Baseline assessment- Ghana

Scaling up programs to remove human rights-related barriers to HIV services

(Draft for review, 26th April 2018)

The Global Fund

Acknowledgements

List of Acronyms

AIDS - Acquired Immunodeficiency Syndrome

AfeD- Alliance for Equality and Diversity

ART - Antiretroviral therapy

ARVs – Antiretroviral drugs

CCM – Country Coordinating Mechanism

CHRAJ-Commission on Human Rights and Administrative Justice

CSO – Civil society organization

DFAT –Department of Foreign Affairs and Trade

DVVSU- Domestic Violence and Victims Support Unit

FGD – Focus group discussion

GAC- Ghana AIDS Commission

HCW – Healthcare worker

HIV - Human Immunodeficiency Virus

HRAC- Human Rights Advocacy Center

IBBS - Integrated Biological and Behavioral Surveys

ID – Identification

ILO – International Labor Organization

JSI - John Snow, Inc.

KI(I) – Key informant (interview)

KP - Key Population

KPI – Key Performance Indicator

MoH – Ministry of Health

MSM - Men who have sex with men

NGO – Nongovernmental organization

NSP - National HIV & AIDS Strategic Plan

PEPFAR – The United States President's Emergency Plan for AIDS Relief

PITC – Provider-initiated HIV testing and counseling

PITCH – Partnership to Inspire, Transform and Connect the HIV response

PLHIV - People Living with HIV

PMTCT – Prevention of mother to child transmission

RiH – Results in Health

SPM - Minimum Standard Service Procedure

STI – Sexually transmitted infection

SWs - Sex workers

UNAIDS - The Joint United Nations Programme on HIV/AIDS

UNDP – United Nations Development Program

UNFPA – United Nations Population Fund

UNODC – United Nations Office on Drugs and Crime

UNTF – United Nations Trust Fund to End Violence Against Women

USAID - United States Agency for International Development

USC - University of Southern California

VAW – Violence against women

VCT – Voluntary counseling and testing

WHO - World Health Organization

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I. Executive Summary

This baseline assessment examined human rights-related barriers in Ghana that inhibit access to, uptake of, and retention in HIV-related services. Data were collected through a desk review, followed by in-country work, which involved a total of 39 in-person and 6 telephone interviews carried out with 63 key informants engaged in research and/or activism related to key and vulnerable populations, and 9 focus group discussions with 67 individuals from the key populations of people living with HIV, female sex workers, and men who have sex with men, and one interview with a person who used to inject drugs. The interviews and focus group discussions were carried out in Accra, Berekum, Kumasi, Sunyani, Takoradi, and Tarkwa.

Based on the desk review carried out for this assessment, the following key and vulnerable populations have been identified in Ghana: female sex workers, men who have sex with men, people who inject drugs, people living with HIV, HIV-negative partners of people living with HIV, prisoners, 'kayayei'[1], people with disabilities, women, and vulnerable children, including orphans and street children. Government documents suggest a slightly different definition with key populations limited to female sex workers, men who have sex with men, people who inject drugs, and people living with HIV and vulnerable populations encompassing prisoners, non-paying partners of sex workers, 'kayayei', long distance truck drivers, uniformed (security) personnel and health workers. (GAC, 2016) Throughout this report, we use 'key' and 'vulnerable' populations to include the broader list of populations above. Adolescents are not included as a priority 'vulnerable' population as HIV prevalence is less than 1% among adolescents in Ghana. (GAC, 2016)

Human rights-related barriers to HIV services

In summary, the major barriers to services are:

Stigma and discrimination - Key and vulnerable populations experience higher burdens and more intense forms of stigma and discrimination, including social exclusion. There is also continued stigma and discrimination in relation to HIV generally, grounded in limited understandings as well as misconceptions about HIV. For those who identify as key populations, specifically female sex workers and men who have sex with men, in and of themselves highly stigmatized, the specter or diagnosis of HIV can represent a "double burden". People who use drugs are also highly stigmatized and a particularly invisible key population.

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[1] «Kayayei» refers to women and girls who migrate from rural areas to urban areas where they work as porters.

Because of the continued stigma attached to HIV, people living with HIV, those from key and vulnerable populations, and others may not use HIV-related health services because they fear it will "brand" them as someone living with HIV. Openly judgmental attitudes and treatment by health service providers are also major barriers to utilization of services. If and when certain populations, such as female sex workers, and men who have sex with men, do attend services, they may not wish to openly disclose their partners, sexual history or risk behaviors such as drug use. They may also experience unauthorized testing and disclosure. Self-stigma is also a major barrier to key populations accessing care.

Punitive laws, policies, and practices – There are mixed opinions about if and to what extent the punitive law represents an actual barrier to services, but most key informants agreed that reforming the laws is not a viable strategy in the short-term given the political climate and general public attitudes toward the behaviors at issue. Therefore, the focus should be on understanding how the laws play out in practice, the impacts on different populations, and in particular current and potential new "workarounds".

One of the most salient examples of how the legal environment creates harms and barriers for key populations involves police harassment and violence against female sex workers. For men who have sex with men, the criminalization of 'unnatural carnal knowledge' contributes to their marginalization and vulnerability to police mistreatment, which means that they may not seek police assistance when they need protection. Blackmail is a particularly significant problem for men who have sex with men, perpetuated by those outside as well as those within the community. For people who inject drugs, fear of the police is a salient part of their lives and keeps them hidden.

Some health policies may also prevent or inhibit key populations from accessing services. For example, some services require people living with HIV to bring a "monitor" before they can start treatment, or they require parental authorization to provide health services for youth under 18 (although health workers may use their discretion to provide services to people as young as 15 based on their perceived maturity) (WHO, 2013).

The recently passed Ghana AIDS Commission (GAC) Act contains important provisions for promoting and protecting the rights of people living with HIV, as well as those suspected of living with HIV. However, there is still a need for broad-reaching advocacy to build awareness and ensure implementation.

Gender inequality and gender-based violence – Women living with HIV experience heightened discrimination because of gender norms regarding acceptable sexual behaviors for women and perceived implications of a positive diagnosis - whereas social norms condone men having multiple sexual partners, women are expected to be monogamous. There is much reported discrimination and violence against women living with HIV, particularly in marital contexts where a woman who tests positive may be blamed for having brought the infection in to the marriage. This is a growing issue due to the expansion of provider-initiated HIV

testing and counselling in antenatal care, which is greatly increasing the numbers of women testing for HIV and learning their status but without a similar increase in counseling and testing of men.

Women who are sex workers face inequality in power dynamics and violence in various ambits of their lives, including with their non-paying partners. Young sex workers and adolescent girls who engage in transactional sex are also vulnerable to disproportionate levels of abuse, as are Kayayeis – women and girls who migrate from rural areas to urban areas where they work as porters. Children and adolescents who live on the streets, especially girls, also suffer high levels of rape.

Rigid and harmful gender norms also create barriers for men's utilization of services. Norms that espouse masculinity as strength and self-resiliency may inhibit men from seeking preventive care or treatment services. Men who deviate from those norms also experience significant barriers to care, particularly in the form of stigma, discrimination, and even violence.

Transgender persons are still largely invisible from discussions as well as interventions and policies due to the extremely challenging political, social and cultural environment.

Poverty and economic and social inequality - Poverty exacerbates situations of vulnerability for people living with HIV and other key and vulnerable populations and serves as a barrier to accessing, enrolling, and remaining in services, particularly HIV treatment, which can entail relatively significant costs for transportation and laboratory exams. Certain key and vulnerable populations, including younger female sex workers, younger men who have sex with men, and street children are particularly susceptible to financial hardships.

Highlights of interventions to date: Some of the main interventions designed to address human rights barriers to accessing HIV services are highlighted below, organized by the 7 key program areas to the extent possible.
In Ghana, there have been a series of large, multi-sectoral and integrated programs that have focused on creating enabling environments for key populations to access HIV-related care and services, the most recent of which have had the United Nations "90-90-90" as their guiding framework both for designing activities and monitoring impact. Although these large programs may not have explicitly incorporated human rights language and frameworks in their implementation, many of their components have in effect addressed human rights-related barriers to services. Some of these components have included peer-to-peer outreach and communication, drop-in-centers, and a network of M-Friends (prominent community members e.g. lawyers, doctors, police, traditional leaders) and M-Watchers (people living with HIV and key population peer educators) who were trained on stigma and discrimination and how they affect and drive HIV infection, the

effects of human rights abuses and negative gender norms and gender-based violence on key populations and PLHIV, and how to identify cases of violence and help individuals access health and legal services.

To ensure supportive environments for key populations to access and be retained in services, organizations have used a combination of activities, including case managers– individuals who have the crucial role of ensuring that people living with HIV are enrolled and remain in the care system – peer education and outreach, as well as drop-in centers, fixed spaces that provide information, psychosocial support, and free services, including HIV testing and counseling, and STI treatment. There have also been examples of mobile outreach, taking HIV testing services to harder-to-reach groups such as out-of-school youth. These activities are designed to reduce the impact of stigma and discrimination to accessing HIV services for key and vulnerable populations. There have been various initiatives to reduce stigma and discrimination in health facilities by sensitizing and training health care workers to be key population-friendly – particularly in relation to interacting with female sex workers and men who have sex with men. Several of these trainings have incorporated, or are now seeking to incorporate, human rights perspectives and content.

There have also been significant large-scale efforts to sensitize law-enforcement agents in Ghana, including in-service training for police with approximately 2,000 trained annually as well as pre-service training for all officers-in-training, which involves approximately 3,000 graduates annually.

Legal literacy efforts: to date have been limited in scale, and there is a need to increase awareness among people living with HIV and key and vulnerable populations regarding their rights and existing protections against discrimination, including specifically the Patient Charter and recently passed GAC Act.
Both government and civil society organizations (CSOs) have established initiatives to promote access to legal services and redress for cases of HIV-related discrimination and human rights abuses. The M-Watchers and M-Friends serve as a key population-centered, rapid response network by which allies and peers are on alert for human rights abuses against key populations. The Commission on Human Rights and Administrative Justice (CHRAJ) also provides a reporting mechanism dedicated to addressing issues of discrimination and stigma against people living with HIV and key and vulnerable populations. However, the system has not realized its full potential and is under-utilized.

There are not many substantial programmatic efforts specifically focused on reducing discrimination against women in the context of HIV. The Ministry of Women, Gender and Children has carried out some HIV-related activities, including public sensitization, but also faces financial constraints.

Ensuring a comprehensive approach to addressing and removing barriers to services

Current funding and programmatic efforts have a strong focus on intensifying interventions to reach, test, and link key populations, particularly female sex workers and men who have sex with men, into care and treatment services. However, as was evident throughout the assessment, there are significant continued barriers and gaps to the achievement of 90-90-90 that are not being adequately addressed by current programming, many of which implicate human rights concerns. The recommendations below map out various opportunities to enhance existing efforts and ensure a comprehensive and rights-based response to Ghana's HIV epidemic. They should thus be viewed as complementary to and in synergy with the existing programming on which they build. The recommendations are designed to cover all seven key human rights programmatic areas and, following some overarching recommendations, are structured as such.

There are several overarching recommendations for re-orienting existing programs to maximize their impact including:
- Increase programs that seek to address socio-cultural dynamics that create barriers to accessing HIV services
- Target hard-to-reach populations of female sex workers and men who have sex with men
- Outreach for other under-served key and vulnerable groups including street children, transgender people and male sex workers
- Mainstream attention to people with disabilities
- Ensure a supportive environment for people who use drugs
- Expand programs geographically beyond current 'priority districts'
- Scale-up and institutionalize training efforts
- Public education about HIV, stigma, and human rights
- Engage religious and traditional leaders
- Livelihood options for Models of Hope, Peer Educators
- Increase attention to the quality of programs and services alongside the number of people reached

Specific recommendations related to the 7 key human rights program areas include:
- Public education/media campaigns to increase knowledge about HIV and human rights:
  - National scale media campaign.
  - Training of journalists to promote appropriate reporting on relevant topics, covering all 'major' media organizations.
- Scale up 'Models of Hope', 'M-Watchers' and support groups

- o Training of 203 Models of Hope. Across 5 regions, some have already been trained but may require refresher training; in addition, new Models of Hope will have to be recruited and trained.
- o Training of, at a minimum, 90 M-Watchers to cover the 15 'priority districts' or, preferably, training of 192 M-Watchers to cover all 32 districts where relevant work is ongoing.
- o Creation of support groups attached to ART centres, drop-in centres, and elsewhere as appropriate (e.g. building on nascent activities for transgender populations)
- Institutionalize pre-service and in-service sensitizations and trainings of health care workers on HIV, human rights, stigma and discrimination reduction, and medical ethics:
  - o HIV-related human rights and stigma and discrimination reduction should be incorporated into curricula at all medical, nursing and allied health sciences schools to reach all pre-service trainees. Educators will have to be trained to deliver the curricula.
  - o Standardization of in-service training curricula and scale up at least to all 'priority districts' where services for key populations are being provided, preferably to all 32 districts. Currently multiple organizations are implementing in-service training on a small scale in different locations; coordination, standardization and scale-up is needed.
  - o Training of, at a minimum, 90 M-Friends (who include police, and other community leaders as well as health workers) or, preferably, training of 192 M-Friends to cover all 32 districts where relevant work is ongoing.
- Strengthen pre-service and in-service training on HIV and human rights for police and prison guards:
  - o HIV-related human rights and stigma and discrimination reduction should be incorporated into/strengthened in the training curricula for all pre-service police and prison officers. Educators will have to be trained to deliver the curricula.
  - o Standardization of in-service training curricula for police and scale up. Ghana Police Service has been providing some training throughout the country but, with no budget, trainings are currently limited. NGOs have been carrying out trainings across a variety of regions but at a small scale. Standardization and scale-up is required.
  - o There is good coverage of in-service training for prison guards by PPAG, which should be supported/maintained.
  - o Advocacy with senior police and prison officials to secure high-level support for these initiatives.
- Human rights education/legal literacy work through peer education and campaigns:
  - o Expansion of existing work of AfED and HRAC on human rights education to all priority districts and, preferably, beyond.
  - o Ensure that all relevant target populations are included in human rights education efforts, with information tailored appropriately.
- Paralegal training and 'bridging' to legal services:

- o Revitalization of AfED's paralegal network to promote linkages to legal services, including *pro bono* lawyers.
  - o Connect the above with HRAC's free legal consultations, which currently operate in 6 regions but on a small scale and could be expanded.
  - o Build on population-specific paralegal training efforts such as SWAA's work with 'kayayei'.
  - o All of this work should be considered as a continuum of service provision from initial legal literacy work through access to paralegals, bridging to legal services and access to CHRAJ, which means that scale-up of all of these activities should be geographically matched.
- Capacity building of CHRAJ to improve access to justice in cases of discrimination:
  - o Assessment of why uptake of CHRAJ services for HIV-related human rights violations has remained low.
  - o Capacity building should include staff training across all regions (as well as centrally), and financing to ensure that staff have the available resources to provide needed services.
- Institutionalize pre-service and in-service sensitizations and trainings of judges and lawyers on HIV, stigma, and rights:
  - o Incorporate HIV-related human rights and stigma and discrimination reduction into law school curricula.
  - o Standardize in-service training on HIV, human rights, stigma and discrimination for lawyers and judges, and roll out across at least the 15 priority districts.
  - o Community-level public education building on existing model being implemented by WAPCAS that involves taking CHRAJ, DOVVSU and others to community level to meet key and vulnerable populations and talk about HIV and human rights. This should be scaled up at least to the 15 'priority districts', preferably to the 32 'currently active districts'.
- Stigma index implementation: National level
- Dissemination of the GAC Act, the Patient Charter, and other relevant laws and policies:
  - o Through the media campaign mentioned above
  - o Through the above-mentioned trainings for duty-bearers as well as other key stakeholders such as peer educators, Models of Hope etc.

It will be important to ensure consonance across the training curricula for all of the different groups mentioned above to ensure that the same messages are being given to all stakeholders.

Additionally, there are several cross-cutting recommendations that are crucial to moving forward many of the above program areas but fall outside the remit of the human rights matching funds:

- Implement services and research for under-reached groups including people who use drugs, children and adolescents working on the streets, and people with disabilities; and
- Decentralize ART distribution, including through drop-in centres;

- Operationalize the GAC HIV fund.

Some outputs to the recommended interventions can be measured in numerical terms, but the real changes in barriers to access to services will likely only be found by qualitatively learning from the experiences of key and vulnerable populations, and longer term changes to the test and treatment cascades for HIV.

Due to the compressed timeline for the in-country work, it was not possible to capture the perspectives of all stakeholders; among the perspectives that are not included here are those of lawmakers, traditional and religious leaders, widowers, and prisoners. Moreover, relatively few inputs were received from people outside the five regions where primary data collection took place.

This assessment highlights that strong programs exist in Ghana, which provide an important foundation to which additional activities can be added to bolster the national response to addressing human rights barriers to accessing HIV services. There is national commitment to expanding the range and scale of interventions, and this is an opportune moment for advancing these efforts.

II. Introduction

Overview of the Global Fund Baseline Assessment Initiative

Since the adoption of its strategy, *Investing to End Epidemics*, 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services*;" and, to "*scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities.*" (Global Fund, 2016)

The Global Fund has recognized that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

The programs recognized by UNAIDS and other technical partners as effective in removing human rights-related barriers to HIV services comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.[2]

Background & Rationale for Baseline Assessment in Ghana

Though the Global Fund will support all countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation". This KPI measures "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries".[3]

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[2] See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Technical *Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

[3] 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Ghana, with 19 other countries, for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, is the first component of the package of support the country will receive.

The findings of this baseline assessment will be used by the country, the Global Fund, technical partners and other donors to develop a five-year plan by which to generate interest and commitment from all stakeholders to fund and implement a comprehensive set of these programs to remove human rights-related barriers to HIV-related services in Ghana. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund strategy.

Purpose, objectives, and expected outcomes of the baseline assessment

The objectives of the baseline assessment are to:
- identify the key human rights-related barriers that prevent access to and use of health services;
- describe existing programs to reduce such barriers;
- describe the programs needed to comprehensively address the barriers, their coverage and costs; and
- Identify opportunities to bring these programs to scale over the period of the Global Fund Strategy.

The assessments will provide a baseline of the situation as of 2017 and will be followed up by similar assessments at mid- and end-points of the Global Fund Strategy in order to assess the impact of the scale-up of programs to reduce barriers.

III. Methodology

Conceptual framework

The human rights-related barriers assessed in Ghana are those that inhibit access to, uptake of, and retention in HIV-related services. The general categories of barriers, as specified by the Global Fund, include those related to stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and poverty and economic and social inequality.

The process of determining which sub-groups within the general population of Ghana may constitute a key or vulnerable population in relation to HIV has been based on the three criteria set out by the Global Fund (Global Fund, 2013), as well as how the government itself has chosen to do so:

- Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to HIV – due to a combination of biological, socioeconomic and structural factors;

- Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and

- The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.

The Global Fund has defined 'vulnerable populations' to include those who have increased vulnerabilities in a particular context, i.e. adolescent/women and girls, miners and people with disabilities.

Based on this desk review, key populations in Ghana were found to include female sex workers, men who have sex with men, people who inject drugs, the prisoner population, and people living with HIV; vulnerable groups were found to include HIV-negative partners of people living with HIV, 'kayayei', people with disabilities, women, and vulnerable children, including orphans and street children. Adolescents were not included in this list given the low HIV prevalence among this population (<1% nationally).

Steps in the baseline assessment process

The steps of the baseline assessment were:

A. **Desk Review**. The desk review entailed literature searches, legal and policy environment data extraction, and key informant interviews related to human rights barriers to accessing HIV services

in Ghana and programs to address these barriers. To identify relevant peer-reviewed literature, a comprehensive search was conducted using PubMed, Popline, and Embase. Articles were initially selected for keywords in their abstracts and then further searched for relevance. Of the 595 articles initially identified on the basis of keywords in abstracts, 23 were ultimately selected for inclusion in the desk review. The grey literature was also reviewed: data were extracted from a range of documents identified through a combination of google searches as well as documents and reports recommended by Global Fund and key informants. Overall, 31 documents were reviewed in depth, including reports, newsletters and presentations (Annex 1). The legal and policy environment data extraction was based on an assessment of legal and policy environment carried out in 2010 as well as primary analysis of relevant laws, policies and strategies that post-date this assessment. Finally, to garner additional insights about barriers and programs, as well as suggestions for the in-country data collection, telephone interviews were carried out with five key informants representing a range of institutions including the Global Fund, a Ghana HIV Principal Recipient, UNAIDS and UNDP.

B. **In-country data collection**. In July of 2017, a team of three researchers conducted interviews with key informants and focus groups with key populations in Accra, Berekum, Kumasi, Sunyani, Takoradi, and Tarkwa (areas of Ghana that have been particularly affected by the HIV epidemic). The purpose of the in-country data collection was to deepen the understanding of the most urgent and important barriers to HIV services in Ghana, the most effective programs to date, and the costs of a scaled-up approach to reducing these barriers. Data collection tools are available on request. At the onset of the in-country data collection, there was an inception meeting with over 30 national stakeholders and community members to discuss the baseline assessment and data collection procedures, and to present the findings of the Desk Review. The meeting provided an opportunity to collect reactions, clarifications, and additions to the findings from the Desk Review, to map particular concerns or gaps for further exploration during in-country work, and to identify additional potential key informants and relevant programs.

