Health Seeking Behaviour and Experiences of Key Population in Southeast Nigeria

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ABSTRACT

Key populations experience significant difficulty accessing healthcare services, resulting in unfavourable disparities in the health outcomes of key populations when compared to the general population. The overall objective of this study is to explore the healthcare-seeking experiences of key populations (KPs) in southeast Nigeria, aiming to address the existing gap in research and inform policy development for inclusive healthcare services. The study adopted a mixed-method approach. For the quantitative aspect, 110 persons who identify as any of the target population or who fall within the intersection of the groups (MSM, FSW, and PWUD) responded to the online survey distributed across the five southeastern states. Participants fall between the ages of 15 and 35. Due to the nature of the population being studied, convenience sampling was used to select participants for the three sets of focus group discussions. Analysed data revealed that pervasive stigma and discrimination experienced by KPs when accessing healthcare services, compounded by financial constraints, fear of disclosure, and past negative experiences, are the key challenges to accessing healthcare services. Subgroup analyses identified heightened discrimination faced by younger MSMs and feminine-presenting MSMs, as well as female PWUD. Participants expressed reliance on alternative care due to previous mistreatment and significant barriers within public hospital settings. Recommendations include training healthcare staff to be sensitive to diverse identities, engaging KPs in healthcare delivery, expanding services at community-based organisations, and promoting economic empowerment. Addressing these barriers is crucial to improving access to non-discriminatory healthcare services for HIV KPs in southeast Nigeria, contributing to the global effort to end AIDS by 2030.

Keywords: HIV, Key Population, Human Rights, Health Seeking Behaviour

INTRODUCTION

Globally, certain groups of people are more vulnerable to HIV infection (WHO, 2016). In most cases, systemic and social exclusion from access to necessary healthcare services, including lack of access to Comprehensive Sexuality Education, place both themselves and the general population at higher risk of HIV transmission (Bonabida et al., 2023; Babel et al., 2021). Interventions often fail to make a distinction between the risk behaviours and vulnerabilities of individuals within key populations and those of the general population as interventions are mostly focused on risk behaviours with no consideration to the vulnerabilities which are usually specific to key populations (Baggaley et al., 2015; HIV Language Compedium, n.d). This is because of the varying societal issues which key populations are faced with; they include marginalisation, criminalisation in social and legal environments, leading to discrimination. Failure to distinguish and address the specific prevention, treatment, and care needs of these groups will continue to drive HIV transmission to general populations and prevent countries from achieving universal access to HIV prevention, treatment, care, and support. Universal access is hereby focused on increasing HIV testing services, preventing new infections, and decreasing the morbidity and mortality of people infected and affected by HIV, with the ultimate goal; the elimination of HIV. Generally speaking, there are five typologies under the Key population categorization. These typologies are;

Men who have sex with men (msm): From a scientific standpoint, MSM are at greater risk of contracting HIV due to anal sex (Biello et al., 2017). Studies have shown that unprotected anal sex puts a person at a higher risk of HIV transmission, considered to be at 18 times higher than unprotected vaginal sex (Boskey, 2024). The biological risk factor is the same whether unprotected anal intercourse is practised between males, or males and females. However, it is worth noting that anal sex is the primary form of penetrative intercourse between two males, therefore putting MSM at higher chances of contracting HIV. However, studies show that consistent and accurate use of condoms approved for anal sex and water-based lubricant can reduce the transmission of HIV during anal sex, just as in vaginal sex (Miller, 2022). Aside from the biological factor, societal factors also play a role in this categorization. Such social determinants are race and ethnicity, economic status, geographic location, drug use, etc. Concerning race and ethnicity, studies have shown that one in two black MSM would be diagnosed with HIV in their lifetime, one in four Latinos would be diagnosed with HIV in their lifetime, while one in eleven White MSM would be diagnosed with HIV in their lifetime. Other factors, like homelessness and economic dependency, have also been identified to be drivers of new HIV infections in the MSM typology. This goes to show the multiple layers of factors that contribute to disproportionately affecting MSM at varying risk levels of HIV transmission.

Sex workers: Sex workers globally face an overwhelming burden of sexually transmitted infections (STIs) and blood-borne infections; with female sex workers estimated to be 30 times more likely to acquire HIV compared to other women of reproductive age (UNAIDS, 2019). The prevalence of HIV among sex workers stands at an alarming 36%, as reported by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2019), while active syphilis prevalence ranges from 5.8% to 30.3% (WHO, 2020). Although data on other STIs and viral hepatitis infections are limited, studies have consistently shown increased rates among sex workers worldwide (Shannon et al., 2015). Structural barriers such as stigma and criminalization further compound these health risks. However, modeling studies suggest that decriminalizing sex work could yield significant reductions in new HIV infections, up to 46% over a decade, with an additional 20% reduction possible by addressing sexual violence against sex workers (Platt et al., 2018).

