Assessment: Legal and Regulatory Framework Affecting Treatment and Services for Most-at-Risk Populations in Ghana
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Interviewers:

- Ms. Joanne Bennett Jeffers
- Mrs. Nana Oye Lithur
Foreword

The Government of Ghana has responded progressively to the HIV epidemic, using locally generated evidence and gradually scaling up effective HIV interventions. Even though the HIV epidemic in Ghana is generalized, there are pockets of high HIV prevalence, particularly among most-at-risk populations such as commercial sex workers, men who have sex with men, and injecting drug users, that exceed by more than 10–20-fold the prevalence of the general population. There is evidence to show that these sub-populations have become the bridging population, seeding and fuelling HIV transmission dynamics among the general population. To sustain a stabilized transmission level and reverse the epidemic by 2015 and beyond, it has become imperative to review and address challenges associated with the policy and legal environment that impact the key drivers of the epidemic as well as the delivery of HIV-related services.

Gathering the views of legal institutions, the Police Service, persons living with HIV, civil society, and United Nations agencies, among others, as we have in this qualitative assessment, will contribute to our understanding of the extent to which the laws in Ghana protect the rights of Ghanaians, including most-at-risk populations.

I am grateful to all the researchers and most importantly to the participating institutions for contributing to this body of knowledge to help streamline the policy and legal environment in which we deliver the national response. The recommendations made will help shape the development of the National Strategic Plan for HIV&AIDS 2011–2015.

Dr. Angela El-Adas,
Director-General
Ghana AIDS Commission
The Human Immunodeficiency Virus (HIV) epidemic in Ghana is a mature, generalized epidemic with pockets of high concentration among select sub-populations and geographic areas. The National AIDS&STI Control Programme (NACP) estimates that national prevalence among all adults was 1.85 percent in 2009 and projects that it will rise to 1.92 percent by 2015 (NACP, 2010b). While prevalence in the general population is relatively low, prevalence among most-at-risk populations (MARPs), including female sex workers (FSWs) and men who have sex with men (MSM), has been consistently higher. Studies indicate that the primary mode of HIV transmission in Ghana is heterosexual intercourse, which provides opportunities for HIV transmission from MARPs into the population at large through partners of clients of sex workers, female partners of MSM, and partners of injecting drug users (IDUs). To a great extent, prevalence in the general population depends on continuous bridging from these groups. Hence, slowing the spread of HIV among low-risk groups—the majority of the population in Ghana—depends on success in halting the bridging by providing MARPs access to needed services, including targeted HIV prevention programmes and care and treatment services for acquired immune deficiency syndrome (AIDS).

In recognition of the importance of an enabling legal and policy environment that supports MARPs and their access to services, the Ghana AIDS Commission (GAC) requested that the United States Agency for International Development–supported Health Policy Initiative (USAID/HPI) conduct a qualitative assessment to develop an understanding of the current legal and policy framework for MARPs. An enabling environment reduces stigma and discrimination (S&D) against MARPs, protects their rights, and ensures that they have access to needed services. The current assessment adds to existing knowledge about important HIV&AIDS stakeholders' views on the legal and policy environment affecting MARPs in Ghana. It also contributes to interventions and policy and legal reform processes that will help reduce the vulnerability of MARPs to HIV and thus the nationwide impact of the HIV epidemic. The assessment findings complement an ongoing assessment by the United Nations Programme on HIV/AIDS (UNAIDS) and contribute to Ghanaian efforts in the area of policy and legal reform. They will also help inform the National Strategic Plan for HIV&AIDS (NSP) 2011–2015, which is currently under development.

All respondents identified commercial sex workers (CSWs), MSM, and discordant partners of persons living with HIV (PLHIV) as being key MARPs. While respondent knowledge about laws and regulations was quite general, all respondents were aware that Ghana’s 1992 Constitution protects against discrimination and that Ghanaian Criminal Code classifies “unnatural carnal knowledge,” commercial sex work, and use of injection drugs as illegal activities. They were also aware of laws that prohibit mandatory HIV testing and dismissal of sero-positive workers from their jobs because of their HIV status.

There is no law that specifically protects PLHIV. Therefore, the rights of MARPs must be upheld by the laws that protect all Ghanaians. Hence, survey respondents felt that legal reform is needed and that some laws, specifically the Criminal Code, need to be clarified as to how they should be applied and enforced within the context of the HIV epidemic. While many felt that the rights of most PLHIV are protected, they did not feel that CSWs and MSM have sufficient protection; many expressed that they do not know about IDUs. A minority of
respondents called for decriminalization of commercial sex work and homosexuality, while the majority cautioned that S&D against MSM and CSWs continues to be very high and that the country is not yet ready to legalize homosexuality or commercial sex work. There has been some debate regarding interpretation of the phrase “carnal knowledge” in Ghana's Criminal Code; some argue that it does not refer to homosexuality, while others assert that it does. MSM or rights advocates must bring cases before the court to determine the interpretation of this language. Many survey respondents believe that it will take a long time for Ghanaians to legalize homosexuality.

Respondents provided many examples of S&D against MARPs and the resulting barriers to programs designed to provide information and services to these groups. They observed that personal biases of members of the judiciary and the police force influence the way laws are interpreted and enforced. A recent survey of police officers indicated that more than 15 percent of those involved in swoops on CSWs barter sex with the CSWs rather than prosecuting them (“Police in Sex Scandal,” 2010). There have also been documented cases of aggression against FSWs and MSM by other types of authorities, including religious leaders, as well as by pimps/managers of CSWs and their clients (Nzambi et al., 2009). According to the respondents, these cases need to be brought to court and publicized in order to raise awareness of human rights violations and advocate for increased respect for the rights of MARPs and improved application and enforcement of the law for their protection.

Survey respondents also provided many examples of S&D and how it discourages MARPs from seeking services and service providers from offering services to MARPs. The majority of respondents stated that health workers need additional sensitization to the special needs of MARPs in order to decrease S&D.

Many countries are struggling with issues related to MARPs similar to those in Ghana. Culturally sensitive and evidence-based advocacy has often catalyzed unexpected and relatively rapid shifts in the views of decisionmakers and other important stakeholders, making it possible to develop appropriate interventions and initiate policy and legal reform processes. Timely, appropriate, and cost-effective interventions addressing MARP issues and their access to needed services have the potential to make considerable difference in the future course of the HIV epidemic in Ghana and elsewhere. According to the Goals exercise recently completed in Ghana, outreach to CSWs and MSM (along with condom promotion and prevention of mother-to-child transmission (PMTCT) of HIV) are the most cost-effective interventions with the largest potential impact in the Ghanaian context (Sanders, 2010).