Based on the Desk Review, an initial list of key informants and key populations was identified - this list was subsequently expanded over the course of data collection through consultations with stakeholders and key informants. For the desk review, six key informants were interviewed by phone. In-country, the research team carried out 39 in-person and 6 telephone interviews with 63 key informants engaged in research, programming and/or activism related to key and vulnerable populations. Key informants represented a range of entities including non-governmental organizations, government agencies and hospitals, research universities. The team also carried out 9 focus group discussions and one key informant interview with 67 individuals from the key or

vulnerable populations of people living with HIV, female sex workers, and men who have sex with men, people who use drugs. Data were collected on:

- Human rights-related barriers to HIV services;
- Key and vulnerable populations most affected by these barriers;
- Current or recent programs that have been found, either through evaluation or consensus among key informants, to be effective in reducing these barriers;
- Funding for all such programs as available;
- Retrospective costing of programs shown to be effective as available; and
- Gaps and recommendations regarding what is needed to comprehensively address the most significant barriers for all groups most affected by these barriers.

At the conclusion of the in-country work, there was a follow-up meeting to present and discuss a preliminary synthesis of the data collected and to garner reactions and inputs from stakeholders and community members.

A follow-up visit was conducted in September 2017 to share preliminary findings with in-country stakeholders and gain input with regard to which activities should be prioritized moving forward.

C. **Data analysis**. The detailed notes from the in-country data collection were synthesized and analyzed, together with the Desk Review findings, to establish a baseline understanding of the barriers that key and vulnerable populations face in accessing and using HIV services in Ghana and the strengths and gaps of existing programming to address these barriers. Building on this analysis, a description of a comprehensive response was developed, with a specific focus on what programs should be scaled-up, and what programs should be added. Draft indicators for the monitoring and evaluation of the recommended comprehensive response were also developed.

D. **Report**. This report was compiled according to the Country Report Outline and is being submitted to the Global Fund Secretariat before being presented to Ghanaian stakeholders for further discussion.

IV. Baseline and Findings

HIV epidemic in Ghana

Ghana has a mixed HIV epidemic with a low-level prevalence of 2.0% among the general population and disproportionately higher prevalence among key and vulnerable populations (GSS, GHS and ICF International, 2015). As of 2016, an estimated 290,000 people were living with HIV (UNAIDS 2017). Current data show that 85% of all infections are among people aged 15 years or older, and that 65% of these infections (among people aged 15 years and older) are among women.[4] The most recent HIV sentinel data also show an increasing prevalence rate among pregnant women – 2.4% in 2016 compared to 1.6% in 2014; while this could be due to improved longevity and increased childbearing among women living with HIV who are on antiretrovirals, it may also be the result of a programmatic focus on specific regions, leading to low access to services in other regions (NACP HSS 2016). Analysis of district level data (soon to be available through USAID) might help better understand this.

In 2016, there were an estimated 20,000 new infections and 15,000 AIDS-related deaths, reflecting the continued expansion of the epidemic. (UNAIDS 2017). A breakdown of new infections by population is shown in the table below:

Population	New infections (2016)
Children (0-14)	3,000
Adolescent girls 10-19	1,900
Adolescent boys 10-19	<500
Young women (15-24)	4,500
Young men (15-24)	1,500
Female adults (15+)	11,000
Male adults (15+)	6,800
Women 50+	<1,000
Men 50+	<1,000

Source: UNAIDS

Troublingly, the number of annual new infections has increased from 17,000 in 2010 (UNAIDS 2017). While this is true for all ages, an increase in new infections among young women (aged 15-24) is particularly evident over this time period as shown in the graph below:

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[4] http://www.unaids.org/en/regionscountries/countries/ghana/

New HIV infections among young people (15-24) - by sex
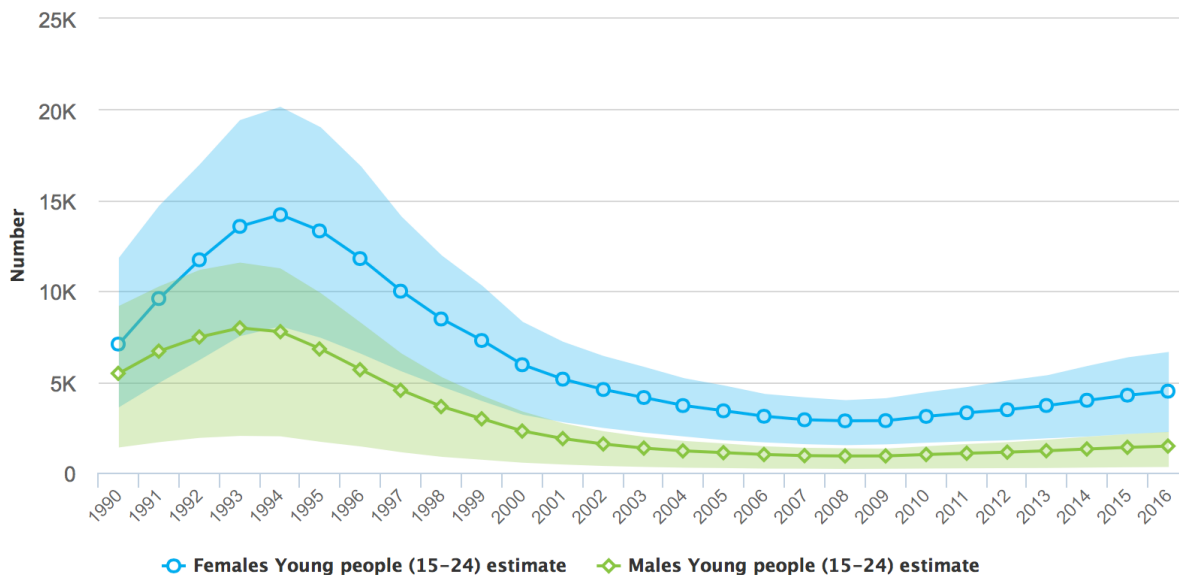
Source: UNAIDS Estimates 2017

In terms of the 90-90-90 benchmarks, it is estimated that only 45% of people in Ghana who are living with HIV know their status, and that only 37% of adults and 15% of children who are living with HIV are on antiretroviral treatment (UNAIDS, 2017; GAC NSP, 2016). Moreover, there are significant gender-related imbalances underlying these statistics: the HIV testing (ever tested) rate among women (49%) is twice that of men (22%), largely because of high antenatal coverage, and, as a result, 73% of adults who are on ART are women (CCM Dec 2016 funding request).

There has been regional variation in prevalence rates, but the most recent epidemiological data reflect notable shifts in regional prevalence. According to the 2014 Ghana Demographic and Health Survey, HIV prevalence was highest in the Eastern (2.8%), Western (2.7%), and Greater Accra (2.5%) regions, and lowest in the three northern regions (Northern, Upper East and Upper West) at less than 1%. However, the 2016 HIV Sentinel Survey found, for example, that the prevalence in Upper East and Upper West had increased to 1.7% and 2.5%, respectively. Moreover, programmatic data show that some districts and health facilities in "non-prioritized" regions (in terms of funding) have higher disease burden than some districts and health facilities in prioritized regions (CCM funding request, 2017). The mean HIV prevalence has also continued to be higher in urban areas (2.5%) than rural areas (1.9%) (HSS 2016).

Figure 1: HIV prevalence by region in Ghana, 2014
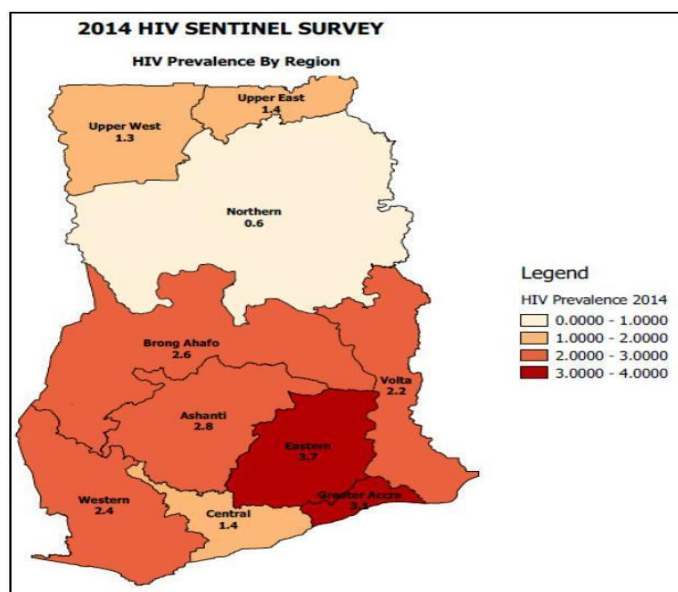
Source: HIV Sentinel Survey 2014

Figure 2: HIV prevalence by region in Ghana, 2016
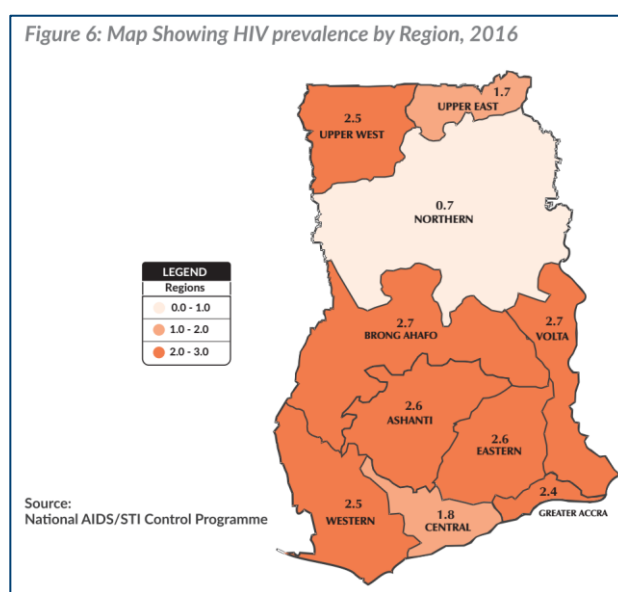
Source: HIV Sentinel Survey 2016

Across the country, the populations recognized to be most at risk of HIV infection, as indicated in the National Strategic Plan, include female sex workers, men who have sex with men, people who inject drugs, and the HIV-negative partners of people living with HIV (GAC NSP, 2016).

- Among *female sex workers*, HIV prevalence in 2015 was estimated at 7%, a decline from 11% in 2011. (GAC, 2016, citing HSS statistics) The estimated size of the female sex worker population is 63,475. (GAC, 2015) Sex work accounted for 18.4% of new HIV infections in 2014 (down from 27% in 2009), with female sex workers themselves accounting for 2.9% of new infections, their clients accounting for 5.0% and the female partners of their clients accounting for 10.5% of new infections. (GAC, 2017).

- Among *men who have sex with men*, national HIV prevalence in 2015 was estimated at 17.5%, with regional prevalence in Accra/Tema reaching 34%. (GAC, 2016, GAC, 2015a) The estimated size of the population of men who have sex with men is about 18,700. (GAC, 2015) Men who have sex with men account for 3.6% of new HIV infections while their female partners account for a further 1.8% of new infections. (GAC, 2017). The 2014 Modes of Transmission study found that people who inject drugs had the highest HIV incidence rate of all key populations at 3,543 per 100,000 population (constituting 3.6% of all new infections). However, no population size estimate is available. Furthermore, little is known about HIV among people who use drugs generally (but do not inject). Cocaine and marijuana are commonly used (Ghana has the highest rate of marijuana use in Africa, and the third highest in the world with 21.5% of citizens aged between 15 and 64 reportedly heavily

involved in the smoking of marijuana[5]) and are known to lead to disinhibition; as such, it would be useful to better understand HIV-related behaviours, care-seeking, and outcomes among this population.

- Among *prisoners*, HIV prevalence is estimated at 2.3%. (UNAIDS, 2017). As a result of programming described below, ART coverage for prisoners is currently 100% (UNAIDS, 2017). There is very little epidemiological information available about HIV among male sex workers, transgender persons, people who use drugs through non-injecting methods or other key populations and vulnerable groups.

Although HIV prevalence among key populations is disproportionately high compared to the general population, according to the 2014 Modes of Transmission Study, 72.3% of new HIV infections occurred in the context of stable *heterosexual couples and casual heterosexual sex*.

The testing-to-treatment cascade for select populations (based on 2016 programmatic data) reveals striking differences in HIV testing coverage, HIV prevalence and uptake of ART.

Population	Tested for HIV (n,%)	HIV-positive (n,%)	Initiated on ART (n,%)
Pregnant women	702,381 (62%)	18,116 (2.6%)	9,680 (53%)
Female sex workers	20,623 (32%)	1,130 (5.5%)	396 (35%)
Men who have sex with men	6,372 (21%)	639 (10%)	185 (29%)
Patients with tuberculosis	12,275 (84%)	2,838 (23%)	1,207 (43%)

These data highlight the need to increase HIV testing coverage, particularly among female sex workers and men who have sex with men, and to increase ART initiation across all affected populations. Given that 15% of all new infections are among children 0-14 years old, it is also particularly crucial to increase ART coverage among pregnant women and to strengthen access to early infant diagnosis. The current Global Fund grant aims to increase ART initiation to 82% across all of these groups.

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[5] https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Ghana-is-3rd-consumer-of-marijuana-globally-Report-451744

Human rights barriers to access to, uptake and retention in HIV services

The major human rights barriers described in the literature were also prominent in discussions with key informants and focus groups:

- ***Stigma and discrimination against key and vulnerable populations***, including people living with HIV, is pervasive and includes continued stigma and discrimination in relation to HIV generally, specific stigma related to belonging to certain populations, and significant self-stigma.

- ***Criminalization of certain behaviors are persistent barriers to access for key populations***, particularly female sex workers, men who have sex with men, and people who use drugs. Some existing health policies may also inhibit people living with HIV and youth from utilizing services, such as policies that require a 'monitor' in order for people living with HIV to access ART meaning that they have to disclose to somebody, and age of consent policies with regard to access to services.

- ***Gender inequalities and power dynamics create vulnerabilities for women and adolescent girls***, particularly in the context of intimate relationships. Certain groups of women and girls, including 'Kayayei'[6], younger sex workers, and street children are particularly at risk of violence. Harmful gender norms also shape men's health-seeking behaviors, as well as violence that they may face for not adhering to norms.

- ***Poverty*** – including the inability to pay for health insurance, transportation to ART centers and laboratory tests for monitoring treatment – is a salient barrier for people living with HIV to access, enroll, and remain in services.

It is important to also state that many other barriers to services were identified – including stock-outs of confirmatory test kits which leave people with 'unconfirmed' results; limited ART centers which mean people living with HIV may have to travel on difficult roads and/or long distances for treatment and; medication shortages which mean that people are given low (or no) supplies of ART and thus have to go back frequently for refills. While these barriers do not fit squarely under any of the headings below, they all affect standards of availability, accessibility, acceptability, and quality of services, and thus the realization of the right to health.

Stigma and discrimination
HIV-related stigma and discrimination

As in the literature, participants in interviews and focus groups described stigma and discrimination against key and vulnerable populations, including people living with HIV as pervasive, with negative

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[6] Women and girls who migrate from rural areas to urban areas where they work as porters.

impacts on the uptake of HIV testing, prevention behaviors, disclosure and, as a result, access to social and legal supports (see also Jeffers et al., 2010, Anafi et al, 2013). Because of actual and feared stigmatization by the community as well as service providers, individuals may avoid (or fail to return to) services – particularly public services. A recent study in Ghana found that key populations and people living with HIV have a strong preference for NGO-organized services, precisely because they feel they are more likely to be protected from stigma and discrimination (NACP 2017) – this same preference was also articulated in focus groups.

There was strong consensus among participants in this research that there is continued stigma and discrimination in relation to HIV generally and that community perceptions – from those of families and acquaintances to those of small business owners and school administrators – comprise a major barrier to accessing and utilizing HIV-related services (KII15; KII14; KII17).

According to interviews and focus groups, the community-level stigma and discrimination related to HIV is grounded in limited understandings as well as misconceptions about HIV. Interviews and focus groups described inadequate, somewhat outdated, levels of knowledge about HIV among the general population, as well as among key populations, particularly about ART and the possibilities for managing an HIV diagnosis (FGD4; KII38). Although the availability of ART has transformed the implications of a positive HIV diagnosis, research participants explained that many of the old perceptions of HIV – which were formed earlier in the epidemic before there were viable treatment options – had stuck (FGD3). Indeed, the 2014 DHS study found that while overall 63 percent of women and 76 percent of men ages 15-49 said they had heard about ARVs, less than half of the women in Western, Volta, and Northern regions had heard about the drugs, and only 25 percent of the men in the Northern region had. (GSS, GHS and ICF International, 2015). As a result of limited understanding about the potential of ART and how HIV has become a treatable, chronic disease like numerous others, many in the communities continue to equate an HIV diagnosis with imminent death (KII40; KII21; FGD4; FGD6; FGD3; FGD5) and stigmatize those living with HIV and/or are thus fearful or reticent to test.

Many of the research participants also traced community stigma and discrimination to beliefs that a positive HIV diagnosis is a supernatural or spiritual manifestation and marker of an immoral lifestyle or behaviors (KII28) – the result of "bewitchment" or a curse (FGD4; FGD3, FGD7). As a result, some people with HIV would rather seek help from religious figures or traditional healers, rather than formal health services (FGD4; FGD3; FGD7; Laar et. al. 2013). Again, these findings resonate with the results of the 2014 DHS study, which found that only 35 percent of women and 52 percent of men agree that HIV cannot be transmitted by supernatural means.

Key and vulnerable populations-related stigma

Key and vulnerable populations – including men who have sex with men, people with disabilities, and street children, among others – experience higher burdens and more intense forms of stigma and discrimination, including social exclusion (GAC, 2014; KII28). For those who identify as key and/or vulnerable populations, in and of themselves highly stigmatized, the specter or diagnosis of HIV can represent a "double burden" (FGD6; FGD9). For example, as research participants described, there is still a high level of stigma and discrimination against homosexuality and homosexual behaviors generally, including against men who have sex with men (KII28; FGD6) – homosexuality is seen by some as something immoral, even "satanic" (FGD6). Although there has been some reduction in stigma against men who have sex with men, it is still comparatively high (FGD7). Men who have sex with men who are perceived to be more effeminate in their mannerisms are especially stigmatized – and may suffer increased risk of harassment and physical violence (KII41; FGD9). In addition to the general stigma related to their sexuality, HIV-positive men who have sex with men may experience even more psychosocial stressors, with implications for enrolling in and staying on treatment (FGD9). As one man who has sex with men explained: "Being an MSM is not easy, being an MSM with HIV is even more complicated." (FGD6).

Similarly, female sex workers are often seen by society as being engaged in immoral behavior, and, as a result, suffer high levels of stigma and discrimination (KII27; KII44). Moreover, those sex workers who are "roamers" – those who look for clients in bars, hotels, and on the streets – are not only exposed to the most dangerous and unpredictable situations, but are also more vulnerable to stigma and discrimination. (FGD8).

Although focus groups described changing their behaviors to avoid stigma – for example, female sex workers changing how they dress when they are not working (FGD5), or men who have sex with men dressing less effeminately during the day (FGD6) – there still persists significant judgment of both groups on the basis of appearance, with negative impacts on those affected.

Another highly stigmatized and particularly invisible key population are people who inject drugs – as one key informant described, "we are still in denial about [people who inject drugs] – people think they do not exist" (KII24). In tandem with this denial, there is limited public understanding about drug use and addiction generally, which in turn perpetuates much stigma and discrimination against people who inject drugs. As one woman who formerly injected drugs described, many still perceive drug use as a morality issue rather than a health one that can be treated and managed (KII46). Being HIV positive can worsen the stigma and discrimination. A psychiatrist who works at a rehabilitation program in Cape Coast shared how they only test a resident for HIV if they present with AIDS-related symptoms, otherwise they do not

routinely test for HIV (KII34). As he explains, people who inject drugs already face significant discrimination, if they are HIV positive, it is only worse.

People with disabilities also face significant stigma and discrimination in various dimensions of their lives - from having to deal with the prejudice and judgments of healthcare personnel to the physical and communication barriers related to accessing information and services (KII16; Tun et al., 2013).

Direct impacts of stigma on accessing services

Visibility of HIV services

Because of the continued stigma attached to HIV, key populations and others may fear using HIV-related health services because it will "brand" them as someone living with HIV (KII22; FGD3). Research participants described how many key populations and people living with HIV may fail to access, enroll, or remain in HIV-related services because of the fear of being seen by someone they know (KII6; FGD7; FGD2; FGD10) – even just attending health services for testing may lead to assumptions and gossiping (FGD4; FGD6). "As you frequent the facility, people will see you, start to ask questions – the more you are seen at the facility, the more they assume you have HIV" (FGD5; FGD4). Some may even prefer to access facilities outside their community where they are less likely to be seen by individuals they know (FGD4): one focus group participant in Takoradi was a resident in Accra but attended the Takoradi drop-in centre for all of his HIV and sexual health-related needs. As another focus group observed, the fear is so salient for some that it can take only one incident – one run-in with a familiar face from the community – for an individual to completely desist from services (FGD5). However, the distance (and costs) may mean that these people are more likely to be lost to follow-up (FGD4).

The fear of being seen utilizing services – and hence "branded" in the community – is a particularly acute problem where facilities offer distinct areas or hours for HIV-related services, particularly ART (FGD4; FGD5). One group described how ART centers are "condemned" and emphasized the need to rebrand and restructure ART centers such that they are integrated with other services (FGD2). Indeed, a recent NACP evaluation found that one of the reasons key populations give for not staying in care included branding of HIV services and facilities (NACP 2017). It is important to note, however, that this separation of services is not the situation everywhere – as a focus group participant in Sunyani who is living with HIV explained, "before there was separate facilities and this created high stigma, now they are integrated so people do not necessarily know you are there because of HIV" (FGD7). In addition, other focus groups highlighted the value of standalone services as 'safe spaces' where key populations can get together and share information (see below for more on this).