Transgender people: Due to entrenched structural and systemic obstacles such as criminalization, pervasive stigma, and widespread violence, transgender individuals face significant barriers in accessing healthcare services, resulting in a startling statistic: they are approximately 13 times more likely to be HIV-positive than other adults of reproductive age. Disproportionate rates of new infections are particularly pronounced in certain regions, with transgender women contributing significantly to the HIV burden in areas such as Asia and the Pacific (7%), Latin America (6%), and the Caribbean (5%). The prevalence of HIV among transgender women varies across different regions, with estimates of 28.4% in Eastern and Southern Africa, 13.5% in Western and Central Africa, 22.2% in Latin America, and 23.7% in the Caribbean (UNAIDS, 2020).

People who use drugs: Broadly speaking, drug users (PWUD) continue to be stigmatised and criminalised, which exacerbates severe health disparities, such as seen in the exceptionally high prevalence of tuberculosis (TB) and HIV in this community (Eng et al., 2021). The danger of contracting HIV is greatly increased by injectable drug use, especially when needles are shared. Furthermore, drug use has been frequently associated with high-risk behaviors such as unsafe sexual practices including transactional sex or unprotected intercourse, which increases the risk of HIV transmission. The breadth of the HIV and other opportunistic infections in PWUD populations is largely due to the negative societal perception, which has resulted in a dearth of integrated health care that can provide HIV, and harm reduction services in one location.

Prisoners and other incarcerated people: Prisoners and other people in closed settings/restricted environments are also at higher risk of HIV transmission. According to available data, HIV and other opportunistic infections such as TB, and hepatitis are a major concern for this population, with the global HIV prevalence rate for the population being estimated at 3% (UNODC, 2020). In prisons and other incarcerated situations, inmates and the like find it difficult, or almost impossible, to obtain testing and treating services that have proven helpful in curbing new infections and suppressing the viral load of present infections. It is worth noting that people who use drugs (PWUD) are often highly represented in prisons,

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further exacerbating their health outcomes and health disparities. Also, younger males, feminine-presenting males, and female folks are often vulnerable to gender-based violence such as assault, sexual violence, and other physical and psychological violence that makes them susceptible to HIV and other opportunistic infections. Economically dependent partners, victims of human and sex trafficking do fall under the umbrella of people in closed settings. Within such settings, they often lack agency and other bargaining power for safe sex. They also may often lack access to the comprehensive sexual reproductive health rights education needed to make informed and autonomous decisions about their bodies, thereby making them more susceptible to HIV transmission.

Although there are five key population groups as identified above, this study is delimited to three of these typologies; MSM, FSW, and PWUD. This decision is because this research is part of a broader intervention commissioned by the Centre for Health Education and Vulnerable Support, aimed at improving access to equitable and non-discriminatory healthcare for the delimited typologies in Southeast Nigeria. Consequently, this broader initiative facilitated access to participants in the study.

Background of HIV Key Populations in Nigeria

The epidemic of Human Immunodeficiency Virus (HIV) is still a significant health issue in several countries across the world. In 2016, an estimated 36.7 million people were living with HIV (PLHIV) and about 1.8 million new infections were detected in that year. Nigeria is one of the most affected countries by HIV (Ekere et al., 2020). A national HIV/AIDS indicator and impact survey (NAIIS) conducted in 2018 revealed that an estimated 1.9 million Nigerians are living with HIV and about 1.1 million of these PLHIV are currently receiving antiretroviral therapy (ART) (Onovo et al., 2023). Although this seems like a significant improvement compared to previous years, the statistics reveal that the HIV prevalence in Nigeria is still quite alarming considering Nigeria's large population. This also explains the reason for Nigeria having the second-largest HIV epidemic in the world. There are many factors that have contributed to the ongoing crisis of HIV in Nigeria and one of them is the lack of access to healthcare that key populations are faced with.

In the National HIV and AIDS Strategic Framework 2017-2021, the Government of the Federal Republic of Nigeria outlined the need for interventions to increase testing and treatment for key populations in order to fast-track the national response toward ending AIDS in Nigeria by 2030 Reliable and accurate information on where key population members socialise is needed for the strategic placement of services and the allocation of limited resources for targeted interventions.

The vulnerability of key population and their high risk of being exposed to HIV notwithstanding, the measures that have been taken by Nigeria in response to HIV amongst key population have been inadequate (Djomand et al., 2014). Policy makers however have recently tried to pay attention to scaling up the efforts of HIV response through HIV programming for key populations. Some of these efforts include estimating the size of the population and identifying their hot spots (Lo et al., 2021; Ezirim et al., 2015), the development of national guidelines for the prevention of HIV for female sex workers (FSW) by the National Agency for the Control of Aids (NACA, 2014) and people who use drugs (PWD) (NACA, 2017), which has contributed to the design and implementation of HIV prevention programs with the use of the combination of different HIV prevention strategies.

