National Strategic Plan to Reduce Human Rights-Related Barriers to HIV and TB Services: Ghana

2020-2024

MAY 2020

Under the Office of the President

Strategic Plan for a Comprehensive Response to Human Rights-related Barriers to HIV and TB Services in Ghana

2020–2024

November, 2019

Table of Contents

List of Acronyms/Abbreviations

AGD	Attorney General's Department
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
CHAG	Christian Health Association of Ghana
CHRAJ	Commission on Human Rights and Administrative Justice
CSO	Civil Society Organization
CDC	Centers for Disease Control and Prevention
CEPEHRG	Centre for Popular Education and Human Rights, Ghana
DOVVSU	Domestic Violence and Victims Support Unit
EARC	Educational Assessment and Research Centre
FSW	Female Sex Worker
GAC	Ghana AIDS Commission
GBV	Gender-Based Violence
GHS	Ghana Health Service
HFFG	Hope for Future Generations
HIV	Human Immunodeficiency Virus
HR	Human Rights
HRAC	Human Rights Advocacy Center
IBBS	Integrated Biological and Behavioral Surveillance
INERELA+	International Network of Religious Leaders Living with or Personally Affected by HIV & AIDS
JSI	John Snow, Inc.
KP	Key Population
KVP	Key and Vulnerable Populations
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
NACP	National AIDS/STI Control Programme
NETEWAG	Network of Teachers and Educational Workers in HIV/AIDS, Ghana
NGO	Non-Governmental Organization
NSP	National HIV and AIDS Strategic Plan, 2016 - 2020
NSP-TB	National Health Sector Tuberculosis Strategic Plan of Ghana
OPD	Out-Patients' Department
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPAG	Planned Parenthood Association of Ghana
PWD	People with Disabilities
PWID	People Who Inject Drugs
SC-HR	Human Rights Steering Committee

STI	Sexually Transmitted Infection
SW	Sex worker
TB	Tuberculosis
ToT	Training of Trainers
UNAIDS	The Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WAPCAS	Ghana West African Program to Combat AIDS & STIs
WHO	World Health Organization

Foreword

The protection and promotion of the rights of PLHIV and key affected populations remain paramount to the national HIV/TB response. To ensure effective prevention of new infections and enhance access to HIV/TB services by all persons living with HIV and TB requires effective integration of rights-based approaches into all facets of programming. Over the years, human rights and gender-related inequalities have remained major barriers that make people vulnerable to HIV and TB and hinder their access to prevention, treatment, care and support services.

In the last decade, as part of efforts in promoting and strengthening an enabling environment, the Ghana AIDS Commission has taken concrete steps to expand the frontiers of rights-based approach through progressive policies and legislation in addition to strategic collaborations with partners and stakeholders at various levels.

Despite these innovative interventions and significant progress and gains made, there remain significant gaps. It is in this vein that the Commission, together with all relevant stakeholders and other social forces worked together to develop this strategic document.

The goal of the Strategic Plan is to effectively expand the scope and adequately integrate human rights interventions into the HIV/TB national response to ensure that all Ghanaians have access to HIV/TB prevention, treatment, care and support services.

It is my expectation that all stakeholders and partners will fully and actively implement the content of this Strategic Plan in their world of working and communities to ensure the scale-up of human rights interventions to increase access to HIV and TB services.

The removal of human rights related barriers is the responsibility of everyone. We must therefore all work together to ensure epidemic control and end AIDS as a public health threat by 2030.

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Acknowledgements

The Ghana AIDS Commission acknowledges all partners and stakeholders who contributed in diverse ways to the development of this National Strategic Plan for a Comprehensive Response to Human Rights-Related Barriers to HIV and TB Services in Ghana. The insights and expertise of all contributors ensured a well thought through, evidence-informed and comprehensive approach to the development of the Strategy.

We recognize the support of Ministries, Department of Agencies (MDA) particularly, the Parliament of Ghana, Ministry of Health (MOH), Ministry of Gender, Children and Social Protection (MGCSP), Office of The Attorney General and Ministry of Justice, The Judicial Service, The Commission on Human Rights and Administrative Justice (CHRAJ), Ghana Health Service (GHS), National AIDS/STI Control Programme (NACP) and National Tuberculosis Programmes (NTP).

We also acknowledge the immense contributions of the Country Coordinating Mechanism (CCM) of the Global Fund, Development Partners, Country Team of the Global Fund to Fight AIDS, Tuberculosis and Malaria, civil society organizations (CSOs), faith-based organizations (FBOs), traditional authorities, religious bodies and National Association of Persons Living with HIV (NAP+) for their insight and invaluable contributions, commitment and resilience demonstrated throughout the development process.

We deeply appreciate the Joint United Nations Team on AIDS (JUTA) for making available key personnel and technical resources in the development of this Strategic Plan.

We also wish to extend our sincere appreciation to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and President's Emergency Plan for AIDS Relief (PEPFAR) for providing technical expertise in developing this Strategy.

Sincere thanks go to the members of the Steering Committee for excellently guiding the development of the document.

We also want to acknowledge Dr Bernard Dornoo for providing technical assistance and leadership for the preparation of this Plan.

We would like to express our profound gratitude to the Ghana AIDS Commission Team, particularly the Director General, Mr. Kyeremeh Atuahene and Directors of the Commission for their leadership, commitment, technical oversight and coordination of the entire process. Special thanks go to the Policy and Planning Team namely; Mr. Cosmos Ohene-Adjei (Director for Policy and Planning), Mrs. Dinah Akukumah (Policy and Planning Manager) and Ms Gladys Semefa Agbenyo (Policy and Planning Officer) for their tireless efforts and commitment leading to the success of the entire process.

We wish to extend our appreciation to Prof. Kofi Awusabo-Asare for making time out of his busy schedule to chair the two-day multi-stakeholder consultation, the outcome of which immensely improved the quality of this Strategic Plan.

We further recognize and acknowledge the contribution of the hardworking Rapporteur Team for capturing the relevant inputs from stakeholder consultations towards finalization of this document.