Health worker attitudes and actions

While the stigma of being seen at health services may be a major barrier to utilizing services – another significant barrier to access as well as uptake and retention is the stigma and discrimination experienced within services. A national study with people living with HIV who use health facilities found that approximately 25% had experienced discrimination in HIV services in the last 6 months (USAID et al., 2017). In a focus group discussion in Accra, one participant shared how a friend who had HIV had accidentally touched a nurse and she had panicked, saying "don't you touch me." (FGD2). Another participant described how health professionals sometimes wear face masks and gloves before attending someone they may perceive as being at risk for HIV. (FGD2). The same national study mentioned above found that fear of HIV transmission in the workplace is indeed high among all levels of health facility staff and that this fear manifests itself in self-reported adoption of stigmatizing behaviors such as using double gloves (USAID et al., 2017). Moreover, this fear and stigma is not limited to interactions with patients: health facility staff described significant hesitation in relation to working with colleagues who might have HIV as well as to seeking HIV testing or treatment for themselves (USAID et al., 2017).

In relation to key populations specifically, a recent study with health providers in Kumasi and Accra found notable levels of stigmatizing behavior: 37% of service providers reported always hearing their colleagues make derogatory remarks about key populations. (NACP 2017). Indeed, many research participants spoke of humiliating and degrading treatment by providers (e.g. KII26; KII14; FGD2) - often grounded in personal moral beliefs about key populations' lifestyles and behaviors. Focus groups shared stories of providers "preaching" to men who have sex with men and female sex workers, citing religion and the bible (FGD9; KII14). As one group of men who have sex men described, "some health workers think MSM are a menace and don't even want to touch them," "the health workers asked me why I became a fag and then gossiped among themselves. They can't separate their work from their feelings" (FGD9). The groups of female sex workers reported similarly judgmental and stigmatizing treatment: "the way we dress is a form of branding – we have to look attractive but when people (health providers) see you they think you are immoral, treat you like you do not belong" (FGD5). "If a FSW shows up saying they might have an STI, the first thing the provider asks is "what kind of work do you do? If you are a sex worker, of course you have an STI" (FGD3). As one key informant described, some health providers may even tell female sex workers or men who have sex with men, "you are immoral so you deserve testing positive to HIV" (KII27). One man who has sex with men shared that sometimes nurses refuse to provide him ARV drugs, especially if there is a shortage – in his view, they prefer to give the drugs to heterosexual patients. (FGD9).

These openly judgmental attitudes and treatment by health providers are major barriers, as they can dissuade individuals from testing and seeking out services (KII27). For example, female sex workers described how those living with HIV may refuse to go to the hospital without being accompanied by a case

manager for fear of mistreatment, or may only use hospitals as a last resort, preferring to self-medicate with traditional medicines or over-the-counter drugs, while others have died unnecessarily because they refused to seek out health services (FGD8; FGD10).   Similarly, a study on the HIV needs of persons with disabilities found that they may delay testing because they fear the "double" or additional stigma they may experience if they are HIV positive – as well as the prospect of services that are not adequate or accommodating in terms of their disabilities (Tun et al., 2013)

If and when key and vulnerable populations do attend services – particularly female sex workers and men who have sex with men, they may not wish to openly disclose their partners or sexual history (FGD3; FGD6) or risk behaviors, such as drug use. In the case of men who have sex with men, for example, individuals may not feel comfortable disclosing certain STI symptoms for fear of providers' reactions (FGD9). As one man who has sex with men explained, "MSM are hardly taking STI problems to general services - for example, anal warts, imagine showing that to an unfriendly nurse. She will not deal with the problem, she will just bring out a bible and start preaching without attending to the problem" (FGD2). Indeed, in a recent study with men who have sex with men, the majority were not willing to declare their sexual history to service providers; female sex workers also expressed similar hesitancy to share their sexual history (NACP 2017).

In addition to stigmatizing attitudes, research participants identified the problem of unauthorized testing and disclosure. A group of female sex workers and men who have sex with men shared: "KPs don't go in for a simple headache because then they test you without asking you - so it hinders them from accessing general services. At first, counseling and testing, now testing and counseling, and we are not comfortable with that" (FGD2). Indeed, the WHO has affirmed that informed consent is one of the key components that must be adhered to in HIV counseling and testing– as is confidentiality. Research participants, however, shared several stories of unauthorized disclosure by health care professionals, particularly to family members (KII26; KII21; FGD3). One such story involved a 16-year old girl who, upon hospitalization, was tested for HIV by a provider who suspected she might be HIV-positive, without counseling or consent; the provider then announced her positive diagnosis to her family (FGD3). Counseling should be a pre-requisite to HIV testing and provides an opportunity for providers to assess adolescents' ability to consent to HIV testing; without this, any testing and disclosure of the result is a violation of human rights.

The concerns and stories that research participants shared about stigma and discrimination in health facilities resonate with findings from other studies – for example, in a recent study with adults living with HIV in five regions across Ghana, approximately 30% felt that medical records were not kept confidential

and that health facility staff were allowed to test for HIV without a person's knowledge (USAID et al., 2017).

Limited number of health workers who are 'friendly' to people living with HIV and key and vulnerable populations

Research participants reported a limited number of providers whom people living with HIV and key and vulnerable populations trust – "who are very accommodating, who are friendly and sensitize others, and very responsive": "there are some KP-friendly nurses but not enough and not everyone knows about them" (FGD10; also KII38; FGD9; KII14; FGD2). Moreover, as some focus groups described, because these providers are fewer in number, they may be more susceptible to burn out due to overburdening – "you can see the load of work they carry, everyone waiting for one nurse, it's exhausting for them" (FGD2; FGD9). One program officer explained: "The "friendly" nurse is the person the clients know, if she is not there nobody else attends to you – as if you do not belong there. We have had cases where there is just one nurse who will attend people living with HIV, so even though they are attending to all diseases (e.g. diabetes and others) to try to reduce stigma, there are nurses who will refuse to treat HIV-positive clients and others will notice." (FGD4). Some key informants also noted that health professionals who are 'key population-friendly' may themselves experience stigma from their colleagues, who may pressure them to stop their activities or quit (inception meeting).

Because of the fear that they will not be able to access a friendly provider, some people living with HIV and key populations may choose to not access services (FGD9; KII41; FGD5). It takes just one negative experience with a provider for a person to decide to not continue care – and that one experience can have ripple effects. As one peer educator explained, "after (mistreatment), MSM…are deterred from services and as a result they don't trust our project anymore. They tell others (about mistreatment at services) and that news spreads like wildfire" (FGD2).

Similarly, for female sex workers, one study found that one of the main factors determining a sex worker's choice to seek health care, where, and under what circumstances, is tied to past interactions with specific providers and service locations (Amos et. al. 2013). The authors of the study observed: "[female sex workers] reiterated that positive interactions with specific health care workers guided [their] decision making around health care seeking. The value placed on previous interactions was tied in part to respectful treatment and lack of stigma against sex work. It was also examined specifically relating to concerns regarding confidentiality."

Interestingly, and in contrast to the observations gathered in the assessments other locations, focus groups in Sunyani reported a solid contingent of "friendly" providers: "At our ART center, we (key

populations and others) are all treated the same" (FGD4). "Nurses are good to us. If somebody is unfriendly, we can speak to the senior nurses – they address it." According to those focus groups, the barriers are getting *to* the services, not at the services themselves (FGD7).

Nonetheless, even those providers identified as friendly might still engage in stigmatizing behavior – as one nurse observed, providers may find it difficult to separate their personal and religious beliefs from their professional demeanor (KII18). "We (peer educators) have friendly nurses that we work with - we tell peers to go to those nurses. Some are friendly but after you walk out they start talking about you. Some are very good, but a particular one, last time I saw her she said "you are a nice guy, why are you doing this? (the "this" being gay)" (FGD6).

Some people living with HIV also noted generational differences in provider attitudes, linking them to the discontinuation of public education around HIV: "in 2006, the doctors were willing to care for you, to listen to you, but they are phasing out and being replaced by a younger generation that has no time for you - they do not pay attention, they are always busy on their phones" (FGD3).

Self-stigma

As identified in the literature, self-stigma or internalized stigma among people living with HIV and other key populations is also a major barrier to accessing care (KII27; KII32; KII18). Research participants spoke, for example, of how men who have sex with men internalize stigma against themselves, and how some in the community stigmatize others – "The MSM community is well-networked, which 'brings us together and divides us'… Friends/lovers fall out, spread false rumors and that can break people. Nobody keeps others' HIV status secret. (FGD9; see also KII41). Focus groups of men who have sex with men spoke of the weight of the negative cultural assumptions surrounding homosexuality, how it inhibits them from identifying as gay, how instead of medicine, some men who have sex with men may seek out spiritual treatment, and how all of this imposes a high toll in terms of depression and suicide (KII41; FGD9). Some men who have sex with men noted that self-stigma is even higher among older men – who because they have a certain social status, worry about being identified as a man who has sex with men, particularly one who is HIV positive (FGD6; KII18). As referenced above, men who have sex with men who are effeminate perhaps face the highest levels of internalized stigma: "Even other MSM don't want to be seen in public with them for fear of being suspected of being gay by association" (FGD9). Other vulnerable populations, including street children and people with disabilities, are also reported to experience self-stigma and stay away from services as a result. (KII10; KII29)

Punitive laws, policies, and practices including non-enforcement of protective laws

In October 2016, Parliament passed the Ghana AIDS Commission (GAC) Act (Act 938), which contains important provisions for promoting and protecting the rights of people living with HIV, as well as those suspected of having HIV. The GAC Act includes specific provisions on the rights to health, education,

employment/work insurance benefits, and privacy and confidentiality. It also stipulates penalties for individuals who discriminate against or violate the rights of someone living with HIV, such as making unauthorized disclosures concerning someone's HIV status, denying or excluding them from employment or education on the basis of their status, or denying them sexual and reproductive health rights and the right to a family.

Key informants emphasized the significance of the Act, particularly the penalty provisions but noted that the legislation itself was only a start, and, while there had been some dissemination efforts, there is still a need for broad-reaching advocacy to build awareness and ensure implementation (KII10; FGD7; KII32). The next step is for GAC to present a legislative instrument for implementing the law to the Parliament for approval. The Legal and Ethics Sub-Committee of the Governing Board should be officially inaugurated in late 2017 to draft the executive instrument for the Executive Chair to review and send to Parliament. GAC hopes the draft instrument will be completed by the end of March 2018, and it will then have to be disseminated to stakeholders at all levels. However, a very limited budget is currently available to support the dissemination of the GAC Act and accompanying instrument throughout the country, which is critical to their implementation.

In addition to the challenges involved in fully implementing the GAC Act, there is an array of punitive laws, policies, and practices that both collectively and individually continue to constitute potential barriers to access to, uptake of, and retention in HIV services for a variety of populations.

Criminal laws

Certain key and vulnerable populations face particularly strong barriers to access due to criminal law: this is particularly the case for men who have sex with men, female sex workers, and people who use drugs. However, there is a lack of agreement among key informants and others about the extent to which these laws are enforced or the extent to which they even represent barriers. Most notably, in the case of men who have sex with men, while 'unnatural carnal knowledge' is criminalized in the penal code and is widely read to apply to same-sex sexual relations, some key informants during the desk review reported that there have been no convictions under the provision, suggesting it is not implemented. In contrast, the law related to sex work is more straightforward – there are provisions in the criminal law that explicitly prohibit prostitution as well as soliciting in public.

During the in-country work, some research participants again emphasized that the actual legal barriers for key populations to access services are minimal and that a public health approach has always provided some space for supporting key populations (KII10; KII32). Some say to therefore "let sleeping dogs lie" when it comes to the criminal laws (KII14; KII15; FDG8).

However, other research participants felt strongly that, until associated behaviors are decriminalized, there will continue to be stigma (FGD2) and abuses against key populations (KII15; KII14) – because the existence and even passive acceptance of the law facilitates and reinforces a culture that condones certain treatment and marginalization of key populations. During the same period of this assessment, for example, the Speaker of Parliament, Aaron Mike Oguaye, spoke publicly about what he perceives as the need to resist external pressures to accept the "right to do homosexuality" and bestiality.[7] In citing the recent incident, one key informant explained: "People will tell you that the law is vague but when policymakers make certain statements it pushes people especially young people into the underground" (KII25).

When considering if and to what extent the existing criminal laws may pose barriers for key populations, it is necessary to look to implementation practices among the law's gatekeepers e.g. the police and the judiciary. As a superintendent of the Ghana Police Service affirmed, "police are the bridge between the general public and the law" - they are major players, wielding the choice to enforce, or not, laws that are inimical to key populations' lifestyles and behaviors (KII9). He explained that while legal reform is likely not a viable option in the short term, given the political climate, there are ways to "work around" the laws (KII9). However, these work-arounds require that police, for example, have an adequate understanding and appreciation for rights - as discussed in the next section, although there have been significant sensitization efforts and progress with police, these efforts have not yet reached sufficient scale. The law 'on the streets' is still an extremely harsh one for too many key population members (FGD9).

Throughout discussions with research participants, one of the most salient examples of how the legal environment creates harms and barriers for key populations involves police harassment and violence against female sex workers. As focus groups described, because sex work is criminalized, there are police who treat female sex workers as deviants rather than protect them – arresting them or wielding the threat of arrest on the basis of their appearance (clothes, tattoos) or their possession of condoms or lubricant (FGD8; FGD10; FGD2). Female sex workers across locations described a spectrum of harassment and violence at the hands of police and shared numerous stories of police demanding money from them, forcing them to have sex to avoid (often arbitrary) arrest, threatening to take photos of them, and verbal harassment, among other abuses (FGD10; KII14; FGD2; FGD5). However, as one interview participant noted, it can be hard to bring a case against the police for harassment or abuse because they tend to close ranks around one another (KII36).

- Female sex workers: experience high levels of violence from clients, non-paying partners, and others – yet they cannot rely on police for protection (KII6). Because they are treated as marginal, female sex workers often will not go to the police to help their 'sisters' – or for anything at all - for

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fear that they too will be arrested (FGD8). As expressed by one group of female sex workers, they believe that, if sex work were legalized, it would increase respect towards them – and ensure protection from institutions such as the police. The belief is that if their work were normalized, people would not be able to take advantage of them in the same way (FGD10).

- <u>Men who have sex with men</u>, the criminalization of homosexual relations contributes to their marginalization and vulnerability – as research participants described, the criminal law means men who have sex with men stay hidden and this shapes how they find sexual partners, whether they have access to information and condoms, and whether they seek out services or disclose to health care professionals, as well as whether services can, in turn, find and access them (KII25; KII43; FGD2). In combination with pervasive social stigma, focus groups described how they believe that criminalization contributes to police mistreatment toward men who have sex with men (FGD6) which means that men who have sex with men may not seek police assistance when they need protection. As one focus group described, "when you seek help, they ask you questions, treat you badly, put on your statement that you are MSM - will say you got it coming" (FGD2). "The fact that you are queer spoils your case… You can't (file a) report because everything will turn back to you." (FGD9)

Nearly all of the research participants identified blackmail as a significant problem for men who have sex with men, perpetuated by those outside as well as those within the community (KII25; KII28; KII9; FGD9; KII18; FGD2). As part of blackmail, for example, individuals may take compromising photos and threaten to disclose individuals' sexuality publicly (KII25; FGD6). However, due to fear of disclosure and police mistreatment, men who have sex with men may not report these threats (FGD2). Research participants explained that men who have sex with men fear reporting these or other legal situations because they do not expect the cases will be resolved, yet they will have been forced to disclose their sexuality (KII25; KII15; KII38; FGD2). Sometimes police will demand money to help them (or subsequently blackmail them) or verbally abuse them. (FGD9)

- <u>People who use drugs</u>, criminalization and fear of the police is a salient part of their lives and keeps them hidden. (KII24; KII39). The recent Mental Health Act creates some space for harm-reduction activities but people working in the field believe it remains overly restrictive; furthermore, there appears to be little interest among high-level authorities to actually implement these protective provisions. A new Narcotics bill, promoted by civil society, is due to be reviewed by Parliament by the end of 2017. The original architect of the bill began this work when he was the head of NACOB. However, he subsequently left NACOB, so he has continued to work on this from a civil society position; various stakeholders, including within the government, remain supportive of this effort. The bill includes specific reference to harm reduction and adopting a less

prohibitionist approach e.g. allowing for rehabilitation instead of incarceration for minor offences, and decriminalizing marijuana use. However, political success is not guaranteed as drug use continues to be viewed through a moral/religious lens, making it difficult for politicians to support these harm-reduction measures without alienating many of their constituents so many of which continue to favour a prohibitionist approach. (KII47) One key informant described the illegality of drug use as a smokescreen for not ensuring adequate policies and services for people who use drugs – as he pointed out, although female sex workers and men who have sex with men are engaged in illegal activities, there are numerous robust interventions for them – yet there have been no "work arounds" for people who use drugs, because they are still relatively a highly invisible and voiceless group (KII24).

Although the police featured most significantly in discussions about how the law impacts key and vulnerable populations, they were not the only actors identified as important gatekeepers to the enforcement (or non-enforcement) of criminal laws – key informants also emphasized the role of the judiciary as well as customary law and traditional structures (Inception Meeting; KII10).

Health policies

It is not just criminal law that can be a barrier to services – research participants identified examples of health policies that may prevent or inhibit key and vulnerable populations from accessing services.
People living with HIV, some health facilities may require individuals to bring a "monitor" before they can start treatment – someone to help ensure adherence (Inception Meeting; KII44; Exit Meeting; FGD2). However, if the individual has not disclosed or does not plan to disclose their serostatus to anyone, this policy can be a barrier to enrolling in treatment (Inception Meeting; FGD10; Exit Meeting; FGD2). Similarly, for youth who may not want to disclose their sexual activity or serostatus to their parents/ guardians, the law which requires that people must be 18 to access health services without parental consent can be a barrier to accessing services as it makes it difficult for youth to independently and privately test for HIV or STIs (KII10; KII17). There is an exception if the adolescent is considered a "mature minor" - thus, in practice, again, implementation of the law appears to vary according to the discretion and attitudes of gatekeepers, in this case health providers (WHO, 2013). Whereas some if not most facilities may indeed only provide services to minors with parental authorization, some research participants stated that some providers will provide services (including HIV testing) without parental authorization – although they may not record doing so (KII10; KII20; FGD2). The 2017 Adolescent Health Service Policy and Strategy actively encourages the provision of adolescent-friendly health services but it is not yet clear the extent to which this is being implemented.

There was general agreement among key informants that adolescents and youth should have access to services earlier than the law allows, particularly given the fact that the age of legal consent for sex is 16

and that about 10% of women, for example, have their first sexual intercourse by age 15 (DHS, 2014). Existing policies also create barriers to accessing HIV prevention information and methods – for example, sex education is given in schools but condoms cannot be promoted (KII10) and peer education programs may have to limit their outreach to youth above the legal age for consent, which means that younger key and vulnerable populations may not have adequate access to information and services (FGD2).

Finally, while the Ghana Patient Charter addresses the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age, and type of illness or disability, it does not provide protection on the basis of sexual orientation. Similarly, the Code of Ethics for the Ghana Health Service prohibits discrimination on the basis of various grounds, but, again, not sexual orientation.

Gender inequality and gender-based violence

Women and girls

As research participants explained, women living with HIV experience heightened discrimination because of gender norms regarding acceptable sexual behaviors for women and perceived implications of an HIV-positive diagnosis - whereas social norms condone men having multiple sexual partners, women are expected to be monogamous - and so when a woman gets HIV, the perception is that she is immoral and she may even be tagged as a sex worker (FGD7; FGD5). There is much reported discrimination and violence against women living with HIV, particularly in marital contexts (Exit Meeting) where a woman who tests positive may be blamed for having brought the infection into the marriage (especially if the husband does not know his status) and even abandoned, although where the roles are reversed, the woman often stays with her husband (KII21; FGD7). If a married woman is indeed abandoned, she might become financially vulnerable (FGD7). This vulnerability in the context of marriages and relationships is a growing issue due to the expansion of provider-initiated HIV testing and counselling in antenatal care, which is greatly increasing the numbers of women testing for HIV and finding out that they are living with HIV, but without a similar increase in male testing. A woman who tests positive may be reluctant to disclose her HIV status to her husband or partner for fear of being abandoned – her non-disclosure in turns creates a barrier to ART retention and access to other health and social supports. Additionally, one key informant observed that socio-cultural norms that impose domestic and caregiving responsibilities on women may also serve as a barrier to women managing the time to get to clinics for treatment (KII32). Moreover, because many ART clinics do not provide appointments, patients may have to sit and wait for several hours – thus further creating barriers for women's access to the life-saving treatment.

Women who are sex workers face inequality in power dynamics and violence in various ambits of their lives (FGD8). In addition to abuse at the hands of clients and police (as described above), they may also suffer abuse at the hands of their non-paying partners (FGD8; KII19). Female sex workers explained how,

although they may be able to negotiate condom use with paying partners, they do not necessarily wield the same power to negotiate condoms with non-paying partners (KII14; FGD5). There is also often an expectation that the women hand over a portion of their earnings to the non-paying partners – in the words of one sex worker, "if we resist, they beat us". As a focus group described, this is a norm with these partners - "they are our "husbands", they protect us and provide us some security. If we report them to the police, we lose that security. So, you have to keep your cool with them" (FGD5). As one key informant explained, sometimes these partners are also a barrier to care because they are HIV positive but do not want the women to find out their status (because they will then find out they too are HIV-positive) (KII19). One key informant emphasized that there are many younger female sex workers – particularly adolescent girls engaged in transactional sex – who are not being reached by existing programs, likely because said programs are designed for adults and are thus not effective for reaching adolescents (KII6; Exit Meeting). Moreover, because providers are legally required to report these adolescents as victims of sexual exploitation, they may choose to not seek out services (Inception Meeting). However, their sexual and reproductive health needs are significant – they have high levels of STIs and many of them have children (who in turn need support and services). (KII6; FGD8). As research participants emphasized, there are adolescent girls around ages 16, 17 (FGD8), but also girls as young as 12, engaging in transactional sex – however, these young women and girls may not be "welcomed" by other female sex workers because they may be perceived as "competition" (FGD10). Young and adolescent girls engaged in transactional sex also suffer disproportionate levels of abuse because they are inexperienced and may be physically weaker (FGD8).