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5 The Goals dissemination took place in Accra in August 2010. The Goal Model allows simulation modelling and estimates costs and impacts of different scenarios. The Goals Model and Spectrum suite are available for downloading at www.healthpolicyinitiative.com
### Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AD</td>
<td>Auto-Disable [syringe]</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
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<td>EF</td>
<td>Efavirenz</td>
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<tr>
<td>EKN</td>
<td>Embassy of the Kingdom of the Netherlands</td>
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<td>GAC</td>
<td>Ghana AIDS Commission</td>
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<td>GBCA</td>
<td>Ghana Business Coalition Against HIV/AIDS</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GTZ</td>
<td>German Agency for Technical Cooperation</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPI</td>
<td>USAID</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>IDU</td>
<td>Injection Drug User</td>
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<tr>
<td>ISSER</td>
<td>Institute of Statistical, Social and Economic Research (University of Ghana)</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NACP</td>
<td>National AIDS/STI Control Programme</td>
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<td>NASA</td>
<td>National AIDS Spending Assessment</td>
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<td>NSF</td>
<td>National HIV &amp; AIDS Strategic Framework</td>
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<td>NSP</td>
<td>National Strategic Plan for HIV &amp; AIDS</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PEPFAR</td>
<td>President's Emergency Plan for AIDS Relief</td>
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<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<tr>
<td>RCH</td>
<td>Reproductive And Child Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TDF</td>
<td>Tenofovir</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>WAPCAS</td>
<td>West Africa Project to Combat AIDS and STI</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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The human immunodeficiency virus (HIV) epidemic in Ghana is a mature, generalized epidemic with pockets of high concentration among select sub-populations and geographic areas. The National AIDS&STI Control Programme (NACP) estimates that national prevalence among all adults was 1.85 percent in 2009 and projects that it will rise to 1.92 percent by 2015 (NACP, 2010b). While prevalence in the general population is relatively low, prevalence among most-at-risk populations (MARPs), including female sex workers (FSWs) and men who have sex with men (MSM), is much higher. Studies indicate that the primary mode of HIV transmission in Ghana is heterosexual intercourse, which provides opportunities for HIV transmission from MARPs into the population at large through partners of clients of sex workers, female partners of MSM, and partners of injecting drug users (IDUs). To a great extent, prevalence in the general population depends on continuous bridging from these groups. Hence, slowing the spread of HIV among low-risk groups—the majority of the population in Ghana—depends on the success in halting such bridging by providing MARPs access to targeted HIV prevention programs and care and treatment for acquired immune deficiency syndrome (AIDS).

To respond to the unique characteristics of the HIV epidemic in Ghana, the Government of Ghana (GOG) developed the National Strategic Framework II (NSF II) (Ghana AIDS Commission [GAC], 2006). Its goals were to 1) reduce new HIV infections among vulnerable groups and the general population; 2) mitigate the impact of the epidemic on persons living with HIV (PLHIV) and others affected by the epidemic, and on the health system and the economy; and 3) promote healthy lifestyles, especially in the area of sexual and reproductive health (RH). A supportive policy environment is essential to achieve these goals and requires a legal and regulatory framework that reduces stigma and discrimination (S&D) against MARPs, protects their human rights, and ensures their access to HIV prevention programs and AIDS care and treatment. In a meeting in Johannesburg, South Africa, in 2009, eminent African Jurists observed the following: “The law, and the manner in which it is interpreted, applied and developed, has the potential to mitigate and aggravate the impact of the epidemic. Some laws afford protection whilst others may exacerbate vulnerability to HIV.”

In recognition of the importance of an enabling legal and policy environment, the GAC requested that the United States Agency for International Development–supported Health Policy Initiative (USAID/HPI) conduct a qualitative assessment of how laws, regulations, and policies affect treatment of and services for MARPs. The assessment was funded by the President’s Emergency Plan for AIDS Relief (PEPFAR). The findings complement an ongoing legal assessment by the United Nations Programme on HIV/AIDS (UNAIDS) and contribute to Ghanaian efforts to undertake MARP-related policy and legal reform. The results also help inform the National Strategic Plan for HIV&AIDS (NSP) 2011–2015.
Assessment

The objectives of this assessment are to
- Review laws and policies that affect treatment of and services for MARPs in Ghana;
- Assess stakeholders' perceptions of S&D against MARPs;
- Assess stakeholders' awareness of laws and policies that protect MARPs from discrimination;
- Assess the degree to which S&D affect the health-seeking behaviour of MARPs and the behaviour of healthcare providers towards MARPs; and
- Explore stakeholders' views on needed reform.

Methodology and Confidentiality

HPI developed the questionnaire and conducted this study in close collaboration with the GAC; the Ghana Health Service (GHS), including the NACP; UNAIDS; USAID/Ghana; and other experts working with MARPs. HPI staff, an international consultant with experience in RH and HIV&AIDS policy, and a Ghanaian legal expert specializing in human rights carried out the assessment, which included 1) desk review of current policies and laws affecting treatment of and services for MARPs; 2) tools development; 3) survey of key stakeholders familiar with the impact of laws and policies on the treatment of MARPs and their access to HIV prevention and AIDS care and treatment services; and 4) report writing.

The assessment team requested informed consent prior to the interviews and collected data through one-on-one confidential interviews. All data collected were kept confidential. In this report, all stakeholder quotes are presented in quotation marks and italics but are not attributed to individuals.

Key Stakeholders

The GAC and the GHS selected a purposive sample of 19 key organizations (see Appendix A), and HPI interviewed one or more informants from each. These informants, all of whom routinely develop, apply, and/or are familiar with laws and policies affecting MARPs and their access to health services, included the following:

- Legal experts and government officials representing the Office of the Attorney-General and the Commission on Human Rights and Administrative Justice (CHRAJ) who are responsible for developing and implementing laws and policies affecting MARPs;
- Development partners who support programs for HIV prevention, AIDS care and treatment, services for people living with and affected by HIV&AIDS, and S&D reduction;
Representatives from the government as well as the private nonprofit and for-profit sectors who defend the rights of MARPs or provide medical and/or other services to them;

- Government officials representing the GAC, NACP, and other relevant government offices and ministries.

Limitations

The questions posed in this study were open-ended to generate responses that allowed the assessment team to collect a wide range of information from the stakeholders. The nature of the responses, combined with the diverse backgrounds of the stakeholders, limits the types of analyses and comparisons that can be made between the responses of individual stakeholders or different categories of stakeholders. Other limitations of the assessment include the short timeframe, the use of purposive sampling, and the relatively small sample.
The Role of MARPs in HIV Transmission

Annual sentinel survey data of antenatal patients reported in the 2009 HIV Sentinel Survey Report (NACP, 2010a) showed an overall downward trend in Ghana's HIV prevalence, which declined from 3.6 percent in 2003 to 2.9 percent in 2009. Prevalence varies by geographic area. Median HIV prevalence is higher in urban areas (3.6%) versus rural areas (2.2%). Prevalence also varies by sex and age. The sentinel survey data showed that of the 240,802 people estimated to be living with HIV in 2009, about three-fifths are female (NACP, 2010a). It also suggested that the highest prevalence in 2009 was among people ages 40–44 (4.0%) whereas the lowest prevalence was among those ages 45–49 (1.8%). Prevalence was 2.1 percent among those ages 15–24, a slight increase from the rate of 1.9 percent recorded in 2008.

In Ghana, the populations considered most at risk of HIV infection include commercial sex workers (CSWs), MSM, IDUs, and HIV-negative partners of PLHIV. In this report, the term “MARPs” refers to those groups. Prevalence among MARPs, especially CSWs and MSM, is significantly higher than in the general population. It should be noted that the 2009 Modes of Transmission study (Bosu et al., 2009) and projections of prevalence among MARPs rely on regional data because country-specific data on MARPs are relatively scarce.