Despite the aforementioned efforts to reduce the risk of HIV exposure amongst key populations, several studies have shown that there are still barriers that hinder HIV testing treatment amongst the key population, which also affects the general population in Africa. These barriers include fear of legal prosecution, transportation costs, stigma and discrimination, misinformation, and availability of healthcare facilities (Pilgrim et al., 2018; Nakawangi et al., 2016; Yehia et al., 2015; NACA, 2019; NACA, 2017; Odimegwu et al., 2017). Also, Adeoye et al. (2021) noted that there still exists a huge gap in the response to key populations nationally, which can be associated with socio-cultural barriers and the politically and legislative unfavourable environment in the country, which on a larger scale, impacts the results of HIV prevention. Globally, there is a dearth of research addressing the challenges faced by HIV Key Populations (KPs) in accessing healthcare services.

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This gap is further pronounced when considering the limited scope of studies conducted on the experiences of KPs in Nigeria, specifically lacking region specific studies in Nigeria. Under the larger intervention to improve access to equitable and non-discriminatory healthcare for key popu-lations in southeast Nigeria, this study serves as a baseline assessment.

The primary objective of this study is to explore the healthcare-seeking experiences of HIV Key Populations (KPs) in southeast Nigeria. In addition to addressing the existing gap in research on this topic, the study aims to inform the development of inclusive policies aimed at enhancing access to non-discriminatory healthcare services for HIV KPs across Nigeria. By shedding light on the challenges and barriers faced by KPs in accessing healthcare, this study seeks to contribute to the formulation of comprehensive and supportive policies that prioritise the healthcare needs of this marginalised population.

METHODOLOGY

Study design:

This research employed a mixed-methods approach, combining both quantitative and qualitative data collection methods. The aim was to provide a comprehensive understanding of the experiences of HIV Key Populations (KPs) in accessing healthcare in southeast Nigeria. The mixed method enabled us to both elicit quantitative and qualitative data. Through the distributed survey, we were able to give numerical values to experiences of discrimination and other variables, while through the use of FGDs, we were able to elicit more descriptive data on the sample population experiences.

Quantitative data collection:

Quantitative data were collected through a structured survey distributed across the five southeastern states in Nigeria, namely, Abia, Anambra, Ebonyi, Enugu, and Imo. The survey targeted the key populations, namely Female Sex Workers (FSW), Men who have Sex with Men (MSM), and People Who Use Drugs (PWUD). A total of 110 responses were obtained, ensuring a fair distribution across the target populations.

Qualitative data collection:

To delve deeper into the lived experiences of the key populations, three Focus Group Discussions (FGDs) were conducted for each community: FSW, MSM, and PWUD. Each FGD comprised 10 participants who were selected based on their representation of the respective key population. Prior to participation, informed consent was obtained from all participants.

Data analysis:

Quantitative data analysis involved the use of descriptive statistics to summarise the responses obtained from the survey. Through this, we are able to determine the most prevalent form of challenge experienced by the target population in southeast Nigeria, ranging from; discrimination, verbal abuse, all the way to lack of attention.

Qualitative data analysis was conducted using the Phenomenological-Hermeneutic approach. Themes identified from both the survey and FGDs were systematically analysed and discussed to provide insights into the research questions. Qualitative data was most helpful in eliciting details about the perceptions of the target communities on the adoption of alternative healthcare.

Ethical considerations:

This research project on the experiences of HIV key populations in southeast Nigeria adheres to rigorous ethical standards, with approval obtained from the Center for Health Education and Vulnerable Support (CHEVS), an NGO actively engaged in providing support and services to these communities. Informed consent was obtained from all participants before their participation in the survey and FGDs. Measures were taken to ensure the confidentiality and anonymity of participants throughout the research process.

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Limitations:

It is important to acknowledge certain limitations of the study, including the potential for sampling bias in both quantitative and qualitative data collection methods. Additionally, the findings may not be generalizable beyond the study population due to the specific context of southeast Nigeria. Despite these limitations, the study provides valuable insights into the experiences of HIV Key Populations in accessing healthcare, contributing to the existing body of knowledge in this area.

RESULTS

A combined total of 110 individuals participated in an online survey, representing diverse target populations as detailed in the accompanying table. Additionally, 30 individuals from the target population contributed to the findings through focus group discussions.

Through rigorous data analysis, overarching themes emerged that encapsulate the challenges faced by HIV key populations when accessing healthcare in Southeast Nigeria. These themes include but are not limited to stigma and discrimination, financial constraints, sexual exploitation, and lack of self-acceptance. Participants also offered valuable recommendations aimed at enhancing the quality and accessibility of health services for HIV key populations in Southeast Nigeria.