Another group of vulnerable young women and girls are Kayayeis – women and girls who migrate from rural areas to urban areas where they work as porters. Because this type of work is in the informal sector, many of these women and girls fall between the cracks and are hard for programs to find (KII33). They have no housing arrangements so they often sleep on the street, where they are particularly vulnerable, especially to sexual violence. Many of them may also be forced to provide sex for protection (KII4).
Generally, children and adolescents who live on the streets, especially girls, suffer high levels of rape and other forms of sexual, physical, and psychological violence. For those who do seek assistance, there are many barriers to services – for example, doctors may charge 200-600GHS (USD45-136) to complete a police report, police may demand an informal payment to transport the girl to a shelter, and post-exposure prophylaxis is not free (KII29). To be sure, however, the underlying problem is a lack of protection for these children and an inadequate social safety net.

Men and boys

Rigid and harmful gender norms also create barriers for men's utilization of services. For men generally, norms that espouse masculinity as strength and self-resiliency may inhibit them from seeking preventive

care or treatment - indeed, men have proportionally lower uptake of HIV services and AIDS-related mortality is higher among men (KII2).

While rigid norms around masculinity may serve as a barrier to men seeking out care, men who deviate from those norms also experience significant barriers to care, particularly in the form of stigma, discrimination, and even violence. As one peer educator explained, "Our society stereotypes men as having to be strong, masculine. Once you deviate from that you are attacked - derided as "effeminate". If you are effeminate, people assume you are gay, and then they assume you are HIV positive. It's not just at healthcare facilities, but the workplace, all around town (FGD2; also FGD6). "The feminine guys are at risk of stigma, even if they are not gay. We advocate behavior change - we tell them to dress, walk, and speak like men. If they change, the stigma will go down. Sometimes they can't change how they walk, but they can change how they dress" (FGD6).

As for male sex workers, one key informant noted that that they may access services set up for men who have sex with men (e.g. drop-in centers), but that there is generally very little discussion about them or specific efforts to reach them (partly because they are difficult to identify) (KII38). Another key informant emphasized the importance of considering the broader issue of transactional sex among men who have sex with men, which he believes is happening to a significant degree and implicates a need to also address economic vulnerability (KII42).

Transgender persons

Transgender persons are also still largely invisible from discussions as well as interventions and policies. In some focus groups, there were debates about whether there was even a sizeable number of transgender persons (FGD6; FGD2). One peer educator responded: "Transgender? Not in Ghana. There was one, but he was a foreigner, not part of our community" (FGD6). There was only one group that was identified as working with transgender persons: Solace Initiative, an Accra-based LGBT advocacy group that is focused on protecting rights, though paralegal trainings and a hotline, among other activities. (KII26). As one key informant who advocates specifically for sexual/gender rights reflected, there is still a tremendous amount of need for awareness and education among health workers, police, and others, as well as direct outreach to transgender persons themselves (KII26). He explained: "Currently female-to-male transgender persons are not attended to at all in services; male-to-female transgender persons are particularly discriminated against (especially in health facilities where they are told: 'walk like a man', 'get up, you're a man' etc.) and expected to use MSM programs." (KII26)

Poverty and economic and social inequality

One common thread through nearly all of the discussions with research participants was the importance of economic empowerment for people living with HIV and other key and vulnerable populations given how poverty both underlined and exacerbated situations of vulnerability but also served as a barrier to accessing, enrolling, and remaining in services (e.g. KII26; KII6; KII14). Many of the participants spoke about the particular impacts poverty has on access to treatment services – as a recent study found, lack of funds was one of the key barriers to people living with HIV consistently taking their medicines (NACP 2017). Nearly all participants commented on the costs involved in accessing and adhering to ART, most notably the laboratory tests required to monitor viral load, liver function, etc. (KII19; KII25; KII44; KII6; FGD6; FGD3; FGD7; KII14; KII32), but also supplementary needs, such as vitamins and pain killers. Depending on the quality of roads and/or distance to the nearest health facility providing ART, transportation costs can also be a barrier. (KII25; KII44; FGD6; KII22; FGD7; KII17). As discussed above, transportation costs can be even higher for those who may choose to access facilities further away from their home in order to minimize the risk of being seen by someone in their community. (FGD3). Similarly, younger men who have sex with men and others who may not have sufficient incomes may experience more challenges to access facilities and pay for tests than older men who generally have more means to get to facilities, eat more healthily, etc. (FGD6). As a group of people living with HIV explained, some people with HIV may threaten suicide because they think their diagnosis will only add to their economic burden (FGD7). The financial implications of a positive diagnosis may also dissuade some from seeking testing in the first place – as one study with female sex workers found: "[female sex workers] also raised concerns regarding the cost of services and the fear of learning negative health diagnoses as reasons [they] avoid seeking services relating to health concerns," (Laar et. al. 2013).

For female sex workers and 'Kayayei', their high mobility and unusual working hours may further limit access to services: moreover, time away from work to access services would constitute lost income, which many cannot afford – particularly when services are structured such that clients may have to spend hours waiting (KII10).

Several research participants also spoke of the consequences of not being able to afford to maintain an adequate diet while on treatment – and how because of the side effects (stomach pains) of not having enough food to take alongside ART, individuals may default (FGD10; KII39; FGD4; KII38). Other research has also found that lack of food can be a barrier to staying consistently in HIV care as HIV positive clients skipped their medications when they did not have food (Weiser et al, 2010).

Although the National Health Insurance Scheme is designed to provide equitable access and financial coverage for basic health care services, there are still financial barriers to access, such as the cost of the mandatory insurance card (approximately USD7). Existing programs cover the cost of the cards for people living with HIV, female sex workers, and men who have sex with men (although this does require these

individuals to identify themselves to programs, which in and of itself can be a barrier). Waivers are supposedly in place for pregnant women, indigent persons, street children and people with disabilities, but they may not always be implemented, and in practice authorities still often demand payment (KII29). Street children are a particularly vulnerable, yet under-served, group. The most recent census (2010) found 65,000 street children in Greater Accra, a population which is estimated to double every 5 years (Ghana Department of Social Welfare et al., 2011). Most of these children are out of school and most struggle to access health services. As discussed above, street children are also extremely vulnerable to sexual violence (KII29). However, there is very limited programming engaging them and there is currently no data available on HIV prevalence.

Programs to address barriers to HIV services

Overview

In Ghana, there has been a series of large, multi-sectoral and integrated programs that have focused on creating enabling environments for key populations to access HIV-related services and care, the most recent of which have had the United Nations "90-90-90" targets as their guiding framework both for designing activities and monitoring impact. Many of the components of these large programs also address human rights barriers to services (although they may not explicitly incorporate human rights language and frameworks)– while these individual components will be addressed within the context of the seven different program areas, it is worth first locating them within the broader, comprehensive programmatic contexts in which they have been implemented.

The USAID SHARPER project (Strengthening HIV/ AIDS Response Partnership and Evidenced-based Results), implemented from 2010-2014, with FHI 360 as the principal, was focused on information, prevention, and referrals for reducing HIV transmission among key populations, including female sex workers, people living with HIV, and partners – with a focus on reducing stigma and discrimination permeating many activities/components (KII39). Primary activities, carried out in 166 high prevalence districts, included peer-to-peer outreach and communication, drop-in-centers, a cellphone-based counseling and health messaging system, and daily SMS reminders for antiretroviral therapy adherence.[8] One component that was widely referenced in conversations with research participants as important resources/allies (and overlaps several of the seven programmatic areas) was the initiation of a network of M-Friends (prominent community members e.g. lawyers, doctors, police, traditional leaders) and M-Watchers (key population and people living with HIV peer educators/paralegals) who were trained on stigma and discrimination and how they affect and drive HIV infection, the effects of human rights abuses and negative gender norms and gender-based violence on key populations and people living with HIV, and how to identify cases of violence and help individuals access health and legal services. The network focuses on creating an enabling environment for the protection of rights of people living with HIV and key populations (KII10; FGD10). Between February and June 2013, more than 98 cases of gender-based violence and other human rights abuses against people living with HIV and key populations were handled by M-Friends and M-Watchers (GAC, 2015). As of March 2015, there were 365 M-Friends and M-Watchers distributed across all ten regions of Ghana (GAC, 2015).

SHARPER was followed briefly by Linkages (again, FHI 360 as principal), which has now ended, – and then the current USAID Strengthening the Care Continuum (JSI principal), which commenced in March 2016 – both projects focused on a range of activities to reduce HIV transmission among key populations,

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promote routine HIV testing and counseling, and actively enroll those with HIV into care and support interventions that enable them to remain in care. As part of improving access to and use of HIV services, the Care Continuum also works toward reducing stigma and discrimination in health settings for key populations and people living with HIV. Principal activities include: peer education (KII41; KII45; KII44; KII6); training health workers, police, lawyers, and the judiciary to address key populations' needs in non-stigmatizing ways; M-health stigma and discrimination program using bi-directional text messaging and; the continuation of the M-Friends and M-Watchers network. The Care Continuum constitutes an excellent opportunity for integrating additional elements (as recommended below) to strengthen the human rights components of this large-scale project.

Alongside this, the Global Fund has disbursed $294 million for HIV-related work in Ghana, some of which has supported activities that fall within the seven human rights program areas.

The first part of this section presents several of the overarching recommendations that emerged from the interviews and focus group discussions. Following this broader perspective on programming, the section then delves into each of the specific seven program areas, providing a brief synthesis of existing efforts and limitations as well as recommendations for scale-up moving forward.

Cross-cutting recommendations for re-orienting existing programs

Current funding and programmatic efforts in Ghana are largely oriented around the UNAIDS 90-90-90 targets, with a strong focus on intensifying interventions to reach, test, and link key populations, particularly female sex workers and men who have sex with men, into care and treatment services. However, as was evident throughout the assessment, there are significant continued barriers and gaps to the achievement of 90-90-90 that are not being adequately addressed by current programming, many of which implicate human rights concerns as well as populations other than men who have sex with men and female sex workers. The recommendations below map out various opportunities to enhance existing efforts and ensure a comprehensive and rights-based response to Ghana's HIV epidemic – these recommendations should thus be viewed as complementary to and in synergy with existing programming. While human rights matching funds can only be used to fund the human rights-related components of this work, it might be possible to use this to leverage additional funds to also expand HIV prevention and treatment services along these lines.

Eleven overarching recommendations that cut across the UNAIDS program areas underpin the recommendations for the comprehensive package of services to address human rights barriers to accessing HIV services in Ghana. Prior to laying out specific recommendations according to the UNAIDS human rights program areas, each of these eleven recommendations is explained below.

Increase programs that seek to address socio-cultural dynamics that create barriers to accessing HIV services

The first overarching recommendation is to broaden the reach of programming to be more responsive to the socio-cultural dynamics as well as the epidemiology that continue to underlie vulnerabilities and barriers. As discussed earlier, stigma and discrimination, both in the community generally as well as within services, are among the most salient barriers that people living with HIV face to accessing care and treatment, thus efforts narrowly focused on key populations are inherently limited. While there have been some training efforts with health care workers to reduce stigma in the context of services, there has been little programming targeting more general populations, as reflected, for example, in the documented decreases in HIV-related knowledge. Working at broader community and societal levels is not only necessary to address barriers facing key populations – it is also crucial given the fact that over 70% of new infections are occurring in the context of stable heterosexual couples and casual heterosexual sex. Certainly, there are many factors driving this statistic, but at the core are harmful gender norms and power dynamics that perpetuate women's vulnerabilities and burdens in intimate relationships. Programs and services must thus more systematically incorporate gender and relational perspectives into their activities – seeking, for example, to ensure adequate access and supports for women, but also striving to more systematically engage their male partners.

Target hard-to-reach populations of female sex workers and men who have sex with men

With programs for men who have sex with men and female sex workers now quite well-established in some areas, there is nascent recognition of the heterogeneity of these populations. Key informants spoke about certain groups of men who have sex with men and female sex workers who have been harder to reach. Among men who have sex with men, older men (the "big men") were described as being more discreet and more difficult to engage through the predominant intervention models of peer education and drop-in centers, for example (KII25; KII41). Some pointed to the potential of social media to reach them. Similarly, among female sex workers, the older, higher-income women (FGD10) and the younger ones (KII6) were described as harder to reach. This nuanced understanding of the needs of different populations can be used to inform appropriate programs and services moving forward to ensure that "no-one is left behind".

Outreach for other under-served key and vulnerable groups including street children, transgender people and male sex workers

The current focus of major funding has been on certain key populations (primarily female sex workers and men who have sex with men) – however, a narrow focus on certain identified key populations is

neither sufficient for ensuring their access to services, nor is it adequate for responding to the main contours of the epidemic. Populations that would benefit from additional programming include people who use drugs, HIV-negative partners of people living with HIV, prisoners, people with disabilities, transgender people, women (including girls and young women), and vulnerable children, including orphans. Although outreach and programming for these groups would likely imply higher costs and possibly lower quantitative "yields" in terms of testing and diagnosis (at least initially, as knowledge, partnerships, and trust are developed), supporting these underserved groups in programming is fundamental to ensuring a comprehensive rights-based response. At a minimum, efforts should be made to reach these groups with appropriate information both about HIV and about where they can access services.

Street children, estimated at 65,000 in just the Greater Accra region are an extremely vulnerable, yet under-served, group. Existing NGO services might provide an entry point for activities to understand and address human rights barriers to accessing HIV services for this population.

Very little is known about transgender populations, including the population size, primary health concerns and other rights-related needs, resulting in very few programs or services for these groups. With increasing, albeit still small scale, civil society-run activities for transgender populations, an infrastructure is being developed for reaching this population that has traditionally remained very hidden. This might constitute an opportunity for the provision of additional programs and services.

Male sex workers remain a fairly invisible population. While male sex work is acknowledged, informants reported a lack of programming targeting male sex workers. They reportedly use the same drop-in-centres as other men who have sex with men but there is a stigma attached to this work, which it would be useful to better understand.

Mainstream attention to people with disabilities

The National Disability Law provides a useful framework for ensuring sufficient appropriate and accessible facilities, programs, and materials for people with disabilities. This law requires that all structures, including health facilities, be disability-friendly but, to date, little has been done, there is no enforcement, and physical access to facilities is still a real problem. Too often, people with disabilities are an "afterthought" (KII16). Attention to people with disabilities should be mainstreamed across programs and policies - for example, when a new information campaign is launched, there should automatically be materials to accommodate blind and deaf audiences. Likewise, when a new clinic or facility is built, it should be made to be accessible. In order to inform programmatic efforts moving forward, additional data may be required to provide a comprehensive understanding of the specific vulnerabilities and barriers that people with disabilities face in accessing services, including those with mental disabilities.

Ensure a supportive environment for people who use drugs

The Mental Health Act of 2012 and, if passed, the Narcotics Bill that is due to be debated in Parliament constitute a useful legal framework for increasing access to services for people who use drugs. If the latter Bill is passed, opportunities will emerge for the provision of additional services within the public sector for people who use drugs. Currently, most existing rehabilitation services are private and fee-based, making them inaccessible for many (KII46; KII35; KII7). Most are affiliated with government psychiatric hospitals (of which there are only three in the country), enhancing the stigma associated with their use (KII34; KII46). Many people who use drugs are taken to 'prayer camps' by their families where they are left with 'healers'; reports of human rights abuses (such as physical violence, being chained up, and being denied food) in the camps are rife but, despite some investigation by CHRAJ, there appears to be reluctance to regulate them. (KII47) A few NGOs provide rehabilitation services but these are under-funded and cannot provide the full range of services that people who use drugs could benefit from, including building the 'recovery capital' that helps people reintegrate into society following rehabilitation. (KII31) Other support services such as Alcoholics Anonymous meetings are also not widely available, known about or easily accessible (KII46). Additional data may be required to understand the nature and configuration of services to best meet the needs of people who use drugs (KII24; KII35) but an increasingly supportive legal and policy environment might allow the provision of more appropriate and accessible services for this population.

Although there is often a tendency to focus on research before intervention, key informants emphasized, that as part of building trust, it is important to ensure that the provision of quality services for people who use drugs precede research efforts to begin to build trust with the community (KII30; KII7). Such services should be made available to all people who use drugs, not just those who inject. One key informant suggested that if services were available to support drug users, use of the controversial 'prayer camps' might decrease. (KII47) Another key informant, a doctor in a rehabilitation service, urged specifically for early intervention for health care workers, who, according to a recent study, are disproportionately represented among people who inject drugs, at least in terms of those who are accessing rehabilitation services (KII35). Training service providers to run appropriate rehabilitation centres will be key, including how to adopt a human rights based approach to HIV within the population in the rehabilitation centres that is based on respect for privacy and confidentiality. In one rehabilitation centre, for example, where 3 of the 47 residents were living with HIV, staff reported not knowing how to balance respect for confidentiality of their HIV status with what staff saw as the other residents' 'right' to know about it; staff wanted to act appropriately but did not know what this meant in this context.

Expand KP programs geographically beyond current 'priority districts'

Recently, the major funding entities (Global Fund and USAID/PEPFAR) have prioritized certain regions in Ghana with higher disease burden for HIV interventions; in large part this prioritization has been guided by calculations based on yield of testing of HIV-positive diagnoses. Several key informants spoke critically of the concept of priority districts[9] given the magnitude of need and recent surveillance data indicating rapidly increasing prevalence in other parts of the country. (KII19; KII15; KII38; KII22). Key informants described how the concentration of funding in "priority" districts had left other districts without organizations, information, or services for people living with HIV as well as other key and vulnerable populations, which in itself might have been the reason for increasing prevalence (KII39; KII15; KII22).

Moreover, one example was provided of premature relocation of interventions and structures as a program sought to be responsive to shifting epidemiology. Particularly concerning are the implications for established community relationships and those who came to rely on services and may now be left without options, or with less palatable options (KII39). While there is a general understanding of the need for services and interventions to be responsive to need, there are also concerns about the sudden withdrawal from districts as the epidemiology shifts and HIV testing yield rates drop as has already occurred in at least one district.

The CCM's most recent funding request acknowledged that the "restriction of (KP) programming support to 15 districts by PEPFAR and the GF means that there is a large programmatic gap by 2020". Moving forward with a comprehensive, rights-based approach may require some flexibility in the geography of programming – specifically, how to balance being responsive without inadvertently creating inequities or disruptions in access. The use of data to prioritize geographical areas where KP interventions are most required is critical but must be balanced with a need for continuity and access to a minimum package of services for the whole population. Alongside this, blanket interventions such as media campaigns and training of duty-bearers (both of which are discussed in greater depth below) should not be geographically restricted. Opportunities exist to institute the provision of information and education across all settings to ensure minimal levels of prevention behaviors and non-stigmatizing attitudes which might be a first step towards stimulating demand for additional programs and services.

Scale-up and institutionalize training efforts

Recent and existing training efforts have helped to establish a valued network of friendly health care workers, police, lawyers, and others. This provides a strong foundation to more systematically provide

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[9] Currently, HIV-related funding for key populations from the Global Fund and PEPFAR is channeled to 15 'priority districts' including Jaman North, Techiman, Sunyani, Kumasi, Mekwai, Obusai, Prestea-Huni Valley, Shama, Sekondi-Takoradi, Ga west, New Juaben, Tema, and Accra.

rights-based training at a larger scale and across different sectors – to move beyond individuals to systems. Several key informants and key population members recommended that stigma and other human rights content affecting people living with HIV and key and vulnerable populations should be incorporated into professional education curricula, including law schools, medical schools, and nursing schools (KII13; KII41; FGD2). It will be important to ensure that such efforts reach the full range of actors and decision-makers within institutions (e.g. doctors and administrators as well as nurses, lawyers and judges, technocrats and regulators) (KII13; KII41; KII14).

Public education about HIV, stigma, and human rights

Many research participants noted that public education efforts had ceased over the years and pointed to the need to revitalize campaigns to reduce stigma (FGD3; FGD7; KII32) – with emphasis on education that is consistent, national in coverage, and encourages dialogue (KII32). In addition to increasing the general population's understanding about HIV and sensitivity to people living with HIV and key and vulnerable populations, participants also emphasized the need to provide training on human rights more broadly (Exit Meeting; KII25; KII11; KII30).

The importance of representation by Models of Hope and others living with HIV on television (and other media vehicles) was highlighted as a way to sensitize the public about the experiences and rights of people living with HIV (stakeholder meeting). Similarly, members of key populations highlighted that messages could be included to educate the public that mistreating people is a crime in and of itself irrespective of the victim's sexuality, HIV status, profession etc. (FGD2; FGD6) Education to increase tolerance, understanding, and respect for everyone's human rights was recommended. This included support for a mass media campaign to raise awareness on HIV; this had been done previously and was considered useful but it was discontinued. Lessons could be learnt from this previous effort to inform a new campaign.

Alongside these public education efforts, training journalists and other media professionals to be more sensitive and responsible in how they report on HIV, the experiences of key and vulnerable populations, and other related issues could help ensure more appropriate coverage (stakeholder meeting).

