GHANA AIDS COMMISSION

Under the Office of the President

NATIONAL HIV AND AIDS ANTI-STIGMA AND DISCRIMINATION STRATEGY 2016-2020

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ACRONYMS

BCC	Behaviour Change Communication
CBO	Community Based Organization
CDC	Centres for Disease Control
CEPEHRG	Centre for Popular Education and Human Rights, Ghana
CHRAJ	Commission on Human Rights and Administrative Justice
CSOs	Civil Society Organizations
DAC	District AIDS Committees
DP	Development Partner
FBO	Faith Based Organization
FHI	Family Health International
GAC	Ghana AIDS Commission
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GIPA	Greater Involvement of People Living with AIDS
H2H	Heart-to-Heart
HIV	Human Immune Deficiency Virus
HRAC	Human Rights Advocacy Centre
IBBSS	Integrated Bio-Behavioural Surveillance Survey
KP	Key Populations
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MIPA	Meaningful Involvement of Persons Living with AIDS
MMDAs	Municipal, Metropolitan and District Assemblies
MSM	Men who have sex with men
MTCT	Mother-to-Child Transmission
NACP	National AIDS/STI Control Program
NAP+	Network of Persons Living with HIV
NGO	Non-Governmental Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SAMC	Social Accountability Monitoring Committee
SHARPER	Strengthening HIV/AIDS Response with Evidence based Results
SIS	Stigma Index Study
STI	Sexually Transmitted Infection
UNDP	United Nations Development Programme
WAPCAS	West Africa Program to Combat AIDS and STIs

EXECUTIVE SUMMARY

A Stigma Index Study was conducted in Ghana in 2014 to provide comprehensive data on the extent of HIV-related stigma and discrimination among PLHIV including KP's living with HIV. The Study revealed that:

(i) PLHIV respondents avoided all the forms of social exclusion and other forms of discrimination through non-disclosure of their HIV status to individuals and groups outside the health care delivery system;

(ii) experiences of stigma and discrimination were observed to be more prevalent among PLHIV in rural than in urban locations;

(iii) a greater proportion of PLHIV respondents who were members of PLHIV network/support groups experienced discrimination from their peers than those who were not members and

(iv) PLHIV who did not belong to the key populations sub-group, tended to inflict considerable emotional and psychological distress on PLHIV who belong to the key populations sub-group.

Apparently, the fear surrounding the emerging HIV epidemic in the 1980s persists today as the results of the Stigma Index Study in Ghana also revealed that majority of people stigmatize others because of fear that they would be infected through casual contact.

Extensive regional consultations were done with stakeholders to share the information from the Stigma Index Study and to elicit their views and contributions to enrich the next phase of the study i.e. developing a National HIV and AIDS Anti-Stigma Strategy.

The National HIV and AIDS Anti-Stigma Strategy, among other things,

- will strengthen evidence-based advocacy for policy change and programmatic interventions
- lobbies pro-actively for all social forums to identify and address stigma and discrimination explicitly
- advocates for the elimination of all forms of HIV-related stigma and discrimination in public forums, including the media
- addresses the roles of public and private sectors, development partners, faith based and civil society organizations in eliminating HIV-related stigma and discrimination
- advocates for PLHIV and KPs' active role in eliminating stigma and discrimination.

In responding to HIV and AIDS related stigma and discrimination, which is manifested in the form of power, inequality and exclusion, this strategy has been developed using structural and environmental interventions to help change these context. In addition, individual and interpersonal interventions such as psychological approaches have been outlined as this would effect change at

multiple levels, with the tendency to reinforce each other. Importantly, evidence based tried and tested approaches that have been successful in bringing about positive changes in attitudes, behaviours and skills within communities in other countries have been adapted and applied within the Ghanaian context. All these would contribute to the final achievement of the three main objectives of the strategy which are to; increase the accepting attitudes of the populace, promote and protect the human rights of PLHIV and KPs and strengthen stakeholder capacity to prevent, recognize and deal with stigma and discrimination.

1.0 INTRODUCTION

1.1 Background

1.1.1 The HIV and AIDS Situation

The first case of AIDS in Ghana was diagnosed in 1986. Ghana is classified as having a generalised HIV epidemic with pockets of high prevalence among Key Populations. According to the 2014 Ghana Demographic Health Survey, HIV prevalence in Ghana was 2.0% having decreased from 2.2% in 2006. Prevalence among males, 15-49 years (1.1%) is lower than that of females (2.8%) in the same group across all regions of the country. By the end of 2015, there were an estimated 274,562 Person Living with HIV (PLHIV) with women constituting about 60% and 89,113 PLHIV on Anti-retroviral treatment.

According to the 2015 HIV Sentinel Survey (HSS report), the HIV epidemic is more prevalent in urban areas (2.4%) than rural areas (1.4%). Western, Ashanti, Greater Accra and Eastern Regions have an HIV prevalence of more than 2%.

1.1.2 Ghana's HIV and AIDS Response

Ghana's HIV and AIDS response is based upon a vastly expanded effort of public and private sector partnership, civil society, PLHIV network, development-partners, religious and traditional groups. The response aligns with the Three Ones Principle, with one coordinating authority i.e. the Ghana AIDS Commission (GAC); one national action framework i.e. the National Strategic Plan (2016 – 2020); and one agreed monitoring and evaluation Plan. Financing the HIV response is a major issue in Ghana since the evidence shows that majority of the funds expended on direct HIV and AIDS programme activities are from external sources. This has been corroborated by previous National AIDS Spending Assessments (NASA) Reports for Ghana which indicate a significant reliance on international funds in financing the response. The key sources of support for the national HIV response in recent years have included the Government of Ghana (GoG), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), President's Emergency Plan for AIDS Relief (PEPFAR), the UN system, German Development Cooperation (GIZ), Japan International Cooperation Agency (JICA) and private sector partners.

