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**How can we achieve person-centred care for people living with HIV/AIDS?
A qualitative interview study with healthcare professionals and patients in
Ghana.**

Mary Abboah-Offei^{a*}, Katherine Bristowe^a, Jonathan Koffman^a, Naa Ashley Vanderpuye-Donton^b, Gloria Ansa^c, Melanie Abas^d, Irene Higginson^a, Richard Harding^a.

^aCicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King's College, London, United Kingdom; ^bWest Africa AIDS Foundation, Accra, Ghana; ^cUniversity Health Services, University of Ghana Hospital, Accra, Ghana; ^dInstitute of Psychiatry, Psychology and Neuroscience King's College, London, United Kingdom.

*Corresponding author: Mary Afi Dela Abboah-Offei

Bessemer Road London,

SE5 9PJ United Kingdom,

Phone: +44 (0)20 7848 5698

Email: mary.abboah-offei@kcl.ac.uk.

How can we achieve person-centred care for people living with HIV/AIDS? A qualitative interview study with healthcare professionals and patients in Ghana.

Although person-centred care (PCC) has been identified as a means to achieve the 90-90-90 targets, limited research has considered PCC in low- or middle-income settings. We aimed to explore what constitutes PCC from the perspectives of PLWHA and healthcare professionals (HCP) in Ghana. We conducted 39 semi-structured qualitative interviews with PLWHA and HCP in two community clinics in Ghana, West Africa. Interviews were analysed deductively using thematic analysis, and sampling continued until thematic saturation was achieved. Twenty-four PLWHA (median age 42.5, 50% female) and 15 HCP (median age 34, 53% female) were interviewed. Three interconnected themes emerged across PLWHA and HCP: (1) care structures not built around the person, (2) priority outcomes and components of PCC and (3) re-engineering HIV care to be more person-centred. A conceptual model showing the overlap between PLWHA and HCP's perspectives of PCC, and a framework to inform PCC delivery have been developed from these findings. Our data revealed that PLWHA want PCC to improve care outcomes, wellbeing and quality of life. Further testing of this model is required to inform PCC delivery for PLWHA in low- and middle-income countries.

Keywords: HIV/AIDS, holistic care, person-centred care, Ghana, community-based care.

Introduction

People living with HIV/AIDS (PLWHA) frequently experience highly distressing physical, psychological, social and spiritual concerns (Harding et al., 2010; Harding, Selman, et al., 2012; Harding et al., 2013; Harding et al., 2014) which negatively impact upon their quality of life (Harding, Clucas, et al., 2012). Moreover, these symptoms and concerns influence engagement and retention in care and treatment adherence (Gonzalez, Batchelder, Psaros, & Safren, 2011; Nachega et al., 2013). Greater attention has been paid to viral suppression at the expense of broader psychological, social and spiritual concerns that persist despite treatment advances (Fontaine, Larue, & Lassaunière, 1999; Harding et al., 2010). To address these issues, holistic assessment and person-centred care (PCC) is required.

Person-centeredness is key to quality healthcare (Epstein, Fiscella, Lesser, & Stange, 2010), and is represented in the statement ‘nothing about me, without me’ (Delbanco et al., 2001). It is defined as care ‘dedicated to the promotion of health as a state of physical, mental, sociocultural, and spiritual well-being, as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person’ (Mezzich, Snaedal, van Weel, & Heath, 2009). PCC has been recognised as a means to achieve the 90-90-90 targets set by the World Health Organisation (WHO) (WHO, 2016). However, PCC is a Western-originated concept that is claimed to be potentially applicable universally, despite it not being tested in Africa (Jeroen De Man et al., 2016; Setlhare, Couper, & Wright, 2014).

The WHO’s “Global Strategy on Integrated People-Centred Health Services”, recommends that people should be provided with opportunities, skills and resources to make informed and effective decisions about their own health (WHO, 2015). Evidence from high income countries for conditions other than HIV has shown that a shift to PCC enhances collaboration between healthcare providers and patients and adherence to treatment plans (Roumie et al., 2011; Thompson & McCabe, 2012), improves health outcomes, and increases patient satisfaction (Bertakis & Azari, 2011; Ekman et al., 2012). Moreover, the adoption of person-centred approaches in primary healthcare has resulted in significant benefits for patients, enabling better health management by being informed and supported (Delaney, 2017). This will be increasingly important as PLWHA age and live with complex comorbidity and clinical uncertainty.