Engage religious and traditional leaders

There have been notable efforts to engage religious traditional leaders on issues affecting key and vulnerable populations and to more systematically enlist their support to curb human rights violations and opportunities exist to expand these efforts, as well as to involve these leaders in promoting general awareness about HIV (KII27; KII10; KII44; KII15). It is important for community leaders to understand the issues affecting people living with HIV and key and vulnerable populations so that they can step up as

needed. Some leaders can be particularly important allies for certain groups. For example, "queen mothers" can play a powerful role in protecting and vindicating the rights of female sex workers – as stakeholders explained, because "people listen to them," queen mothers can intervene in cases of abuse, provide protection, and engage community organizations (stakeholder meeting).

Livelihood options for Models of Hope, Peer Educators

Models of Hope and peer educators constitute important interventions where content on human rights, stigma and discrimination reduction, legal literacy and access to legal services can be strengthened. Yet, one resounding concern was the lack of sustainable livelihood options and/or adequate financial support for case managers, Models of Hope, and peer educators – these are all individuals who dedicate substantial amounts of time and energy to programs, who are in fact the fundamental link in efforts to reach and support people living with HIV and key and vulnerable populations, but who do not themselves have sufficient financial security (KII44; KII45; KII22, KII37). This concern was particularly salient for the Models of Hope, who are in effect filling a crucial vacuum in health and support services for people living with HIV, but lack the formal recognition and livelihood security of colleague nurses (KII22). Indeed, economic issues are a core consideration for the sustainability of all of these important efforts and could be an integral design feature of efforts such as these that are designed to reduce HIV-related stigma and discrimination, and promote access to services. In strengthening and expanding these programs, it may be useful to seek partners who could explore financing options to promote their sustainability.

Increase attention to the quality of programs and services alongside the number of people reached

Relevant both to the recommendations below and existing programs/services, there is a need to move beyond numbers of people reached and to increase attention to the quality of services and activities. It is important to consider, for example, who the people are behind the numbers, their experiences in gaining access to programs/services, their satisfaction with such programs/services, and how other rights considerations (e.g. access to food, education, and employment) shape their uptake and adherence. Periodic assessment of these issues by CSOs, including those run by/for key and vulnerable populations, will be important for understanding the lived experiences of these populations and how they might be impacting uptake of services.

Below, the programmatic response, broken down by the seven key program areas by which to remove human rights-related barriers to services, is further explored. Within each sub-section, a table provides an overview of current programmatic efforts as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Stigma and discrimination reduction

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Stigma and discrimination reduction for people living with HIV and other key and vulnerable populations						
Program	*Description*					*Limitations*
Peer education	Provides information, HIV risk reduction counseling, and referrals; provides information on HIV-related human rights; discusses stigma and discrimination (including internal stigma); promote access to services; distributes condoms, lubricants. The degree to which stigma and discrimination reduction is central to the peer education program varies by implementer.					Insufficient attention to psychological/ emotional concerns; Inconsistent quality; Not effective for certain sub-populations e.g. reaching youth Lack of clarity of the centrality of human rights, stigma and discrimination in the different programs
Implementer	*Population targeted*	*# trained*	*Clients reached*	*Region(s)*	*Timeframe*	*Recommended scale-up*
LRF	PLHIV[1]	3	99	Western (STMA, Jomoro district)	2017	There is ongoing discussion about the scope of the role of peer educators, with some implementers preferring to train people to the standard of case managers, which are remunerated positions and thus more sustainable than volunteer peer educators. This seems preferable where feasible and should be prioritized in the regions where service provision is also being prioritized. Although regional coverage is currently quite good, the number of peer educators within each region remains insufficient, especially for PLHIV and people with disabilities. There are no peer educators for people who use drugs or transgender populations.
MICDAK	PLHIV[1]	3	151	Ashanti	Nov 2016 – Sept 2017	
ADRA	FSW	155	11,705	Greater Accra, Eastern, Volta and Ashanti regions	Jan-Dec. 2016	
HFFG	FSW	55	4,913	Brong Ahafo, Greater Accra	May 2015 – April 2016	
LRF	FSW	12	1795	Western (STMA, Jomoro District)	Oct 2016 – Sept 2017	
WAPCAS	FSW	70	3,483	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta, Upper East, Upper West, Northern	2016-2017 (USAID RISK)	
WAPCAS	FSW	20	3,313	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta, Upper East, Upper West, Northern	2016-2017 (Care Continuum)	
WAPCAS	FSW living with HIV[1]	8	294	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta,	2016-2017 (USAID RISK)	

						GFD's work demonstrates that the peer education model works for reaching people with disabilities. This work should be revitalized and scaled up to reach all (priority) regions.
				Upper East, Upper West, Northern		
WAPCAS	FSW living with HIV[1]	3	100	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta, Upper East, Upper West, Northern	2016-2017 (Care Continuum)	
MIHOSO	MSM/FSW	320	500	Brong Ahafo (10 districts); Ashanti (2 districts); Upper West, East and Northern (1 district each).	2010-2016	There is good coverage of prisons, which should be maintained; PPAG has the capacity to implement these activities.
WAPCAS	FSW/MSM	400	21,6343	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta, Upper East, Upper West, Northern	2016-2017 (GF)	It will be important to look at the peer education training curricula that are in use by the different implementing partners to see how these might be standardized to cover a minimum set of information on HIV, human rights, stigma and discrimination.
WAPCAS	FSW/MSM living with HIV[1]	42	470	Western, Brong Ahafo, Greater Accra, Ashanti, Eastern, Central, Volta, Upper East, Upper West, Northern	2016-2017 (GF)	
Pro-Link	FSW, MSM and NPPs[2]	91	3,900+	Ashanti; Greater Accra; Volta	GF/NFM (2015-2017; 60 PEs); USAID/JSI (2016- date; 31 PEs)	
CEPEHRG	MSM	55	9,480	Greater Accra, Eastern, Volta	2015-2017	
MICDAK	MSM	48	6053	Ashanti	Nov 2016 – Sept 2017	
MLPF	MSM	45	4495	Western, Central	2016	
Ghana Federation of the Disabled	People with disabilities	57	6,081 (stigma reduction activities) 3,518 (youth HIV prevention) 4,389 (adult HIV prevention)	Ashanti, Eastern Region	Jan – June 2013	
PPAG	Prisoners	645	15,491 (peer education)	National	Jan-June 2017	
PPAG	Prisoners		6,500 (interactive theatre performances)	National	Jan-June 2017	

Program	Description					Limitations
Models of Hope	PLHIV serve as community counselors and liaisons for newly diagnosed. Help PLHIV navigate health system. Provide information on HIV-related human rights; discuss stigma and discrimination (including internal stigma).					No provisions for livelihood or financial compensation
Implementer	*Population targeted*	*# trained*	*Clients reached*	*Region(s)*	*Timeframe*	*Recommended scale-up*
LRF	PLHIV	10	1800	Western	2015-2016	This seems like a promising model. It has been estimated that 203 Models of Hope would be needed for adequate coverage. There could be useful synergies with the M-watchers program. In addition, Models of Hope could be used as part of the media campaign to address stigma and discrimination recommended below. Ideally this intervention should reach beyond the current five regions to also include other high prevalence regions such as Volta and Upper West.
NAP +	PLHIV	90	11,601/ month	Ashanti, Eastern, Greater Accra, Western	Dec 2015-Dec 2017	
HFFG	FSW	5		Brong Ahafo	May 2015 – April 2016	
Program	*Description*					*Limitations*
Community outreach/mobilization	Includes education on 'know your rights' as well as HIV stigma reduction					Lack of clarity of the centrality of human rights and HIV stigma reduction in the different interventions. Training curricula were not available for the programs described.
Implementer	*Population targeted*	*# trained*	*Clients reached*	*Region(s)*	*Timeframe*	*Recommended scale-up*
ADRA	FSW	60	3,112	Greater Accra, Eastern, Volta and Ashanti regions	Jan-Dec 2016	Community outreach can be an expensive activity if it includes service delivery but critical for certain hard to reach populations who are not accessing HIV services such as prisoners, 'kayayei' and people with disabilities. Coverage in prisons is good and should be maintained. SWAA's work with kayayei is important and could be
LRF	FSW	4	1711	Western (STMA, Jomoro District)	Oct 2016 – Sept 2017	
Pro-Link	FSW and NPPs	17 facilitators (5 HWs and 12 project staff)	Step down training for 5000+ clients	Greater Accra, Ashanti, Volta	2015-2017	
SWAA	Kayayei	150	1500 Kayayei directly and	Ashanti Region-Kajatia and Resscross markets,	2015-2017 (all activities done in	

Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
			700+ indirectly from three markets, 300+ received health services	Brong Ahafo-Techiman market and Greater Accra Region-Agbobloshie, and Darkuman markets.	the months Nov – Jan)	replicated in additional markets. Reaching street children is also important, but this should be done as part of a broader package of services for them and will thus require multi-sectoral collaboration. Outreach for people with disabilities could be incorporated into GFD's peer education program described above. In addition, community mobilization for transgender population is needed so as to create spaces where peer education and outreach can eventually be carried out. The Solace Initiative is well-placed to expand their existing work in this area. As above, it will be useful to consider existing training curricula and create a common 'minimum standards' curriculum on human rights and stigma reduction for all to use.
Solace Initiative	LGBT communities			Support groups in Accra and around the country.		
PPAG	Prisoners	15,410		National	Jan-June 2017	

Program	Description					Limitations
'Heart to Heart' ambassadors	Community engagement on stigma, discrimination and human rights; media appearances					

Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
WAPCAS	PLHIV				No longer active.	The Models of Hope program could be a replacement for this role and linked to a media campaign to address stigma and discrimination (see below). But lessons for the media campaign can likely be learnt from the Heart-to-Heart work.

Program	Description					Recommended scale-up
National media campaign (S&D)	Currently non-existent					National media campaign (likely radio but perhaps also with some television content).

		This should be carried out alongside training on HIV, human rights, stigma and discrimination for journalists to ensure appropriate reporting on relevant issues.
Community leaders	Work with community and religious leaders to promote HIV-related human rights	All priority districts at a minimum. Could be incorporated into multi-stakeholder community meetings (see below).
Stigma index	Most recent data are from 2014	National stigma index to provide updated data as well as a baseline for the activities being proposed.

Current programs

There are several programs that have incorporated efforts to address stigma and discrimination – many of which have used peer networks of key populations and/or people living with HIV to provide education and resources to protect against stigma (including self-stigma), referrals to friendly health and legal services, and to ensure people living with HIV are appropriately linked to and enrolled in HIV care and treatment. As described below, many of these programs have been broader in their programmatic aims and/or part of larger initiatives (e.g. Continuum of Care), but in conversations with research participants, it was evident that, while insufficient on their own, these particular programs all play a crucial role in reducing self-stigma as well as facilitating access to non-stigmatizing services.

Peer education

One of the most common interventions with key populations in Ghana has been peer education and outreach. Given the marginalization of key populations, the peer education model is a compelling and effective way to reach them. Key populations themselves are at the center of this intervention model – peer educators are simultaneously described as confidantes, helpers, and advocates (FGD8). They generally carry out one-on-one and group activities, offer an array of useful information, and promote access to services (FGD8, FGD10). Peer education has been primarily used with female sex workers and men who have sex with men, but has also been used with other key and vulnerable groups, including people living with HIV (e.g. FGD2; FGD6), people with disabilities (KII16) and, as discussed below, a large, national effort with people in prisons (KII20).

A 2013 evaluation (of primarily programs for men who have sex with men and female sex workers) found that the most common services provided by peer education programs are distribution of condoms and lubricant, HIV risk reduction counseling, and referrals for STI and HIV testing (Laar, 2013). There are inherent limitations to the type and level of services that peers can provide, thus, these programs need to be carried out in hand with effective referral systems (KII19). In terms of linking individuals to services, peer educators encourage individuals to go where they feel comfortable – be it public facilities or drop-in centers (see below) (KII44; KII45). In the case of public facilities, peer educators may help to point peers to known friendly facilities or staff (KII41) and may even accompany them to services. As described in Section 6.7 on HIV-related legal literacy below, peer educators may also provide information about legal rights and help link individuals with services. For female sex workers, peer education may also include information on sexual and gender based violence, and family planning (KII44; KII6). Some peer education programs also organize "Love & Trust" parties – fun, social gatherings to which partners may also be invited and where individuals (and often couples) can receive education and sensitization about STI/HIV, condom use, and related relationship and communication concerns (KII14; FGD4; FGD5). As one group of female sex workers explained, incorporating a social element "makes it fun. Makes us feel like we belong... They provide information, testing. And you can come as yourself, dressed your way". (FGD4).

Some peer education programs have been trying to increase their range of follow-up activities. Two implementing organizations explained that at the onset of their peer education activities, they were focused only on getting peers to services, but now they are expanding their reach beyond prevention and testing, and also doing follow-up of those who test positive as well as expanding from a focus on only referrals to a focus on referral <u>and</u> engagement (KII45; KII25). As part of the 'engagement', peer educators ask the client about the treatment they received at the facility, then follow-up and discuss client feedback with the health care workers. This seems like an important activity to build on and support.

One key informant noted that there had been an increasing shift in programming from peer educators to case managers, who are generally more highly trained. As he explained, this programmatic shift reflects a recognition that to achieve 90-90-90, it is no longer sufficient just to provide HIV prevention information and voluntary counselling and testing (the primary range of peer educator activities); linkage to care and support for adherence are also critical. (KII30) Case managers have the crucial role of ensuring that people living with HIV are enrolled and remain in the care system. They are generally people living with HIV who are of, or close to and trusted by, key populations – they refer and monitor key population members living with HIV by fixing appointments, helping to dispel anxiety, and providing active follow-up, ensuring that they are appropriately received at health centers, sometimes even accompanying them to services (KII41, KII14, KII37). One organization has also created 'cluster support groups' to promote retention – this essentially entails identifying and training someone with HIV on how to support others and then referring new diagnoses to that person so they can all meet as a group (KII39).

Peer education has also been used to promote large-scale testing in prisons. With support from the Global Fund, Planned Parenthood Association of Ghana has engaged more than 600 peer educators across all 43 prisons in Ghana. As of December 2016, they had reached over 27,000 inmates with HIV testing services in a span of two years – the Program Manager credits the use of peer education with changing perceptions of testing and securing good turnouts. It is important that the peer education program be maintained to ensure continued access to HIV prevention information among the prison population as well as counseling and testing services.

Limitations/Challenges of current interventions
Some key informants were critical of current interventions, including peer education, for being too focused on the provision of HIV information and the distribution of condoms, with insufficient attention to, for example, building self-esteem and addressing psychological and emotional issues, which can be particularly magnified with a positive HIV diagnosis (KII25; KII38) and building confidence to vindicate rights (KII26). All of the latter could be addressed by case managers who could be trained to take on these tasks and remunerated for their work.

The current overlaps between peer education and case management services could usefully be addressed. If both roles are to be maintained (especially if in the same locations), the training required for each and the range of services to be provided by each should be clarified. Furthermore, how these two groups should interact to ensure complementarity and appropriate referral should be outlined.

There is also a need for additional, continuous training to ensure quality contacts with clients. According to a recent evaluation, "KPs have mixed perceptions about the PEs. Some see peer educators as people who have interest in their welfare. They identify with them and trust them. Whereas the FSW in Accra and Kumasi trust and confide in their Peer Educators, a few MSM in Kumasi and Accra have some reservations about Peer Educators. They do not trust them and see them as not capable of keeping their issues in confidence." (NACP 2017). These concerns however are not inherent to peer education programming, but rather the lack of adequate training, capacity-building and supervision. As other researchers and peer educators themselves have identified, additional training is essential to ensure quality programming (Laar et. al., 2013; draft KP assessment). During the fieldwork for this report, no similar reports of distrust were received, but the concerns raised in the NACP evaluation warrant further investigation to ensure the quality of the programs in question.

Finally, interventions primarily based on peer education may have limited reach – for example, because of stigma, some men who sex with men (e.g. older and more affluent men) may prefer to stay underground or anonymous and may not be reached through traditional face-to-face peer meetings. Some programs have thus been using social media to reach these sub-populations (e.g. KII41). There is also apparently an age limitation surrounding much of the current peer education programming – as participants in one focus group explained, peer educators primarily reach only 18 to 25 year-olds. This is because it may be too risky for educators to engage those younger than 18, given the content and topics of peer education and, for those older than 25, it may be too challenging to reach them because they are often working professionals so they may hide more and only attend private parties/events in people's homes (stakeholder meeting).

"Models of Hope"
"Models of Hope", peer case managers who are all living with HIV themselves, serve as community counselors and liaisons to newly diagnosed patients – they are people who can serve as positive role models and provide psychosocial support to peers, helping people newly diagnosed with HIV move beyond denial, fear, and shame. "We emphasize access to treatment – using ourselves as examples" (KII22). Given their personal experiences, 'Models' are uniquely able to sensitize new clients, make them feel comfortable, and help them cope in a positive manner with their own status, thereby helping to reduce self-stigma. (FGD7). They play a fundamental role in keeping individuals connected to services, assisting doctors and nurses, following up with patients who do not show up for treatment (default tracing), doing community outreach,

counseling about nutrition, STIs, and other topics, as well as providing home-based care (KII22). Perhaps their most valuable role is to serve as models for people newly diagnosed with HIV to overcome their self-stigma and accept their diagnosis as a critical first step towards sustained engagement in care.

According to a recent study, there are currently 149 Models of Hope, supported by the Global Fund (Lee et al., 2017). Although no formal evaluation has been carried out, HP+ estimates that each Model of Hope typically tracks 70 defaulters per month of whom 20% are newly diagnosed. On average, one full-time Model of Hope will be able to trace and return to care 10% of newly diagnosed clients who have been lost to follow-up over the course of the month (1.4 clients/Model of Hope/month). In addition, they can typically track and return to care 60% of existing clients who have defaulted (33.6 clients/Model of Hope/month).

Limitations/Challenges

Currently, the Models of Hope work as volunteers, some generally receiving only a monthly stipend of 100-200 GHS per month (about USD23-45 per month) to cover transportation costs and other expenditure (e.g. communication) (90-90-90 costing study, HP+). However, this amount of money does not necessarily cover all of their expenses, particularly for home visits. Some Models of Hope do not receive any allowance. Moreover, despite the substantial time commitment involved with the project, there are currently no provisions for livelihood or financial compensation. As observed in the PEPFAR 2016 Country Operational Plan: "although the Models of Hope is an effective service delivery model for linking people who live with HIV into care, it is unsustainable unless there is an established incentive structure for peer educators and formal recognition by the GHS."

Community outreach/Community mobilization

Because the Drop in Centers might have stigma attached to them and because they are often key population-specific and thus not necessarily accessible to other key and vulnerable populations, many NGOs may also engage in mobile outreach (KII22; KII18; KII37)– taking HIV information and testing services to harder-to-reach groups such as out-of-school youth (KII39) and linking individuals who test positive into care and treatment. Outreach may be integrated with other health screening activities, to reduce the stigma and discrimination attached to stand-alone HIV outreach and testing activities.

The Society for Women and AIDS in Africa (SWAA)'s mobile health services for Kayayei is one recent example of mobile outreach that was effective in providing services to a harder-to-reach group. SWAA organized free sexual and reproductive health services in three market areas in the Greater Accra, Ashanti, and Brong Ahafo regions to provide information and testing to Kayayei – who, because of living and working situations, generally do not seek medical care from public health facilities and usually engage in self-medication. The outreach and services reached the Kayayei at their "door step" and provided pregnancy testing, counselling and provision of contraceptives, HIV testing and STI prevention. About

1,500 Kayayei from the three markets benefitted from the outreach, and over 300 received various health services including 76 who tested for HIV (with none reactive).

As part of their programming for transgender people, Solace Initiative seeks to identify and mobilize transgender communities across the country. They establish support groups around the country and organize gatherings or 'pink meetings' in Accra, which can involve up to 50 people (KII26). These local support groups and larger, more national, gatherings provide essential peer support, thereby helping to reduce isolation and self-stigma. Although no services are provided at these meetings, they constitute the initial steps to ensuring safe spaces for the transgender community to mobilize and come together. In due course, these gatherings could provide a useful entry point for education on HIV prevention and information and skills-building related to vindicating human rights.

Limitations/Challenges

Possibly because of the logistics and costs entailed (particularly in comparison to fixed services), mobile outreach is still not widely utilized. A 2013 evaluation with female sex workers and men who have sex with men found that less than 40% had utilized mobile outreach services in the previous 12 months (compared to 96% who had been in contact with a peer educator and 62% who had been to a Drop-in-center). While peer education and Drop-in-Centers may achieve good coverage generally, mobile outreach can be more effective for reaching sub-populations, including Kayayei, transgender populations, and people who use drugs. Nascent support groups might be a useful entry point for future outreach work more specifically focused on human rights education and advocacy.

Drop-in centers (DiCs)

As service provision falls outside the scope of this program area, DiCs were not included in the table above. However, nearly all research participants referenced DiCs as an important resource for key populations, particularly female sex workers and men who have sex with men. DiCs are fixed spaces that provide information, psychosocial support, and free services, including HIV testing and counseling, and STI treatment (KII44; KII38; KII41; KII37). However, because of policy restrictions, DiCs do not provide ART (FGD2; KII37). People who are diagnosed with HIV are referred to hospitals for confirmation and care (KII44). Some DiCs provide additional services e.g. partner counseling and testing, family planning services (KII6).

Moreover, many research participants strongly emphasized that DiCs offer something beyond provision of healthcare – they serve as a "safe space" for key populations, thus responding to both human rights and psychosocial needs (KII30; KII38; KII41; FGD5; stakeholder meeting). DiCs are noted as being "stigma-free" spaces (FGD10; KII44; KII30; FGD5; KII37): "Before the drop-in centers, MSM would not seek out

health services because of fear of mistreatment. But now they have the drop-in centers, MSM feel comfortable going for testing and counseling" in those places where these services exist (KII14).

