa. *International dental journal*, 54(6), 352-360.
- Onyango, M. A., et al. (2015). "t's all about making a life": poverty, HIV, violence, and other vulnerabilities faced by young female sex workers in Kumasi, Ghana
- Project Star. (2006). Study Designs for Program Evaluation, 1–12.
- Renton, A., Hawkes, S., Hickman, M., Claydon, E., Ward, H., & Taylor-Robinson, D. (1996). 7 Genitourinary Medicine Services. *Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews. Second series*, 397.

- Rispel, L. C., Metcalf, C. A., Cloete, A., Moorman, J., & Reddy, V. (2011). You become afraid to tell them that you are gay: health service utilization by men who have sex with men in South African cities. *Journal of public health policy*, S137-S151.
- Risher, K., Adams, D., Sithole, B., Ketende, S., Kennedy, C., Mnisi, Z., ... & Baral, S. D. (2013). Sexual stigma and discrimination as barriers to seeking appropriate healthcare among men who have sex with men in Swaziland. *Journal of the International AIDS Society*, 16(3Suppl 2).
- SA, U. (2010). HIV and, 1–8.
- Saewyc E, Skay C, Richens K, Reis E, Poon C, et al. (2006) Sexual orientation, sexual abuse, and HIV-risk behaviors among adolescents in the Pacific Northwest. *Am J Public Health* 96: 1104-1110.
- Sanders, E. J., Graham, S. M., Okuku, H. S., van der Elst, E. M., Muhaari, A., Davies, A., ... & Smith, A. D. (2007). HIV-1 infection in high risk men who have sex with men in Mombasa, Kenya. *Aids*, 21(18), 2513-2520.
- Sawyer et al 2012) Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S. J., Dick, B., Ezech, A. C., & Patton, G. C. (2012). Adolescence: a foundation for future health. *The Lancet*, 379(9826), 1630-1640
- Scheibe, A., Drame, F. M., & Shannon, K. (2012). HIV prevention among female sex workers in Africa. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 9(3), 167-172.
- Sexual stigma and discrimination as barriers to seeking appropriate healthcare among men who have sex with men in Swaziland. *Journal of the International AIDS Society*, 16(3Suppl 2), 18715. <http://doi.org/10.7448/IAS.16.3.18715>
- Shaikh, B. T., & Rahim, S. T. (2006). Assessing knowledge, exploring needs: A reproductive health survey of adolescents and young adults in Pakistan. *European J. of Contraception and Reproductive Healthcare*, 11(2), 132-137.
- Shayo, E. H., Mboera, L. E., & Blystad, A. (2013). Stakeholders' participation in planning and priority setting in the context of a decentralised health care system: the case of prevention of mother to child transmission of HIV programme in Tanzania. *BMC health services research*, 13(1), 273.

- Sorensen, S. W., Sansom, S. L., Brooks, J. T., Marks, G., Begier, E. M., Buchacz, K., ... & Kilmarx, P. H. (2012). A mathematical model of comprehensive test-and-treat services and HIV incidence among men who have sex with men in the United States. *PloS one*, 7(2), e29098
- Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A. A., ... & Evans, T. (2004). Overcoming health-systems constraints to achieve the Millennium Development Goals. *The Lancet*, 364(9437), 900-906.
- UNAIDS. (2013). *Global report. Report on the Global Aids Epidemic*
- UNFPA. (2015) countryoffice.unfpa.org/filemanager/files/.../tor_barriers_august_2015
- Van der Elst, E. M., Smith, A. D., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., ... Sanders, E. J. (2013). Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya. *Journal of the International AIDS Society*, 16(4Suppl 3), 18748. <http://doi.org/10.7448/IAS.16.4.18748>
- World Health Organization, & Unicef. (2010). Towards universal access: scaling up priority HI.
- World Health Organization. (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. World Health Organization.
- www.avert.org/professionals/hiv-around-world/sub-saharan-africa/tanzania**