1.2 Anti-Stigma Strategy

1.2.1 Anti-Stigma Strategy Planning – A Prologue

HIV and AIDS-related stigma and discrimination are pervasive problems worldwide and People living with HIV (PLHIV) in Ghana, as elsewhere, face stigma and discrimination. To address this, a Stigma Index Study (SIS) was conducted in 2014 to provide comprehensive data on the extent of HIV-related stigma and discrimination among Persons Living with HIV (PLHIV). A major recommendation from the SIS was to develop a National HIV and AIDS Anti-Stigma Strategy based on the findings of the study to guide implementation of HIV-related Anti-Stigma efforts. During the dissemination of the 2014 SIS, inputs were solicited from key groups such as NAP+ Ghana (PLHIV constituency), CEPEHRG (MSM constituency) and WAPCAS (FSW constituency) to commence the development of the Strategy. The inputs

received were consolidated by the consultant into a draft Strategy which was further reviewed and finalized by the National HIV and AIDS Anti-Stigma Technical Working Group.

This document is expected to provide general principles, strategies and activities which will guide all HIV anti-stigma efforts in the country.

1.2.2 Relevance of Anti-Stigma Strategy

UNAIDS has set a global target to end AIDS by 2030, however a short-term target has been set to be achieved by 2020 known as 90-90-90 treatment targets. This means that by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy will have viral suppression. Sub-Saharan African countries including Ghana adopted these targets at the 25th African Union (AU) Summit in Johannesburg, South Africa in June, 2015.

The National HIV and AIDS Strategic Plan 2016-2020 has identified stigma and discrimination reduction as a critical social enabler that must be addressed if the country is to achieve its targets towards achieving 90-90-90 treatment targets and ultimately ending AIDS by 2030. In other words, national targets to increase uptake of HTS and treatment most likely will be achieved, once HIV- related stigma and discrimination is addressed.

All Governments have recognized that stigma and discrimination and violations of human rights are major barriers to an effective national response to HIV. Consequently, the leadership of these governments have committed to protecting the human rights of people living with HIV as well as the rights of women, children and members of vulnerable and key populations in the context of HIV. [United Nations, June 2011].

1.2.3 Target Group

National level structures, such as GAC, NACP, key institutions (implementing partners) such as, Association of PLHIV, MDAs, private sector organisations, NGOs, CBOs, FBOs, DPs; and individuals such as, heads of key agencies, programme managers and consultants would access technical support.

1.2.4 Funding for Strategy

Funding for Strategy will be sourced from Government of Ghana, Private Sector, Development Partners, International Civil Societies, Religious Bodies, and Philanthropic Organizations. This list is in no way complete, as it provides only a rough inventory of possible technical support funding agencies.

1.2.5 Coordination

Coordination of monitoring and reporting on the Anti-Stigma strategy at the national level will primarily be the responsibility of the GAC through the Anti-Stigma Technical Working Group. The Technical Support Unit will have the responsibility for the coordination of the anti- stigma strategy implementation at the regional and district levels.

1.2.6 Purpose of this Document

The National HIV and AIDS Anti-Stigma Strategy aims to guide and inform actions and programmes of policy makers, development partners, implementing partners and networks of people living with HIV and other stakeholders towards the reduction of HIV stigma and discrimination, through an evidence-informed strategy by and for people living with HIV, key and other vulnerable populations.

2.0 METHODOLOGY

2.1 Conceptual Framework

An all-inclusive and participatory approach that enlisted participation of key HIV and AIDS stakeholders was used for the development of the National HIV and AIDS Anti-Stigma Strategy technical support plan.

The process was operationalised under the four activity-clusters as follows:

- Cluster 1: Preparation of the Anti-Stigma Strategy
- Cluster 2: Identification of challenges
- Cluster 3: Agreement on HIV-related Anti-Stigma Strategies and activities
- Cluster 4: Development of the National HIV and AIDS Anti-Stigma Strategy

2.2 The Anti-Stigma Strategy Development Approach

2.2.1 Preparation of the Anti-Stigma Strategy

Inception report and timelines: Upon the recruitment of the consultant, an inception report was shared and discussed in which timelines for the assignment were agreed upon. The expectations, including the key tasks of the assignment, as well as the organisations and individuals responsible for the tasks were detailed. The document was developed through close collaboration with the Ghana AIDS Commission (GAC) and the Anti-Stigma Technical Working Group.

In broad terms, representation and participation in the Anti-Stigma Strategy development process was enlisted from the public sector (including Ministries, Departments and Agencies), Development Partners, Implementing Partners and Agencies, Media, PLHIV Umbrella Networks and Civil Society Organizations.

Literature Review: Literature on Ghana's HIV and AIDS response in relation to HIV related stigma and discrimination was based on findings from the 2014 Stigma Index Study and available policy documents and reports (e.g. the National HIV and AIDS STI Policy, H2H campaign reports). In particular, the review sought to ensure consistency with the interventions and targets in the National HIV and AIDS Strategic Plan (2016 -2020), specifically the critical social enablers. The process further involved reviewing reports of Anti-Stigma Working Group meetings, the 2014 GDHS, GAC Status Reports and the End-Term Evaluation (ETE) of the NSP 2011-2015 among others.

2.2.2 Identification of Challenges

Evidence from the 2014 stigma index study, the 2014 GDHS, the End Term Evaluation (ETE) of the NSP 2011-2015 and the NSP 2016-2020 identified the following as the key challenges:

1. Limited Knowledge of Policies
   The SIS revealed that majority of respondents had no knowledge about the existence of global and national instruments that urge governments to provide the enabling environment for the protection of the rights of PLHIV. This was confirmed by majority

of stakeholders at the consultation who rated ignorance of policies – which the study found to be higher among females than males – as one of the priority issues to be addressed.