Kyeremeh Atuahene
Director General

Executive Summary

Human rights and gender-related barriers have been identified as major obstacles to accessing HIV and TB services, and negatively affecting the global response to the two diseases. The UNAIDS had over the past couple of years urged countries to take advantage of current global approaches for scaling up the HIV response in three main areas: (1) Preventing new HIV infections (towards fewer than 500,000 by 2020); (2) Increasing access to HIV testing, treatment and adherence support (towards achieving 90-90-90 by 2020); and (3) Reducing stigma and discrimination (towards zero discrimination by 2020). This Fast-Track approach has been endorsed by the United Nations (UN) General Assembly (2016) Political Declaration on Ending AIDS, which requires maximizing existing tools to quicken the pace of progress to end the AIDS epidemic as a public health threat by 2030.

Fast-tracking the HIV and TB response will be almost impossible without addressing the pressing needs of human rights and gender inequalities. Human rights barriers such as stigma and discrimination, violence and other abuses, negative social attitudes, legal obstacles, intimidation by law enforcement agencies, negative attitudes and behaviours of healthcare practitioners and general hostility in the healthcare sector towards key populations need to be addressed urgently. These barriers contribute significant vulnerability to HIV and TB among key and vulnerable populations as well as limit their access to prevention, testing, treatment and care services. The national response seeks to draw on the expertise, resource and specialties of various stakeholders, particularly civil society organizations (CSOs) to institute interventions that address stigma, discrimination and human rights barriers relating to people living with HIV (PLHIV), persons affected by TB and other key and vulnerable populations (KVP).

Ghana, in demonstrating political commitment has increased the funding available for addressing human rights-related barriers to HIV and TB services, primarily through its Global Fund grants. Whereas dedicated funding for these activities was non-existent in the 2014-2016 funding cycle, $4.56 million is being channeled to removing such barriers in the 2017-2019 cycle. Ghana is among 20 countries prioritized by the Global Fund for intensive scale-up of programs to remove human rights-related barriers to accessing HIV and TB services. To effectively evaluate the magnitude of the human rights and gender barriers, and to formulate a comprehensive strategic plan to address these barriers, technical support was procured by UNAIDS to avail technical expertise to the national HIV and TB-related Human Rights Steering Committee, working through the Ghana AIDS Commission (GAC), the Country Coordinating Mechanism (CCM) and the UNAIDS to guide the overall national HIV and TB response.

The “Ghana Baseline Assessment of Human Rights related barriers to HIV Services” (Baseline Assessment) conducted in 2017 highlighted the state of affairs of the national HIV response in the light of human rights, stigma and discrimination barriers. It also evaluated the work of various stakeholders working to address these barriers and found out from PLHIV and key and vulnerable populations, at first hand, the challenges they faced and proposed solutions. The Baseline Assessment recommended that the focus of interventions to remove human rights-related barriers be targeted at improving access to services among PLHIV, people affected by TB, female sex workers, men who have sex with men, people who inject drugs, HIV-negative partners of people living with HIV, prisoners, people with disabilities, and women and vulnerable children (including orphans and adolescent girls).

Consequently, the Multi-Stakeholder Meeting on Addressing Human Rights Barriers to HIV and TB prevention, testing and treatment services in Ghana which took place on the 10th and 11th of July 2019 under the leadership of the GAC and the CCM with technical support from the Global Fund and the UNAIDS brought together stakeholders from government ministries, departments and agencies (in particular representatives of the Attorney-General and the Ministry of Health), the Judiciary, the Commission on Human Rights and Administrative Justice (CHRAJ), as well as varied representation from CSO, NGO, Networks, Associations of persons living with or affected by HIV and/or TB, religious organizations and traditional authority. The forum established key issues, identified challenges, drew conclusions and made recommendations that would contribute to the formulation of this human rights-based Strategic Plan relating to HIV and TB to be implemented in tandem with the National Strategic Plans for HIV and TB respectively.

The development and implementation of this Strategic Plan comes in at the last lap of the current National Strategic Plans of both TB and HIV (National Tuberculosis Health Sector Strategic Plan, 2016 – 2020 (NSP-TB) and National HIV Strategic Plan, 2016 – 2020 (NSP-HIV) respectively) and gives Ghana the opportunity not only to impact the current national responses of the two diseases and also guide in the formulation and implementation of the subsequent strategic plans along rights-based approaches that will significantly address TB and HIV-related human rights and gender-based violations.

This Strategic Plan therefore is designed to take into consideration the complexities of the human rights environment as relating to PLHIV, people affected by TB, and other key and vulnerable populations (KVP), as well as the diversity of stakeholders – both governmental and non-governmental, resource mobilization for implementation, and monitoring and evaluation of all programmes and activities. Taking into consideration the major stigma, discrimination, gender and human rights barriers identified as needing urgent attention, based on assessments and multi-stakeholder engagements in the light of the UNAIDS guidance on human rights, six thematic areas were classified and formulated into the following strategic objectives which formed the basis of this five-year Strategic Plan:

1. To coordinate human rights interventions and advocate for reformation of laws, regulations, and policies relevant to HIV, TB and human rights-related barriers to care services.
2. To eliminate all forms of stigma and discrimination targeted at PLHIV, people affected by TB, and other KVP.
3. To promote access to justice, HIV and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy ("Know Your Rights").
4. To remove gender-based barriers to human rights and healthcare service interventions, and to eliminate TB and HIV-related gender discrimination and violence against women and adolescent girls.
5. To build capacity of healthcare workers and managers on HIV and TB- related stigma, discrimination and human rights barriers that affect PLHIV, people affected by TB, and other KVP.
6. To reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV, people affected by TB and other KVP.

This "Strategic Plan for a Comprehensive Response to Human Rights-related Barriers to HIV and TB Services in Ghana, 2020 - 2024" is set on the goal that seeks "to remove human rights-related barriers to

HIV and TB services and to improve access to quality HIV and TB healthcare and support services through pragmatic implementation strategies". This is to be implemented at community, sub-district, district, regional and national levels through the collaboration of state and civil society organizations with increasing resource mobilization locally and technically as well as financial support of development partners towards the attainment of the overall TB and HIV response.