We aimed to understand the conceptual meaning of PCC for PLWHA in sub-Saharan Africa, and to determine what specific components of care constitute PCC from the perspectives of PLWHA and healthcare professionals (HCP).

Materials and methods

Study design

A qualitative study using semi-structured interviews, reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007), to enhance trustworthiness and transparency of findings.

Setting

This study was conducted in two community clinics in Accra, Ghana, from September 2017 to December 2017. The participating clinics provided services including ART, adherence counselling, and care for key populations (including men who have sex with men (MSM) and sex workers).

Sampling and recruitment

The inclusion criteria for PLWHA were adults aged at least 20 years (WHO, 2013), with an HIV diagnosis and known to the treating clinic for at least 6 months; and had cognitive ability to consent according to their referring clinician. The inclusion criterion for HCP was to have been providing care for PLWHA for at least six months. A purposive sampling frame was applied to recruit a heterogenous sample with respect to gender, sexual orientation and socioeconomic status for PLWHA.

Ethical approvals

This study was approved by King's College London Research Ethics Committee Reference no. LRS-16/17-4507; the Ghana Health Service Ethics Review Committee Reference no. GHS-ERC16/06/17; and Noguchi Memorial Institute for Medical Research - Institutional Review

Board Reference no. NMIMR-IRB004/17-18. All participants provided written informed consent prior to data collection.

Data collection

Face-to-face, semi-structured interviews were conducted by one researcher (MA-O) in participants' respective clinics. An initial semi-structured topic guide was developed and written in English, then forward and backward translated into Twi. This guide was piloted and amended to improve coherence and questioning. MA-O is fluent in both languages, and gave participants the option of participating in English, Twi, or a combination of the two. The interview questions addressed participants' perspectives of their illness, access to care, involvement in care decisions, symptoms and concerns and their preferences for care. Interviews with PLWHA and HCP included questions about PCC: "how involved are you in your care? What role do you play in your care? how do you tell staff what matters to you?" For HCP, we explored: "what do you know about PCC? What in your view constitute PCC for PLWHA?".

In order to increase the validity of data collected, MA-O summarized the discussions at the end of each interview to allow the participant to clarify any misconceptions or add additional information. Recruitment continued until data saturation was achieved (Saunders et al., 2018). Interviews were audio-recorded, transcribed verbatim and pseudonymised to ensure confidentiality. Translated transcripts from Twi to English were checked with the audio recordings for consistency. A distress protocol was developed and enacted for one patient who became distressed during the interviews.

Data analysis

Thematic analysis (Braun & Clarke, 2006) was used to deductively analyse both PLWHA and HCP interviews informed by WHO's framework on integrated people-centred health services (WHO, 2015). MA-O read transcripts for familiarisation with the data, coded line by line to generate initial coding framework. LC and SE independently reviewed four randomly-selected transcripts and performed line by line coding using the initial framework generated by MA-O, in order to develop a mutually-agreed coding framework. The same researchers (MA-O, LC and SE) met to reconcile and agree on a final coding framework through discussion. This unified coding framework was applied to both PLWHA and HCP data sets. Themes and sub-themes were labelled using a definition of their meaning, expounded to specify their content, to enable internal consistency for each discrete code, and exemplified using extracts from the data. QSR NVivo 11 was used to assist data management and analysis. MA-O further refined and revised codes throughout the analysis, which was reviewed with KB and RH until all data was coded. Findings have been used to inform a conceptual model of PCC and a framework to inform PCC delivery (figures 1 and 2 respectively).

Results

Participant characteristics

Twenty-four PLWHA and 15 HCP were recruited for interviews. Median interview duration was 50 minutes (range 45 to 73 minutes). Sample characteristics are reported in Table 1.

[Insert table 1]

Three interconnected themes emerged across PLWHA and HCP data: (1) care structures not built around the person, (2) priority outcomes and components of PCC and (3) re-engineering HIV care to be more person-centred. Illustrative quotes from (1) and (2) are from both however,

the quotes from (3) are just from HCPs. The themes and subthemes are described in turn below, and illustrative quotes are provided in Table 2.