The findings of the 2009 Modes of Transmission study suggest that HIV transmission occurs among MARPs as well as within the general population (Bosu et al., 2009). The study estimated that of 13,437 new infections occurring in 2008, 30.2 percent occurred among the low-risk general population; 15.5 percent occurred among individuals involved in casual heterosexual sex with non-regular partners; 22.2 percent occurred among clients of CSWs; 2.4 percent among CSWs; 7.2 percent among MSM; and 23.0 percent among regular partners of CSWs and MSM. These numbers reflect the fact that the low-risk population has the largest population and thus the largest share of HIV infections. They also show that while MARPs are small, they can have a large impact on the low-risk population through bridging.

Consistent and comprehensive HIV prevention programmes targeting CSWs have had a considerable impact, contributing to a decline in HIV prevalence among FSWs from 38.7 percent in 2006 to 25.0 percent in 2009 (Anarfi et al., 2009). Nevertheless, commercial sex work continues to be an important route of new infection. Therefore, it is important to establish an enabling policy environment that supports continuing efforts to reach MARPs with targeted HIV prevention programs and AIDS care and treatment. In order to better understand MARPs and their role in the transmission of HIV in Ghana, the GAC has commissioned a mapping study (currently ongoing), which will be important for priority setting, program implementation, and developing HIV&AIDS projections.

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1. The data showed that prevalence ranged from 0.7% in North Tongu District to 5.8% in Agomanya and Koforidua. Four sites registered prevalence of 5.0% and above. At the regional level, prevalence ranged from a low of 2.0% in the Northern Region to 4.2% in the Eastern Region.
2. Total = 240,802 (100,228 men and 140,574 women).
3. 22.2% = partners of clients of FSW; 0.7% = female partners of MSM.
4. Earlier research suggested that 84% of all new HIV infections could be attributed to sexual intercourse with FSWs (Côté et al., 2004). Research conducted by the SHARP Project (Strengthening HIV&AIDS Response Partnership) in 2007 found the HIV prevalence among a sample of MSM in greater Accra to be 25%. The SHARP research also found that prevalence among MSM is higher than that for other groups because 1) they have higher rates of HIV transmission and lower rates of condom use, and 2) some engage in high-risk transactional sexual activities (exchanging gifts for sex or engaging in commercial sex work).
Respondents' Awareness of MARPS

“Everybody’s at risk. And then there are some most-at-risk pockets such as FSWs and MSM.”

All respondents identified CSWs, MSM, and partners of PLHIV as being key MARP groups. Some also specified IDUs but added that little is known about this group except that “they are there” and “more information is needed about them.” Additional sub-populations identified by respondents as being at higher risk of HIV infection than the general population include prison officers and inmates; highly mobile personnel, including the police, the military, peacekeepers, long-distance truck drivers, migrants, and segments of the refugee population; people ages 14–35; hairdressers; youth; and street children. Notably, a few respondents took a broader view of the epidemic and gave responses such as “All people in reproductive age are at risk.”

As indicated, within the context of the HIV epidemic in Ghana, the most-at-risk sub-populations include CSWs, MSM, IDUs, and discordant partners of PLHIV. Contrary to the perceptions described above, research conducted by the SHARP Project shows that long-distance truck drivers in Ghana do not engage in some of the high-risk behaviours associated with their counterparts in other countries. Consequently they are not included in the “most-at-risk” category.\(^\text{12}\)

One respondent emphasized the importance of targeting MARPs as well as those at risk through association with MARPs - with HIV prevention efforts: “People in HIV&AIDS work talk about target groups for education and counselling, [but] let us not forget [that] these people come back to their communities and their spouses.”

\(^{12}\) Based on the SHARP Project’s results, informal sector mining labourers in Ghana are also not included in the high-risk category.
The Legal and Regulatory Framework affecting MARPs and their access to Services

According to Mills, there is no single law (act of parliament) in Ghana that protects or provides special rights to Ghanaians living with or affected by HIV&AIDS, or that specifies how they should be treated (Mills, 2007). Although their rights are protected by the same laws that protect all Ghanaians, development, interpretation, and application of law and policy can mitigate or aggravate the impact on HIV. Mills compiled laws applicable to HIV&AIDS issues; drawing mostly upon this research, the following overview describes some of the laws, regulations, and policies that apply to all Ghanaians but are of particular relevance to MARPs.

1. Discrimination

Article 17(3) of the 1992 Constitution of the Fourth Republic of Ghana defines discrimination as

“... giving different treatment to different persons attributable only, or namely to the respective descriptions by race, place of origin, political opinion, colour, gender, occupation, religion or creed whereby persons of one description are subjected to disabilities or restrictions to which persons of another description are not made subject or are granted privileges or advantages which are not granted to persons of another description.”

The Constitution goes on to state the following:

“All persons shall be equal before the law. A person shall not be discriminated against on the grounds of gender, race, ethnic origin, religion, creed or socio-economic status.”

Protection against discrimination is particularly important for CSWs, MSM, and IDUs who are HIV positive. They often face discrimination because of their sero-positive status and their illegal activities.

2. Protection against Involuntary Testing

As shown in the following excerpt, Article 15 of the Constitution supports the right to voluntary testing by opposing violation of a person's human dignity:

“No person shall whether or not he is restricted or detained, be subjected to:

a. cruel or inhuman or degrading treatment or punishment
b. any other condition that detracts or is likely to detract from his dignity or worth as a human being.”

Other articles protect the rights of a child and “a person who by reason of sickness or any other cause is unable to give his consent” by saying “they shall not be deprived of medical treatment, education or any other social or economic benefit by reason only of religious or other belief.” This ensures that medical officers can perform medically necessary tests when patients are unable to give consent.

All articles are not protective. For example, Article 14 (1)(d) permits the restriction of the
personal liberty of a person suffering from an infectious or contagious disease or a person addicted to drugs for the purpose of treatment and care or the protection of the community. This article can be used against a sero-positive person.

3. Privacy and the Disclosure of HIV Status

Clause (2) of Article 18 states the following:

“No person shall be subjected to interference with the privacy of his ... correspondence or communication except in accordance with law as may be necessary in a free and democratic society.”

This provides legal ground for PLHIV to insist that their HIV status be kept confidential. This is particularly important for MARPs who are sero-positive because they frequently want to keep private the fact that they are a CSW/MSM/IDU and HIV positive.

Similarly, the Evidence Decree provides that when a person discloses information to someone with fiduciary responsibility (e.g., a lawyer, religious adviser, psychiatrist, or psychologist) with the intention that the information be confidential, the person can sue if the confidentiality is not maintained.

4. Protection at the Workplace

Labour Act 2003 (Act 651) consolidates the laws relating to labour, employers, trade unions, and industrial relations. This act is applicable to all workers and employers, except the Armed Forces, the Police Service, and the Prisons Service, and protects grant of [annual and sick] leave and terminations of employment. Section 63(4) states

“... a termination may be unfair if the employer fails to prove that:

a. the reason for the termination is fair; or
b. the termination was made in accordance with a fair procedure or this Act.”

The 2004 National Workplace HIV&AIDS Policy provides guidance for the implementation of this law. In addition, many public and private sector employers have developed their own specific workplace HIV&AIDS policies.

5. Abortion

Abortion is defined by section 58(3) of the Criminal Code as “the premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed.” Abortion is illegal and “any woman who, with intent to cause abortion or miscarriage administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever shall be guilty of an offence and liable on conviction to imprisonment not exceeding five years.”