1 BACKGROUND

1.1 Introduction

Modelling done by the Joint United Nations Programme on HIV/AIDS (UNAIDS) shows that in order to achieve the Sustainable Development Goal (SDG) of ending AIDS as a public health threat by the year 2030, countries must:

- Prevent new HIV infections (towards fewer than 500,000 by 2020, and fewer than 200,000 by 2030)
- Increase access to HIV testing, treatment and adherence support (towards achieving 90-90-90[1] by 2020, and 95-95-95 by 2030)
- Reduce stigma and discrimination (towards zero discrimination by 2020, maintained to 2030)

These three main Fast-Track targets were endorsed by the United Nations (UN) General Assembly in the 2016 Political Declaration on Ending AIDS, and later expanded to ten Fast-Track Commitments aligned to the Declaration[2].

Human rights and gender-related barriers have been identified as major obstacles to accessing HIV and TB services, which negatively affect the global response to the two diseases. Addressing these barriers requires maximizing existing tools to quicken the pace of progress towards global targets. From the current levels of intervention and assessment of country, regional and global interventions, it is clear that it will be possible to Fast-Track the HIV response and end the AIDS epidemic without addressing the pressing needs of human rights violations and gender inequalities.

1.2 Country Context

Ghana has a high burden of HIV and TB (including multidrug-resistant tuberculosis). It is among the 20 countries that account for 70% of the worldwide burden of HIV, tuberculosis and malaria, and is therefore prioritized for the Fast-Track approach. Although the country has made some progress as far as interventions against HIV and TB are concerned, Ghana is still considered as one of the 35 designated Fast Track countries that account for 90% of new infections globally[3]. Much more needs to be done as far as interventions are concerned, to ensure key indicators and

[1] The "90-90-90" targets refer to the following: By 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression.

[2] https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf

[3] https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/november/20151124_LocationPopulation

targets of the country regarding HIV and TB are met. These discrepancies between set targets and the reality are attributable to a multiplicity of factors. One main factor that hinders HIV and TB interventions and service delivery in Ghana are human rights-related barriers that inhibit access to prevention, testing, treatment, care and support services. These barriers disproportionately affect key and vulnerable populations (KVPs).

Human rights-related barriers such as stigma and discrimination, violence and other abuses, negative social attitudes, legal obstacles, intimidation by law enforcement agencies, and negative attitudes of healthcare practitioners (especially towards KVPs) need to be urgently addressed. They contribute to significant vulnerability to HIV among KVPs by limiting their access to prevention, testing, treatment and care services in Ghana. In an effort to address these human right-related barriers, the national response in Ghana sought to draw on the expertise, resource and specialties of various stakeholders, particularly non-governmental organizations (NGOs) and other civil society organizations (CSOs) which have been involved in interventions addressing stigma, discrimination and other human rights-related barriers to PLHIV, patients affected by TB and other KVPs.

Ghana has adapted the WHO End TB Strategy and upholds its three pillars and four principles. The third principle recognizes health as a human right and calls for the use of a human rights-based approach that includes respect for ethical values and promotion, pursuit of equity, access to high-quality care and social protection. Progress on these rights are expected to help reduce risk factors for TB infection and disease to ensure positive outcomes for those affected. In the context of TB interventions human rights-based approach would mean the pursuit of non-discrimination and equality, participation and inclusion, and accountability which would be expected to be backed by policies, to form the basis of service delivery and practices in a way that protects and promotes individual human rights while addressing the underlying inequities of the poor and marginalized communities, as well as KVP who bear a greater burden of TB infection, disease, deaths and social impacts. If maximum impact should be made in addressing human rights-related barriers to TB interventions, it would be necessary to have a strong coalition that includes civil society organizations and communities that can give patients and vulnerable populations a voice to enable them play active roles in accelerating the response to the TB epidemic (Implementing The End TB Strategy: The Essentials; The End TB Strategy. WHO, 2015).

Ghana is among 20 countries[4] prioritized for the "Breaking Down Barriers" project to provide intensive support to the countries by the Global Fund to Fight AIDS Tuberculosis and Malaria (hereafter referred to as the Global Fund) for intensive scale-up of programs to remove human rights-related barriers to accessing HIV and TB services. While the international funding support is critical, Ghana endeavours to attain success through increasing mobilization of funds from

[4] Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Côte d'Ivoire, Ghana, Honduras, Indonesia (5-10 cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda, and Ukraine.

domestic sources for a sustainable HIV and TB response. Ghana's human rights response in this direction is being built on the guiding foundations of human rights, equity and the belief that no one should be left behind. The Global Fund's catalytic funding stream, under which Ghana has been receiving additional matching funds for human rights, aims to increase access to and uptake of HIV and TB related services, particularly for KVPs.

Ghana aims at stopping the national TB epidemic through attaining the overall objective of working towards achieving the World Health Assembly (WHA) 67 Resolution and Stop TB Partnership post 2015 TB control strategy targets. This requires intense accelerated efforts to remove all human rights and socio-economic related barriers to the health-sector and community-based TB interventions in order to reduce the adult TB burden of 286 per 100,000-person population established in 2013. Challenges to TB interventions are compounded by stigmatization of persons living in slums and neglected poor communities, MSM, FSW, PWID and PLHIV resulting particularly in lower than national average TB case notification, unacceptably high TB death rates, low ARV coverage among TB/HIV patients and low drug resistant notification and treatment among these KVP.