APPENDICES

S/N	Stakeholder	Role in the program	Role in the evaluation	Utilization of study findings	Ways of involving stakeholders	Way of communication
1.	Key populations(MSM and FSW)	Clients	To provide information through interview and focused group discussion (FGD) as participants	Findings will inform on coverage HIV prevention, services utilization status, and ways to improve the intervention	Community level meeting (at the centre, camps and clubs)	mobile phone, Physical visit
2.	Sex Partners	Clients	To provide information through interview as participants	Findings will inform on the integration of sex partners, utilization and the ways of improve and integrate male and female partners	Individual meeting	Snow ball , mobile phone physical visit.
3	Parents/Guardians	Gatekeeper	To provide information through interview as participants	Findings will inform on involvement of the community and barriers associated and the way to improve the program	Individual meeting	Snow ball , mobile phone physical visit.
4	PASADA Management team	Monitoring Implementation	To participate as key informant, introduce the evaluator to key populations	Findings will inform on lesson learned so far in the intervention, Challenges and ways to improve implementation	Will be involved from the design stage of the evaluation, data collection,, and dissemination of findings. This will be done through staff meeting	Telephone, E-mail, Letters, Physical visit
5	Health Services Provider	Provider of Clinical and counseling	To provide information on through interviews	Findings will inform on access and utilization status and way to improve intervention	Individual meeting	Mobile phone and physical visit
6	MOHSW	Policy Maker	To elaborate the policy and Guideline and standards	To scale up and intervention and improve the standards	Individual meeting	Physical visit
7	Stakeholders/Agencies	Provider of compliment services	To provide information on referrals .	To improve linkages	Individual meeting	Physical visit

Appendix II

Activity	Appendix 1:Time Schedule														Responsible person
	Nov 2015 (week)	Dec 2015 (week)	Jan 2016 (week)	Feb 2016 (week)	Mar 2016 (week)	Apr 2016 (week)	May 2016 (week)	Jun 2016 (week)	Jul 2016 (week)	Aug 2016 (week)	Sept 2016 (week)	Oct 2016 (week)			
	1 - 4	1 - 4	1-3 4	1 - 4	1 2-4	1 - 4	1 - 4	1 2-3	1 - 4	1-3 4	1 - 4	1 - 4			
Contact PASADA Tanzania in Dar and seek for management approval and proposal writing															Evaluator
Consultation to MU supervisor and discussion															
Data Collection															
Data cleaning and data entry															
Data analysis															
Report writing															
Consultation to MU supervisor and Discussion															
Report writing															
Submission of Evaluation report to MU															
Evaluation report presentation and dissemination(to be determined by MU)															

Appendix III

AGREEMENT FORM IN AN IN-DEPTH INTERVIEW

About the Study:

General research: John Ambrose.

Informed that I have the right to withdraw myself in the study today, and if I choose to refuse to participate I can do without giving reasons

It is given that any shall I speak today during the interview will remain confidential; my name not be used nor any information never used.

Informed, sometimes researchers will find it helpful to use my words in reviewing the research. I know this to be applied to any of my words; the name will be stored completely. It is also my consent to allow my words used.

Circle:

I agreed to participate: Yes No

Accept my words to be used in reports stored my name. Yes No

PARTICIPANT

Name of participant: _____

Signature / thumb: _____ Date: _____

SIGNATURE OF WITNESS

Name of witness: _____

Signature/thumb witness: _____ Date: _____

Research:

We discussed about study and relevant name above to language that he understands.
I believe he understood my explanation and has agreed to participate in the debate.

Name: _____

Signature: _____ Date: _____

Appendix IV

In-Depth Interview Topic Guide- For KP MSM&FSWs

Participant, No. |_|_| **Gender(circle)** Male / Female **Interviewer Initials**

|_|_|_|

Date |_|_|/|_|_|/|_|_|

INTRODUCTION

I _____ from _____

✓ *Describe general purpose of the study:*

.....

✓ *Expected duration:*

•

✓ *Why the participant's opinions are important:*

•

✓ *Confidentiality:*

- Your name will not appear on the final transcription, analysis or writing up, only anonym zed names.
- All documents and recordings will be kept in secure locations, accessible only to the research staff.

✓ *Any questions?*

✓ *Happy to be recorded?*

✓ *Take written consent using consent form.*

Demographic and Work Information

Can I ask you few questions about yourself?