However, abortions may be allowed when

- Pregnancy is the result of rape, defilement, or incest;
- Continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; and
- Where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease.

6. **Marriage**

Section 13(2) (d) of the Matrimonial Causes Act states

“... a marriage shall be voidable on the ground: that the respondent was at the time of marriage suffering from an incurable venereal disease in a communicable form.”

In the context of HIV, the sero-negative partner can petition to annul a marriage if, at the time of marriage, 1) he/she did not know the other partner was sero-positive, 2) the action is instituted within one year from the date of marriage, and 3) consensual sexual intercourse has not taken place.

7. **Domestic Violence Act 2007**

This Act protects men and women against domestic violence. There is also a provision regarding HIV that makes wilful transmission punishable, but there is no uniform application of the law by the judiciary.

8. **Rights of Children**

The Children’s Act of 1998 (Act 560) protects the rights of children to education, healthcare, and shelter.

9. **Policies Ensuring Access to Health Services**

The 2002 Patients’ Charter developed by GHS ensures

a) The right of the individual to easily accessible, equitable, and comprehensive healthcare of the highest quality within the resources of the country;
b) Respect for the patient as an individual with a right of choice in the decision of his/her healthcare;
c) The right to protection from discrimination based on culture, ethnicity, language, religion, sex, age, and type of illness or disability; and
d) The responsibility of the patient/client for personal and communal health through preventive, promotive, and simple, curative strategies.

10. **Wilful and Negligent Transmission of HIV**

While there is no specific law for negligent transmission of HIV, it is covered by the Criminal Code of 1960 (Act 29, sections 76, 72, and 73), which criminalizes Intentionally causing harm. The Quarantine Ordinance CAP 77 (Law #2, 1915) and
the Infectious Disease Ordinance CAP 78 also cover infectious diseases, including isolation, quarantine, and evacuation of affected areas. A new Public Health Act, currently under development, will consolidate these law/ordinances and make the right to healthcare basic to all Ghanaians. This law will classify HIV&AIDS as notifiable condition without Identification of individuals (GAC, 2010).

11. Commercial Sex Workers

The Criminal Code criminalizes the following:

a) Soliciting or importuning by prostitutes.
b) Trading in prostitution.
c) Causing or encouraging the seduction of or prostitution of children under 16 years old.
d) “Procuration” (i.e., procuring people to become prostitute or to engage in sex with others).
e) Soliciting or importuning for certain immoral purposes (i.e., obtaining clients (“pimping”) for prostitutes or for any other immoral purpose).
f) Keeping a brothel (i.e., operating an establishment in which prostitution takes place).

12) Sex Offences

The following sexual offences are defined as criminal acts.

a) Rape—having sex with a female 16 years old or above without her consent.
b) Defilement—having sex with a child under 16 years old.
c) All forms of prostitution.
d) Unnatural carnal knowledge (interpreted to mean “homosexuality”; see comments on next page).
e) Incest—having sex with certain family members (close blood relations).
f) Indecent assault—forcibly making sexual bodily contact with or sexually violating the body of other persons in any manner short of carnal knowledge.

In addition to the laws outlined above, there are many policies, regulations, guidelines, and strategies that affect MARPs (Mills, 2007; Ceesay, 2009). While these administrative measures provide guidance, they do not carry the same level of compulsion as laws (Mills, 2007). The National HIV&AIDS and STI Policy, the overarching policy in Ghana, “promotes support and care rather than coercion, tolerance and compassion rather than discrimination, protection of human rights and dignity rather than stigmatization and exclusion.”

One of the objectives of the policy is to “ensure that adequate attention is paid to vulnerable groups such as women and children, the youth, and commercial sex workers.” Notably, the policy does not include either MSM or IDUs as a “vulnerable group.”
Overall respondent knowledge about laws and regulations was quite general. Very few respondents were able to cite specific laws and policies by name. They often replied that there was “some kind of law” but could not remember what it was called. All respondents were aware that the Constitution protects against discrimination and knew that the Criminal Code makes “unnatural carnal knowledge,” commercial sex work, and use of injection drugs illegal. The respondents were also aware of laws that prohibit mandatory HIV testing and dismissal of sero-positive workers from their jobs because of their HIV status. In this context, it should be mentioned that recent television programs and newspaper articles have provided information about the Constitution and the rights it provides to Ghanaians. However, there are frequent letters from readers that reflect and contribute to S&D, often stating that MARPs' activities are immoral and against religion.

With regard to protection for MARPs against discrimination, there was evidence of different perceptions among the respondents depending on the type of MARP. While several respondents felt that current laws offer protection to PLHIV in general, fewer felt that they provide adequate protection to FSWs and MSM. Interestingly, many answered that they did not know about protection for IDUs.

Some laws may afford protection, while others may exacerbate vulnerability. For example, the Criminal Code has been interpreted to make commercial sex work, homosexuality, and drug use illegal, which drives CSWs, MSM, and IDUs underground and makes it very difficult to reach them with HIV prevention programs and AIDS care and treatment services. All respondents identified the Criminal Code as a law that hampers such interventions. Two respondents also identified the Matrimonial Causes Act and its provision allowing a partner to annul marriage to a sero-positive partner as another barrier to prevention, care, and treatment because it discourages people from learning their HIV status. One respondent summarized the obstacles as follows:

“Probably when it comes to prevention I will say that a provision in the 1992 Constitution that allows for cultural practices... there are some cultural practices that allow men to marry more than one [woman, so they] can easily pass on the infection to other women. Then, the Criminal Code criminalizes the activities of the CSWs, IDUs, and MSM so they can't seek treatment. So I will mention the Criminal Code as one document that does not help and it applies to IDUs and MSM and I believe the Matrimonial Causes Act does not help in prevention of HIV&AIDS because one can divorce a married partner for carrying a contagious disease.”

While general knowledge among survey respondents was universal, a majority felt that the MARPs themselves must be made more aware of the laws and the protection they provide. As one respondent noted, “Laws are there, but people don't know about them.” Another respondent observed the following:

“PLHIV, MSM, [and] CSWs need to bring cases to court. They are unlikely to do so due to stigma. And even if they do, they are not persuaded the case will be successful. Their rights are minimal and they are difficult to enforce. PLHIV are lower-class people and many do not know that the Constitution protects their rights.”
A few respondents observed that the personal beliefs of those working in the court system often influence their decisionmaking and cause them to apply the law unjustly. “Different judges interpret laws differently; there is a need for things to be unambiguous [and] clear.” For example, the Criminal Code does not explicitly prohibit homosexuality. Professor Ernest Kofi Abochie, a Law Lecturer at the Kwame Nkrumah University of Science and Technology in Kumasi, explained in a May 14, 2010, lecture that it would be difficult to define homosexuality in terms of the Criminal Code of the Constitution because the word itself is not mentioned. He went on to say that determining the meaning of “unnatural carnal knowledge,” referred to in the Criminal Code Amendment Act, would require legal interpretation by a court of law (Afanyi Dadzie, 2010a) and to clarify that the Criminal Code specifically outlaws homosexuality.