Quantitative data analysis

Demographics

Table 1: Distribution of study participants based on key population identification

Identity	**Percentage (Number)**
FSW	32.7% (36)
MSM	29.1% (32)
PWUD	38.2% (42)
Total	100% (110)

Table 2: Distribution of study participants based on age

Age (years)	**Percentage (Number)**
15-25	25.5% (28)
26-36	63.6% (70)
37-Above	10.9% (12)
Total	100% (110)

Table 3: Distribution of study participants based on sexual orientation

Sexual orientation	**Percentage (Number)**
Lesbian	2.7% (3)
Gay	21.8% (24)
Bisexual	26.4% (29)
Straight	47.3% (52)
Sex worker	0.9% (1)
Female Sex worker	0.9% (1)
Total	100% (110)

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Table 4: Distribution of study participants based on gender identity

Gender Identity	Percentage (Number)
Cishet Male	38.2% (42)
Cishet Female	22.7% (25)
Transgender Female	2.7% (3)
Transgender Male	2.7% (3)
Non-binary	20.9% (23)
Straight	4.5% (5)
Male	3.6% (4)
Female	2.7% (3)

Table 5: Distribution of study participants based on state of residence

State of Residence	Percentage (Number)
Abia	18.2% (29)
Anambra	17.3% (19)
Ebonyi	19.1% (21)
Enugu	17.3% (19)
Imo	28.2% (31)

Table 6: Distribution of study participants based on educational qualification

Educational Qualification	Percentage (Number)
SSCE	27.3% (30)
OND	5.5% (6)
HND	13.6% (15)
BSc	50% (55)
MSc	3.6% (4)
PhD	-
Total	100% (110)

Tables 1-6 showed the demographic information of the respondents. The tables revealed that PWUD account for the highest percentage of respondents (38.2%), while MSM and FWS respectively account for 29.1% and 32.7% of the respondents.

Most of the respondents (63.6%) are between the age ranges of 26-36 years. Straight respondents account for the highest number of respondents (47.3%) based on sexual orientation, cishet male (38.2%) account for the highest number of respondents based on gender identity, and across the demographic variable of educational qualification, most of the respondents were BSc graduates (50%).

Experiences of HIV kps in Southeast Nigeria

Participants from the diverse typologies discussed encountering stigma and discrimination when seeking healthcare services in Southeast Nigeria. This discovery aligns with previous studies by Katz et al. (2013) and Logie et al. (2017), which also highlighted stigma and discrimination as pervasive issues in the healthcare experiences of gender-nonconforming individuals and men who have sex with men (MSM).

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According to our survey data, 30.9% of respondents reported experiencing discrimination as a form of negative behavior from healthcare providers and was supported by responses from the focus group discussions.

Table 10: How will you describe your overall experience with accessing medical services in South-East Nigeria?

Responses	**Percentage (Number)**
Positive	36.4% (40)
Negative	30% (33)
Neutral	33.6% (37)
Total	100% (110)

Table 11: Have you ever experienced any form of negative response or behaviour while accessing medical services in South-East Nigeria?

Responses	**Percentage (Number)**
Yes	71.8% (79)
No	28.2% (31)
Total	100% (110)

Table 12: What are the forms of negative behaviour you have experienced?

Responses	**Percentage (Number)**
Discrimination	30.9% (34)
Verbal abuse	8.2% (9)
Refusal of Care	2.7% (3)
Stigmatisation	7.3% (8)
Physical violence	2.7% (3)
Lack of attention	36.4% (40)
None	9.1% (10)
No	0.9% (1)
None of the above	0.9% (1)
.	0.9% (1)
Total	100% (110)

Table 13: Do you think the negative treatment is because you are LGBTQI+/Sex Worker/Person who use drug?

Responses	**Percentage (Number)**
Yes	62.7% (69)
No	37.3% (41)
Total	100% (110)

Tables 10 – 13 revealed the responses of participants to the questions asked in order to examine the trends and experiences of the target group in accessing healthcare services. Table 10 revealed that the majority of the respondents (36.4%) responded that they have had positive experiences with accessing medical services

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in southeast Nigeria. However, it is worthy of note that there's not much of a gap between the percentage of the positive responses and the negative and neutral responses, which recorded 30% and 33.5% responses respectively. Table 11 showed that 71.8% of the respondents have experienced negative response or behaviour while accessing medical services in southeast Nigeria. In table 12, lack of attention (36.4%) and discrimination (30.9%) were the most recognized negative behaviour or response that respondents have experienced. Table 13 revealed that 62.7% of the respondents think that their negative experiences were as a result of being a part of the key population by either being LGBTQI+/Sex Worker/Person Who Use Drugs.

"… they asked me if I have a girlfriend. I promptly said no, that I have a boyfriend. So, the healthcare staff there started to ask me if I really understand the question. I said, yes. I have a boyfriend, not a girlfriend. She was kind of, do you have sex with this person unprotected? I said, yes. She left me in the office, called one of his colleagues. They came in, started saying that no wonder that I have the disease. First of all, its a punishment by God. Secondly, that I, I don't deserve to live. And this was early 2013. And they were not even saying it as gossip or behind my back, they were saying it in front of me. Like their words were already killing me before the disease itself."