There were some mixed opinions about the best long-term strategies for DiCs. Some key informants thought that although DiCs could make useful contributions in the short-term (including task-sharing the delivery of ART), programming should be moving toward long-term integration of key populations into mainstream services. Others emphasized the importance of maintaining distinct spaces for key populations and expanding available services, at least until the quality of care within mainstream services is improved and non-discrimination can be guaranteed for people living with HIV as well as key and vulnerable populations.

In considering DiCs as a potential location for ART provision, lessons might usefully be learnt from the various factors that appear to contribute to the high quality of care at the ART center in Sunyani including: dynamic leadership, regular training of all staff (technical and administrative), community leadership involvement in HIV in all programs, committed staff and stakeholders (staff have a motivation package as appreciation for commitment), strong involvement of trained M-Friends and M-Watchers, regular participatory monitoring (with stakeholders), and regular input from key populations on improving the services at the facilities.

Limitations/Challenges

Because they cater primarily to stigmatize populations, DiCs may be targeted for discrimination (KII14). Several research participants explained how organizers have to be sensitive about location and visibility, ensuring that DiCs are not conspicuous in terms of who they serve (KII14; KII37). One key informant shared his opinion how this "tagging" and stigma is more of a concern in interventions for men who have sex with men than for female sex workers because "it is difficult to "see" someone and identify that they are [a female sex worker] (and) there is also not the same aggression toward [female sex workers] as there is toward [men who have sex with men]," (KII45). The key informant shared how, because of concerns about stigma, his organization was trying to minimize the use of DiCs in their interventions for men who have sex with men.

Currently, DiCs offer a limited range of basic services – essentially only screening, testing, and counseling. Many research participants spoke about how they wish DiCs would offer additional and more comprehensive services, including additional hours/days (FGD2) and particularly ART (FGD2; FGD5) – precisely because they believe it would be better than going to general facilities, where they may encounter stigma and discrimination (KII14). Given that some DiCs have reported low levels of utilization, expansion of services may help to bolster numbers – however, it will be important to generally review strategies for ensuring centers are bringing in sufficient numbers of clients.

Research participants also expressed concern about the current movement to close down DiCs, particularly those that are not meeting their yield targets in terms of numbers and percentages of key population clients who are testing HIV-positive. (KII30; KII25; KII39). As participants emphasized, reliance on quantitative indicators does not capture the full significance of these spaces and the fact that that they make it easier for key populations to access services with non-judgmental, discreet providers (FGD2; FGD5). These indicators also do not reflect the ways in which access to safe spaces and peers can also help to counteract feelings of self-stigma amongst individuals and provide a sense of community.

<u>Moving toward a comprehensive response</u>

As discussed earlier, community knowledge about and attitudes toward HIV and key and vulnerable populations, which manifest through stigma and discrimination, represent significant barriers to services for the general population and for key and vulnerable populations (e.g. reticence to test or seek treatment). Community public education and media campaigns to increase comprehensive knowledge about HIV as well as awareness about human rights could help correct continued myths and misperceptions about HIV, and increase knowledge about ART, as well as seek to build appreciation for human rights as they relate to the entire population including vulnerable and key populations. Such campaigns could also constitute an opportunity to raise awareness about the Patient Charter and the GAC Act, including the protections and responsibilities they confer. While the Government could take the lead on this work, given some of the current misperceptions about HIV and discriminatory beliefs about people living with HIV as well as key and vulnerable populations that are rooted in socio-cultural norms and beliefs, it would be essential to engage traditional and religious leaders (perhaps through local CSOs) in any such campaigns. Lessons can be learnt from the government's 'Heart-to-Heart' campaign that involved people living with HIV in a range of media activities and is the most recent large-scale campaign to address HIV-related stigma and discrimination. Capacity building of people working in the media on HIV, human rights and stigma and discrimination (including against key and vulnerable populations) will be essential to inform a national campaign as well as to promote responsible reporting on these topics.

There are several notable intervention models that focus on linking and retaining people living with HIV, including key populations, in services and which key informants describe as particularly effective. These programs provide strategic entry points for integrating additional activities on human rights, stigma and discrimination reduction, legal literacy and support and even peer paralegal support. These programs include the Models of Hope, case managers, and support groups. According to a recent costing exercise carried out by HP+, there would need to be 203 Models of Hope/Community Health Workers to track all newly diagnosed clients that are lost to follow-up along the clinical cascade (NAP+ currently supports approximately 90 Models of Hope in four regions). Scale-up should also seek to develop "a cohesive policy and structure to incorporate Models of Hope and other KPLHIV community workers into the national

program to enhance their authority and improve their performance," (PEPFAR COP). In addition to making adherence efforts more relevant and personalized and supporting achievement of the 90-90-90 targets, involving people living with HIV in such efforts can empower these individuals as well as contribute to stigma reduction by improving health care worker and community perceptions about the contributions of people living with HIV (see, for example, Pulerwitz et al., 2010). Critical to the success of any of these efforts is providing an adequate allowance to the people providing these services. Many of the Models of Hope are being trained as 'M-Watchers' and it will be important, as above, to give due attention to how these different programs (case manager, peer educators, M-Watchers and Models of Hope) fit together and complement one another. It will be important to monitor training curricula for such efforts to ensure a strong focus on human rights, stigma and discrimination reduction, and legal literacy and support. Furthermore, ensuring that they reach vulnerable populations in addition to key populations will be important.

Support groups can also be an effective way to both address internalized stigma (by reducing isolation, building self-esteem, etc.) and provide additional adherence counseling, but have been scaled back in recent programming (e.g. KII39; KII25; FGD7). A targeted approach to scaling up support groups with a view to reaching people most at risk of becoming lost to follow-up could be a relatively cost-effective way of providing useful support for linkage to and retention in HIV services. This could be done through DiCs, ART clinics or using peer education as an entry point. Targeting support group leaders with capacity building on human rights, stigma and discrimination reduction and legal literacy could help strengthen how these issues are covered through support group activities.

In order to better understand the climate around HIV-related stigma, it would be useful to implement the *Stigma Index*, which has not been carried out since 2014. This can also help understand changes in stigma over time, which will be useful given the range of interventions to tackle stigma and discrimination being implemented and planned.

Finally, as was repeatedly emphasized throughout interviews and discussions: DiCs can play a pivotal role in reducing experiences of stigma and discrimination. In addition to providing needed information and services related to HIV, human rights, and other issues, DiCs can offer social support and foster a sense of community among key populations. At the same time, from the perspective of structural sustainability, it is essential to also invest in mainstream health services – particularly adequate training for health care professionals. In the long-term, health services should generally be capable of providing services that are welcoming, responsive, non-stigmatizing and non-discriminatory. However, in the meanwhile, given the pervasiveness of stigma – systemic as well as internalized – DiCs are an essential tool for reducing experiences of stigma and discrimination associated with HIV services.

Training for health care workers on human rights and medical ethics related to HIV

The table below provides an overview of current programmatic efforts to train health care workers on human rights and medical ethics related to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon. In the text that follows the table.

Implementer	Description	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
ADRA	HW training including KP rights	HWs	27	2,694	Greater Accra, Eastern, Volta and Ashanti regions	Jan-Dec 2016	It would make sense to rationalize these trainings so that there is a single, standard curriculum that all implementers could use for training health workers at all levels (and others working in health facilities). It should cover stigma, discrimination, gender based violence and human rights relevant to people living with HIV, key populations, vulnerable populations, the GAC Act, the Patient Charter and any other relevant codes of conduct, including relevant medical ethics, as well as the forthcoming Narcotic bill if it is passed. Existing training curricula could be used as the basis. To comprehensively cover the 15 'priority' districts, at least 90 M-Friends (6/district) would be needed.
HRAC/ WAAF	Training on 'implementing access to healthcare for KPs and SGBV'	HWs	150		Western, Central, Eastern, Ashanti, Greater Accra	2012-2014	
HRAC/ WAAF	Value Clarification and Human Rights education (linked to above project)	HWs	360		Western, Central, Volta, Eastern, Ashanti and Greater Accra	2014-2017	
JSI	Key KP competency training (5-6 day training, largely S&D)	HWs	193 (in 117 health facilities)			2016-7	
Pro-Link	Community Capacity Enhancement to reduce stigma and promote access to treatment services using story telling approach	HWs (also project staff as listed in previous table)	5		Greater Accra, Ashanti, Volta	2015-7	
Multiple	M-friends[1]	HWs, police etc.	151		5 regions; 32 districts	2014-2017	
	Pre-service training: medical and nursing schools				None currently		Introducing all of the topics listed above into pre-service training for health professionals would be an efficient way of training the health workforce. High level meetings with the authorities responsible for these training curricula would be a useful starting point for trying to introduce this material so as to ensure that all new trainees have basic knowledge across this range of topics.

[1] It was not possible to obtain disaggregated data on which duty bearers received this training so this also includes professions other than health workers.

There have been various initiatives to reduce stigma and discrimination in health facilities by sensitizing and training health care workers to be key population-friendly - particularly in relation to female sex workers and men who have sex with men. Several of these trainings have incorporated or are now seeking to explicitly incorporate human rights perspectives and content (KII10; KII15; KII30; KII32; KII18). Often these trainings provide spaces for participants to address their personal perceptions and biases – for example, Pro-Link's Community Capacity Enhancement (CCE) intervention (originally pioneered by UNDP) uses storytelling and roleplaying to build empathy toward key populations (KII27; KII14).

As part of its collaborative efforts with the West African AIDS Foundation to protect and promote LGBT rights, the Human Rights Advocacy Centre (HRAC) has conducted human rights education workshops for 360 health care professionals in six regions (60 in each region). The workshop exercises entail values clarification exercises, 'Human Rights 101', and advocacy training on stigma and discrimination. JSI's 'KP Competency and Sensitization' training curriculum (although currently under revision) includes sessions on 'Identifying and understanding human rights issues as relates to most-at-risk populations and people living with HIV', 'Family laws and the protection of the rights of key populations and people living with HIV', 'Legal options and structure for dealing with violations against key populations and people living with HIV' and 'Practicing responding to rights violations'.

Another health worker training program is the above-mentioned M-Friends program[10]. M-Friends are health workers, other duty bearers and community leaders who are expected to serve as a resource and support group in facilitating redress for human rights abuses and gender-based violence within formal or informal structures/channels. They are appointed by the community to ensure their acceptability to their targeted clients. They undergo a three-day training to prepare them for this role, which comprises three modules:

1) 'HIV, key populations at risk, PLHIV, the concept of gender, Stigma and Discrimination, and Gender-Based Violence (GBV)',
2) 'Human rights of MARP and PLHIV and the Protection of these Rights' and
3) 'M-Friends and M-Watchers' Roles and Responsibilities and Processes/Protocols for Addressing Human Rights Abuses and GBV'.

This curriculum is also currently being revised. Existing M-Friends provide peer education, and JSI, FIDA (the International Federation of Women Lawyers), and HRAC are involved in trainings. One key informant estimated that each M-friend helps secure a favourable outcome (i.e. no inappropriate prosecution, release of

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[10] Note that there is a suggestion that the 'M-Friends' (and 'M-Watchers) program should be renamed. The original name stems from 'Most-at-risk-populations'; the proposal is that the name be changed to 'KP-Friends' (and 'KP-Watchers'). However, this seems limiting given that key populations are generally understood to only include female sex workers and men who have sex with men. 'Community-Friends' (and 'Community-Watchers') could be used to expand the stated scope to also encompass people living with HIV and vulnerable populations as well.

the community member, case being dropped, ability to refuse requests for sex from police officers etc.) in approximately 3 cases per month. (KII30)

Female sex workers and men who have sex with men reported great appreciation for the M-Friends but also highlighted their insufficient numbers. (KII39; FGD 9). One focus group discussion participant noted the fear and uncertainty that this can engender: "When you go to the public facility to test, there are trained-M-Friendly-nurses but one was not there one day that I went and the nurse on duty was not friendly. So, you become afraid – what if the friendly nurse is not on duty?" (FGD 7)

<u>Limitations/Challenges</u>

To date, training efforts for health care workers have been limited to certain regions and relatively small cohorts of staff. There is certainly a need for more systematic efforts – as one key informant described, many trainings and programs have focused on nurses (because they are generally considered the "frontlines" in services) and there is a need to increase training for doctors and others in the health system including laboratory technicians, receptionists, data clerks etc. (KII14).

<u>Moving toward a comprehensive response</u>

Key informants emphasized the potential reach of incorporating HIV-related human rights sensitization into pre-service training that is, existing curricula for professional schools e.g. medical, and nursing. They also stressed the importance of couching HIV sensitization in a broader focus on human rights, stigma, and discrimination, not just a focus on HIV or certain key populations. It is important to note that this content is distinct from medical ethics but equally important to include. There is also a general need to increase awareness about the Patient Charter and codes of conduct for health professionals, as well as human rights and complaint mechanisms. While there would certainly be initial costs related to securing buy-in for these institutional approaches, incorporating content into existing curricula, and building capacity to implement, the long-term costs would be relatively minimal and the broader human rights focus would have impacts in the context of HIV and beyond.

In addition, scaling up in-service training of health workers as well as other people working in health facilities (e.g. receptionists, data clerks) around these issues will be required. The M-Friends model might be useful to replicate for this purpose. JSI and HRAC are well situated to lead this work given their experience to date and organizational expertise.

As discussed above, there have been numerous training efforts with a spectrum of actors, one of the more prominent being M-Friends – what has been lacking is scale and sustainability. It is estimated that in order to 'comprehensively' cover the 15 priority districts, a minimum of six M-Friends per district would need to

be trained. In addition, at least six M-Watchers per district should be trained (see below); this can be done in synergy with the M-Friends training. USAID is currently providing some funding towards these activities but it is estimated that they will only cover 50% of this proposed coverage. Ideally, this would be scaled up 32 districts, which would involve training 192 M-Watchers, which would require greater funding.

Alongside this, the capacity of local NGOs should be developed through 'training of trainers' to enable them to train additional M-Friends as the need arises. There are currently at least ten local NGOs involved (including NAP+, WAPCAS, HFFG, HOFA, WAAF, WIYO, RAAF, LRF) who could benefit from this capacity building. This will help promote the sustainability of the program.

These institutionalized sensitizations and trainings are also an important vehicle for engaging stakeholders in the implementation of certain policy "work arounds"- such as, for example, provision of HIV testing services to youth under 16 as well as harm reduction services for people who use drugs.

Sensitization of law-makers and law enforcement agents

The table below provides an overview of current programmatic efforts on the sensitization of law-makers and law enforcement agents as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Implementer	Description	Population targeted	# trained	Region(s)	Timeframe	Recommended scale-up
Ghana Police Service	Pre-service training – curriculum on stigma and discrimination against key populations. In-service training – rights-based approaches to policing (based on OHCHR guide).	Police officers		National		A range of trainings exists, primarily targeting the police. It will be important to update training curricula to include the GAC Act, the potentially forthcoming Narcotic Bill and appropriate content on HIV, human rights, stigma and discrimination (including against key and vulnerable populations). Standardized messages should be provided to: - Pre-service police - In-service police - Law school students - In-service lawyers and judges - Pre-service prison officers - In-service prison officers - Parliamentarians (if possible) All of the organizations involved in ongoing training could usefully collaborate to help inform these training curricula and to carry out the trainings. While the pre-service police training appears to be institutionalized, the curriculum might still benefit from being updated. Meetings of senior representatives from all these sectors will be useful to galvanize the work.
CEPEHRG	Training with CHRAJ, focused on LGBT	Police	46	Greater Accra, Volta, Eastern and Western	2016-2017	
HRAC	Training workshop for officers on human rights, GBV and human rights protection against KPs	Police	30	Aflao and Elubo	2016-2017	
HRAC	Value Clarification and Human Rights Education - activity implementing Access to LGBT Rights and Healthcare	Police	60	Western, Central, Greater Accra, Ashanti, Eastern, Volta	2014-2017	
MIHOSO		Police	88	Brong Ahafo (18), Upper West, Ashanti (5 districts)	2012-2017	
WAPCAS	Collaboration with the Police HIV Program especially DOVVSU, and HRAC to follow-up on abuse cases, arbitrary arrests of KP	Ghana police service				
UNFPA/ Regional judges forum	Sensitizations, include LGBT focus	State institutions, judiciary		Limited reach		
HRAC	Dissemination forum on legal audit findings on HIV	Judges and magistrates	25	Greater Accra	2015	
PPAG	Advocacy meetings	Prison officials	300	National	Jan-Sept 2017	
	Pre-service training of lawyers			None currently.		
	In-service training of lawyers and judges			None/very limited currently.		

There have been significant large-scale efforts to sensitize police agents in Ghana. In 2000, the Ghana Police Service started to incorporate a public health approach into their law enforcement practices. With funding from UNFPA, WAPCAS worked with the Ghana Police Service AIDS Control Programme to introduce a rights-based approach to policing (drawing on an OHCHR guide on human rights standards and practices for the police) and ensuring the rights of marginalized populations - they targeted all levels of the police from recruits to top administrators. This included instruction to police on the consequences of abusive behavior and the importance of divorcing moral beliefs from professional functions; and discussions on discretionary power police exercise in their work and how they can effect positive change in lives of sex workers by reducing raids, ensuring they can carry condoms, and taking reports of violence seriously. The training also included testimonials of individuals from key populations and documentaries about police abuses and the consequences for those involved. Monitoring was then carried out by the Chief Superintendent through site visits and communication with WAPCAS and local police focal points. Much of this was later formally incorporated into training for the Ghana Police Service.

According to Superintendent Blantari, who has spearheaded the training efforts, the challenge now is to reach all 38,000 police in the country. When sufficient funding is available, they do 'training of trainers' targeting 30 senior officers and 60 people of other ranks per region in each of the 12 police regions twice every year. Collaborators include GAC, NACP, and UNFPA.

In 2013, with PEPFAR funding, the Ghana Police Services developed a curriculum for pre-service training for officers on stigma and discrimination reduction against key populations – female sex workers, men who have sex with men and people who inject drugs are covered but the latter only 'on the surface' because so little is known about them. This is now used in all pre-service training, which involves approximately 3,000 graduates annually. There are 8 police training schools in Ghana; two instructors in each have been trained as trainers. The material is examinable so new recruits have to pass it to graduate.

Also, as mentioned earlier, the police have been involved in the 'M-Friends' network, in which they help key populations to access health and legal services. Many of the original cohort are still serving and for some of them the work continues to be part of their remit (although there is currently no external funding). Indeed, many focus groups referenced the M-Friends and other trained police as important allies within the police – identifying them as individuals to whom they reach out and who are engaged as stakeholders in programming (FGD4; FGD10; KII44). At the same time, focus groups also emphasized that there are still many police who stigmatize – hence the need for additional and more systemic sensitization and training efforts (KII38; FGD2).

The Human Rights Advocacy Centre (HRAC) has organized advocacy workshops in Accra and Takoradi for human rights defenders and state institutions in charge of protecting rights, including the Ghana Police Service, CHRAJ, Domestic Violence and Victim Support Unit of the Ghana Police Service (DOVVSU), and Legal Aid. As with their workshops for health care professionals, these workshops originally had a specific focus on the rights of the LGBT community; however, HRAC subsequently realized that, because of homophobic attitudes, framing and identifying the workshops as such affected the turnout. They have subsequently decided to package the workshops as general human rights discussions, with LGBT rights as an integral component of the training.

With Global Fund funding, UNDP supports an ongoing initiative working with the judiciary on HIV and human rights. The Regional Judges' Forum aims to sensitize senior judges throughout Africa, including a handful from Ghana, to protect the rights of people living with HIV. The initiative includes annual meetings that focus on topics such as the human rights of sex workers, men who have sex with men, transgender people, prisoners, women and girls, and sexual and reproductive health and rights. The idea is that the judges then share the information received and advocate for a human rights-focused approach in their respective jurisdictions.

As described in the desk review, there have also been some other efforts to provide capacity building for legal and paralegal groups, Parliamentarians, Members of the Judiciary, Ministry of Justice, CHRAJ, and the Attorney General's Department (UNAIDS 2012; Jeffers et al., 2010). Key informants also spoke of plans to carry out future trainings with judiciary, including on the recent GAC Act (KII30; KII15).

Limitations/Challenges

Although the sensitization and training efforts with police have been at a larger scale than those with health workers, there is still a need to increase the reach of these efforts and to ensure they are institutionalized and that there is adequate support for refresher trainings and continuous monitoring. For example, in reflecting on their training activities with police, HRAC has noted that most of the reported abuses of LGBT rights by police officers is a result of continued ignorance about homosexuality, lack of knowledge and understanding about human rights laws, and difficulty in interpretation of the Ghanaian laws on sexual activities.

Similarly, there is a need to implement sensitization efforts with member of the judiciary and other law-makers. (Inception Meeting; Stakeholders meeting). GAC has done some advocacy with Parliamentarians, but it has not been continuous. Ensuring the complementary of these efforts, including consonance in training content, will be key to the effectiveness of the overall system.

Moving toward a comprehensive response

In addition to the CSO-implemented M-Friends program, which has included training police officers, the Ghana Police Service itself has also carried out both pre- and in-service training on HIV and human rights for its members. While the pre-service training for police now appears established, its curriculum might require updating in light of recent legislative changes, and the reach of in-service training remains limited and should be scaled up. In addition, key informants suggested incorporating material on human rights, including how they relate to HIV, into law school curricula to ensure that new lawyers have a minimal level of awareness on these issues. In-service training for lawyers and judges should also be scaled up. HRAC will be a key resource for moving forward this work given their experience developing and delivering human rights-related training curricula; central involvement of key populations will of course also be critical. As with the health worker training described above, institutionalizing HIV and rights-oriented trainings at police academies, law schools, and other such spaces, could have impacts on human rights beyond the context of HIV and, once established, would be an efficient way to continuously reach new cohorts of legal and law enforcement professionals. Engaging prison officials might also afford useful opportunities for creating policy "work arounds" that might facilitate, for example, the provision of condoms in prisons. This work should be done in collaboration with PPAG and building on their work in prison settings to date. Meetings of senior level officials from the police, judiciary, Bar Association and prison service will be useful to galvanize attention to these issues and promote commitment across all of these duty-bearers at the senior level.