Similarly, S&D can influence those in law enforcement and how they apply the laws to MARPs. In 2007, the results of a Police Service survey of its personnel revealed many negative perceptions of MARPs and insufficient knowledge of the law on sex-related offences. The survey also showed that 15.5 percent of police personnel involved in swoops on CSWs barter sex with the CSWs instead of prosecuting (“Police in Sex Scandal”, 2008). In addition to documented cases of aggression against FSWs and MSM by other types of authorities, including religious leaders, there have been cases of attacks by managers/pimps and clients of CSWs (Nzambi et al., 2009). As suggested by the respondents, more documentation of these types of cases, bringing them to court, and increased publicity would raise awareness of human rights violations.

Several institutions in Ghana assist individuals who feel that their rights have been abused or that they have been unjustly treated by the law:

- **CHRAJ** - established by the Constitution and the Commission on Human Rights and Administrative Justice Act of 1993. The CHRAJ is an independent body that people may use to file complaints about human rights violations.

- **National Labour Commission** - established by the Labour Act. Facilitates the settlement of labour-related complaints, especially unfair labour practices, and including unfair dismissal.

- **Police Service** - Established by the Constitution (Article 200) and the Police Act of 1970, and given the statutory duty of preventing and detecting crimes and apprehending offenders.

- **Domestic Violence Victim Support Units (DOVVSUs)** - These units exist in all regions of the country and handles cases of abuse against all Ghanaians (women and children as well as men).

- **Judiciary** - The judiciary has received specialized training to improve their understanding of HIV issues and their ability to address such issues.
• **Legal Aid Scheme** - established by the Legal Aid Scheme Act of 1997 (Act 542) and charged with providing legal assistance at minimal cost to defend and prosecute the human and legal rights of all citizens of Ghana.

The following nongovernmental organizations also advocate for and defend the rights of PLHIV and MARPs: the International Federation of Women Lawyers (FIDA), the Center for Democratic Development (CDD), the Human Rights and Advocacy Centre (HRAC), and the Network of Persons Living with HIV (NAP+).
Stigma and Discrimination against MARPs: Impact on Access to Health and other Services

“Code for the GHS does not forbid people from being offered services. Rather, people's prejudice and belief system keep people from being offered services.”

According to the respondents, S&D “stem from fear of the unknown” and “human nature.” They also indicated that S&D against PLHIV, CSWs, and MSM among Ghanaians is very high, despite efforts to raise awareness of the importance of “not judging others.” The respondents provided many examples of how S&D against MARPs presents a real barrier to identifying and reaching those engaging in high-risk behaviours. Hence, S&D hampers the provision of information, treatment, care, and support to MARPs, and makes it difficult for them to protect themselves, their partners, and others that they may expose to HIV infection.

People Living with HIV&AIDS

“Still it is a serious, serious issue, even amongst those you would expect to be more enlightened.”

Research confirms the respondents' views that the level of S&D against PLHIV is very high. According to the 2008 Ghana Demographic and Health Survey of women ages 15–49, only about 32 percent would buy fresh vegetables from a sero-positive shopkeeper and almost 62 percent believed that a female sero-positive teacher who is not sick should be allowed to continue teaching. A study conducted in Kumasi confirms that there is a considerable level of HIV-related stigma, ranging from gossip to outright discrimination against PLHIV and affected families, including work place discrimination (Ulasi et al., 2009). The informants' responses below reflected the subtlety and various forms of S&D:

- “Lots of subtle discrimination.”
- “People will not be fired from a job once their status is known; rather, a file against them will be built.”
- “When a PLHIV raises an issue in a meeting, in high-level meetings, it is not recorded ... serious issues are not recorded.”

The respondents also provided examples of outright rejection - even violence - as result of S&D:

- “People have been rejected by their own mothers when they learnt they are positive.”
- “We had a case where the whole community had to ostracize one of our members who was keeping people in his home for care and support ... like a hospice. When they found out that all the inmates were PLHIV, they started to vandalize the place, and the PLHIV reported the case to the police, but nobody helped them out. So as we speak, we have the evidence; the case is with the police.”

Hence, the social and economic cost of learning and disclosing one's HIV status can be high for Ghanaians; a 2005 study of discordant couples conducted by the SHARP Project showed that only 30 percent of HIV-positive respondents had informed their partner (or partners) of their positive status. The research also showed that approximately 70 percent of PLHIV were discordant with their regular partner. This has serious implications in view of the large number...
of Ghanaians living with HIV. The number of PLHIV will increase as the population grows and more PLHIV receive antiretroviral drugs (ARVs) and thus live longer.

Respondents observed that S&D keep PLHIV from seeking much needed treatment, care, and other services, and that they often fear that seeking a particular service will “brand them” as sero-positive. Many respondents cited an article from the Daily Graphic\(^{13}\) that asserted the following: “…people who go for treatment at the Fevers Unit in Korle Bu Teaching Hospital sometimes pour out medicines that have been given them in HIV&AIDS containers into other containers because people think when you see them carrying the containers of drugs they have been given, they will [be branded] as PLHIV.” [If] you even go … to the Fevers Unit to get information … as soon as you enter …, everybody thinks you have HIV.”

Respondents provided other examples of the effects of S&D, including poor families choosing to forgo benefits from the Livelihood Empowerment against Poverty Programme rather than risk being identified as a family affected by HIV. In addition, sero-positive beneficiaries of the private insurer, Momentum Insurance, often forgo claiming benefits for their healthcare rather than risk that insurance administrators and employers learn of their positive status.

Not only do PLHIV stop seeking services but health workers sometimes stop offering them services. According to the respondents, “PLHIV are discriminated against by providers.” A nurse observed that before performing C-sections, for example, doctors will say “I want to know a person’s status before I operate” and some will go so far as to say that they are “busy and cannot do the operation.” Another case described the experience of a heart patient seeking healthcare: “the doctor wrote a prescription but when he learned the patient’s status, he left the room and sent a nurse to provide the rest of the care and he never returned.” Health workers also have biases against PLHIV that influence the types of services they provide to them. According to respondents, health workers perceive that PLHIV should not be sexually active and consequently do not provide FP services to them.

A minority of respondents stated that they sense a change in attitudes as a result of the introduction of antiretroviral therapy (ART). In the past, AIDS was known as the “slimming disease, a deadly disease.” “Now, with ART, AIDS is seen more as a chronic disease. People who are positive are healthy longer and consequently there is not as much fear and ignorance of HIV.”

Notably, the respondents also mentioned “self-stigmatization” and S&D within the PLHIV community resulting from the perceived level of “sin” committed and personal “guilt” and shame for becoming infected.
Commercial Sex Workers

“CSWs—they are also Ghanaians.”

The respondents indicated that there is “big stigma” against CSWs: “Stigma is there, comments are made behind their backs.” They are “frowned on” and “socially rejected for doing something immoral.” People also perceive CSWs to be at higher risk of HIV, which makes them subject to HIV-related discrimination as well. Research confirms the respondents’ statements: according to Nzambi et al. (2009), about 35 percent of the general population and 32 percent of the police surveyed in Accra and Tema would exclude a person from the family if they were a FSW.

Several respondents commented that CSWs are “harassed by law agencies.” Four observed that if a “woman is found with a condom in her purse out late at night near the Togo Embassy, she is assumed to be a CSW and is arrested.” Another respondent observed, “There needs to be better awareness; while police are better informed, it [aggression against CSWs] is still happening.” The police provide sensitization and training on the rights of CSWs to discourage conduct of “swoops” and stop officers from aggressively accusing women of soliciting sex. However, some officers’ treatment of CSWs—and underlying S&D—puts both groups at higher risk of HIV and violates these women’s rights.