(Participant #02-MSM-FGD)

It is particularly surprising that such experiences occurred within a key population (KP) clinic in Onitsha, where staff members are expected to have undergone sensitization on providing non-discriminatory services to KP individuals. Similarly, participants from the female sex worker (FSW) community expressed immediate perceptions of stigma from predominantly older female hospital staff in waiting rooms. This perception was often triggered by their attire and frequently escalated into discrimination, including name-calling, refusal of care, and, in some instances, physical violence between FSWs and healthcare personnel.

"a hospital No be church, keep your church for house, keep your culture for house, na human being I be and I deserve care"

… a hospital is not a church, keep your culture and religion to yourself, I am human and I deserve to be treated as such."

(Participant #05-FSW-FGD)

In the discussions concerning the people who use drugs (PWUD) community, participants highlighted "denial of services" as the most prevalent form of discrimination. This involved healthcare staff, possibly driven by fear or prejudice, either delaying care or outright refusing services to PWUD individuals. According to participants, healthcare providers often viewed members of the PWUD community as lacking value to society or presumed they were unable to afford medical services. Repeatedly, participants cited instances where the Alex Ekueme Federal University Hospital was identified as an institution where PWUD, even in emergency situations such as overdoses, were neglected by healthcare providers who attributed their circumstances to the personal responsibility of the PWUD. the two instances that were provided were said to have happened in 2017 and 2018.

The research team sought to identify subgroups within key populations that may experience heightened levels of discrimination when accessing healthcare services in Southeast Nigeria. Participants from the MSM community noted that young MSMs and feminine-presenting male folks are particularly vulnerable to discrimination. They highlighted the intersectional challenges faced by young MSMs, including ageism and economic disparities, which exacerbate their healthcare-seeking experiences. Additionally, feminine-presenting MSMs encounter stigma and discrimination due to societal norms and expectations for male folks. Existing literature supports these findings, as studies have documented the increased vulnerability of certain subgroups within the MSM community to discrimination in healthcare settings (Logie et al., 2017; Poteat et al., 2016). For instance, Logie et al. (2017) found that feminine-presenting MSM individuals often face heightened levels of stigma and discrimination due to societal expectations of masculinity. Similarly, Poteat et al. (2016) highlighted the intersecting layers of discrimination faced by young MSMs, including

ageism and economic marginalisation.

The FSW participants were of the opinion that as long as a person is known to be FSW, they would always face some form of stigma and maybe discrimination. Furthermore, participants from the people who use drugs (PWUD) community highlighted the additional burden of stigma and discrimination experienced by female PWUD.

This observation aligns with existing research indicating that women who use drugs often face heightened levels of stigma and discrimination due to gender norms and expectations (Sherman et al., 2017; Small et al., 2017).

A participant shared that patriarchal norms and traditional values characterise Southeast Nigeria, therefore, female PWUD face intersecting layers of stigma related to both their drug use and their gender identity. This intersectionality of stigma has been documented in various cultural contexts, highlighting the need for targeted interventions to address the specific needs of female PWUD (Collins et al., 2018; Stoicescu et al., 2019).

A female PWUD shared a personal experience in which healthcare staff berated her for being a PWUD, she said they kept saying "why would a woman like you engage in act like this, are you a man" she further mentioned that she was in need of assistance but care was delayed, instead they continued verbally abusing her.

Barriers

The quantitative data highlights the perceived primary barriers to accessing healthcare services by key populations in mainstream healthcare centres.

Table 14: What are the main barriers you experience in accessing healthcare services?

Responses	**Percentage (Number)**
Lack of awareness about available services	30.9% (34)
Economic constraints	8.2% (9)
Fear of discrimination	2.7% (3)
Limited availability of healthcare institutions	7.3% (8)
None	2.7% (3)
Transportation constraints	36.4% (40)
Abuse	9.1% (10)
The way the nurse talk	0.9% (1)
Too many delay	0.9% (1)
.	0.9% (1)
Total	100% (110)

Table 15: Have you experienced any specific challenges in accessing healthcare services that are not experienced by the general population?

Responses	**Percentage (Number)**
Limited availability of specialized services	22.7% (25)
Poor attitude of healthcare providers	25.5% (28)

Stigmatization and discrimination from healthcare providers	25.5% (28)
Longer waiting time to access healthcare services	20.9% (23)
None	1.8% (2)
No	1.8% (2)
All of the above	0.9% (1)
None of the above	0.9% (1)
Total	100% (110)

Table 16: Are there any geographic, economic, or social factors that hinder your access to healthcare services in southeast Nigeria?

Responses	**Percentage (Number)**
Distance to healthcare facilities	20.9% (23)
Lack of healthcare facilities	12.7% (14)
Financial constraints	44.5% (49)
Community stigma	20.9% (23)
None	0.9% (1)
Total	100% (110)

Table 14 showed that transportation constraints (36.4%) and lack of awareness about available services (30.9%) accounts for the major barriers that key populations experience while accessing healthcare services. In table 15, the responses recorded revealed that limited availability of specialised services (22.7%), poor attitude of healthcare providers (25.5%), stigmatisation and discrimination from healthcare providers (25.5%), and longer waiting time (20.9%) are barriers that key populations specifically encounter in accessing healthcare services, which are not encountered by the general population. Table 16 revealed that financial constraints, distance to healthcare facilities, community stigma and lack of healthcare facilities with response percentages of 44.5%, 20.9%, 20.9%, and 12.7% respectively, are the geographic, economic and social factors that hinder the access of respondents to healthcare services.