HIV Legal Literacy ("Know Your Rights")

The table below provides an overview of current programmatic efforts in the area of HIV legal literacy as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program	Description						Limitations
Human rights/ legal education	Workshops on human rights and navigating police, complaints Convene CHRAJ, DOVVSU, heath facilities, social welfare agencies, and legal aid lawyers, among others.						Limited reach
Implementer	Description	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
HRAC/ WAAF	Workshops: human rights education and free legal consultation[1]	KPs	156		Western, Central, Eastern, Ashanti, Greater Accra	2013-2014	This work is generally small-scale and fragmented. All legal literacy work should be linked to efforts to increase access to legal services (see next sub-section) as well as the work of other peer educators described above. The sustainability of these efforts will need to be well thought out. The roundtable community engagement work that WAPCAS is carrying out at district level with CHRAJ, DOVVSU and others could usefully be scaled up and expanded to include attention to other key and vulnerable populations as well as female sex workers. The work being carried out by HFFG and LRF also aims to bring together relevant stakeholders to raise awareness of their obligations. It might be possible to learn lessons across these initiatives and standardize/streamline efforts moving forward.
HRAC/ WAAF	Workshops: human rights education and free legal consultation[1]	KPs	360		Western, Central, Volta, Eastern, Ashanti and Greater Accra	2014-2017	
MIHOSO		FSW/MSM	840	1,800	Brong Ahafo (18), Upper West, Ashanti (5 districts)	2012-2017	
WAPCAS	'Know your rights as a FSW' booklet. 100 copies printed, used by PEs during IEC sessions.	FSW			National		
HFFG			11		Brong Ahafo	May 2015 – April 2016	
LRF			20	30	Western (STMA, Jomoro district)	2017	
LRF	Advocacy group met with regional health director and HWs		15	45	Western (STMA)	2017	
WAPCAS	Roundtable community engagement on FSW rights in collaboration with CHRAJ	FSW					
WAPCAS	KP Technical Working Group: updating KP TWG and other stakeholders on human rights abuses against KPs	KPs and relevant stakeholders					

Program	Description						Limitations
Paralegal training	Educating and empowering individuals to advocate for human rights among peers, communities						Limited reach

Implementer	Description	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
Solace Initiative	Project on violence against LGBT populations, including training paralegals and linking community members to psychologists.	LGBT			Accra, Kumasi, Cape Coast	Ended in 2014	The LGBT populations that were part of the Solace Initiative's paralegal training work could now participate in the M-Watchers program, which Solace Initiative could help roll out. As kayayei are not included in M-Watchers, scale-up of this work alongside the other activities SWAA is implementing with kayayei would be useful.
SWAA		Kayayei	45	100	Ashanti, Greater Accra and Brong Ahafo	2015-2017	

Program	Description						Limitations
M-Watchers	M-Watchers are a rapid response network of peers who support PLHIV and KPs who have experienced rights violations. Their training includes paralegal training.						No provisions for livelihood or financial compensation

Implementer	Description	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
Multiple		PLHIV & KPs	200		5 regions; 32 districts	2014-2017	Comprehensive scale-up across the 15 priority districts would require 90 M-Watchers (6/district). If this were to be scaled up across all 32 districts currently targeted, 192 M-Watchers would need to be trained and supported.

[1] Note that this also encompasses HIV-related legal services and is therefore equally relevant to the next sub-section. The aspects relevant to the provision of legal services will be discussed in the next sub-section.

As described above, peer education programs have been an important vehicle for legal literacy and promoting knowledge of rights. The programs included here are different from those covered under 'peer education' in the 'Stigma and Discrimination Reduction' sub-section above.

M-Watchers, which was conceptualized alongside the 'M-Friends' program mentioned above, is a prominent example of a legal literacy program. M-Watchers are members of key population groups including people living with HIV who are trained to assist other community members in the face of human rights violations: they are a community-based 'rapid response network'. M-Watchers are known community resources so they are available to the community whenever the community wish to approach them. The training for M-Watchers runs for 10 days and is essentially a paralegal training curriculum covering 'know your rights', legal frameworks etc. and using a range of training methods including group work and role plays. As with M-Friends, FIDA and HRAC are involved in the training to ensure the quality of the human rights content. One informant reported that police raids of female sex workers 'fail' when there are empowered M-Watchers present as they can articulate their rights. (KII30)

Between 2013 and 2015, HRAC was able to train 20 lawyers, paralegals, and others and assist over 50 key population members including people living with HIV in accessing legal aid services. Over 200 others received human rights education and free legal advice.

Key informants also spoke about how projects actively seek to engage with and establish ongoing dialogue with key government entities – for example, as part of their ongoing activities to ensure female sex workers are linked into care and support services, Life Relief Foundation (LRF), working in the Western region, organizes quarterly meetings with stakeholders from CHRAJ, DOVVSU, heath facilities, social welfare agencies, and legal aid lawyers, among others to discuss issues affecting people living with HIV and key populations. Similarly, WAPCAS convenes meetings between CHRAJ and DOVVSU representatives and communities at the district level - these meetings serve as important sensitization opportunities for the duty bearers: by bringing them to interact with people living with HIV and other key populations, the officials become more aware of how they can better respond to human rights-related needs. Hope for Future Generations, working in the Brong Ahafo and Greater Accra regions, organizes monthly stakeholder meetings, also involving traditional authorities. All of these activities are designed to ensure that laws, regulations and policies that are protective are being appropriately implemented, as well as to discuss potential 'work-arounds' where obstructive laws, regulations and policies might exist.

Several other training initiatives have also sought to increase awareness about rights among key and vulnerable populations. For example, as part of the HRAC-West Africa AIDS Foundation (WAAF) collaboration described above, which includes training for health care workers and police, the organizations

are also carrying out human rights and legal education training workshops for 360 people who identify as lesbian, gay, bisexual or transgender in six regions. HRAC is also a founding member of Alliance for Equality and Diversity (AfED), a network of organizations and individuals focused on promoting and protecting LGBTI rights in Ghana - a significant part of AfED's focus is on human rights education and legal literacy, ensuring that lesbian, gay, bisexual, transgender and intersex populations understand their rights and know how to navigate the police and complaints systems.

The Solace Initiative previously had a project on violence against lesbian, gay, bisexual and transgender populations through which they trained paralegals and linked community members to psychologists but the project ceased in 2014 when the funding ended and activities could no longer be sustained. It was a small project in Accra, Kumasi, and Cape Coast. (KII26)

As part of SWAA's project with Kayayei (see above), they have also implemented an integrated livelihood and rights-based paralegal training for 45 adolescent Kayayei in three markets (Greater Accra, Ashanti, and Brong Ahafo). A five-day training in late 2016 aimed to educate and empower the 45 Kayayei to advocate for human rights, including sexual and reproductive health and rights, among their peers and in their communities – they are now expected to be referral points for legal literacy and addressing human rights abuses in their communities, including making referrals to institutions (e.g. CHRAJ, DOVVSU) as necessary.

Limitations/Challenges

Legal literacy efforts to date have been limited in scale, but there is a common recognition among research participants that there is a need to increase awareness among people living with HIV and other key and vulnerable populations regarding their rights and existing protections against discrimination, including specifically the Patient Charter and recently passed GAC Act (KII15; KII38; FGD7).

One key informant reported that although most M-Watchers are active for as long as they remain in the community, the sustainability of their functions might be enhanced if they could be paid a stipend, much as peer educators are. (KII30)

Moving toward a comprehensive response

As mentioned above, in the context of the M-Friends program, to 'comprehensively' scale up the M-Watchers program in the 15 priority districts would require training at least six people per district (90 people total). To scale up beyond this to the current 32 districts would require training at least 192 M-Watchers. The training of the M-Friends and M-Watchers is complementary so there are synergies to be gained by implementing them together. USAID has partly funded this work but additional financing is

needed. In addition, also mentioned above, capacity building of local NGOs to enable them to become trainers of M-Watchers as a way of promoting sustainability and expanded reach will also be important. AfED appears well placed to expand their work training community members on human rights and the law, and could perhaps assess the potential of reviving the paralegal network initiated by the Solace Initiative, perhaps under the M-Watchers remit. However, attention to how to ensure the sustainability of the latter will be key.

The community engagement work that WAPCAS and others are implementing whereby they convene meetings with CHRAJ, DOVVSU and others along with female sex workers at district level could be expanded to also include attention to other key and vulnerable populations, and scaled up geographically at least throughout the 15 priority districts, and preferably beyond.

HIV-related legal services

The table below provides an overview of current programmatic efforts to provide HIV-related legal services as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program		Description						Limitations
Government-run complaints mechanisms		CHRAJ – mechanism re: stigma and discrimination against key populations, includes website DOVVSU- domestic violence unit of Ghana Police						Low utilization; Not readily accessible; Under-resourced; Delay in follow-up.
Implementer	**Description**		**Population targeted**	**# trained**	**Clients reached**	**Region(s)**	**Timeframe**	**Recommended scale-up**
CHRAJ	Mechanism for reporting human rights violations		Everyone			National		CHRAJ seems like a critical resource and real investment is needed to understand why it is so under-utilized and then how to promote its accessibility and uptake by PLHIV and key and vulnerable populations. Capacity building will be needed at national, regional and district levels, and adequate staffing and operating budgets will be key.
Program		**Description**						**Limitations**
Accessible legal services	Human rights clinic (free). Pro-bono network. Assistance with CHRAJ.							No core funding; limited geographic reach
Implementer	**Description**		**Population targeted**	**# trained**	**Clients reached**	**Region(s)**	**Timeframe**	**Recommended scale-up**
AfED	Assistance to KPs to access lawyers and report human rights violations to the police.		KPs					These services could be a very useful bridge to making CHRAJ more accessible to PLHIV and key and vulnerable populations. Scale up throughout the five regions.
HRAC	PLHIV, KPs and LGBTs' cases of abuse, HR violations, stigma and discrimination are received and attended to in the Human Rights Clinic's walk-in facility and also through our mobile clinic outreaches.		PLHIV, KPs, LGBT	20+	72	Nationwide with particular focus on Greater Accra, Eastern Region, Central and Western Regions and recently, Volta Region	2012-2017	
	Human rights clinics in law schools					None currently.		Suggest pilot testing this in Accra.

Both government and civil society organizations (CSOs) have established initiatives to promote access to legal services and redress for cases of HIV-related discrimination and human rights abuses.

The primary government institutions for handling key population-related human rights abuses are the Domestic Violence and Victim Support Unit of the Ghana Police Service (DOVVSU) and the Commission on Human Rights and Administrative Justice (CHRAJ).

In 2012, CHRAJ launched a reporting mechanism – including a website – dedicated to addressing issues of discrimination and stigma against key populations. Various research participants spoke about how they engage with this government institution – particularly as part of efforts to increase awareness and reporting capacity. For example, peer educators spoke about training they had received from CHRAJ on how to file discrimination complaints and how they in turn disseminate this information to their peers: "(We assure them) that just because you are a FSW does not mean you have no rights. Some women have no idea about rights but we educate them about the institutions, why they were established, and the fact that they are for everyone." (FGD3; see also KII41)

However, the system has not realized its full potential (KII32), and research participants described it as under-utilized. As the CHRAJ senior leadership reports, one of the challenges has been demand generation, he notes how they had expected the demand would come via CSO referrals but the numbers have been low - "we thought there would be an avalanche of complaints, but they didn't come". They have thus far received 85 complaints, 40% of which are still under investigation (website). In Takoradi, CHRAJ reports very low numbers – only 3 HIV/key population-related complaints in the last 2-3 years, all of which were walk-ins. In Kumasi, the staff could not provide exact numbers at the time of the interview but estimated that they have received a maximum of 10 complaints/year involving people living with HIV and other key populations. Despite the low volume of complaints, CHRAJ does not have sufficient resources to investigate them: critical insufficiencies in funding and human resources do not allow for timely and efficient responses, which serves as a deterrent for use of the system.

As mentioned above, the M-Watchers and M-Friends serve as a 'people living with HIV- and other key population-centered, rapid response network' by which allies and peers are on alert for human rights abuses against people living with HIV and other key populations and able to provide appropriate referrals. HRAC runs a human rights clinic which provides free legal support – and which receives many stigma-related cases (KII15). They established a *pro bono* lawyers network, but it is now non-functional as the original project did not plan for sustainability beyond the funding period.

The recently-established Alliance for Equality and Diversity (AfED) seeks to serve as a "first-stop" resource for responding to human rights violations. They help key populations access lawyers and report cases to

police. If an individual agrees, they may submit the complaint to CHRAJ; however, many prefer to handle the problem directly. (KII26) Alliance regional representatives only engage when cases are reported. Key advocates are identified and trained multiple times; they work full-time as volunteers, and, according to a local informant, should get stipends to enhance sustainability. (KII26)

Limitations/Challenges

Research participants identified various factors that may restrict the "demand" for the CHRAJ reporting mechanism – factors relating both to awareness and acceptability. Some emphasized, for example, that knowledge about the reporting mechanism is likely limited to those who are accessing services (e.g. by seeing a CHRAJ poster in the health facility waiting room) and/or connected to a program (e.g. Models of Hope). (KII22) For individuals who are aware of the mechanism, they may fear disclosure and/or stigmatization related to coming forward. (KII40, KII36). Or, given the discrimination and abuse that people living with HIV and key populations still often face at the hands of the police, they may be unwilling to seek out the police and file the report that is a part of the CHRAJ process. As a result, research participants described how very often the response to situations of stigma and discrimination, rather than seeking redress, is to just "give it to god" (KII36; KII22).

As for the online mechanisms, both CHRAJ staff and peer educators pointed out challenges related to illiteracy and low educational levels (KII22; KII36; FGD2) and the need for accessible alternatives. Similarly, there is some continued distrust in the idea of an online system, particularly in terms of confidentiality and some thought it would be better to have walk-in desks that are more accessible and staffed by well-trained, key population-friendly people. (FGD2; KII36)

Another challenge are the delays in follow-up and resolution of complaints. Research participants shared that the fact that the process can be time-consuming – sometimes three months – may discourage individuals from filing complaints (FGD2; KII37; KII25). As one key informant explained, if one person in the community says the process is a waste of time, that perception spreads (KII25).

Related to many of these issues is the lack of sufficient resources for investigation e.g. personnel, transportation for field investigations (KII40; KII36; KII45). As one group explained: "CHRAJ has no money; they send us to the police first. So, sex workers won't go there again." (KII37). CHRAJ is aware of the issues raised here but insufficiently resourced to address them.

Research participants reported similar frustrations about DOVVSU and the need to streamline their processes, as well as ensure more competency-based training. They noted that filing complaints was a time-consuming process that did not necessarily always lead to resolution (KII33; KII37).

As for the CSO efforts related to legal services, including the HRAC clinic and AfED's advocacy and case management, although they clearly fill an important role in facilitating access to services and supports, they are limited in their funding. HRAC, for example, currently has no core funding for its clinic, which they continue to run as a labor of love. They also recognize their limited geographical accessibility and are looking into possibilities to make their services mobile.

Moving toward a comprehensive response

There are several interconnected programmatic areas for ensuring access to justice for people living with HIV and key populations and "effective, accountable, and inclusive" institutions. These should be seen as a package of complementary interventions. These include reducing stigma and discrimination, promoting legal literacy, and strengthening HIV-related legal services - while there have been efforts in each of these areas, albeit to various degrees, there is a need to scale up and better coordinate all of these efforts.

Based on conversations with research participants, it is clear that civil society organizations play a central role in protecting and promoting rights – from providing legal education to key populations and engaging in dialogues with police and other stakeholders to facilitating access to complaints mechanisms and legal services. AfED is a notable example of organizations coordinating to strategize, advocate, and intervene collectively to ensure the protection and respect of rights – in AfED's case, nine organizations collaborating on the rights of lesbian, gay, bisexual and transgender populations specifically. As part of their management of cases of rights violations, AfED refers cases to CHRAJ and DOVVSU, thus serving an important "bridge" role. AfED's work, including peer educators and paralegals, could usefully be scaled up across the country to increase awareness and uptake of HIV-related legal services. To do this would require creating standardized training curricula and materials; in-country capacity exists to do most of this work but a small amount of high-level technical assistance might be useful to help ensure consonance with international best practices.

Reviving HRAC's network of *pro bono* lawyers would be another useful approach to improving access to legal services. Another promising program that was suggested was human rights clinics within law schools wherein trainee lawyers would assist paralegals/other community members to promote access to justice. This would require updating existing training materials and designing a sustainable system that is accessible to those who could benefit from it. The *pro bono* network and law school clinics could be connected to the above work, which could all be conceptualized as a single system so as to improve efficiency, complementarity, and accountability: an expanded network of peer paralegals could generate knowledge of rights, do simple dispute resolution, and make referrals to the pro bono lawyers or legal clinics.

However, for this to work the quality of all legal services must be addressed. CHRAJ is currently falling short of its potential – in part due to insufficient funding, but also perceptions among key and vulnerable populations regarding possible risks of disclosure and delayed processes, among other things. Indeed, HRAC (an AfED member) has found that the vast majority of cases reported to their legal clinic were not reported to CHRAJ or other state human rights defenders. (KII15). It might be useful to further research reasons for under-utilization of CHRAJ services to inform efforts to strengthen the institution.

Moreover, to pursue a case, people need a police report – however, because of actual or feared stigma, key and vulnerable populations might be unwilling to go to the police. Thus, in moving forward, any efforts to bolster CHRAJ and other rights reporting mechanisms should be done hand-in-hand with continued training and sensitization efforts with the police (see above) as well as continued support for the civil society organizations, such as the AfED, who fill the essential 'bridging' role described above.

Monitoring and reforming laws, regulations, and policies relevant to HIV

The table below provides an overview of current programmatic efforts on monitoring and reforming laws, regulations and policies relevant to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Monitoring and reforming laws, regulations, and policies relevant to HIV							
Implementer	Description	Population targeted	# meetings	Clients reached	Region(s)	Timeframe	Recommended scale-up
GAC	Dissemination of GAC Act and other relevant laws such as the potential Narcotic Bill etc. (information provision as well as stakeholder trainings)	HWs, law enforcement, judiciary, general population			None currently		As mentioned in earlier sub-sections dissemination of the GAC Act, Patient Charter, Narcotic Bill, and other relevant laws and policies nationwide is critical.

As illustrated in various examples thus far, CSOs play a fundamental role in pushing government to be more responsive and rights-oriented – from facilitating trainings of police to linking affected individuals to human rights institutions. Much of this work has been described in previous sub-sections. Although there were mixed opinions about if and to what extent the criminal law represents an actual barrier to services, most key informants agreed that reforming the laws was not a viable strategy in the short-term given the political climate and general public attitudes toward the behaviors at issue. As one key informant described, there is likely an extremely high bar in terms of the data that would be necessary to start to engage parliamentarians on amending the criminal laws – they would want specific facts e.g. the size of affected populations and statistics on enforcement, numbers that are not currently available at a national level (KII15). The key informant also emphasized that there are some pressure groups vehemently opposed to key population programs and who would likely "pitch a tent" at parliament to resist the making of any laws in favor of key populations. Therefore, the focus should be on understanding how the laws play out in practice, the impacts on different populations, and current and potential new "workarounds". In line with this, most of the existing work in this program area has been focused on monitoring, not reforming laws. HRAC expressed interest in bringing cases to "test" the new GAC Act's protections, but noted that that kind of process and advocacy requires substantial time and resources. Moreover, most victims do not want to pursue cases, particularly not publicly, for fear of disclosure.

Moving toward a comprehensive response

There have been some key changes to the legal and policy environment recently with more expected in coming months. It is critical that information on relevant laws and policies be made widely available. As

previously discussed, this could be done through mass media, training of duty bearers at multiple levels, peer paralegals, provision of quality integrated services in health facilities etc.

Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity

The table below provides an overview of current programmatic efforts to reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program	Description						Limitations
Community engagement	Workshops/trainings e.g. USAID/AED's 'My Life: Positive Living Toolkit'						Limited programming engaging men, partner testing
Implementer	Description	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
SWAA	Community Engagement to reduce discrimination against women in the context of HIV	HW, church leaders, community leaders, FSW	50	2000+	Central Region	2008-2010	This is an area where large-scale additional programming is needed. SWAA appears well placed to build on their earlier work. Other partners, including government, local NGOs and international organizations will also need to be involved.
WANE	Vocational and entrepreneurship training	Widows		400 widowhood clubs with 8,000 members		Launched in 2007. No up-to-date information found	

Neither the desk review nor in-country assessment identified many substantial programmatic efforts in this program category. GAC has not carried out any women-specific campaigns because of limited funding. The Ministry of Women, Gender and Children has carried out some HIV-related activities, including public sensitization, but also faces financial constraints. As for civil society efforts, there were two of note: SWAA, which carries out community engagement workshops based on USAID/AED's 'My Life: Positive Living Toolkit', spending 2-3 days in each community advocating for women's sexual and reproductive rights and addressing gender issues, and men's engagement; and the Widows Alliance Network (WANE), which seeks to alleviate hardships widows experience through vocational and entrepreneurial skills training.

Limitations/Challenges

As mentioned above, there is limited programming in this area. The focus on HIV counseling and testing in antenatal care has led to more women living with HIV knowing their status than men, but there is a lack of support for safe disclosure, access to services, and interventions to encourage partner testing. This is an area of growing importance, but with donor funds earmarked to interventions targeting key populations and the government struggling to mobilize domestic funding at the levels required, it has received relatively little attention to date.