[Insert Table 2]

(1) Care structures not built around the person

Participants discussed multifaceted concerns including discrimination, stigma, and care structures and processes that hinder access to HIV care services.

Discrimination and stigma

HIV related stigma and discrimination remain a major barrier to PLWHA accessing care services. Discrimination from HCP prevented PLWHA from accessing services at both private and public health facilities (quote 1). Participants also described perceptions and experiences of stigma related to an HIV diagnosis. Stigma emerged as self-stigma, as well as perpetrated by family and community. Expectations and experiences of stigma were a major barrier to accessing care services (quote 2).

Fear of status disclosure

Fear of recognition as someone living with HIV also acted as a barrier to accessing care. For example, signposts placed in front of clinics describing services provided at the clinic (including HIV and related services) was identified as a barrier for PLWHA to accessing the clinic (quote 3). These barriers were recognised by HCP who emphasised effects of these signposts in front of the clinic (quote 4).

Dual burden of disclosure of HIV status and sexual orientation

For MSM, the dual burden of disclosure of HIV and homosexuality were a major concern since same sex relationships have not been legalised in Ghana. Participants felt they could not disclose their sexuality to family, friends or work colleagues. Unable to disclose to their families, some MSM described challenges when family members found out about their HIV or relationship status themselves, causing high levels of distress (quote 5).

Poverty, Community care and waiting times

Furthermore, many participants described poverty as their biggest barrier to accessing appropriate care. Although ART is dispensed free of charge, PLWHA have financial difficulties that prevented them from accessing services or adhering to treatments (quote 6). For some, this was compounded by the decision to travel long distances in order to access care far from home to avoid being identified by people in their community (quote 7). The importance of care services being located in the community and flexible to the needs of PLWHA was recognised. Most participants described wanting their care available in community and with walk in services to enable easy access to care when needed (quote 8). However, extended periods of waiting in the clinic, where their status may be disclosed was an additional barrier to accessing care for PLWHA (quote 9).

Care communication and continuity of care

HCP also described the importance of careful communication to retain PLWHA in care and ensure adherence to their ART. Due to the stigma associated with ART, HCP identified creative and innovative approaches of discussing and reminding PLWHA about medication (quote 10). Communication between PLWHA and HCP was further described in relation to topics of

discussion. PLWHA described interactions with HCP being mainly focused on their HIV and ART, not broader psychosocial domains (quote 11). They also described frustration due to lack of continuity of care, with staff changes undermining relationship building and discouraging disclosure of concerns (quote 12).

(2) Priority outcomes and components of PCC

When asked what mattered most to them, PLWHA described outcomes across broad domains of need including symptoms, living a “normal life”, marriage, having children and being employed. This strongly contrasts those outcomes identified by HCP, which were achieving high CD4 counts and lower viral loads; adherence to treatment with normal kidney and liver function tests.

Physical, psychological, social and spiritual wellbeing

PLWHA described the need for support for symptoms and concerns in four domains: physical, psychological, social and spiritual. Participants described a range of physical symptoms that affect their activities of daily living, wellbeing and quality of life (quote 13). Living with HIV also impacted significantly on the psychological wellbeing of PLWHA. In particular they described worries for their future, fears regarding disclosure of their HIV status, and, regrets and anger for contracting HIV, and how it has affected their life to date (quote 14). This psychological morbidity was compounded by the social, economic and physical environment for PLWHA. They expressed concerns about lack of family support, unemployment, and lack of money to support self and family (quote 15). The overwhelming impact of HIV across physical, psychological and social domains resulted in PLWHA questioning the meaning of their existence. They described spiritual distress, feeling the need to be at peace with God, and

the importance of spiritual support to engender hope and bring meaning to their lives (quote 16).

Family and intimate relationship

Concerns for PLWHA also extended to intimate relationships. They described a need for PCC that also addressed these relational needs, in particular information about starting sexual relationships with an HIV negative person and having children (quote 17). PLWHA also expressed uncertainties around fertility and their ability to have children while living with HIV, particularly in the cases where one partner is HIV negative. They described a lack of information on these resulting in them questioning the future of their relationships (quote 18).