Furthermore, the focus group discussions corroborated certain findings ascertained from the survey, offered insights from lived experiences and explored additional themes that were not covered in the survey.

Past Experiences and Fear of Future Experiences: A consistent theme emerged across all typologies regarding past experiences as a significant barrier to accessing healthcare facilities among key populations (KPs) in Southeast Nigeria. Participants unanimously cited previous negative encounters, whether personally experienced or heard of, as the primary reason for their reluctance to seek healthcare services. One participant from the PWUD focus group discussion succinctly captured this sentiment by stating, "once beaten twice shy." This sentiment was echoed by another participant who expressed reluctance to return to a healthcare facility after enduring previous mistreatment. Similarly, another participant revealed that they had avoided healthcare facilities for over seven years, expressing a hope to never have the need to return due to the ill-treatment experienced by themselves and others within their typology. These accounts underscore the deep-rooted fear and apprehension among key populations in Southeast Nigeria, fueled by past negative healthcare encounters, which significantly hinder their willingness to seek essential medical care.

Lack of self-acceptance and fear of disclosure: Another barrier identified, particularly within the MSM community, is the lack of self-acceptance and fear of disclosure. Participants highlighted that many MSM individuals refrain from seeking professional healthcare services due to the fear that their sexual practices may be discovered. This fear of disclosure stems from societal stigma and discrimination against non-

heteronormative sexual orientations and behaviours. Consequently, MSM individuals may avoid seeking necessary healthcare out of concern for potential judgement or mistreatment based on their sexual identity. This barrier underscores the importance of creating inclusive and non-discriminatory healthcare environments that prioritise the confidentiality and dignity of all patients, regardless of their sexual orientation or gender identity.

Financial constraints: Financial constraints present a significant hurdle to healthcare access among key populations (KPs) in Southeast Nigeria, particularly affecting marginalised and economically disadvantaged individuals. Limited resources often prevent KPs from affording essential medical services, including HIV testing and treatment (Logie et al., 2017). High out-of-pocket expenses for consultations, laboratory tests, and medications exacerbate this challenge (Makofane et al., 2015). Moreover, unemployment, poverty, and unstable income sources further compound the impact of financial constraints on healthcare access (Piot et al., 2015). These economic barriers intersect with other challenges, such as stigma and discrimination, creating a complex web of obstacles hindering KPs from seeking necessary care.

Lack of trust in healthcare staff: Participants expressed concerns regarding the perceived lack of knowledge and training among healthcare providers to deliver specialised care tailored to the needs of their communities. Specifically, the people who use drugs (PWUD) community highlighted this issue. Additionally, members of the men who have sex with men (MSM) community shared experiences where breaches of doctor-patient confidentiality, such as unauthorised disclosure of HIV status and sexual practices, eroded trust in healthcare facilities. These instances of privacy violations have contributed to a loss of confidence among MSM individuals in seeking healthcare services, further exacerbating barriers to access and utilisation.

Sexual exploitation: The most pervasive hindrance to healthcare services highlighted during the focus group discussion (FGD) with the men who have sex with men (MSM) community is the occurrence of sexual exploitation and requests for sexual favours from MSM individuals seeking healthcare services, particularly by healthcare staff who are also MSM. A participant shared that when an MSM individual declines such requests, communication with healthcare providers becomes slow, and services are often delayed or withheld. This disturbing practice was reported to occur even within MSM-based clinics, highlighting the urgent need for comprehensive measures to address exploitation and ensure the provision of safe and

respectful healthcare services for all individuals, regardless of sexual orientation or identity.

Seeking Alternatives and Impact

Table 17: Has your negative experience with accessing mainstream healthcare services made you opt for alternative healthcare practices before?

Responses	**Percentage (Number)**
Yes	69.1% (76)
No	30.9% (34)
Total	100% (110)

Table 18: Which of the following alternative healthcare practices have you adopted?

Responses	**Percentage (Number)**
Seeking care from traditional healers	18.2% (20)
Using herbs and home remedies	20% (22)
Purchasing medication from informal source	24.5% (27)

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Self-prescribing medication	47.3% (52)
None	7.3% (8)

Table 19: How satisfied are you with the alternative healthcare practices you have adopted in comparison to mainstream healthcare services?

Responses	**Percentage (Number)**
Satisfied	22.7% (25)
Dissatisfied	30% (33)
Neutral	47.3% (52)
Total	100% (110)

Table 20: What are the factors that contributed to your decision to seek alternative healthcare practices?