- How old are you?
- Your highest level of education?
- Place of living

AN ASSESSMENT ON PERCEPTIONS AND EXPERIENCES OF YOUNG KEY POPULATIONS ON PROVISION OF RESPONSIVE SERVICES FOR MSM& FSWS - THE CASE OF PASADA PROJECT, DAR ES SALAAM TANZANIA

1. What services do you receive from this program station?
2. From your experience, what are your views on the services provided to you?

Probes:

- a. Do they fulfil your needs?
- b. If yes, to what extent?
- c. What do you consider as the best part of the services?
3. What issues do you encounter to access the services?
 - a. Can you say something about the place/environment?
 - b. What are your opinions on waiting time?
 - c. What can you say about transportation to the centre?
 - d. What is your opinion on the health workers? i.e. communication, care, treatment process etc
4. Would suggestions can you give to improve the situation?

Probes:

- a. Mention specific areas e.g. toilets, language of workers, availability of drugs, food etc
5. What other services that PASADA do not provide but are important to you?
 - a. How did you know these services existed? Who told you about them?
 - b. Where do you receive them?

- c. What are the challenges (on each you mentioned) in accessing these services?
 - d. Do you think they can be intergrated in PASADA? OR Do you wish you could receive these services at PASADA? How would you suggest their intergration?
6. Tell me about your impression regarding the referral process and any network you are linked with?

Probes:

- a. How efficient is it?
- b. What are the challenges?
- c. How can it be improved?

Appendix V

In-Depth Interview Topic Guide- For FGD

Participant, No. |_|_| **Gender(circle)** Male / Female **Interviewer Initials**

|_|_|_|

Date |_|_|/|_|_|/|_|_|

INTRODUCTION

I _____ from _____

✓ *Describe general purpose of the study:*

.....

✓ *Expected duration:*

•

✓ *Why the participant's opinions are important:*

•

✓ *Confidentiality:*

- Your name will not appear on the final transcription, analysis or writing up, only anonym zed names.
- All documents and recordings will be kept in secure locations, accessible only to the research staff.

✓ *Any questions?*

✓ *Happy to be recorded?*

✓ *Take written consent using consent form.*

Interview Guide for MSM/FSW

AN ASSESSMENT ON PERCEPTIONS AND EXPERIENCES OF YOUNG KEY POPULATIONS ON PROVISION OF RESPONSIVE SERVICES FOR MSM& FSWS - THE CASE OF PASADA PROJECT, DAR ES SALAAM TANZANIA

1. From your experience, what are your views on the services provided to KPs?

i. MSM

ii. FSWS

- Do they fulfil their needs?
- If yes, to what extent?
- What do they consider as the best part of the services?

2 What issues do they encounter to access the services?

Probe:

- Linkage of the services
- Acceptability
- Stakeholder involvement
- Staffing.

Appendix VI

Interview Guide for Services Provider

In-Depth Interview Topic Guide- For

Participant, No. |_|_| **Gender(circle)** Male / Female **Interviewer Initials**
|_|_|_|
Date |_|_|/|_|_|/|_|_|

INTRODUCTION

I am _____ from _____

✓ *Describe general purpose of the study:*

.....

✓ *Expected duration:*

.....

✓ *Why the participant's opinions are important:*

-

✓ *Confidentiality:*

- Your name will not appear on the final transcription, analysis or writing up, only anonymized names.
- All documents and recordings will be kept in secure locations, accessible only to the research staff.

✓ *Any questions?*

✓ *Happy to be recorded?*

✓ *Take written consent using consent form.*

1. What are HIV/Sexual Reproductive Health (SRH) needs of Key populations?

- i. MSM
- ii. FSWs

Probe: where did you learn these particular needs? If not from training, probe if organization provides adequate sensitivity for services provider to understand the particular needs of KPs

2. What are the KP perceptions of existing HIV/Sexual Reproductive Health (SRH) services?

Probe: if she/he talks about services discrimination

What is your obligation to protect KPs from stigma, discrimination, and breach of confidentiality?

3. How are the needs incorporated in the policy, design of the responsive services, (and the training of service providers)?

Probe: If the needs mentioned in question one are integrated in new KP policy/National guideline of Tanzania

4. How can HIV/SRH services to KP be improved?