Involvement in care and personalised care

In addition to the inadequate information, PLWHA also felt they were not actively involved in making decisions about their own care, as involvement in care was rare and they felt unable to have a say in their care (quote 19). PLWHA described a need for care that addresses what is important to them, involving them meaningfully in care decisions, and delivered by professionals who are interested in them as a person and not only their HIV (quote 20).

What is person-centred care?

Some HCP did recognise the construct of PCC, describing the importance of considering the psychosocial and spiritual needs of the individual in order to see beyond the HIV diagnosis to the whole person (quote 21). However, HCPs described PCC differently, as ‘tailored care’ and ‘targeted care’ (quote 22). Although this care is targeted toward the individual, decisions around what that care should include, and care needs are led by the HCP’s view of what is

important not by the expressed priorities of PLWHA.

While some views regarding PCC were common across the PLWHA and HCP interviews, others were specific to one or other of the participant groups. Both PLWHA and HCP in Ghana described PCC as care that is delivered in the community, free from stigma and discrimination, that addresses financial, human and time resource issues. We present a conceptual model demonstrating the differences and commonalities of views expressed on PCC in Figure 1.

[Insert Figure 1]

(3) Re-engineering HIV care to be more person-centred

Achieving person-centred care

HCP identified a need for training to understand what PCC means and how it could benefit PLWHA (quote 23). Alongside training for professionals, HCPs identified the need for support in coordinating and integrating adjunct services to address the holistic care needs of PLWHA, and more evidence from research undertaken in Ghana to inform service design and delivery (quote 24). HCP also outlined challenges related to resources required to deliver PCC, including financial, human and time resources (quote 25). They also identified challenges specifically in relation to providing care for key populations. One solution proposed was to train selected staff in providing care to these highly stigmatised communities, and to support their specific needs (quote 26).

Changes to services and infrastructure required to enable PCC have been modelled in Figure 2.

[Insert Figure 2]

Figure 2 provides potential steps required to implement PCC in community HIV care settings, building on the WHO's five strategic goals for integrated people-centred health services. This

could be achieved through a system wide approach by carefully working to understand the needs of PLWHA, alongside training and mentoring HCP on PCC delivery, effective communication, holistic assessment and management of symptoms and concerns. Together these would foster relationships building, collaborative decision making, resulting in desired outcomes.

Discussion

This study provides novel insight into what constitutes PCC for PLWHA beyond the original western-oriented concept.

PLWHA understand PCC as care that involves them in their care decisions, which is concerned about the whole person and not only viral suppression and addresses what matters to them (Figure 1). PLWHA also view PCC as addressing broader social issues: living a normal life like anyone else, getting married and having children and being employed. In contrast, HCP described PCC as ‘tailored care’ and ‘targeted care’, however, this was focused on their own perspectives as to what is important, rather than that of the PLWHA. This was borne out in HCP data, which identified priority outcomes as biomedical (CD4, viral loads). This contrasts starkly with PLWHA data, which described social outcomes (living a normal life, getting married and having children). These differing priorities resulted in care that was not person-centred, as HCP expressed uncertainty about how PCC could be practiced, and a need for training.

A major challenge faced by PLWHA in low- and middle-income countries is the stigma associated with HIV disease, which also impact on service utilisation and physical health (Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016; Herek, Saha, & Burack, 2013). It has been argued that PLWHA are ensnared in a sequence where psychological problems are

compounded by stigma (Miller et al., 2016). These and other issues relating to diversity, ethnicity, gender, sexual orientation, religion and socio-economic status could be addressed using a person-centred approach (Epstein et al., 2010) in ensuring that patients have equal access to vital care service (Groene, 2011). As a recent study demonstrate the potential to increase PLWHAs' resistance to stigma using PCC delivery (Lowther et al., 2018).

PCC is associated with improved clinical outcomes and cost effectiveness (Bezold, 2005; Olsson, Hansson, Ekman, & Karlsson, 2009; Soman & Larson, 2009), as it allows services to target scarce resources at greatest need, which could also prevent further health service use due to unmet needs. 'Person-centred care made simple', a UK Health Foundation report presented evidence about cost savings and a decrease in healthcare services utilization (Health Foundation, 2014), which implies that when individuals are better informed, they could choose different treatments that are less expensive when supported to manage their own care more effectively (Coulter & Collins, 2011; LM, 2012). This is clearly highly relevant to HIV care services in Africa.