The National TB Control Programme (NTP) target is to (i) reduce by 20% the 2013 TB prevalence baseline level of 286 per 100,000 person population by 2020 in line with post 2015 Global TB Control Strategy, (ii) reduce by 35% the 2012 TB mortality rate baseline of 4 deaths per 100,000 person population by 2020 and (iii) end the TB epidemic in Ghana by 2035 without catastrophic cost due to TB affected families (The National Tuberculosis Health Sector Strategic Plan for Ghana, 2016 – 2020, Ministry of Health). Efforts to attain set targets in the strategic plan however are greatly impeded by the substantial cost incurred by TB patients in Ghana despite the free diagnosis and treatment. In a recent TB cost survey conducted in Ghana[5], it was established that high rates of catastrophic costs and coping strategies in both non-MDR and MDR patients show that new policies are urgently needed to ensure TB care is actually affordable for TB patients as failure to address this in the midst of prevailing poverty tend to act as a barrier to care with human right implications.

1.3 Process to develop this plan

First, a "Baseline Assessment on Human Right Barriers to HIV Services and Interventions" which was conducted as part of the "Breaking Down Barriers" project in Ghana was conducted in 2017. A desk review carried out as part of the process for the baseline assessment, identified the following key and vulnerable populations in Ghana; female sex workers, men who have sex with men, people who inject drugs, people living with HIV, HIV-negative partners of people living with HIV, prisoners, 'kayayei'[6], people with disabilities, women, and vulnerable children, including orphans and street children. The Baseline Assessment highlighted the need for the comprehensive integration of various human rights and stigma reduction interventions to

[5] Pedrazzoli D. et al. "How affordable is TB care? Findings from a nationwide TB patient cost survey in Ghana", Tropical Medicine and International Health, volume 23 no 8 pp 870–878 August 2018.

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

galvanize the multiple stakeholders, networks and implementers to act together to remove human rights-related barriers relating to HIV and affecting KVP, including people living with HIV and other sub-populations in Ghana. Although the baseline assessment only focused on HIV and HIV-related barriers that affect the PLHIV and other KVP, the National Tuberculosis Strategic Plan of Ghana, gives an insight into which categories of persons or communities constitute key affected populations. The nature of the TB epidemic in Ghana put the population generally at risk, the most vulnerable populations which include PLHIV, prisoners, diabetics and mining communities are scattered throughout the geographical spread in both TB high incident districts and non-high incident districts among the general population. This puts the vulnerable populations in 4 key settings: 1. Hospital care setting (PLHIV, diabetes, elderly, pregnant women). 2. Community (household contacts, community contacts). 3. Residential institutions such as Prisons. 4. Work places (e.g. miners and those exposed to silica). Specific interventions have been geared towards reaching these most at risk populations but in some instances have been hindered by poverty, stigma, marginalization, ignorance and human rights abuses. Addressing these barriers is therefore essential to the overall success of the national TB intervention.

Subsequently, a Multi-Stakeholder Consultative Meeting on Human Rights was held in July 2019. The Meeting brought stakeholders together to have an in-depth discussion on all perceivable human rights-related barriers with ways of addressing them. The Ghana Baseline Assessment was a key background document, informing the consultative meeting. The various discussions, presentations, findings and group discussions held at the Consultative Meeting, together with the findings of the Ghana Baseline Assessment, form the basis of this plan. This plan further draws on the synergy of the strengths of government agencies and human rights, healthcare, HIV and TB CSOs and networks that can together feed into an effective national response that is cohesive and sustainable.

The formulation of this strategic plan has been under the leadership of the Ghana AIDS Commission (GAC) with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Country Office who procured services of and guided the consultant for facilitation of the Stakeholder Consultative Meeting and the drafting of this strategic document. The GAC constituted a Steering Committee on Human Rights which comprised of representatives from relevant government agencies, CSO including stakeholders and implementers of HIV and TB interventions, as well as members of networks and associations of PLHIV, persons affected by TB and other KVP. A team of supporting consultants of UNAIDS and the Global Fund have been on hand to make inputs and review the draft document at various stages. The Steering Committee under the GAC provided guidance for both the Stakeholder Consultative Meeting and the drafting of this Strategic Plan. See page 59 under the section 6.5 on the Implementation Plan of this document for the list of institutions whose representatives constituted the membership of the Steering Committee.

2 SITUATIONAL ANALYSIS

2.1 Demography

The last Population and Housing Census held in Ghana was in 2010 which put the population of Ghana for 2010 to be 24,658,823 (Ghana Statistical Service, 2012). With the average annual rate of population change of 2.3% from 2010 the United Nations Population Fund (UNFPA) estimates the total population of Ghana for 2019 to be 30.1 million, with the following age specific percentage categorizations: 0 -14 years (38%), 10 – 24 years, which represents young people (31%), 15 – 64 years (58%), 65 years and older (3%), The population is dominantly urban; with an estimated 54.8 % living in urban and peri-urban areas. Total fertility rate per woman in 2017 was 3.8%, while the Life Expectancy at Birth for 2019 is 64 years (UNFPA World Population Dashboard, 2019).[7] Various studies and attempts have been made to estimate size of specific key populations in Ghana particularly as they represent an-at-risk group as far as HIV and TB are concerned. The population size of female sex workers (FSW) was estimated to be 65,053 (IBBSS, 2015), that of men who have sex with men (MSM) was 54,800 (IBBSS, 2017), and the population size estimate for PLHIV according to the national estimates data for 2018 was 334,713.[8]

2.2 HIV and TB

Despite much progress, HIV persists as a public health concern. Sub–Saharan Africa bears the greatest burden, with more than two thirds (69%) of all persons infected with HIV (UNAIDS, 2018). There is an estimated 19.4 million [17.5-21.1] PLHIV living in sub-Saharan Africa, 59% of whom are women. In sub-Saharan Africa, three in four new infections among adolescents aged 15–19 years are girls. Young women aged 15–24 years are twice as likely to be living with HIV as men. Key findings in the GDHS 2014 indicate that 2.0% of Ghanaian adults aged 15- 49 are HIV positive. The prevalence is higher in females (2.8%) than in males (1.1%). According to the study, 38% of women aged 15-49 and 49% of men in the same age group who are living with HIV had never been tested for HIV previously. HIV prevalence was higher in urban areas (2.4%) than in rural areas (1.7%).