Responses	**Percentage (Number)**
Lack of trust in healthcare providers	30.9% (34)
Previous negative experiences	37.3% (41)
Fear of disclosure and stigma	49.1% (54)
None	2.7% (3)

Tables 17 – 20 recorded the response of respondents to questions that were asked to achieve the objective of assessing the use of alternative healthcare amongst key populations. In table 17, 69.1% of respondents revealed that they have opted for alternative healthcare practices as a result of their negative experiences with mainstream healthcare. Table 18 showed that 47.3% of respondents indulge in self-prescribing medication, 24.5% indulge in purchasing medication from an informal source, 20% of respondents use herbs and home remedies, and 18.2% of respondents seek care from traditional healers. In table 19 the satisfaction level of respondents with the use of alternative healthcare was measured and while 47.3% of the respondents revealed that they felt neutral about using the risk of alternative healthcare, 30% and 22.7% of the respondents were respectively dissatisfied and satisfied with the option of alternative healthcare. The record in table 20 showed that fear of disclosure and stigma (49.1%), previous negative experiences with mainstream healthcare (37.3%) and lack of trust in healthcare providers (30.9%) were factors that contributed to the decision of respondents to seek alternative healthcare.

The negative experiences and barriers discussed above have significant ramifications for the health and well-being of HIV key populations (KPs) in southeast Nigeria. Research by Katz et al. (2013) underscores the impact of stigma and discrimination from healthcare providers on influencing health outcomes, with negative attitudes contributing to reduced adherence to antiretroviral therapy (ART) among HIV-reactive clients. Findings from the focus group discussions (FGDs) revealed that the lack of trust in the healthcare system prompts KPs to seek alternative means of care, which often have adverse effects on their health outcomes. This aligns with literature highlighting the negative implications of seeking alternative healthcare, where suboptimal treatment regimens and delayed interventions can exacerbate health conditions (Smith et al., 2014). Satisfaction levels with alternative healthcare were measured, with 47.3% feeling neutral, while 30% and 22.7% expressed dissatisfaction and satisfaction, respectively, underscoring the complex dynamics of seeking alternative care among KPs.

The focus group discussions with various typologies underscored participants' reluctance to seek alternative care, but are often driven by a lack of viable options. A poignant example shared during the PWUD FGD highlighted the consequences of delayed professional intervention. He shared the experience of a friend who exhibited signs of schizophrenia, and who initially sought alternative care, resulting in a worsening of their condition. The friend later sought professional care, but it was too late. Despite the perceived risks and

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challenges within hospital settings, the participant emphasised the importance of prioritising health over potential stigma and discrimination, advocating for accessing professional care despite the barriers encountered.

The survey response showed that 47.3% of respondents indulge in self-prescribing medication, 24.5% purchase medication from informal sources, 20% use herbs and home remedies, and 18.2% seek care from traditional healers. These are the same alternative methods that were provided during the FGDs, with them being couched under the orthodox method, self-medication, and receiving services from community-based organisations.

I have not been to a hospital in seven years, I go to a pharmacist because I hate see finish

(see finish: to be mocked)

(Participant #01-FSW-FGD)

There is this ngo that comes to our brothel every three months, to provide us with HIV testing, they also so provide us with condoms and lubricant

(Participant #08-FSW-FGD)

While participants in the focus group discussions (FGDs) expressed appreciation for the sensitivity of non-governmental organisations (NGOs) and community-based organisations (CBOs) in southeast Nigeria to their diverse identities, they also highlighted limitations in the scope of care provided. Despite offering HIV testing, prevention, and management services, participants found the services offered by CBOs to be less comprehensive. Moreover, they noted that CBOs are predominantly located in state capitals, placing individuals residing in rural areas at a disadvantage. As a result, KPs in rural areas often face additional barriers, such as having to travel longer distances to access services or resorting to visiting health facilities where they are more likely to experience discrimination.

RECOMMENDATIONS FROM THE COMMUNITIES

Training healthcare staff to be more sensitive to our identities: This recommendation emphasises the critical need for ongoing training and sensitization programs aimed at healthcare staff to enhance their awareness and understanding of the diverse identities within key populations (KPs). By providing education on issues related to sexual orientation, gender identity, and other aspects of diversity, healthcare providers can cultivate a more inclusive and supportive environment for KPs seeking care. Training should also focus on addressing stigma, discrimination, and unconscious biases to ensure respectful and nonjudgmental treatment for all patients.

Engaging KPs to work in KP health centres: This recommendation advocates for the involvement of key populations (KPs) in the delivery of healthcare services within KP-specific health centres. By employing individuals from within the community, these health centres can benefit from firsthand knowledge and understanding of the unique needs and challenges faced by KPs. Additionally, hiring KPs as healthcare providers can enhance trust and rapport between service providers and clients, leading to improved access to care and better health outcomes.

Expansion of healthcare services at CBOs to go beyond HIV services: While community-based organisations (CBOs) play a crucial role in providing HIV testing, prevention, and management services, there is a need to expand their scope of care to address broader health needs. This recommendation calls for the integration of additional services, such as malaria testing and treatment, fever management, blood pressure (BP) testing, and blood sugar testing, into existing CBO programs. By offering a comprehensive range of healthcare services, CBOs can better meet the diverse health needs of key populations and contribute to overall health promotion and disease prevention efforts.