Strengths and limitations

This study provides, for the first time, an understanding of the meaning of PCC in HIV population in Ghana, from the perspectives of key stakeholders. A maximum variation sample was achieved, and we oversampled MSM (29%), which is notable considering that same sex relationships are not legalised in Ghana. This study had some limitations: we were unable to recruit heterosexual participants between the age group 20 to 29 years; hence their specific views and experiences may not have been represented. Furthermore, it is possible that some subtleties derived from the data interpretations may have been lost due to translated transcripts from Twi to English, as there is not always a direct translation from Twi to English.

Clinical and research implications

In order to implement and achieve PCC in community settings, we recommend:

- (1) Relationship building between stakeholders through effective communication, and acknowledgement of patients as experts in their own healthcare through partnerships that allow for sensitivity to patient's values, needs and preferences for care.
- (2) Ongoing education and training for providers on PCC delivery, with a specific focus on holistic patient assessment, management of symptoms and concerns, collaborative care planning and delivery.
- (3) Increased understanding of patient's perspective for PCC in order to inform the content of HCP training.
- (4) Future research should test this framework for PCC and validate it across a larger and more diverse sample of PLWHA.

Conclusion

We present a framework for PCC delivery informed by the experiences and perspectives of PLWHA and their HCPs. Further testing of this framework can serve to inform national policies and plans for HIV service implementation and delivery. While this framework can provide guidance for implementing PCC, there is still a need for health systems to be responsive to their specific contexts and to identify priority areas to encourage innovation for PCC. Policies and plans for strengthening health systems to better serve people with chronic conditions such as HIV/AIDS should be aligned with principles of PCC in order to strengthen patients' knowledge and skills to participate in, and benefit from their care.

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Declaration of interest

No potential conflict of interest was reported by the authors.

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Table 1: Participants' characteristics N=39

PLWHA (n=24)	N (%) Total
<u>Gender:</u>	
Male	12 (50%)
Female	12 (50%)
<u>Sexuality:</u>	
Men who have sex with men	7 (29%)
Heterosexual	16 (67%)
Women who have sex with women	1 (4%)
<u>Religion:</u>	
Christian	13 (54%)
Muslim	4 (17%)
Traditional believer	7 (29%)
<u>Relationship status:</u>	
Single	9 (38%)
In relationship	15 (62%)
<u>Age:</u>	
Median (range)	42.5 (20-65)
<u>Clinical:</u>	
Median years since diagnosis	5.5 (6months - 18years)
PLWHA with comorbidities (diabetes, hypertension, arthritis, migraine, hepatitis)	16 (67%)
HCP (n=15)	
Median Age	34 (24-56)
<u>Profession:</u>	
Doctor	2 (13%)
Nurse	5 (33%)
Pharmacist	2 (13%)
Counsellor	2 (13%)
Social worker	1 (7%)
Human resource manager	1 (7%)
Laboratory technician	1 (7%)
Healthcare assistant	1 (7%)
<u>Gender:</u>	
Male	7 (47%)
Female	8 (53%)
Median years delivering HIV care	2 (6months – 14years)

Table 2: Sub-themes and illustrative quotations from participants.