The main health sector response agencies are the National AIDS/STI Control Program (NACP) and the National Tuberculosis Control Programme (NTP) of the Ghana Health Service (GHS). As of December 2018, the NACP has established 375 antiretroviral therapy (ART) sites and 3,750 prevention of mother-to-child (PMTCT) and HIV testing services (HTS) sites for prevention, testing and treatment services of HIV and TB. Thirty Thousand four hundred and ten (30,410) persons were newly enrolled on ART in 2018 contributing to a cumulative total of 113, 171 ART clients by end of December 2018. The NTP is currently implementing the National

[7] https://www.unfpa.org/data/world-population/GH

[8] http://www.aidsinfoonline.org/kpatlas

Tuberculosis Health Sector Strategic Plan, 2016 – 2020 (NTP-NSP, 2016 - 2020) toward rapid scaling up in accordance with its adapted post 2015 Global TB control strategy. The NTP aims to achieve:
(i) early screening, detection and enrollment into treatment of all forms of notified (new cases) from the baseline of 15,606 in 2013 to 37,302 by 2020, while increasing the proportion of bacteriologically confirmed pulmonary TB from 51% in 2013 to 60% by 2020; (ii) early detection and enrollment into treatment of at least 85% of confirmed MDR-TB cases among new and previously treated cases by 2020; (iii) attainment of higher treatment success for all forms of TB from 84% in 2012 to at least 91% by 2020 through improved quality clinical care and community TB care; (iv) reduction in death rates of TB/HIV co-infected cases from 20% in 2012 to 10% by 2020 and uptake of ART coverage among co-infected from 37% in 2013% to 90% by 2020; (v) improvement in Programme management; coordination Monitoring & Evaluation and operations research to support treatment and screening strategies for TB/HIV.

The NACP/GHS have been conducting the HIV Sentinel Survey (HSS) annually among pregnant women attending ANC since 1992 and uses that to provide strategic data on the trend of HIV infection in Ghana. The 2018 HSS gives an overall national median ANC HIV prevalence of 2.4% (95% Confidence Interval: 2.18-2.62), an increase from the 2017 value of 2.1%. The Greater Accra and Western Regions recorded the highest (3.1%) and the Northern region recorded the lowest (0.6 %) prevalence. In terms of age group, HIV prevalence was highest among women age 35-39 years (3.4%) and was lowest in age 15-19 years (0.9%). HIV prevalence in the age group of 15-24 (proxy for new infections) remained 1.5%, same it was the previous year. The 2018 National HIV Prevalence which is representative of the general population was estimated to be 1.69%. According to the 2018 HIV and AIDS estimates report of Ghana, 334,713 people were living with HIV; there were 19,991 new HIV infections of which 5,532 were youth (15–24 years); and there were estimated 14,181 AIDS deaths in 2018.

Ghana's epidemic has been characterized by a relatively higher HIV prevalence in urban sites compared to rural sites over the years; being 2.6% for women residing in urban sites and 2.2% among pregnant women residing in rural sites according to the 2018 HSS. Also, HIV prevalence among STI clients saw a significant increase from the previous year's 6.3% to 9.2% with females predominantly affected. Prevalence was higher among females in the age group 35-39 (25.7%) followed by 45-49 (23.1%) and in males was 40-44 (12.5%).

The TB epidemic of Ghana is generalized with geographic variation in relation to case notification linked to better access to health facilities. Case notification rates are particularly high among people living with HIV (PLHIV), prisoners, miners, pregnant women and people with diabetes. Cases among children constitute approximately 5% of all notified TB cases (CCM Ghana, 2019). According to the report on the "TB situation in Ghana (2017)" published by the Stop TB Partnership, 44,000 persons, including 2,200 children were estimated to have developed TB in 2017; 9,500 who developed TB were co-infected with HIV and 2,759 people were diagnosed with both HIV infection and TB disease. Number of people who died because of TB

was 15,200 (Stop TB Partnership, 2017). The NTP operates in partnership with civil society organisations under the umbrella of the Stop TB Partnership Ghana which collaborate to perform case finding and treatment support activities in all regions of the country. In dealing with human rights, stigma and discrimination, the contribution of CSO is critical and the NTP partnering 135 CSO in case finding also contributes to dealing with and reducing stigma and human rights violations pertaining to case finding, treatment, care and support of people living with TB (NTP-NSP, 2016 - 2020).

2.3 Key Populations and Stigma-based Barriers to Healthcare

Ghana usually views key populations (KP) as being mainly female sex workers, men who have sex with men, people who inject drugs, and people living with HIV, and vulnerable populations as including prisoners, non-paying partners of sex workers, '*kayayei*', long distance truck drivers, uniformed (security) personnel and health workers (GAC, 2016). The overall HIV prevalence among sex workers in general was found to be 6.9%, with a gender skew of a higher prevalence amongst women being 11.1%; those less than 25 years had a prevalence of 3.4% and those 25 years and above had a prevalence of 9.6%. The estimated population size of sex workers according to the Integrated Bio-Behavioural Surveillance Survey of 2015 (IBBSS, 2015) was 65,053. A similar survey in 2017 estimated the population size of MSM to be 54,800 with an HIV prevalence of 18% and a mere 3.7% coverage for anti-retroviral therapy (IBBSS, 2017). Although there was no clear data on avoidance of healthcare by MSM due to stigma and discrimination, evidence of the general stigma towards MSM by the general population significantly impacts on their unwillingness to access healthcare in general and ART in particular.