2. Weak and Non-Enforcement of Policies
   The legal environment in Ghana is inadequate to promote and protect the human rights of key populations including PLHIV. Whilst policies such as the National HIV and AIDS, STI Policy, National HIV and AIDS Workplace Policy have been developed to provide an enabling environment for the provision of HIV services to these sub populations, enforcement of existing policies and promulgation of an HIV law is necessary. Stigma and discrimination act as barriers to the ability of PLHIV to enforce their rights and seek redress for cases where violations of their rights have occurred.

   Despite the existence of the National HIV and AIDS Workplace Policy, the SIS 2014 and the ETE of the NSP 2011-2015 revealed that many workplaces did not have specific workplace policies.

3. Discrimination in household, community and health setting
   Physical violence was meted out to PLHIV and KPs by household, community members and spouses because of their HIV status. When stigma and discrimination occur in the community and family, people lose their main sources of physical, mental, and emotional support.

   The SIS confirmed that the health care setting is a key location for stigma and discrimination, and privacy violations. When this occurs, it causes people living with HIV and key populations to avoid medical care, increase fear and internal stigma, and create emotional distress.

4. Discrimination by Omission
   Occasional drug stock –out and shortage of reagents for critical tests put undue stress and anxiety on PLHIV and contributes to non-adherence to medication. These were explained by some health personnel, as partly due to challenges encountered in accessing transport to take delivery of drugs from the Central Medical Store.

5. Low comprehensive knowledge of HIV
   Low comprehensive knowledge about HIV contributes significantly to stigmatising, discriminatory attitudes and prejudices towards PLHIV and affected populations. Unfortunately, the 2014 GHDS shows a low and a decline in the comprehensive knowledge about HIV and AIDS (18% and 30% for women and men respectively).

2.2.3 Consensus on HIV-related Anti-Stigma Strategies and Activities

Inputs received from consultations with the Anti-Stigma Technical Working Group, findings from the 2014 Stigma Index Study and strategies from the NSP 2016-2020 informed the development of strategies and activities in this document. The development of these strategies and activities were guided by interventions that are likely to:

- have the greatest possible impact on the overall national response (goals of NSP 2016-2020)
- accelerate progress towards achievement of universal access to HIV prevention, treatment, care and support
- address the key challenges that promote HIV-related stigma and discrimination
- fit with the logical framework (flow) of the Anti-Stigma Strategy
- be feasible within cost and time parameters

2.2.4 Development of the National HIV and AIDS Anti-Stigma Strategy

All the relevant information compiled were used in generating the Anti-Stigma Strategy framework and matrix as presented in sections 3.4, 3.7 and 3.8

3.0 ANTI-STIGMA STRATEGY

3.1 Goal

The goal of this strategy is to significantly reduce HIV-related stigma and achieve zero discrimination by 2020. The achievement of this goal is in line with the SDGs, the UNAIDS fast-track targets of 90-90-90, as well as the NSP 2016-2020.

3.2 Objectives

The main objectives of this strategy are as follows:

1. Prevent and reduce HIV related stigma and discrimination
   (Increase the adult accepting attitudes towards PLHIV from 14% and 11% for males and females respectively in 2014 to 35% and 30% by 2020).
2. Promote and protect the Human Rights of Key Populations including PLHIV
3. Strengthen capacity of stakeholders including community systems and structures, health workers, PLHIV and the media to recognize stigma and embark on context-specific stigma reduction interventions.

3.3 Principles of the Strategy

The strategy is anchored on five (5) main principles described below:

1. Meaningful involvement of PLHIV
   The Code for Civil Society and other bodies working in the HIV arena recognizes that involving PLHIV and affected communities in the HIV response make powerful positive contributions to the epidemic by enabling individuals and communities to draw on their lived experiences. This ultimately reduces stigma and discrimination and increases the effectiveness and appropriateness of the HIV response.

The diagram below (fig 1) illustrates areas for meaningful involvement of PLHIV.

UNAIDS POLICY BRIEF: The Greater Involvement of People Living with HIV (GIPA)

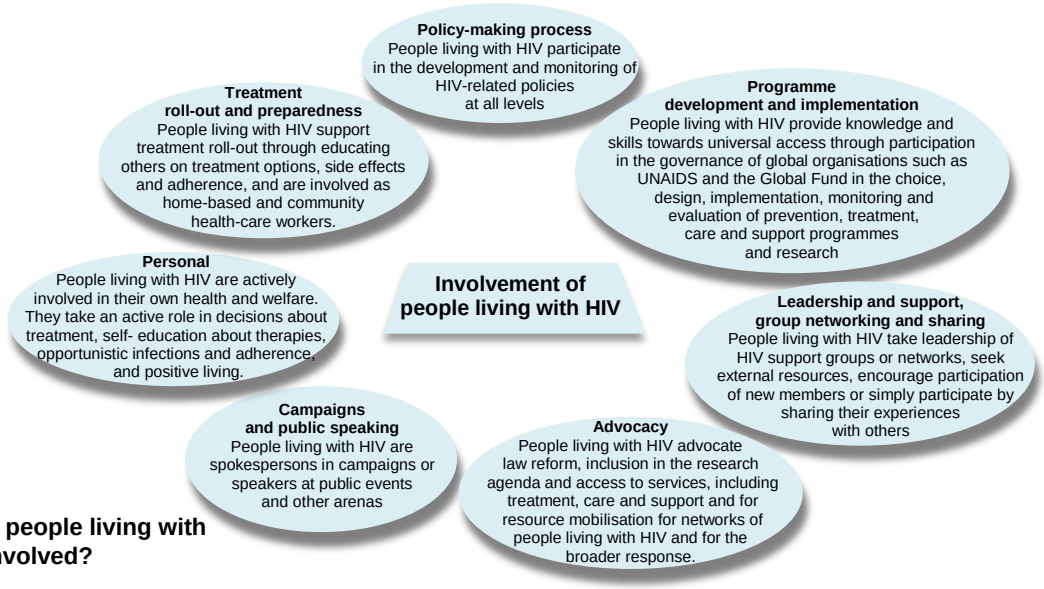

Figure 1:
How can people living with HIV be involved?