Sub-themes	Source	Representative quote
Discrimination	PLWHA	(1) “Due to mistreatment from health workers some of us stopped attending such clinics until we find a place where we are treated as human beings. Another issue is when you attend the clinic and you are a man with the complains of diarrhoea, even without asking you what or how did the diarrhoea started, staff just assumed that you are gay they will just leave you there without any medical assistance, is as if they wish you die at that moment with your symptoms. This is very demoralising you know most importantly when you soil yourself with the diarrhoea, no health worker is even willing to change your soiled clothes or linen, this really gives you a low spirit and also you begin to have self-stigma.” MSM, age 25.
Stigma	HCP	(2) “Stigma is also another major barrier that prevent PLWHA from being free in themselves and to utilise the services available for them. Sometimes when you are being nice to the clients, they don’t understand why you should be nice to them because they have always been stigmatised even at health facilities” female age 46.
Fear of status disclosure	PLWHA	(3) “I think a good care should be delivered in the community where it is near to the community members to access however, there should not be any signpost indicating that the clinic cares for HIV/AIDS clients, otherwise people will start to know our status and we may have to abandon those community clinics for other ones that are not closer to us” MSM, age 26.
	HCP	(4) “We had enough signpost around the community however, some members of the community realising what we do, begun to label any client that comes to the clinic, some even went to the extent of discriminating against some of our staff because they cared for PLWHA” male, age 32.
Dual burden of disclosure of HIV status and sexual orientation	PLWHA	(5) “My family has not accepted me with my HIV status, my dad doesn’t talk to me, he only talks to me when he thinks I should conform to his rules then he will address me with my status; my house is like mummy and daddy makes the rules and you are only to conform but I am very stubborn, so I don’t usually obey what mum and dad says so it looks like I am the odd one out. My mum keeps reminding me of how she is at risk of getting HIV from me, dad also tries to say things that will make me feel guilty like he will say things like I am a disappointment to the family and telling me to give birth because he thinks am going to die soon” MSM, age 20.
Poverty	HCP	(6) “The main discussion has been around finances because even though the ARTs is free, there are other supplementary drugs or lab investigations that clients need to do. Generally, clients think that because the HIV/AIDS treatment is free, everything else that comes with it should be free; others may also come, pay for all their treatment and when it is time to go home, they tell you they don’t have money for transport. So the clinic has to find a way to pay for their transport or if these clients live close by, then the clinic vehicle will take them home” female, age 32.
	PLWHA	(7) “The main thing that will prevent me from attending my appointments will be when I don’t have money to take car to the clinic because I don’t have a straight car from my house to the clinic, I had to charter a taxi that will bring me closer to the town before I take a commercial vehicle from town to the clinic. And I don’t want people to see me going to the clinic and be asking questions” male, age 43.
Community care	PLWHA	(8) “I think that the care in the community is good because it is less formal and you don’t need an appointment to go to the clinic” female, age 52.
Waiting times	PLWHA	(9) “I expect that the moment I arrive in the clinic, they will just see me, give my medications then I go because we MSM we know ourselves and I am a bit popular too so when I am delayed in the clinic, other MSM will come to the clinic and identify me the

Sub-themes	Source	Representative quote
Care communication	HCP	<p>same way I will identify them, and they will go and talk about the fact that they saw me in the clinic and the rest of us will like to know why I was at the clinic” MSM age 27.</p> <p>(10) “So now the concern is what can we do to keep our clients in care? And because clients take their pill every day when you go back to talk to them that please take your pills, they feel derailed, they want to see other innovations that are interesting to them like, pill boxes, colourful text messages. I noticed that most of my clients don’t want to hear you asked them have you taken your drugs, so I have started using things like pebbles, so like have you taken your pebbles, just things that will not remind them of what they are taking. Most of them are getting used to it that I get messages from them like ‘my pebbles have finished can I come and get some more?’” male, age 33.</p>
Continuity of care	PLWHA	<p>(11) “Staff usually speak to me about my ART and how to take my medication regularly so that my viral load will go down. But they don’t ask me about my home and my life outside HIV” male, age 43.</p> <p>(12) “It’s also important to me that the same staff is maintained at the clinic because I hardly open up to people about my issues and concerns. The last time I came I met a doctor who was nice to me so I started sharing my issues and concerns with her but today when I came to the clinic, the doctor that saw me is a new doctor as a result, I couldn’t discuss my issues and concerns with her because she is new to me and I have to try and develop a relationship with this doctor before I can open up to this doctor about my issues which will really take a while to happen” MSM age 25.</p>
Physical, psychological, social and spiritual wellbeing	PLWHA	<p>(13) “I have headaches, pain, fatigue and weakness in my body which sometimes prevent me from going to work. The pain can be unbearable to the extent that I am not able to get out of my room.” female, Age 42.</p> <p>(14) “I worry most of the time about how I got HIV, I feel if it hadn’t been for this HIV, I would have achieved greater heights in life. I feel that being HIV positive has really drawn me back in life, this makes me sad and am filled with regrets.” female, Age 43.</p> <p>(15) “My husband does not treat me well since he got to know my HIV status. He won’t look after the children and he will insult me sometimes in front of the children making me feel that I am not a human being. I don’t have any money because when I got HIV and news of it went round, it made people stopped buying from me which has rendered me jobless because people feel they will get HIV if they buy from me or even talk with me.” female, Age 35.</p>
Family and intimate relationship	PLWHA	<p>(16) “May be God is even the one who punished me with the HIV because when I had a girlfriend I was not diagnosed of HIV until I started dating a man. I don’t really understand my life anymore, I am always praying for God’s forgiveness.” MSM, Age 25.</p> <p>(17) “What I want to ask staff, is about me and my wife, we want to have another child but we are not sure if we can have a child while on treatment or if it is even possible to have children at all because we have been advised to have protected sex so we are not sure if we can have unprotected sex let alone have a baby. I have been thinking about this for a while now but have not had the courage to ask the doctor or any other staff” male, age 41.</p> <p>(18) “I just wanted to have unprotected sex with this other woman so that perhaps she might get pregnant for me, then I can have a child of my own because after my wife had the still birth I wasn’t sure if she will be able to carry another pregnancy for me so that is why I decided to date this other woman to see if I stand the chance of having another child even if it is outside my marriage who cares” male, age 43.</p>
Involvement in care and personalised care	PLWHA	<p>(19) “I am not involved in my care and staff don’t ask me my opinion about my care. I am not sure if I have a role to play in my care if I do, then staff have not told me about the role I need to play in my care. Staff don’t ask me what matters to me and I don’t think I have a say in my care.” male, Age 36.</p> <p>(20) “Staff should have other conversations with us regarding other aspects of our life apart from HIV. Staff should also ask us about what is most important to us so that we can tell them about it. Staff should not assume they know all things, they should also</p>