According to respondents, members of the judiciary also need to be more sensitive to the rights of CSWs. “I know there is S&D [against CSWs]. We had an incident [in which] police officers conducted swoops at Osu, the prostitutes were taken to court, and the judge publicly disclosed the status of one who was HIV positive. And, also, [there is] the fact that their activities are considered criminal .... So at the end of the day, no matter what they do, so far as they are tagged for their activities, they are criminalized. Obviously they won’t have access to protection or any services available in the justice system.”

Research indicates that CSWs do seek healthcare services and that HIV prevention programs targeting CSWs have contributed to a decline in HIV prevalence among FSWs (from 38.7% in 2006 to 25% in 2009) (GAC, 2010). In some places, health providers and police know the CSW community and work with them to promote condom use and HIV prevention. According to the GAC, FSWs surveyed in Accra and Kumasi were “seaters”—older women (mean age 35 years) who are highly organized and primarily receive clients at home—or “roamers” (mean age 25 years), who are less organized, mobile, and solicit their services in “hot spots.” According to the same study of FSW, from 2006 to 2009, prevalence among roamers in Accra dropped from almost 37 percent to about 17 percent and prevalence among roamers in Kumasi dropped from 24 percent to about 21 percent. Meanwhile, prevalence among seaters in Accra dropped from about 52 percent in 2006 to almost 32 percent in 2009 and in Kumasi from about 39 percent in 2006 to a little less than 29 percent in 2009. According to the GAC, more than 38 percent of CSWs reported being tested for HIV in the last 12 months and knowing the results. In 2006, 98 percent of CSWs reported using a condom with a paying client as compared to 90 percent in 2001 (Anarfi et al., 2009); far fewer (almost 34%) reported using a condom with a non-paying partner.
The respondents suggested that healthcare providers need to “appreciate the specific needs of CSWs” and develop “treatment-friendly sites.” While the challenge of reaching CSWs is that sex work is illegal, several respondents observed that one must “accept the fact that [commercial sex] will always be there” and that it is essential that CSWs protect themselves and their clients. As one respondent observed, “I tell people that the next person a CSW provides services to may be their husband.”

### Men Having Sex with Men

“People are not ashamed to say that [MSM] are like animals [and that] they should be killed. I am shocked and sad ... this is a serious, serious issue.”

According to survey respondents, MSM is a “totally ‘no-no’ issue” that is “taboo” to most Ghanaians. The response to MSM among the general population goes beyond “frowning upon [them],” with some respondents asserting that “there is a religious code that abhors this practice.” One respondent observed that “religion makes it difficult to address MSM.” Another noted, “The Bible tells us of Adam and Eve. If God wanted something else, he would have made Adam and another man and Eve and another woman.” One respondent suggested that with regard to MSM with HIV, many Ghanaians hold the view that “you were unfaithful, you’ve had sex with men, you deserve to be sick.” Respondents also suggested that many Ghanaians view homosexuality as a “foreign thing.”

Research confirms the respondents’ statements regarding MSM-related S&D. A 2009 survey conducted among the general population and police in Accra and Tema indicated that about 40 percent believed that a man who has sex with men should be excluded from the family (Nzambi et al., 2009). The survey also indicated that stigma against MSM is compounded by the perception that MSM are more likely to be infected with HIV.

Despite these strong feelings against MSM, several respondents observed that “there is a transition going on—in the past, MSM did not exist at all in communities. Now, people are talking about it—that there are minority groups with that orientation.” In fact, the first ever anti-gay protest in Ghana took place in Sekondi-Takoradi on June 4, 2010 (Afanyi Dadzie, 2010b). Many newspaper and Internet articles and radio discussions followed this event and substantiated survey respondents’ observations about the need to raise awareness surrounding homosexuality. One respondent cautioned that it is important to be “careful about how they manage the MSM phenomenon.” Another respondent recommended efforts to “inform Ghanaians about experiences in other regions of the world, such as the United States and Europe, vis-à-vis the status of homosexuals, so that people will open their minds and, perhaps, relax the laws.” However, several respondents observed that you cannot “address the issue the American way. Activists would be too abrasive and might in fact trigger a backlash.” The respondents indicated a need to “educate health providers about the unique health needs of MSM.” One observed that “the challenge of convincing healthcare providers continues; ... when someone presents with an STI, your job is not complete unless you look at the back passage.”
MSM participating in a 2007 SHARP Project study had STI infection rates of 24 percent. These MSM reported seeking care from multiple service providers, including pharmacies and doctors, suggesting good health-seeking behaviour. However, MSM also reported that they preferred care from public facilities and Centre for Popular Education and Human Rights, Ghana (CEPEHRG) drop-in centres that were “welcoming and MSM-friendly.” Only half of the SHARP Project study participants who had anal sex in the last 12 months used a condom the last time they had anal sex; more than one-third did not use condoms consistently or the last time they had anal sex. This has serious implications; a 2006 Behavioural Surveillance Survey reported that 61 percent of MSM surveyed self-identified as bisexual and 39 percent as gay (Anarfi et al., 2009). Thus MSM represent an important bridge of HIV transmission into the general population, because many have sexual contact with both men and women. As some interview respondents pointed out, “some MSM are married.”

**Injection Drug Users**

Currently, little is known about IDUs in Ghana, and this was reflected in the assessment responses. As noted, interviewees knew that IDUs “are there, but not clear how many” and also stated that injection drug use is “not a common phenomenon.” Notably, one-third of respondents to a survey on S&D in Accra and Tema knew someone who was an IDU (Nzambi et al., 2009). The German Agency for Technical Cooperation (GTZ) is currently undertaking research to learn more about the IDU community, including its behaviours. The results will be extremely important for Ghana as they will help guide the selection of interventions, program design and implementation, and legal and policy reform.

What is known about injection drug use in Africa overall could have implications for the HIV epidemic in Ghana if the issue does not receive sufficient attention and appropriate interventions. A review of injection drug use and HIV indicates that injection drug use is no longer rare in sub-Saharan Africa (Reid, 2009); hence, it could be more prevalent in Ghana than expressed by the respondents. Another issue is the possibility of growing numbers of IDUs in the future; scientists at the July 2010 International AIDS Conference in Vienna highlighted the impact of injection drug use on the AIDS pandemic in many countries (“‘Seek, test, treat,’” 2010).

IDUs in Africa tend to be male, are often unemployed, and may engage in petty theft to support their drug habits. Sex workers may also be IDUs. Drug criminalization and drug-related crime contribute to high drug prevalence in African prisons. As per Reid, more than one-third of inmates in Ghana in 2007 reported having injected drugs, although only 10 percent had been arrested for drug trade or possession. Injection drug use may be the strongest behavioural risk factor for HIV infection for prison inmates in Ghana.

Needle sharing among IDUs is common, but there is often a lack of knowledge that needle sharing can spread HIV and that the virus can live for several hours outside the body on blood-contaminated instruments. Resources for harm reduction, including correct HIV information and proper counselling, treatment for drug addiction, and needle exchange programs, are often insufficient.
Other Sub-Populations at Higher Risk of HIV Infection Affected by Stigma and Discrimination

With regard to MARPs, respondents specifically mentioned orphans and vulnerable children (OVC) and prisoners. One respondent was familiar with a case where a child was rejected because of sero-positive status, an indication of potential vulnerability due to lack of family and social support:

“The mother died, and then the caretaker ... they took the child to the hospital and then through testing the child, it was confirmed that the child was also HIV+. And it's like everybody abandoned the child. So it was the regional chairman of NAP+ who went for the child and now the child is with NAP+ in the Central Region. So, they ask, if we can help ... . So the child [has] no father, no mother—and because he's HIV+, they throw him away.”