2. Gender Sensitive Response

   Several population studies in Africa indicate that females are more vulnerable to HIV than males - (a gender ratio of 3:1). Examples of gender-based inequalities and inequities including harmful gender norms, gender-based violence and stigma abound and are key drivers of the epidemic as they effectively hinder women and adolescent girls from accessing HIV prevention and treatment services. Therefore, gender equality and gender-sensitive approaches must be an integral part of the policies and actions that drive the HIV response and the anti-stigma strategy.

3. Human Rights Based Approach

   Widespread stigma, discrimination, physical and verbal abuse and harassment against KPs including PLHIV occur in communities and institutions at large due to moral judgement disapproving their behaviours. KPs including PLHIV, therefore, need their human rights protected to minimize their exposure to discrimination, abuse, gender-based violence (GBV) and school-related gender-based violence (SRGBV).

4. Evidence-Based Targeted Interventions

   With the decreasing resources for HIV, there is the need for efficient utilization and cost saving measures to maximize outcomes. Interventions must be focused, targeted and based on available evidence.

   The interventions for this strategy encompass all six identified broad domains proven to be effective for stigma reduction i.e. information-based approaches, skills building, counselling interventions, contact with stigmatised populations, structural and biomedical approaches.

5. Results Oriented Approaches based on Contextual Realities

   The NSP 2016-2020 has identified that Community Systems have inadequate capacity to address constraints and scope of community-based service provision to support the HIV response and sustainable development at community level. The SIS 2014 identified the main arena where KPs including PLHIV experience stigma, as being within households and communities. A participatory process whereby community groups and stakeholders plan and articulate their long-term development goals towards stigma reduction (for example, while identifying the conditions within their community setting which will have to unfold for those goals to be met effectively) is the hallmark of the theory of change. It aims at achieving specific results and is based on the realities experienced by community members or groups at their level.

3.4 Framework for Addressing Stigma and Discrimination

Table 1. Framework for Addressing Stigma and Discrimination

An effective large-scale response to HIV stigma and discrimination…	
addresses key underlying drivers	Interventions need to address the root causes of stigma. These include lack of awareness of stigma and its damaging effects, fear of acquiring HIV through everyday contact, and values linking people with HIV to behavior considered improper and immoral.
addresses multiple layers of stigma	Vulnerable groups typically experience stigma from multiple sources (e.g., drug use, sexuality, gender, sex work, HIV). Interventions that address HIV stigma alone may not improve outcomes for these groups.
operates at multiple levels	Individual, family, community, organizational/institutional and government/legal
engages multiple target groups, potential change agents, marginalized and vulnerable populations	These might include opinion leaders and the influential (e.g., politicians, faith-based leaders), front-line HIV responders (e.g., health care workers, NGO and community workers), people living with HIV and other stigmatized groups, communities, the media, private sector, schools, police and the judiciary.
employs a range of strategies to 1. prevent and reduce stigma 2. challenge discrimination in institutional settings 3. promote and protect human rights through laws and policies	Successful approaches may involve a combination of: • Strengthening and building capacity of stigmatized individuals and groups (e.g., through skill-building, network building, counseling, training, income generation) • Involving people living with HIV and other stigmatized people (e.g. men who have sex with men and sex workers) • Participatory and interactive education • Behavior change communication such as media campaigns and edutainment programs • Institutional reform to address discrimination in workplaces, health care settings, schools and other institutions • Policy dialogue and legal and policy reform together with enforcement and mechanisms for redressing rights abuses especially at local levels • Equal treatment of people living with HIV in the provision of services, care and treatment

3.5 Success Factors for an Anti-Stigma Strategy

Overarching factors necessary for the success of an anti-stigma strategy implementation includes ownership by stakeholders, adequate funding and the presence of a coordination mechanism.

Measures of success of stigma reduction activities are generally difficult to obtain except through extensive surveys such as stigma index etc. However, quick assessment of progress

could be carried out at the different levels of implementation by observing the factors outlined in Table 2 below.

Table 2: Critical Success Factors of an Anti-Stigma Strategy	
Setting/Levels	Indicators
Community	Increased willingness of relatives and community members to care for PLHIV.
	Enhanced care resulting in better quality of life for PLHIV
	Increased willingness of community members to volunteer in HIV prevention and AIDS care programmes
	Increased disclosure of sero positivity by PLHIV and their increased involvement in prevention, care and advocacy efforts
	Reduced self-stigma and increased confidence among PLHIV
	A more open expression of positive attitudes within communities towards people living with and affected by HIV
	Increased uptake of HIV counselling and testing services
Health Facility	Increased access to, and uptake of treatment services
	Reduced numbers of complaints of discrimination by KPs including PLHIV and their families at health facilities
	Increased number of volunteers within health facilities participating in HIV programmes
	Improved quality of care of HIV-positive patients, resulting in enhanced quality of life
	Increased openness of HIV-positive employees about their status
	Increased willingness of health workers to relate constructively with PLHIV
	Increased expression of positive attitudes towards PLHIV by health workers and in non-health-care settings.
	Reduced number of complaints of discrimination and Human Right abuses
Employment/Work Place	Increased willingness of employees to work alongside PLHIV
	Increased uptake of voluntary counselling and testing services
	Enhanced uptake of treatment services offered by workplaces.
	Supportive HIV workplace policies and practice.