Sub-themes	Source	Representative quote
What is person-centred care?	HCP	<p>treat us like human beings because our HIV status is not written in our faces to scare them of, we are human beings just like staff” male, age 61.</p> <p>(21) “Like dealing with PLWHA is very different because when you are caring for PLWHA you are psychosocially and spiritually involved with their issues that are related or intertwine, so you see that you are sitting there trying to help someone’s child enrol in school, or you are talking to somebody’s husband who is discriminating against her. So you are involved in so many levels, and that is what is interesting about HIV care, because strictly PLWHA mainly come here for their counselling and medication refill but what we need to have at the back of our mind is we are not focusing on just HIV, we are dealing with a whole human being” female, age 46.</p>
Achieving person-centred care	HCP	<p>(22) “When we talk about person-centred care it should be having tailored care or targeted care because people are different. For me person-centred care is having differentiated models that will suit their needs. So we call it targeted care because a married man walking to the clinic who is HIV positive will have different needs to a young man who is HIV positive, and it will also be different with MSM who walk into the clinic.” male, age 33.</p>
	HCP	<p>(23) “Yes, it is possible to practice person-centred care but only when we are trained to understand what it means to be person-centred and what benefit it will be to PLWHA. Because what I observe is that one doctor mostly consults on Saturdays due to her busy schedules on week days; but because of her approach to caring, most of the PLWHA prefer to come for the Saturday clinic” male, age 32.</p>
	HCP	<p>(24) “I think the only thing we need to do is what we call integration of services and resource ourselves to do more capacity building and training for health workers to understand what person-centred care means so that they are fit to handle some of problems and concerns of PLWHA. Another thing too is that we need to do a lot of research because for us in Ghana we need research to tell us what influences what we do and because we don’t have the research most of the time we do things the old way” male, age 33.</p>
	HCP	<p>(25) “I think we need both financial and human resources because before you can have a discussion with a client with psychological issues to come out smiling you need more than 30minutes with that client. And as you are having such conversation with clients you will realised that there are financial issues that you may need to help the client with, like paying their transportation etc. I find it difficult to ask my client ‘what is really bothering you?’ And I am not happy that when clients share such problems, I am not in a position to help them so I will rather not ask” male, age 25.</p>
	HCP	<p>(26) “Or we can also identify and train staff to be able to handle such things, because we have at least 5 nurses we can identify at least 2 nurses who can be trained to support our clients especially MSM with these psychological issues, then we know we have such team in place. We should also focus our conversation on the client like trying to find out what is happening in the person’s life before touching on HIV related issues at the tail end of the conversation” female, age 38.</p>

Figure 1. A conceptual model of person-centred care from the perspectives of HCP and PLWHA in community care in Ghana.