One respondent explained that prison policy in Ghana does not require mandatory HIV testing of prison inmates. When prisoners enter the system, officials encourage and ensure access to voluntary testing and counselling (VCT). If an inmate tests positive, to maintain confidentiality, only the officer in charge of the cellblock and the nurse are informed about his/her sero-positive status. The respondent further explained that the Prisons Service actively supports peer education programs and works with inmates to learn more about their behaviour. He also noted that “MSM is not as prevalent among the prison population as perceived, largely due to lack of privacy in the prison setting.” However, inmates are involved in other high-risk behaviours, such as exchanging blood in “brotherhood” initiations where they “incise themselves with a blade and exchange the blood or merge the blood from the incisions.” Insufficient data are available to fully understand risk behaviours among prison inmates, including injection drug use.

The Police Service has worked with its personnel to raise awareness of HIV prevention. However, respondents stressed that more needs to be done to strengthen and expand efforts to sensitize the police.
Overall, respondents felt that “society is changing and there is need for lots of sensitization and education” about how policies should be implemented to better meet society’s changing needs. For example, several respondents emphasized the importance of disseminating and training people on existing policies, such as the National HIV&AIDS and STI Policy 2004, workplace policies, and World Health Organization (WHO) and UNAIDS recommendations.

Most respondents suggested there should be legal reform; some talked about basic law, others about an HIV-specific law; some stated the need for greater clarity and specificity in laws and policies to address HIV&AIDS. As one respondent observed, “Society is dynamic” and “the policies were formulated when HIV was not such an issue.” Another respondent specifically mentioned the need for an AIDS statute, similar to the statute protecting disabled Ghanaians. A few proposed decriminalizing commercial sex work and homosexuality. However, respondents were unanimous in stating that the country is not ready for such decriminalization and thought that it would take a long time for attitudes to change.

While respondents felt that the country is not ready for decriminalization of commercial sex work and homosexuality, there was consensus that it is important to sensitize the police to stop them from 1) conducting “swoops” on sex workers and 2) accusing women of soliciting sex when they are on the street late at night, carrying condoms. Instead, they felt that police must recognize that commercial sex will “always be there” and that it is important to ensure proper precautions among CSWs to prevent the spread of HIV. One respondent stated that there needs to be more flexibility with “locking up people” who are assumed to be CSWs and that commercial sex work should be “regulated with mandatory annual HIV testing to stay in business.” A recent survey of police in Accra found that 25.6 percent thought FSWs and MSM should not be arrested when they are identified; however, more than 60 percent of the general population surveyed in Accra and Tema were not in favour of amending laws to legalize or decriminalize MSM and commercial sex work (Nzambi et al., 2009).

Respondents pointed out that parliamentarians have inadequate knowledge about HIV and present a barrier to reform: “There is resistance among legislators and lack of appreciation on their part that AIDS is a unique disease with its own unique issues.” One respondent observed that parliamentarians are “hostile” towards CSWs and related that when he was meeting with a group of parliamentarians, one asked, “Why should I allow for decriminalization of CSW? Do I need to allow my daughter to do that kind of job?” Another said, “It’s [MSM] against the law. Show me who they are and I will shoot them.”

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The respondents did not mention injection drug use in the context of decriminalization.
Conclusion

Many countries are struggling with MARP-related issues similar to those in Ghana. Culturally sensitive and evidence-based advocacy has often catalyzed unexpected and relatively rapid shifts in the views of decisionmakers and other important stakeholders, thus making it possible to develop appropriate interventions and initiate policy and legal reform processes. Timely, appropriate, and cost-effective interventions addressing MARP issues and their access to needed services have the potential to make a considerable difference in the future course of the HIV epidemic in Ghana and elsewhere. According to the Goals exercise recently completed in Ghana, outreach to CSMs and MSM (along with condom promotion and prevention of mother-to-child transmission (PMTCT) of HIV) are the most cost-effective interventions, with the largest potential impact in the Ghanaian context (Sanders, 2010).  

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As the agency with the mandate to coordinate and manage the HIV&AIDS response in Ghana, GAC is responsible for implementing recommended activities, and will need to work in close collaboration with the NACP/GHS, the MOH, and other services and organizations mentioned in this report. Donors play an important role in ensuring that MARP and other cost-effective interventions are funded and in helping the GAC enhance coordination of HIV programmes.

1. **ENCOURAGE, INITIATE, OR STRENGTHEN REVIEW OF CURRENT POLICIES, LAWS, AND REGULATIONS THAT NEGATIVELY AFFECT MARPs AND THE SERVICES THEY NEED**

The respondents stressed the need for policy and legal reform, although they think that Ghanaians are not yet ready for decriminalization of commercial sex work and homosexuality. This recommendation needs to be preceded by sensitization and advocacy (described further below). Suggested activities include the following:

- **Do final review of NSP 2011–2015 to ensure that MARP issues are addressed according to their high importance to public health.** This plan will guide the national response for the next five years, so it is important for the GAC to ensure that MARP issues are adequately addressed in this important guiding document.

- **Develop a MARP action plan to address key MARP issues.** Use the NSP 2011–15 as a guide to develop a list of priority MARP issues that could have the greatest impact on HIV prevention. For each issue or set of issues, develop a detailed action plan to address the issues.

- **Establish an interagency group to review policies.** The GAC should consider establishing an expert group with representatives from the Police Service, the Prisons Service, the NACP/GHS, the MOH, and others to review important policies highlighted in the MARP action plan, including major RH and public health policies, the GHS Patient Charter, the Police Code of Conduct, and the draft Prisons HIV&AIDS Policy. Upon their return to their respective organizations, with GAC guidance, members of the interagency group will review the policies with their colleagues. Interagency group members and relevant colleagues should be selected as soon as possible in terms of priority for sensitization and advocacy.

- **Mainstream MARP issues in important policies and assist programmes with concrete measures.** Once MARP issues are mainstreamed into the policies, relevant agencies must support programmatic interventions, including pilots, to ensure implementation. The activities will flow from the MARP action plan and will include a number of different interventions. For example, they may include qualitative prison research related to high-risk behaviours and appropriate risk
reduction programming, and support of the DOVVSUs to continuously strengthen their response to both female and male rape victims and ensure that they receive post-exposure prophylaxis (PEP). 16

- Establish an expert group to review criminalization of MARP activities and develop a strategy to advocate for legal reform. Many countries have introduced an AIDS law. HPI has assisted many countries in this endeavor and could share some of its experiences and assist with strategy development and the subsequent process, as well as policy reform activities.