3.6 Main Strategies and Activities

A variety of interventions to decrease HIV-related stigma have been tested and shown to be effective when a combination of two or more are used simultaneously. These are

1. information-based approaches which consist of fact-based information conveyed through verbal or written communication such as video, peer education, pamphlets, media advertisements,
2. skill-building interventions which aim to teach coping skills to people in the general population and PLHIV,
3. counselling interventions and
4. contact with stigmatised groups through direct interactions.

The main strategies and activities are categorised based on the identified environments and approaches to address each of the main objectives. As indicated, a combination of approaches which have been noted to be more effective than a sole approach will be adopted nationally and implemented at sub-national levels. Stigma reduction strategies will also be implemented

at personal/interpersonal, community, organizational/institutional, as well as government and structural/policy levels.

It must be noted that raising awareness about stigma and allowing for critical reflection on the negative consequences of stigma for patients (such as reduced quality of care and patients' unwillingness to disclose their HIV status and adhere to treatment regimens) are important first steps in any stigma-reduction programme.

Objective 1: Prevent HIV-related Stigma and Discrimination

Throughout Sub Saharan Africa, there have been examples of how stigma reduction has been integrated into policies and programmes. This has led to interventions at the national level by governments to address structural issues around stigma. The overall results show that creating opportunities for greater awareness and understanding of stigma and its negative effects, is a critical step to reducing stigma. The most common approach has been through the incorporation of stigma reduction exercises into training courses, workplace programmes and community activities.

Strategies & Activities

1. **Personal/Interpersonal level**
   a) Enhance access to psychosocial support by PLHIV to reduce self-stigma

   Activities
   (i) Strengthen psychosocial counseling units at health delivery points/facilities
   (ii) Update and assign Models of Hope to provide services in facilities where they do not exist
   (iii) Provide periodic capacity building for Models of Hope

   b) Enhance engagement with PLHIV networks and support groups.

   Activities:
   (i) Conduct quick assessment of existing PLHIV support groups and networks
   (ii) Provide technical assistance on coping strategies, assertiveness training and the possibilities available to get support etc. to groups by Task Team (from the TWG/GAC) in collaboration with other relevant institutions.

   c) Develop Peer mobilization and support for PLHIV aimed at promoting health, well-being and human rights
   d) Involve male partners of pregnant women in ANC and PMTCT: As a result of pregnant women's fears of male partner reactions and their resultant lack of disclosure, programmes would include and scale up interventions that engage male partners of pregnant women in antenatal HIV testing, PMTCT, and HIV care.
   e) Increase access to education and economic empowerment opportunities for women living with or vulnerable to HIV infection

   Activities
   (i) Scaling up of NGOs' programmatic interventions to:

- improve women's economic empowerment,
- enhance women's self-esteem,
- build assertiveness and skills to negotiate safe and responsible sexual practice, including the use of condoms, as well as
- transform gender roles and relations between men and women, and reduce gender-based violence.

(ii) Empowerment of young women entrepreneurs in the informal economy through the creation of collective enterprise initiatives (cooperatives, associations).

2. Community-Level Strategies

a) Advocate for incorporation of stigma-reduction programmes as part of core technical assistance to organizations working at community level with PLHIVs and KPs.

b) Increase coverage of stigma-reduction programmes to all sub-districts: Stigma-reduction programmes would address all key drivers of stigma i.e. lack of knowledge, fear, negative cultural norms and practices, and the weak enabling environment. Medium to long-term plans would include covering all sub-districts in the country. The strategic opening of Technical Support Units of Ghana AIDS Commission in all regions will go a long way to ensure country-wide spread of programs and coverage. The District AIDS Committees (DAC) in all the District Assemblies in the country are well placed to play effective roles as collaborators in stigma reduction.

c) Develop and implement programmes to reduce harmful gender norms and traditional practices that put women, girls, men and boys at risk of HIV infection, including capacity development of Civil Society groups working for women's rights and gender equality

d) Enhance engagement of traditional authorities and religious leaders through
   (i) Anti-stigma durbars
   (ii) Forum theatre approaches
   (iii) Traditional events including festivals, naming and marriage ceremonies

e) Use of media including advertising campaign, entertainment designed to educate as well to amuse (edutainment) and integration of non-stigmatizing messages into local TV and radio programmes

f) Actively engage the Social Accountability Monitoring Committees (SAMC) in monitoring stigma and stigma reduction activities

3. Organizational, Structural & Policy Level

a) Develop national guidelines for integrating stigma reduction into HIV programmes

b) Integrate stigma reduction into policies and programmes at all levels including educational and employment/workplace settings.

Interventions addressing stigma and discrimination have not been adequate. Given the role of stigma in hindering service uptake, a comprehensive programme of stigma reduction shall be developed and implemented in a sustainable manner over the next five years. The programme will target the general population and community leaders, health care workers, policy makers, PLHIV and Key Populations. The stigma reduction

interventions will be implemented through community-based activities as well as through the media throughout the five years of implementation.

c) Develop and implement policies that address the concerns of health workers including those in maternity care.

   Strategies and operational plans at the national level should include programmes and approaches to support facilities, healthcare providers, people living with HIV, and key affected populations to reduce stigma and discrimination for PMTCT and maternal health programmes.

d) Conduct periodic assessment and monitor of stigma among workers of relevant institutions e.g. health workers, the law enforcement agencies and institutions of learning.

Activities

(i) Assist health facilities to enact institutional regulations that mandate the monitoring of staff attitudes and behaviors towards KPs and PLHIV
(ii) Establish benchmarks for monitoring Stigma and discrimination
(iii) Access stigma and discrimination levels of facilities and possibly rate them

Objective 2: Promote and Protect the Human Rights of Key Populations including PLHIV

Main Strategies and Activities

Addressing the needs of groups at higher risk for HIV infection requires strong actions to uphold their human rights and protect them from violence and exclusion. Focused efforts are needed to remove punitive laws and create enabling legal environments that address human rights violations currently blocking effective AIDS responses.