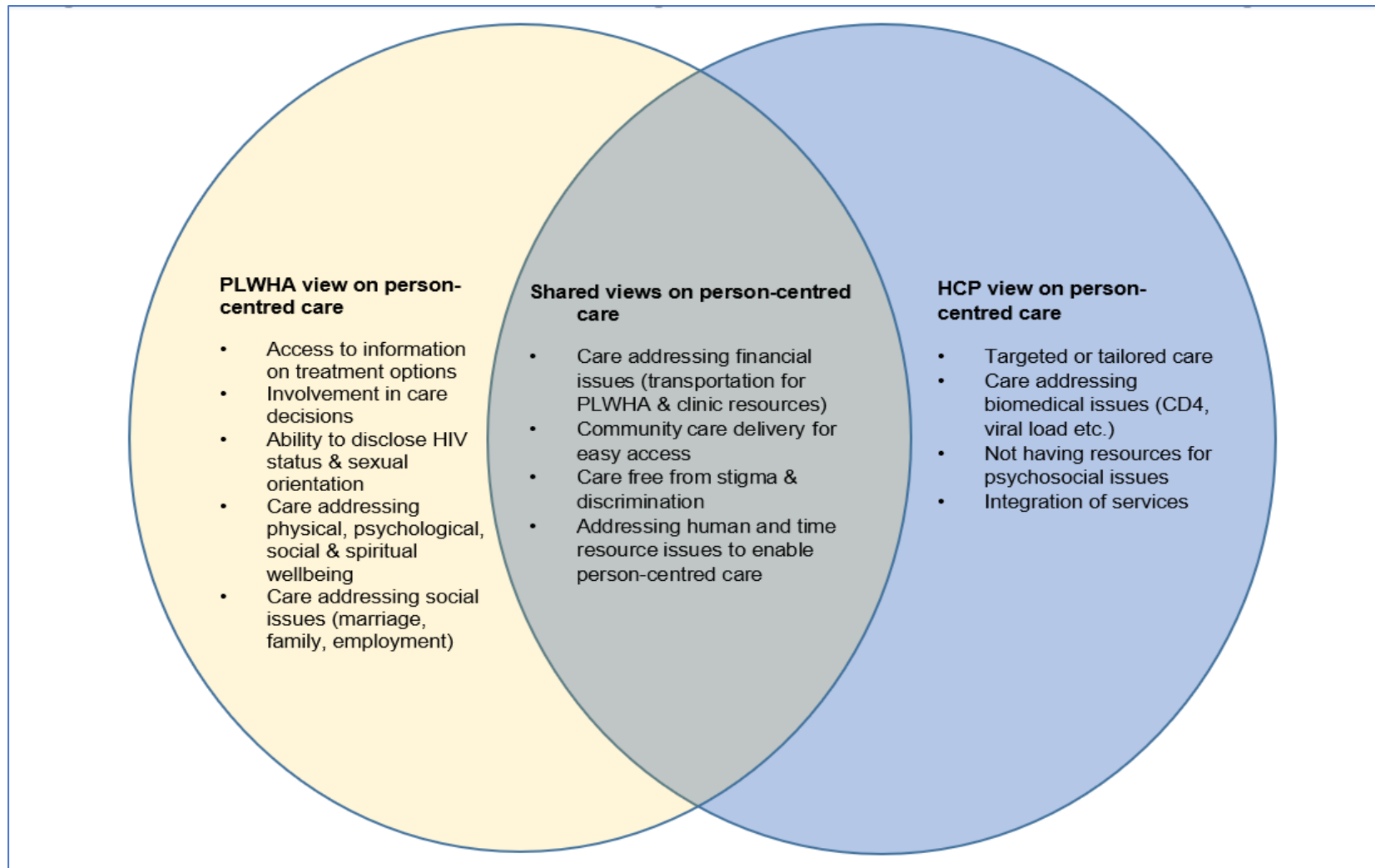


Figure 2. Framework to inform person-centred care delivery