Moving toward a comprehensive response

Given the paucity of information found on this program area, it is difficult to propose a comprehensive response. As a first step, gender should be mainstreamed across all program areas to ensure that gender dynamics and issues relating to gender-based violence are considered throughout the response to human rights barriers to accessing HIV services. There would seem to be tremendous scope for activities such as peer paralegals for women living with HIV, training of religious/traditional leaders on gender and human rights, attention to human rights in maternal health and PMTCT services, as well as particular attention to adolescent girls' vulnerability to HIV. Convening relevant partners in-country to discuss priorities and available resources for action might be a useful step towards integrating some of these activities into national gender equality efforts and informing greater action in this area.

Cross-cutting research and service provision activities that are beyond the 7 key human rights program areas

Implement research and services for people who use drugs, children and adolescents working and/or living on the streets, transgender populations, and other hard-to-reach/underserved groups

There are several groups for whom there is still very little available information, including about HIV prevalence and barriers to services. As discussed above, while research is an essential piece to moving forward and ensuring appropriate program and services, key informants urged that research must be done

subsequent to or concurrent with the provision of services, as well as livelihood opportunities where appropriate and possible (KII23; KII30). For people who inject drugs, for example, research efforts should be accompanied by some form of harm reduction and/or perhaps peer education, which has proven to be effective in reaching hard-to-reach groups. As part of building knowledge about these groups and providing them needed services, it is also essential to keep in mind intersections across "categories" – e.g. sex workers who inject drugs – and how this intersectionality may shape access to services.

Decentralize distribution of ART to community levels, including DiCs

As discussed above, there are various barriers surrounding the current physician-centered ART service delivery model, including the cost that may be involved in traveling to and from facilities and the risk of being exposed to stigma and discrimination. While Ghana appears to have acknowledged the need for task sharing in HIV services, the exact modalities of this are not yet clear. If Ghana were to move toward a community-centered model, people living with HIV could more easily access treatment, which in turn would help increase uptake and adherence, while reducing stigma and discrimination. One possible option for community-centered delivery at the Community-based Health and Planning Services; another option are the DiCs, which have already established themselves in many settings as accessible, friendly spaces for key populations. A combination of these might have most effect on increasing access to ART.

Support operationalization of GAC HIV fund

The recently passed GAC Act provides for the establishment of an HIV fund, the purpose of which is to provide financial resources for the national HIV and AIDS response, with special focus on HIV prevention, prevention of mother-to-child transmission, stigma reduction, treatment, and the care and support of persons living with HIV. UNDP is currently seeking a consultant[11] to help GAC develop the framework for the HIV fund. Given its focus on implementing the 2016 National Strategic Plan (which specifies rights-based approaches to scaling up services as well as stigma reduction), the fund can be considered a vital strategy for helping to promote and protect rights (KII11). Funding some advocacy meetings to bring together a wide range of national level stakeholders to explore how to sustainably raise funds for distribution through this mechanism might a way to catalyze this new initiative.

Other investments

JUTA is supporting stakeholder engagement with CHRAJ, CSO capacity strengthening to address stigma reduction, and dissemination of key anti-stigma provisions of the GAC Act. (CCM funding request, 2016) As mentioned previously, USAID/PEPFAR is also funding some relevant activities, including through the Care Continuum project.

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[11] http://procurement-notices.undp.org/view_notice.cfm?notice_id=38010

Implementation Capacity

An organizational capacity assessment was recently carried out of all 12 local NGOs that provide direct services to female sex workers and men who have sex with men in Ghana. (Laar et al., 2013) The assessment concluding that "While all the organizations had a set of "core" competencies in breadth of services offered and depth of human resources, community engagement, and M&E responsibilities, the organization capacity assessment revealed a lack of depth in these areas". Substantial variation was found in terms of services offered and how these are monitored, and the report authors ask the question also raised in this report of the extent to which certain organizational functions might be standardized across implementers e.g. training of peer educators and other services providers.

Substantive capacity building on the law and human rights as they relate to HIV, including stigma, discrimination and key and vulnerable populations would be beneficial for most of the implementing partners. While this might not be needed in some of the more specialized organizations (e.g. HRAC who could facilitate such training), in other institutions even where some relevant expertise exists, it will be important to train additional staff to ensure appropriate actions across all areas (e.g. communications, educational materials, trainings, service provision etc.). As noted above, these providers (and potentially others) will require capacity building if they are to assume a role of training additional resource people such as M-Friends and M-Watchers in the districts where they work.

Additional capacity building will be required at least in the following areas:
- CHRAJ: Although this has been covered above in the proposed programs to increase access to legal services, it is worth reiterating the need for capacity building of CHRAJ at all levels. The institution should be an important mechanism through which people living with HIV and other key and vulnerable populations can report discrimination, but it is very under-utilized, and trust in the institution is lacking. A serious injection of resources will be required to make CHRAJ functional, responsive and acceptable to the people for whom it is designed. Ensuring adequate staffing should be accompanied by training to ensure that all staff are key population-friendly, that they do not display discriminatory attitudes, and that they come across as willing to help people access justice.
- Professional schools may require technical assistance/capacity building if they are to introduce new curricula on HIV and human rights.
- Many of the recommended interventions involve streamlining and updating of training curricula. There is good capacity to ensure that these curricula are appropriate to the local context. It might be useful to provide a small amount of high level technical assistance to ensure alignment with global standards and build capacity on international best practices.

- Due to funding priorities, many NGOs focus on programming for key populations. Capacity building to expand their reach to encompass all people living with HIV as well as other vulnerable populations will be important.
- Smaller NGOs would benefit from capacity building in grant management and reporting.

Funding Needs
Unit costs of existing programs, where available, have been provided.

Monitoring

This baseline assessment is designed as the first step in a process that will include a mid-term and end-term assessment during the current 2017-2021 Strategy of the Global Fund. In this section, sample indicators are proposed to be assessed in each of the two future assessments; however final selection of indicators should be done once the comprehensive package of services is agreed upon.

Due to the broad range of barriers, populations, and recommended programs/interventions, the performance framework includes a corresponding range of indicators and data collection methods. While 90-90-90 provides a compelling benchmark for tracking levels of access to services and care – as a quantitative marker, it is not in and of itself sufficient for thinking about all of the programming necessary to actually achieve the benchmark, nor, more specifically, for assessing human rights-related barriers to services (and reductions in these barriers) in particular. There are outputs to the recommended programs/interventions that can be measured in numerical terms, but the real changes in barriers to access to services will likely only be found by examining the experiences of key and vulnerable populations, and in the longer term also changes to the test and treatment cascades for HIV.

Policy Assessment
Each assessment should include a review of relevant laws and policies to capture how this environment evolves over the intervention period. In addition to assessing the existence and content of laws and policies, it will also be important to collect data on implementation including, for example, budget allocation to human rights-relevant activities, expenditure of this budget, and creation/use of any structures to address or monitor human rights barriers to accessing HIV services. This will all require a mixture of desk review and in-country data collection.

Qualitative Assessment
Each assessment should repeat the major steps of this baseline assessment, including desk review, key informant interviews and focus group discussions with key and vulnerable populations:
- The desk reviews should focus on identifying any new research on human rights-related barriers in Ghana and evaluations of any programs to reduce these barriers, including those considered for or

implemented as part of the comprehensive approach. It is worth highlighting here how, with support from the Global Fund and International Treatment Preparedness Coalition, NAP+ is currently beginning to systematically collect and analyze quantitative and qualitative data on barriers to access to HIV treatment and services, which may constitute an opportunity for synergistic data collection.

- Key informant interviews should focus on changes in the legal, social, political, and programmatic environment since the previous assessment, as well as capturing key informants' views on how the comprehensive approach is being implemented, looking for strengths and weaknesses.

- Focus group discussions with people living with HIV and other key and vulnerable populations should emphasize the following questions:

Outcomes

- o Is it now easier to access HIV services than two years ago? Why?

Stigma and discrimination reduction

- o How have stigma and discrimination related to HIV changed?
  - Probe: In healthcare settings? Within the legal system? Within the community?
- o How have stigma and discrimination related to your community changed?
  - Probe: In healthcare settings? Within the legal system? Within the community?

Training for health care providers on human rights and medical ethics related to HIV

- o How have health worker attitudes and treatment towards your community changed?
  - Probe: Are health workers less likely to deny services than 2 years ago? Are they less likely to treat you in a derogatory manner?

Sensitization of law-makers and law enforcement agents

- o How have police attitudes and treatment of your community changed?
  - Probe: Are police less likely to abuse you? Target harm reduction sites to meet arrest quotas? Use possession of condoms or syringes for harassment?

HIV-related legal literacy ("Know your rights")

- o How has your community's awareness about rights changed?

HIV-related legal services

- o Is it easier to access HIV-related legal services than two years ago? If so, how?
- o (Showing the comprehensive approach) Have you been reached by or accessed any of these services? How useful were they?

Additional questions can probe into each of these areas, and general open-ended questions should enquire how participants' lived experiences have changed as a result of any of these changes.

Quantitative Assessment

The appropriate mix of quantitative indicators to assess implementation of the comprehensive package of services to address human rights barriers to accessing HIV services can only be determined once the final package of services is agreed to. Below are some illustrative indicators that might be useful to assess progress based on the programs/interventions:

Indicator	Baseline value (national)	Source	Suggested level of disaggregation
Outcome indicators			
Percentage of people living with HIV who know their status	45%	UNAIDS	Region/district; sex; community; age
Percentage of people living with HIV who are on ART	37% (adults) 15% (children)	UNAIDS	Region/district; sex; community; age
Percentage) of people on ART who are virally suppressed			Region/district; sex; community; age; use of case manager
Percentage of respondents who report experiences of human rights violations	2014 data to be used	Stigma index	Region/district; sex; community; age
Results of getting a government employee to address cases of abused rights	2014 data to be used	Stigma index	Region/district; sex; community; age
Service uptake indicators			
Number of people who use drugs who are reached by harm reduction program			Region/district; sex; age
Number of people who use drugs who are reached by HIV-related services			Region/district; sex; age
Number of Kayayei, younger sex workers, street children, and other traditionally under-served groups who are reached by HIV-related programming			Region/district; sex; community; age
Stigma and discrimination reduction			
Percentage of respondents who report experiences of social exclusion	2014 data to be used	Stigma index	Region/district; sex; community; age; type of social exclusion
Percentage of respondents who report feeling different types of internal stigma	2014 data to be used	Stigma index	Region/district; sex; community; age; type of internal stigma
Percentage of respondents who report discriminatory and supportive reactions of various categories of the people they disclosed to at first knowledge of their HIV-positive status	2014 data to be used	Stigma index	Region/district; sex; community; age
Number (percentage) of people living with HIV who are connected to case manager and/or support group			Region/district; sex; community; age
Number of clients reached with minimum package of peer education services			Region/district; sex; community; age
Number of individuals reached through public education campaigns on HIV, human rights, stigma and discrimination	0		Age; sex; community; region/district
Community outreach for LGBT populations			Number of meetings; Number of participants; Age; Sex; Gender identity; region/district

Number of Models of Hope activities carried out			Type of activity (radio, community meeting etc.)
Number of peer educators trained on HIV-related human rights and stigma and discrimination reduction[1]			Region/district; sex; community; age
Number of Models of Hope trained	149	Lee et al., 2017	Age; sex; community; region/district
Number of journalists trained on responsible reporting around HIV, human rights, stigma and discrimination	0		Sex
Number of traditional and religious leaders engaged in public education campaigns on HIV, human rights, stigma and discrimination	0		Region/district
Training of health care workers on human rights and medical ethics related to HIV			
Percentage of respondents who report that a health care professional has ever told other people about their HIV status without their consent	2014 data to be used	Stigma index	Region/district; sex; community; age
Respondents' perceptions of how confidential they think the medical records relating to their HIV status are	2014 data to be used	Stigma index	Region/district; sex; community; age

Percentage of respondents on treatment who report a constructive discussion with a health care professional in the last twelve months about:
    HIV treatment
    Other subjects
	2014 data to be used	Stigma index	Region/district; sex; community; age

Percentage of respondents who have ever received counseling about their reproductive options after being diagnosed with HIV	2014 data to be used	Stigma index	Region/district; sex; community; age
Percentage of respondents who have ever been advised by a health professional not to have children after being diagnosed with HIV	2014 data to be used	Stigma index	Region/district; sex; community; age
Percentage of respondents who have ever been coerced by a health professional into being sterilized since being diagnosed with HIV	2014 data to be used	Stigma index	Region/district; sex; community; age
Percentage of respondents who report that their ability to obtain ART was conditional on the use of certain forms of contraception	2014 data to be used	Stigma index	Region/district; sex; community; age

Percentage of respondents who report experiences of denial of:
    General health services because of HIV
    FP services because of HIV
    SRH services because of HIV
	2014 data to be used	Stigma index	Region/district; sex; community; age

Number of graduates from medical, nursing, and other relevant health schools and programs who have been trained in HIV and human rights in the last 12 months (pre-service)	0		Cadre of health workers
Number of practicing health care workers who have been trained on HIV and human rights, including communicating with key populations and stigma reduction in the last 12 months (in-service) [2]			Cadre of health workers; region/district
Sensitization of law makers and law enforcement agents			

Number of graduates from law schools and programs who have been trained in HIV and human rights in the last 12 months (pre-service)	0		
Number of graduates from the police academy who have been trained in HIV and human rights in the last 12 months (pre-service)	3000	Ghana Police Service	
Number of practicing police who have been trained on HIV and human rights, including communicating with key populations and stigma reduction in the last 12 months (in-service) [2]	2,160	Ghana Police Service	Rank; region/district; sex
Number of prison officers who have been trained on HIV and human rights, in the last 12 months (pre-service)	0		Rank; region/district; sex
Number of prison officers who have been trained on HIV and human rights, in the last 12 months (in-service)			Rank; region/district; sex
Number of practicing lawyers and judges who have been trained on HIV and human rights, including communicating with key populations and stigma reduction in the last 12 months (in-service) [2]	0		Lawyers vs. judges; region/ district
Number of inter-sectoral meetings (police, lawyers, judges, prison officers, health workers) to promote addressing human rights barriers to accessing HIV services	0		Region (or national level); participants by rank and sex
HIV legal literacy ("Know your rights)			
Number of cases M-Watchers (and/or other paralegals) address			Community; age; sex; region/district; case outcome
Number of M-Watchers (and/or other paralegals) trained	200 (trained in 2014-17)	JSI	Community; age; sex; region/district
Number of individuals from key and vulnerable populations trained in legal literacy	45 kayayei (SWAA)	SWAA	
Number of roundtable community engagement meetings held (community, police, DOVVSU, CHRAJ, HWs, traditional leaders)			Region/district; communities involved; participants
HIV-related legal services			
Number of people access services through legal clinics/pro bono services for HIV-related human rights cases	72 (HRAC)	HRAC	Community; age; sex; region/district
Proportion of complaints/cases resolved by CHRAJ and DOVVSU (in timely manner, to be determined)			
Number of complaints/cases filed with CHRAJ and DOVVSU involving key populations and/or HIV-related discrimination (to be analysed alongside qualitative data to understand whether changes in reports reflect changes in human rights violations or changes in people's awareness of/willingness to use reporting channels);	85	CHRAJ website	Complainant community, sex and age; type of complaint; mechanism through which complaint was received (walk-in, online, SMS etc.)
Reasons for not trying to get legal redress for rights abused	2014 data to be used	Stigma index	Region/district; sex; community; age

Types of organizations or groups that people living with HIV know they can contact if they experience stigma or discrimination	2014 data to be used	Stigma index	Region/district; sex; community; age
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity			
Forced sex among FSW[3]	2015 data to be used	FSW IBBSS[4]	Region/district; age; category of sex worker; perpetrator
Forced sex without a condom among FSW[3]	2015 data to be used	FSW IBBSS[4]	Region/district; age; category of sex worker; perpetrator
Use of physical violence against FSW	2015 data to be used	FSW IBBSS	Region/district; age; category of sex worker; perpetrator
Other			
Budgets and expenditure from HIV funds dedicated to programs to reduce human rights barriers to HIV services (disaggregated by public resources / international funding, and per implementer type)	N/A		
Percentage of respondents who report involvement in efforts to develop HIV legislation, policies or guidelines	2014 data to be used	Stigma index	Region/district; sex; community; age

[1] It will be important to clearly define 'peer educator' and, if necessary, to differentiate it from case manager, Models of Hope, M-watchers etc. as well as to define the 'minimum package of services' that they are expected to provide.

[2] Depending on how training is rolled out, it may be useful to break down which duty bearers are specifically trained as M-friends and those who receive other training.

[3] This could also capture information relevant to 'Sensitization of law-makers and law enforcement agents' as the indicator captures information on police as perpetrators.

[4] Using these data will require another IBSS to be carried out around the time of the endline evaluation of this assessment. Administration of an IBBSS for other populations would provide additional useful information e.g. on violence and blackmail among men who have sex with men.

The 'baseline values' included in the table above are estimates based on data available from this evaluation process. Consultation with key stakeholders during a validation exercise will be critical to ensure that the most accurate and up-to-date data can be included. In addition, there are many gaps in baseline values in the table. This is because the timeframe for each indicator will need to be determined: for each one should it capture what has happened in the last 12 months? 24 months? Or any other period? Once this is determined, some more baseline values can be roughly calculated from data in this report but will still need to be validated by in-country stakeholders.

It will be important to ensure appropriate levels of disaggregation for all of these indicators. Axes for disaggregation have been suggested in the table but will be dependent on data availability. This will also be worthy of discussion with key stakeholders.

Data analysis will bring together the policy, qualitative and quantitative data to provide as full a picture as possible of changes that have occurred since baseline, including, where possible the pathways of change. Triangulation will be important for understanding the complexities and nuances underlying changes, and all data divergence will be explored.

Limitations

Due to the compressed timeline for the assessment, particularly the in-country work, it was not possible to speak to a fully exhaustive range of stakeholders and key and vulnerable populations. Among the perspectives that are not included here are those of lawmakers, traditional and religious leaders, widowers, and prisoners, among many others. Moreover, while the interview process sought to gather information about national as well as local contexts, it is important to emphasize that interviews were only carried out with key informants from five of Ghana's ten regions. These regions were chosen to maximize learning from existing programs, but as a result less information is available on the 'non-priority' regions where, in some cases, HIV prevalence is increasing.

Despite concerted efforts to arrange interviews, there were a few stakeholders the assessment team did not have the opportunity to meet, which limits what could be said about their activities and capacity. This includes DOVVSU and the Social Accountability Monitoring Committees.

There were also some challenges in collecting adequate costing information to accompany the recommendations presented here. Attempts were made in person and by email to collect data on donor funding by HIV-related human rights program area from both the Global Fund and USAID in Accra, who are the two primary donors for this type of work. Unfortunately, neither organization was able to provide this information as their funding allocations are not broken down in this way. This information is, therefore, not included in the retrospective costing. Donor agencies and many implementing organizations were unable to provide the financial information broken down into the categories required for this exercise. While some implementing agencies provided some information, this did not always fit squarely into the program areas used in this review. There was also a lack of

clarity as to how general organizational costs (e.g. salary and overhead) should be factored in as it was difficult to tease apart the proportion of these relevant to specific activities of interest. Organizational staff noted that it was impossible to cleanly delineate the financial information as was being requested and intensely time-consuming to even attempt to do so, which they did not think was a worthwhile exercise for them given their already-high workload. With multiple organizations implementing very similar activities (e.g. peer education) but without standardization, it is also difficult to compare the work of different organizations. Furthermore, some agencies could only provide data from years prior to 2016, which is considered non-comparable and therefore excluded. Overall, the fact that in-country programming has not been conceptualized within the program areas used for this review creates immense challenges for collecting the financial data in the format requested. The burden this places on donors and implementing organizations is too heavy to reasonably expect them to provide the detail requested. Every effort was made to collect the information requested but gaps and shortcomings remain.

V. Conclusion

There is substantial interest in understanding human rights barriers to accessing HIV services in Ghana, and to addressing them. This is evident across many different types of stakeholders including government, health workers, civil society organizations and international agencies, and is promising with regard to what might be achieved with matching funding.

However, a wide range of human rights barriers to accessing HIV services persists in Ghana that affects many different population groups. The extent to which stigma and discrimination, relating both to HIV and key populations, underlies many of the other barriers to accessing services such as the attitudes of health workers, police and other gatekeepers is striking, with implications for the level of attention that will be required to this moving forward.

The identified focus populations for Ghana are key and vulnerable populations including female sex workers, men who have sex with men, people who inject drugs, HIV-negative partners of people living with HIV, prisoners, people living with disabilities, women, and vulnerable children, including orphans and adolescent girls. Yet, HIV-related programming that is currently funded by international donors (Global Fund and USAID/PEPFAR) focuses primarily on female sex workers and men who have sex with men. National resources are insufficient to reach all other populations with the needed services and programs, and there is an urgent need to reach other populations with information and services if the human rights barriers are to be overcome.

For some populations, there is a lack of HIV-related data, which impedes understanding of the populations' needs with regard to services and programs. Providing some basic services to these groups alongside which research might be carried out could be a good entry point for reaching them. A lot of good programs exist that seek to address many of the human rights barriers identified, but they need to be expanded geographically and with regard to the populations they target. This might require substantial capacity building to ensure that appropriate programs can be delivered throughout the country. However, lessons can be learnt from current success stories that can usefully inform this scale-up.

Overall, this assessment highlights that strong programs exist in Ghana, which provide an important foundation to which additional activities can be added to bolster the national response to addressing human rights barriers to accessing HIV services. There is national commitment to expanding the range and scale of interventions, and this is an opportune moment for advancing these efforts.

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