The engagement of affected communities and civil society in policy design, programme management and service delivery remains an essential component of successful HIV and AIDS responses.

1. **Personal /Interpersonal Strategies**
   a) Engage in legal literacy campaigns - 'Know your rights'
   b) Enhance KP including PLHIV access to legal education, referrals and linkages
   c) Enhance access to alternative forms of dispute resolution

2. **Community Level Strategies**
   a) Engage in public education activities at community level
   b) Build skills in community-based conflict resolution for HIV-related human right abuses against KPs including PLHIV.
   c) Design age-appropriate sexuality and life-skills education programmes that also seek to reduce gender inequality and gender-based violence

3. Organizational, Structural & Policy Level

a) Enforce policies protecting the human rights of PLHIV and KPs and ensure implementation and monitoring of the policies.
b) Conduct legal environmental assessment
c) Strengthen the legal and policy environment to ensure that laws protect women and girls from gender inequality and violence
d) Monitor and reform laws, regulations and policies relating to HIV

Activities:

(i) Review of laws and law enforcement practices to see whether they impact the response to HIV positively or negatively
(ii) Assessment of access to justice for Key Populations including PLHIV

e) Increase collaboration with human rights institutions and groups to review discriminatory laws and policies. Working with human rights institutions and groups who have expertise in laws, policies, and human rights instruments, is critical. These organisations have technical expertise in human rights and will be supported to work with associations and support groups of PLHIV in order to build their capacity in this regard.
f) Build partnerships with Ministry of Health, Health professionals and other medical bodies and integrate stigma reduction into curricula for professional training institutions.
g) Train health care providers on human rights and medical ethics related to HIV

Activities:

(i) Training of health care administrators to ensure that health care institutions provide the information, supplies and equipment necessary to ensure health care workers have access to HIV prevention and treatment and are protected against discrimination.
(ii) Training of health care regulators to ensure the enactment and implementation of policies that protect the safety and health of patients and health care workers and prevent discrimination against PLHIV.
(iii) Training of service providers in providing services in a non-stigmatizing way, ensuring privacy and confidentiality and to provide the requisite psychosocial support.

h) Build capacity of the media and human rights organisations working with PLHIV and KP associations.
i) Sensitize law-makers and law enforcement agents on Human Rights and HIV

Objective 3: **Strengthen capacity of stakeholders including community systems and structures, health workers, PLHIV networks and the media to recognize stigma and embark on context-specific stigma reduction interventions**

Stakeholders, including communities, must have the capacity to provide human rights-based programmes themselves, and take strategic and sustainable decisions about the human rights context where their members and beneficiaries evolve.

Main Strategies and Activities

1. **Personal/interpersonal Level**
   a) Train community leaders and champions in human rights and stigma reduction activities
   b) Encourage empowerment of individuals and communities to address stigma and discrimination within their own setting using culturally appropriate methods
   c) Train Network of PLHIV in resources mobilization for stigma reduction activities.

2. **Community Level Strategies**
   Strengthening communities helps community organisations to become more sustainable and resilient, thereby helping the communities they belong to realise economic, social and environmental potentials. Its impact will help supported organisations enhance their capacity, helping them take on more ambitious initiatives. Community in this context is taken to include interest groups such as PLHIV groups and KP sub-groups, community members, community health staff, etc. The community strengthening methodologies which flow from this approach include, but not limited to, Community Empowerment Methods, Community Capacity Enhancement Methodology, Appreciative Inquiry, Assets Based Community Development, Results-Based Community Planning and Results-Based Community Action.
   (a) Strengthen and develop skills of CSOs, community members and the media to reduce HIV-related stigma
   (b) Undertake advocacy training sessions for civil society organizations in legal issues, human rights and stigma reduction.
   (c) Equip health workers with the knowledge and skills necessary to protect them from occupational transmission of HIV is a key step in addressing fear-based stigma.

3. **Organizational, Structural and Policy Level**
   a) Develop skills of civil society organizations including NAP+ to prevent, identify and report issues of human right abuses
   b) Equip networks of Key Populations including PLHIV and other vulnerable groups to intensify stigma-reduction efforts.
      Networks of people living with HIV and other vulnerable groups are often called upon to help design and lead efforts against stigma and discrimination. However, many of these groups are underfunded and have multiple capacity needs including life skills, management and fundraising.

      Their capacity would be built to enable them create the necessary awareness, promote and protect their rights, minimise stigma and seek justice in cases of discrimination and violation of their rights.

The role of civil society in influencing policy is through ‘having a Voice’ or being a voice to the voiceless. ‘Having a voice’ means speaking out and having influence; being allowed to speak out whether you have influence or not; having the chance or avenue to contribute to policy making; organising like-minded peers to participate in advocacy.

CSOs and other community-based organisations, social movements, cultural movements, traditional leaders, traditional healers and others all play a role in shaping attitudes and behaviour. They can train their own to recognize and deal with stigma, incorporate ways to reduce stigma in all activities, and critically examine their communication methods and materials.