2. SENSITIZE AND ENHANCE HIV&AIDS–RELATED CAPACITY AMONG KEY PROFESSIONAL GROUPS AND INVOLVE THEM IN ADVOCACY

There was consensus among the respondents about the need to strengthen advocacy for the issues and special needs of MARPs. Key professional groups could play an important role in this advocacy, provided they have accurate knowledge and the skills required to do so. Sensitization and S&D reduction must be part of the capacity building of these key groups, including meeting PLHIV and MARPs, to give vulnerable groups a “human face”. The professional background and experience of the key group members would be helpful to overcome stigma and recognize benefits to public health. Training representatives from the key professional groups will promote advocacy among peers who have similar professional experiences and encounter similar challenges related to MARP issues (e.g., legal action by MARPs). The list below includes professional groups that are particularly important in terms of having an impact on MARP issues and/or the services that they need (but may not be all-inclusive):

- The judiciary, security services, and police; the Office of the Attorney-General; and the CHRAJ—important stakeholders in efforts to ensure respect for the human rights of MARPs in order to meet commitments made by the GOG.

- Healthcare personnel—responsible for providing VCT, ART and FP/RH and other health services (GHS as well as the private nonprofit and for-profit). It is important for the GAC to work closely with the NACP/GHS and the MOH in these activities.

- Journalists with adequate knowledge about HIV&AIDS and FP/RH will contribute to better coverage and accurate information related to MARP issues in newspaper, radio, and on television as well as S&D reduction (an important component in all advocacy and capacity-building activities).

Suggested activities include the following:

- GAC to identify key professional groups and representatives.
- Adapt/develop advocacy materials (e.g., using information from the Goals model, the AIDS Impact Model (AIM), and RAPID and train selected representatives.

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16 The Police Service has provided special training to these units to make them CSW- and MSM-friendly, and DOVVSU personnel sometimes work with CSW and MSM to change high-risk behaviours.
• Assist trained representatives with implementation of sensitization/advocacy of members in key professional groups. This assistance can take the form of helping with advocacy after capacity building, or identification of appropriate opportunities for advocacy, and/or meeting other needs that the trained representatives may have.

3. STRENGTHEN ADVOCACY TO RAISE AWARENESS AND UNDERSTANDING OF MARP ISSUES AND NEEDS AMONG LEADERS

It is similarly important that leaders understand MARP issues and needs. Key leaders include parliamentarians; ministers of state; government officials; leaders of civil society organizations; and community, traditional, and religious leaders. These leaders influence the development and enforcement of policies, laws, and regulations that affect MARPs, including support for and availability of MARP-friendly HIV prevention, care, and treatment services. It is similarly important to target those who control funding. These leaders need to become champions for effective HIV-related interventions for these groups as they are well positioned to influence the general population.

Suggested activities include the following:
• Develop criteria for selection and identify and select potential “influentials” at different levels.
• Adapt/develop appropriate advocacy materials for different groups/levels, test them in the field, and use them for training.
• Support “influentials” to continue advocacy activities, assisting them to make strategic selections of individuals/groups targeted for advocacy.

4. SENSITIZE PLHIV AND STRENGTHEN THEIR ADVOCACY AND OTHER SKILLS, INCLUDING LEGAL LITERACY

Sensitization within PLHIV networks is an important activity because these networks encompass people with different backgrounds, including various MARPs. This diversity sometimes leads to S&D within networks. Selected network members would benefit from advocacy and other training to ensure greater involvement of PLHIV (e.g., in policy development). Activities also need to build capacity related to legal literacy to enable PLHIV and MARPs to know the law, their rights, and the legal recourse they have when they encounter S&D. Such capacity building will help the networks increase reporting and documentation of cases of police aggression against CSWs and MSM and, if appropriate, take the cases to court. This will help monitor and improve police behaviour and also raise awareness of these issues. Suggested activities include the following:

• Identify/select PLHIV networks and organized MARP groups and the organizations that support them, review their activities, and identify their strengths and weaknesses.
• Review available materials and adapt and/or develop training materials on advocacy, S&D, relevant laws and legal environment, etc.
• Identify and train trainers.
• Provide ongoing support to trainers and networks to “navigate the legal and policy environment.”

5. USE THE GOALS MODEL FOR EVIDENCE-BASED ADVOCACY

Use of the Goals model helps stakeholders identify the most cost-effective interventions to reduce the impact of the HIV epidemic and lower future incidence. The model is also commonly used for evidence-based advocacy. With support from HPI, the Ghanaian stakeholders have recently completed the Goals model for the country (Sanders, 2010). The GAC needs to use the model to help prioritize activities in NSP 2011–2015 (currently under development). For maximum usefulness, the Goals model should be updated when new MARP data become available in Ghana (e.g., the results of the mapping and size estimation studies currently under way). In addition, more costing of various services/interventions should be undertaken to obtain Ghana-specific cost data.

Suggested activities are as follows:
• Update Goals model as needed.
• Conduct additional costing assessments.

6. CONDUCT ADDITIONAL RESEARCH AND USE FINDINGS TO STRENGTHEN MARP PROGRAMS AND GUIDE EVIDENCE-BASED DECISIONMAKING

While considerable research and anecdotal evidence exist, there is need for more in-depth understanding of MARP behaviour, especially that of MSM, CSWs, IDUs, and prison inmates. There is insufficient information on where MSM gather, their risk behaviours, the most effective ways to reach them, their perceptions of health information and available services/care, and their health-seeking behaviours. Similarly, more data about CSWs outside Accra and Kumasi would be helpful.

It is unknown whether, in the future, IDUs could represent an increasingly important bridge to the general population in Ghana; in any case, there is an acute shortage of information and data for this population. Little is known about IDUs’ knowledge and awareness of elevated HIV risk. The size of their population is unknown. Research among prison inmates may provide insights on injection drug use both inside and outside prisons.

Prison research is ongoing and is extremely important. This research needs to focus on increasing knowledge about injection drug use, MSM activities, and other high-risk behaviours, such as initiation rites, that put inmates at risk of HIV infection. The Prisons Service has HIV policies in place and already conducts prevention efforts. Therefore, some of the interventions listed below, such as providing inmates with correct information and effective counselling on HIV, injection drug use, MSM activities, initiation rites, and harm reduction strategies, could be added to ongoing efforts:
• GAC to establish interagency group of experts to review gaps in MARP-related knowledge.

• Based on identified gaps, provide research suggestions to agencies/organizations and donors involved in research to ensure that areas where gaps exist are prioritized.
### Appendix A

#### KEY ORGANIZATIONS INTERVIEWED

1. United Nations Population Fund  
2. United Nations Programme on HIV/AIDS  
3. United States Agency for International Development  
4. Royal Danish Embassy  
5. German Agency for Technical Cooperation Regional Coordination Unit for HIV & TB  
6. Family Health International  
8. Ghana AIDS Commission  
9. Office of the Attorney-General  
10. Ghana Police Service  
11. Ghana Prisons Service  
12. Centre for Popular Education and Human Rights, Ghana  
13. Center for Democratic Development  
14. Human Rights Advocacy Centre  
15. Commission on Human Rights and Administrative Justice  
16. International Federation of Women Lawyers  
17. Ghana Network of PLHIV  
18. Ghana Legal Aid Scheme  
19. West Africa Project to Combat AIDS and STIs
References


• Nzambi, K., M. Bevalot, H. Till, and A. Dzokoto. 2009. Stigma and Discriminatory Attitudes and Perceptions in Accra and Tema Metropolis in Ghana: How Does the General Adult Population See Most at Risk Populations (MARPs) and How Do MARPs See Themselves in the Context of HIV and AIDS? Accra: German Agency for Technical Cooperation, Regional Coordination Unit for HIV & TB.