Due to stringent laws and lack of adequate rehabilitation and programmes on harm reduction, the activities of persons who inject drugs cannot be easily evaluated and difficult to be reached with interventions resulting in the paucity of data for action. Data from prisons survey have shown a declining HIV prevalence over time due to intensive HIV and TB prevention activities within all the 42 prisons of Ghana. Whereas in 2015 the prevalence of HIV was 1.5% for male prisoners and 11.1% for female prisoners, the 2017 survey showed a significantly reduced prevalence of 0.4% with and ART coverage rate of 100%. The HIV and TB right-based preventive activities of PPAG and other CSO and stakeholders in the prisons seem to be impacting positively on the overall interventional outcomes. The overall prison population of Ghana varies between 12,000 and 14,000. The HIV prevalence of Ghana for 2018 according to the "HIV Estimates Report, 2018 -2025" is 1.67%, with an estimated population of PLHIV of 334,713. The overall ART coverage of PLHIV in Ghana was 33.81% as at close of 2018.[9]

A 2016 study on the barriers and facilitators to HIV-related healthcare services across the HIV continuum of care among KP in Ghana conducted by the NACP/GHS & CDC-USG revealed that

[9] UNAIDS Key Populations Atlas (uploaded as of 8 August 2019) - http://www.aidsinfoonline.org/kpatlas

although healthcare workers generally were aware that MSM and FSW formed part of their regular clientele base, they do not specifically take history of clients in a direction as may be beneficial in addressing particular needs of KP. Despite their recognition that MSM and FSW were entitled to good quality health care as other clients, some held the general belief that the acts of these KP may be immoral and unacceptable. These beliefs and judgmental notions tend to act as barriers to not only HIV and TB related healthcare services, but have negative impact on the healthcare services received by these KP. Although many healthcare workers have received training in key HIV-related areas, not many were found to have received training on stigma and discrimination, and human rights in general and on MSM and FSW stigma reduction in particular. The study highlighted the need to provide adequate training for all categories of staff, both clinical and non-clinical.

HIV-related discrimination in the healthcare setting tend to thrive in the light of ignorance, poor supervision and lack of accountability coupled with the underlying attitudes and beliefs that tend to stigmatize and frown on KP and their perceived or real activities. In assessing the reporting of such discriminating encounters within the health setting, the 2014 Stigma Index Survey showed that 1.4% of PLHIV reported being denied health services because of HIV status within the previous 12 months of the survey; and as high as 7.9% indicated that healthcare professionals told others about HIV status without their consent (PLHIV Stigma Index 2014).

2.4 Ghana Baseline Assessment

The "Ghana Baseline Assessment of Human Rights related barriers to HIV Services" (Baseline Assessment) which inhibit access to, uptake of, and retention in HIV-related services in Ghana was conducted in 2017 to inform on the current state of affairs of the national HIV response in the light of human rights, stigma and discrimination barriers. It evaluates the work of various stakeholders working to address these barriers and to find out from PLHIV and key and vulnerable populations the challenges they face, and proposed solutions. The Baseline Assessment recommended that the focus of interventions to remove human rights-related barriers be targeted to support improved access to services among PLHIV, people affected by TB, female sex workers, men who have sex with men, people who inject drugs, HIV-negative partners of people living with HIV, prisoners, people with disabilities, and women and vulnerable children (including orphans and adolescent girls). The baseline assessment corroborated the findings of the 2014 Ghana Demographic and Health Survey which showed that 67.7% of adults aged (15 – 49) responded no to the question: Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?[10] On all the four indicators that measured stigma associated with HIV/AIDS, only 8 percent of women and 14 percent of men age 15-49 expressed

[10] Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. 2015. Ghana Demographic and Health Survey 2014. Rockville, Maryland, USA: GSS, GHS, and ICF International.

accepting attitudes towards persons with HIV/AIDS. The Greater Accra region recorded the highest acceptable behavior whilst the northern region recorded the least.

Based on the desk review carried out for the assessment, the following key and vulnerable populations were identified in Ghana: (i) female sex workers (FSW), (ii) men who have sex with men (MSM), (iii) people who inject drugs (PWID), (iv) people living with HIV (PLHIV), (v) HIV-negative partners of people living with HIV, (vi) prisoners, (vii) '*kayayei'*[11], (viii) people with disabilities (PWD), (ix) women, and (x) vulnerable children, including orphans and street children. The Baseline Assessment describes the unique human rights barriers that each of these populations face. The summary of major barriers to HIV-related services identified through the assessment are:

i. **Stigma and discrimination** – these highlighted high levels of stigma and discrimination faced by Key and vulnerable populations, including social exclusion. Self-stigma was also noted. Female sex workers and MSM are in themselves a highly stigmatized group, thus being diagnosed with HIV exposes them to a "double burden" of stigma. Similarly, people who use drugs are also highly stigmatized though they are not a readily visible key population due to the criminalization of drug use. These high levels of stigma are barriers and may hinder key and vulnerable populations (KVP) from utilizing HIV-related health services because of the fear of being branded as persons living with HIV. This may be further compounded with the overt judgmental attitudes and treatment by some health service providers.

ii. **Punitive laws, policies, and practices** – the cumbersome process of law reforms makes it difficult to repeal or amend existing laws that negatively impact population health. An example of how laws, law enforcement agencies and the legal environment create harm and barriers for key populations were identified to be police harassments and violence against FSW. The MSM are also susceptible to police mistreatment and potential arrests which makes it difficult for most MSM to seek police assistance in cases of violation of their rights. Although the Ghana AIDS Commission (GAC) Act contains important provisions for promoting and protecting the rights of persons living with HIV (PLHIV) as well as those suspected to be living with HIV, there is still a need for broad-reaching advocacy to build awareness and ensure effective implementation.

iii. **Gender inequality and gender-based violence** - Women living with HIV experience heightened discrimination because of gender norms regarding acceptable sexual behaviors for women and perceived implications of a positive diagnosis. There is significant level of discrimination and violence against women living with HIV,

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

particularly in marital contexts where a woman who tests positive may be blamed for having brought the infection in to the marriage. The expansion of PMTCT under the provider-initiated HIV testing and counseling in antenatal care settings, which is greatly increasing the numbers of women testing for HIV and learning about their status (Women aged 15 – 49 HIV prevalence 2.3 [1.9 – 2.8] is without a corresponding increase in counseling and testing of men (Men aged 15 -49 HIV prevalence 1.1 [0.8 – 1.3)[12]. Young people, especially adolescent girls such as "Kayayei" who engage in transactional sex are also vulnerable to disproportionate levels of abuse.

iv. **Economic and social inequality-** Certain key and vulnerable populations, including younger female sex workers, younger men who have sex with men, and street children are particularly susceptible to financial hardships which tend to aggravate their vulnerabilities.