3.7 Objectives and Activity Matrix

Goal: Reduce HIV-related stigma and achieve zero discrimination by the end of 2020					
Objective	**Action Areas**	**Agents/Targets**	**Time frame**	**Estimated Cost (USD)**	**Source of Funding**
Objective 1: Prevent and reduce HIV-related stigma and discrimination	• Develop and implement a comprehensive programme for stigma reduction at national, regional and community level • Develop national guidelines for integrating stigma reduction into HIV programmes at work-places and within communities • Strengthen capacity of CSOs and other implementers in stigma reduction activities • Develop peer mobilization and support for and by people living with HIV aimed at promoting health, well-being and human rights • Involve male partners of pregnant women in ANC and PMTCT • Address actionable causes of stigma and discrimination in health settings and within communities • Engage with religious and community leaders and celebrities in stigma reduction activities • Identify and refine interventions and training tools for religious leaders • Pilot interventions to provide economic opportunities for marginalized PLHIV and KPs • Identify private sector entrepreneurs and foster stronger engagement for greater economic opportunities for vulnerable populations	NAP+ GAC CEPEHRG WAPCAS CHRAJ GHS Traditional leaders Religious leaders MDAs CSOs MMDAs Media SAMCs	2016 - 2020		Ghana Government, Development Partners, Bilateral Donors, National businesses Corporate bodies

	• Partner with the media to ensure visibility of activities to reduce stigma against KPs including PLHIV • Partner with SAMC at regional and national levels to monitor stigma reduction activities and effectiveness of media programmes aimed at stigma reduction • Monitor progress of stigma reduction interventions at all levels				
Objective 2. Promote and protect the human rights of PLHIV and Key populations	• Identify punitive laws and policies • Conduct policy analysis • Review laws and law enforcement practices to analyze their impact on the response to HIV • Assess curricula of professional institutions with a view to facilitating the integration of stigma reduction training materials • Promote the enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention treatment, care and support • Train various categories of health staff on human rights and medical ethics related to HIV • Conduct legal literacy campaigns and legal education, referrals and linkages • Leverage cultural and media efforts to develop and disseminate anti-stigma messages • Organize awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g. TV, radio, print) • Develop programmes to reduce harmful gender norms and traditional practices that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women's rights and gender equality	GAC NAP+ CEPEHRG CHRAJ HRAC MMDAs CSOs Media Traditional leaders Religious leaders	2016 - 2020		Ghana Government Development partners Bilateral Donors National businesses

	• Organize public education activities at community level including community based conflict resolution for HIV-related human rights abuses • Support communities to dialogue and develop community level policies to reduce stigma • Conduct a follow-up Stigma Index Study				
Objective 3. Strengthen capacity of communities, health workers, PLHIV and the media to recognize stigma, develop and embark on context-specific stigma reduction programs and activities respectively.	• Identify capacity needs of key stakeholders including NAP+ and organizations working with KPs, to enable them effectively implement this anti-stigma strategy • Use theatre to reduce stigma and discrimination within communities • Provide training in both stigma and universal precautions • Identify best practice and use them in health settings and within communities • Build capacity to empower individuals and communities to identify and address stigma and discrimination within their own settings using culturally acceptable methods • Monitor progress of and evaluate stigma reduction activities within communities	GAC NAP+ CEPEHRG CHRAJ GHS HRAC MMDAs CSOs	2016-2020		Government funding, regional and district AIDS Committees, and other development partners, Foundations and corporations

3.8 Generation of Strategic Information on Stigma and Discrimination

Data and strategic information on stigma and discrimination in Ghana are inadequate and those available are mostly program data and those from the Ghana Demographic and Health Survey (GDHS). The first round of Stigma Index Survey carried out among PLHIV in 2014 has been useful in providing additional evidence-based information on stigma in Ghana.

The anti-stigma strategy supports the generation of strategic information and the following studies should be conducted in the lifespan of the strategy using internationally accepted standards and protocols:

Study / Survey	Proposed year
Stigma Index among Health Care Workers	2017
Stigma Index Study for and by PLHIV (second round)	2018
IBBSS for FSW's with stigma component	2019
IBBSS for MSM with stigma component	2019

3.9 Indicators for Assessing Progress and Results

a) National Level

At the national level, conventional surveys and studies would be conducted to access the level of stigma and discrimination in the country. The key indicators to be measured are listed below.

	Indicators	Source and Frequency of Measurement	Baseline
1.0	Percentage of women and men aged 15-49 years who have acceptable attitude towards PLHIV	GDHS, Every 4 years	8% females 14% males (2014)
2.0	Percentage of young women and men aged 15-24 years who have acceptable attitude towards PLHIV	GDHS, Every 4 years	8.1% females 10.4% males (2014)
3.0	Percentage of PLHIV who report having experienced discriminatory attitudes	SI study, Every 3 years	
4.0	Percentage of FSW with accepting attitudes towards PLHIV	IBBSS (Proposed, Every 4 years)	
5.0	Percentage of MSM with accepting attitudes towards PLHIV	IBBSS (Proposed, Every 4 years)	
6.0	Percentage of FSW who avoided seeking HIV services because of stigma and discrimination	IBBSS (Proposed, Every 4 years)	
7.0	Percentage of MSM who avoided seeking HIV services because of stigma and discrimination	IBBSS (Proposed, Every 4 years)	

b) Programme at Sub-national levels

Using the Ghana PLHIV Stigma Index Study as baseline, the Anti-Stigma Strategy would be assessed to ascertain whether process and outcomes of the programmes put in place are meeting their strategic goals, problems are identified and corrected, and additional improved accountability mechanisms are created for the country's response. Depending on the programme being implemented by institutions and partners, some of the indicators enlisted can be adopted for use.