Economic Empowerment for HIV KPs: Economic empowerment initiatives are essential for enhancing the socioeconomic status and well-being of HIV key populations (KPs). By providing opportunities for skill development, vocational training, and income generation, these programs enable KPs to achieve economic independence and self-sufficiency. Moreover, economic empowerment initiatives can empower KPs to assert their human rights, advocate for their needs, and combat stigma and discrimination. By fostering economic empowerment among KPs, policymakers and stakeholders can support their holistic well-being and contribute to more inclusive and equitable societies.

DISCUSSION

This study delves deep into the intricate landscape of healthcare-seeking behaviours among HIV Key Populations (KPs) in southeast Nigeria, revealing a myriad of challenges and hurdles. The insights garnered shed light on the complex interplay of factors that hinder access to essential healthcare services for these marginalised communities. Stigma, discrimination, financial constraints, and fear of disclosure emerge as formidable barriers, echoing the voices of individuals navigating a healthcare system fraught with obstacles. Moreover, subgroup analyses unveil the heightened vulnerability of specific demographics within KPs, underscoring the nuanced nature of their experiences. The study revealed that although female sex workers (FSW), men who have sex with men (MSM), and people who use drugs (PWUD) are distinct communities with unique experiences, they face similar challenges when accessing healthcare in southeast Nigeria. Focus group participants described their negative experiences, noting that these were largely fueled by traditional and religious beliefs and norms. For instance, many participants reported that healthcare providers often refused to offer them services or treated them with disdain due to these prevailing cultural attitudes (Nkoma et al., 2022). This finding aligns with the results of a similar study by Henriquez and Ahmad (2021), which identified heteronormativity as a widely held norm contributing to the discriminatory attitudes of healthcare providers towards MSM. Henriquez and Ahmad's research highlighted that healthcare providers' adherence to heteronormative values led to biased treatment, reinforcing stigma and reducing healthcare accessibility for MSM (Henriquez & Ahmad, 2021). Additionally, Okechukwu and colleagues (2020) found that healthcare workers in Nigeria often hold prejudiced views against marginalised groups, further exacerbating the barriers to accessing healthcare (Okechukwu et al., 2020), which aligns with the qualitative findings of this study. The intersection of these cultural, traditional, and religious factors creates a hostile environment for FSW, MSM, and PWUD, preventing them from receiving adequate medical care. This systemic discrimination not only affects their health outcomes but also discourages these individuals from seeking necessary healthcare services in the future (Chukwu et al., 2019). Efforts to improve healthcare access for these communities must therefore address these deep-seated cultural and religious beliefs and work towards sensitising healthcare providers to the unique needs of FSW, MSM, and PWUD (Eze et al., 2021). Another dominant barrier shared by participants of the focus group discussions (FGDs) is the perception that healthcare providers lack knowledge about the specific health needs of the target groups, particularly those of people who use drugs (PWUD). Participants reported that this gap in understanding often leads to inadequate or inappropriate care, further deterring them from seeking medical assistance (Chukwu et al., 2019). For instance, PWUD participants highlighted that healthcare providers frequently fail to address the complexities of substance use disorders and the related health issues, such as overdose management and harm reduction strategies (Okechukwu et al., 2020). This lack of expertise can result in misdiagnosis or insufficient treatment, exacerbating the health disparities faced by this group. Moreover, participants expressed that the lack of specialised training for healthcare providers in handling the unique needs of FSW, MSM, and PWUD contributes significantly to the distrust and fear these communities feel towards the healthcare system (Nkoma et al., 2022). They emphasised the importance of culturally competent care and the need for training programs that educate providers on the specific health concerns and respectful treatment of marginalised populations (Eze et al., 2021).

This perceived lack of knowledge among healthcare providers not only impacts the quality of care received but also reinforces the stigma and discrimination these groups face, creating a cycle of health inequity (Henriquez & Ahmad, 2021).

Addressing this and other barriers identified in this research requires comprehensive training and education for healthcare professionals, aimed at enhancing their understanding and competence in dealing with the health needs of FSW, MSM, and PWUD. By understanding and addressing the underlying cultural and normative drivers of discrimination, interventions can be better tailored to reduce stigma and improve healthcare accessibility for these marginalised populations in southeast Nigeria.

The recommendations put forth emphasise the imperative of fostering a healthcare landscape that is sensitive, inclusive, and empowering, advocating for transformative measures that prioritise dignity devoid of religious, moral, and cultural expectations. By heeding these calls for action, policymakers and stakeholders can chart a course towards a more just and accessible healthcare ecosystem, amplifying the voices and needs of HIV KPs in their journey towards health and well-being.

Areas for further study:

Experiences of KPs in rural areas of southeast Nigeria. A comparative study of HIV medication adherence between Clients in CBOs and mainstream healthcare facilities.

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