The Baseline Assessment as outlined below highlights some of the main interventions designed to address human rights barriers to accessing HIV services and as much as possible aligns them to the 7 key program areas. In Ghana, although many large interventional programs may not have explicitly incorporated human rights language and frameworks in their implementation, many of their components have in effect addressed human rights-related barriers to services. Some of these components have included peer-to-peer outreach and communication, drop-in-centers, and a network of M-Friends (prominent community members e.g. lawyers, doctors, police, traditional leaders) and M-Watchers (people living with HIV and key population peer educators) who were trained on stigma and discrimination and how they affect and drive HIV infection, the effects of human rights abuses and negative gender norms and gender-based violence on key populations and PLHIV, and how to identify cases of violence and help individuals access health and legal services. The use of case managers who ensure that people living with HIV are enrolled and remain in the care system, peer education, outreach and drop-in centers have positively impacted on information dissemination, psychosocial support, and free services, including HIV testing and counseling, STI treatment and mobile outreaches which take HIV testing services to harder-to-reach groups such as out-of-school youth in a way as to reduce the impact of stigma and discrimination to accessing HIV services for key and vulnerable populations.

There have been various initiatives to reduce stigma and discrimination in health facilities by sensitizing and training health care workers to be key population-friendly – particularly in relation to interacting with female sex workers and men who have sex with men. Several of these trainings have incorporated, or are now seeking to incorporate, human rights perspectives and content. There have also been significant large-scale efforts to sensitize law-enforcement agents in Ghana, including in-service training for police with approximately 2,000 trained annually as

[12] UNAIDS Country Fact Sheet, Ghana 2018

well as pre-service training for all officers-in-training, which involves approximately 3,000 graduates annually.

Legal literacy efforts have not been optimized and the Baseline Assessment highlights the need for increased awareness for PLHIV and other KVP regarding rights and existing protections against discrimination including the Patient Charter and the GAC Act. In like manner reporting mechanism of CHRAJ for addressing issues of stigma and discrimination against PLHIV and other KVP have been under-utilized. Further the Ministry of Gender, Children and Social Protection has carried out some HIV-related activities, including public sensitization, but also faces financial constraints.

A comprehensive approach to addressing gaps and removing human rights barriers to services have been outlined by the Baseline Assessment which focuses on current funding and programmatic effort towards interventions and geared towards reaching, supporting and linking key populations, particularly FSW and MSM into testing, care and treatment services and sets out following the recommendations which relate to the 7 key human rights program areas towards the attainment of an effective rights-based response to Ghana's HIV epidemic:

- Public education/media campaigns to increase knowledge about HIV and human rights:
- Scale up 'Models of Hope', 'M-Watchers' and other support groups
- Institutionalize pre-service and in-service sensitizations and trainings of health care workers on HIV and Human Rights
- Strengthen pre-service and in-service training on HIV and human rights for police and prison officers
- Human rights education/legal literacy work through peer education and campaigns:
- Paralegal training and linkages to human rights interventions and legal services
- Capacity building of CHRAJ to improve access to justice in cases of discrimination
- Institutionalize pre-service and in-service sensitizations and trainings of judges and lawyers on HIV, stigma, and rights
- Stigma index implementation at all levels
- Dissemination of the GAC Act, the Patient Charter, and other relevant laws and policies

A baseline study of HIV among TB patients revealed a co-infection prevalence of 14.7%. HIV prevalence among TB patients varied in the different regions ranging from 33.4% in the Eastern Region to 9.4% in the Upper East. The proportion of TB patients tested for HIV rose from 17% during the first year of the introduction of TB/HIV activities to 77.8% in 2012. ART coverage among HIV-positive TB patients increased from 13.9% in 2008 to 42.6% in 2013. (Sourced from the CCM Ghana website, 12th September 2019)

3 Purpose, Guiding Principles, Goal and Strategic Direction

3.1 Purpose

The purpose of this Strategic document is to provide a comprehensive strategic direction that will form the foundation for the planning and implementation of interventions and activities that will identify, address and remove human rights-related barriers to HIV and TB services towards the attainment of HIV and TB epidemic control in Ghana and also guarantee access to quality healthcare. This will include addressing the stigma and discrimination faced by PLHIV, people affected by TB and other key and vulnerable populations (KVP).

3.2 Guiding Human Rights Principles

Based on the premise of leaving no one behind, the following guiding principles of human rights and equity are the under-pinning foundations of this strategic direction:

- Availability, accessibility, acceptability and good quality of services
- Non-discrimination and equality
- Privacy and confidentiality
- Respect for personal dignity and autonomy
- Meaningful participation and accountability
- Health and social justice

3.3 Goal

To remove human rights-related barriers to HIV and TB services and to improve access to quality HIV and TB healthcare and support services through pragmatic implementation strategies.

3.4 Strategic Direction

The human rights-related challenges facing the national HIV and TB response are complex and multifaceted. Addressing them will require a comprehensive multi-sector and integrated approach. It is therefore important that the strategies designed to address these challenges take into consideration the complexities of the problem, including the human rights environment as relating to PLHIV and people affected by TB, key and vulnerable populations (KVP), the diversity of stakeholders – both governmental and non-governmental, resource mobilization for implementation, monitoring and evaluation of all programmes and activities.

The development and implementation of this Strategic Plan comes in at the last mile of both the National HIV Strategic Plan, 2016 – 2020 (NSP-HIV) and the National Tuberculosis Health Sector Strategic Plan, 2016 – 2020 (NSP-TB). It is expected that both will be given

new impetus of fresh focus on right-based approaches that would inure to the realization of respective targets of both the HIV and TB national responses.