Indicators for health and human rights programmes		
Programme	**Human rights indicators (outcome indicators in bold)**	**Health indicators**
Stigma and discrimination reduction programmes	• No. of community mobilization campaigns • Number of stigma reduction media campaigns • No. of health facilities training health providers or their staff on stigma and discrimination reduction • Increased number of enterprises with HIV workplace policies. • No of CSO's/NGO's and staff trained on stigma reduction. • **Reduction in number of people living with HIV or members of KPs excluded from social gatherings** • **Reduction in number of people living with HIV or members of KP who have lost their employment** • **Reduction in number of people living with HIV or members of KPs who have been abandoned by partners and/or families**	• Willingness and ability to use healthcare services • Increased access to and uptake of HIV testing • Increased access to and uptake of prevention services • Adoption of safer behaviours • Increased access to treatment • HIV incidence • HIV prevalence • HIV Morbidity • HIV Mortality
HIV-related legal services	• Number of legal support/advice services for people living with HIV and affected populations provided • Number of cases taken to judicial process • Number of people using legal support services • **Number of cases satisfactorily resolved**	

	• Awareness of PLHIV and KP's on legal support services	
Monitoring and reforming laws, regulations and policies	• Number of discrimination cases documented • Number of discriminatory laws/policies reviewed and repealed • Progress in a particular policy change: baseline of policies undertaken; engagement with decision-makers taken place; policies developed; endorsement by government; policy implemented • **Number of protective laws adopted** • Number of internal disciplinary investigations related to human rights undertaken • Number of discriminatory policies reviewed and repealed	
Legal literacy	• Number of campaigns that include key populations • Number of Know Your Rights media campaigns • Number of education and training sessions for service providers • Number of people reached with legal literacy training	
Sensitising law makers and law enforcers	• Number of education and training sessions for lawmakers and law enforcers • Number of internal disciplinary investigations related to human rights undertaken • Number of police demonstrating increased understanding of rights • **Number of instances of discrimination/human rights violations by law enforcers reduced** • **Number of discriminatory policies reviewed and repealed**	
Training healthcare workers	• Number of education and training sessions for healthcare workers	

	• Number of healthcare workers aware of rights • Number of internal disciplinary investigations related to human rights undertaken • Number of healthcare workers aware of patients who have been discriminated against because they were known or suspected of having HIV • Number of facilities that have a stigma policy in place • **Number of instances of discrimination/human rights violations in healthcare settings reduced**	
Reducing gender inequality, harmful gender norms and violence against women and girls	• Number of men participating in PMTCT programmes • Number of incidences of intimate partner violence • Number of women who know their rights • **Number of discriminatory laws reviewed and repealed**	
Core community-led human rights-related interventions	• Number of individual cases documented • Number of advocacy campaigns undertaking by CSOs and CBOs targeting policy change • Progress in a particular policy change: engagement of CBOs with wider CSO coalitions; human rights issues taken up by coalitions; engagement of decision-makers with issue; direct engagement with decision-makers • Number of CSO and CBO members trained in human rights-based programming • **Number of individual cases satisfactorily responded to** **with crisis response and/or human rights programmes**	

APPENDIX

Prioritization of Issues for Advocacy by Members of NAP+ and Key Populations across the Ten Regions of Ghana

Group	Pressing issues	Advocacy Solutions
PLHIVs	Stigma from household and community members Physical assault and harassment	• Community dialogue • Community involvement in planning for reduction in Stigma and Discrimination
	Culture and Gender Eviction of women from marital homes Cultural norms and practices – widow inheritance, child marriage, attitudes towards sex work and MSM	• Community dialogue, Awareness raising with traditional leaders • Community Capacity Enhancement methodology (CCE)
	Health facilities Stigma and discrimination in health facilities Discrimination against pregnant women in labour Breach of confidentiality by health workers	• Strengthen capacity in providing non-stigmatizing services • Monitor stigma among health workers periodically • Enact policies that protect the safety and health of patients as well as health workers, to prevent S&D. • Mainstream stigma reducing interventions in workplace policies • Integrate Human Rights Education into capacity building manuals and modules of health training institutions. • Develop framework/guide for integrating Human Rights Education into existing Stigma and Discrimination Manuals/Modules and Curriculum for professional institutions e.g. Nursing Training Colleges. • Enforcement of workplace policies
	Internal stigma Stigma within PLHIV networks and support groups	• Build skills in presentation and public speaking, develop coping skills, self-esteem and assertiveness, increase awareness in redress possibilities

	Socioeconomic Food insecurity Inadequate support for Models of Hope and none at all for Models of Hope in the three Northern regions *Rights and policies* High level of ignorance about rights, policies and laws protecting PLHIVs	• Initiate pathfinder projects [1]for economic empowerment • Embark on awareness campaigns; resource mobilization by NAP+ • Empower PLHIV, KPs and vulnerable groups in understanding HIV transmission, assertiveness and provide employment opportunities. • Integrate Human Rights Education into capacity building manuals and modules for KPs and PLHIVs
KPs	a) Abuse of rights by families and community members b) Discrimination in health facilities c) Self-stigma d) Discrimination by religious groups e) Food insecurity	• Community dialogue. • Community involvement in planning for S&D reduction • Strengthen capacity in providing non-stigmatizing services sensitive to the needs of sexually diverse populations • Integrate Human Rights Education into capacity building manuals & modules • Advocacy and awareness campaigns in collaboration with INERELLA • Initiate pathfinder projects

[1]The *pathfinder projects* show the way in the creation of shareable models of good and effective practice that can be copied and used to enable better implementation within one's institution.

Prison Setting	a) Inability of Prison staff to have confirmatory tests done with prisoners on remand who are under the control of the Ghana Police because they are at high risk to escape and they are usually transferred before the arrangements for the test is done. b) Inability to put prisoners who test positive on treatment because their CD4 counts cannot be determined due to lack of supplies. c) Lack of improved food and nutrition within prison conditions for prisoners who test positive.	Policy dialogue
National	a) Stock out of ARVs b) Stock out of reagents for CD4 count c) Long waiting period before receiving PCR reports d) No HIV test kits for general population e) Workplace health and education policies poorly enforced f) Prayer camps contribute to AIDS-related deaths and non-adherence to medication g) Herbalists promising cure for HIV and contribute to loss to follow ups, morbidity and mortality	• Social Protection Policy which addresses Economic Empowerment • Advocacy to enforce laws that prohibits advertisement of medical services and of scientifically unproven cures.

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