This Human Rights Strategic Plan, is in synch with the tenets of the current NSP-HIV in the area of stigma and discrimination as well as human rights. The NSP-HIV proposed to mitigate the socio-economic impact of HIV and AIDS on KP and by extension improve the quality of life of PLHIV and those affected by the epidemic which to a greater extent is being pursued. One of the main pillars of this Strategic Plan which is to reduce stigma and discrimination against KP including PLHIV is being pursued within pockets of interventions and programmes but not optimally. It is the expectation of this strategy that two documents, this Plan and the NSP-HIV would be complementary in implementation and synergistic in approach at least during their period of joint pendency up to the close of 2020. This 5-year Strategic Plan spans 2020 to 2024 and expected to form the basis for advocating for the incorporation of more pragmatic rights and gender-based approaches and interventions into both upcoming TB and HIV Strategic Plans to push for the acceleration towards the attainment of both HIV and TB national and global targets.

The current NSP-HIV calls for the mounting of HIV-related stigma and discrimination reduction campaigns, engagement of traditional authority and preponderance of CSOs in stigma reduction, reduction of stigma in the healthcare setting, meaningful involvement of PLHIV in HIV stigma and discrimination reduction; interventions to mitigate workplace HIV stigma and discrimination; reducing stigma and discrimination against women with HIV. Another section of the NSP-HIV which focuses on strengthening human rights for instance seeks to deal with pre-employment HIV testing which is still mandatory in some public sector organizations especially the security forces and runs counter to the right of individuals to voluntarily HIV testing. This issue of mandatory testing came up again at the Multi-Stakeholder Human Rights Meeting in Accra and addressed in this Strategic Plan. Under this Strategic Plan steps will be taken as a continuum of what pertains in the NSP-HIV, to safeguard human rights issues through the Commission on Human Rights and Administrative Justice (CHRAJ) and training of Police personnel on safeguarding the human rights of KPs.

The right-based approach for TB intervention envisaged in the NSP-TB on one hand focuses on PLHIV, diabetics and household contacts in the hospital setting and on the other hand systematically seeks to reach prisoners. This target will be systematically expanded to cover the entire network of health care facilities and prisons in Ghana for a stigma-free environment. In its penultimate year of implementation, just like that of the NSP-HIV, specific activities under the plans will be taken in consonance for continuity and sustainability. These would include scaling-up to systematically reach-out to more persons affected by TB and to integrate interventions of human rights into routine programme activities in a sustainable manner as envisaged under this human rights strategic plan.

Hitherto, as far as TB was concerned this approach has been passive. TB case notification rate among prisoners is higher than the case notification rate of 62 per 100,000 people in the general population.

The development of this strategic plan took into consideration the UNAIDS Guidance on the seven key programmes targeted at reducing stigma and discrimination and increasing access to justice in national HIV response programmes and tailored it to suit the context of Ghana's human rights and gender-related barriers. The outcome is the merging of some programme areas and the origination of a new area dealing with the sensitization of religious, faith-based and traditional leaders and service providers. Thus, the evaluation of the HIV and TB related human rights situation in Ghana both within and outside of the healthcare sector through the engagement of stakeholders, baseline assessments and the multi-stakeholder meeting against the background of the UNAIDS Guidance on the subject matter. The major stigma, discrimination and human rights barriers identified that need urgent addressing can be classified into the following categories:

- Stigma and discrimination relating to PLHIV and people affected by TB and other KVP
- Violence and other abuses, including police harassment targeting key populations, particularly MSM and FSW
- Legal obstacles and lack of access to justice and human rights interventions
- Negative healthcare-based attitudes, as well as stigma and discrimination within the healthcare setting
- General lack of awareness of rights, and the need to protect the rights and facilitate access to human rights interventions
- Marginalization of PWD, young persons, particularly adolescent girls especially in relation to access to HIV and TB prevention, testing and treatment services
- Gender-based violence and gender inequalities
- Religious, traditional, socio-cultural, traditional medicine practices and healthcare setting related human rights violations

The major Strategic Objectives set out under this strategic plan to guide the strategic direction are the following:

1. To coordinate human rights interventions and advocate for reformation of laws, regulations, and policies relevant to HIV, TB and human rights-related barriers to care services.
2. To eliminate all forms of stigma and discrimination targeted at PLHIV, people affected by TB, and other KVP.

3. To promote access to justice, HIV-and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy ("Know Your Rights").
4. To remove gender-based barriers to human rights and healthcare service interventions, and to eliminate TB- and HIV-related gender discrimination and violence against women and adolescent girls.
5. To build capacity of healthcare workers and managers on HIV- and TB- related stigma, discrimination and human rights barriers that affect PLHIV, people affected by TB, and other KVP.
6. To reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV, people affected by TB and other KVP.

3.5 The Strategic Objectives

3.5.1 Strategic Objective 1

To coordinate human rights interventions and advocate for reformation of laws, regulations, and policies relevant to HIV, TB and human rights-related barriers to care services.

This strategic objective seeks to institute a functional framework for monitoring and coordinating all human right activities and interventions relating to HIV and TB as well as those that affect PLHIV and KVP. The GAC and the CHRAJ are two statutory state agencies that are well placed for the role of guiding review and reformation of laws, regulations, policies and practices that act as human rights barriers to HIV and TB interventions. Putting in place a central and decentralized system of monitoring human rights infractions, coordinating human rights interventions, gathering relevant evidence to call for reformation of laws and policies should be paramount in attaining objectives of this strategy.

As part of the process, there will be the need to consistently engage parliament and sensitize law-makers on the need for legal reformation. Making new laws or amending old ones to address issues of human rights, stigma and discrimination are important interventions requiring the identification of areas that will need new legislation or amendment of old laws and lobbying law-makers or the executive to table such before parliament for consideration and passage.

Aside the role of CHRAJ and GAC, the Attorney-General's Department which has been given the mandate to coordinate the work of the National Mechanism for Reporting and Follow-ups (NMRF) on Human Rights in Ghana, can bring in the added coordinating role of various Ministries, Departments and Agencies and track recommendations and decisions by the International Human Rights Monitoring Mechanisms and assist respective Ministries, Departments and Agencies to implement the recommendations.

i. **Current Interventions:** The GAC is the coordinator of the national HIV response and plays the lead role with respect to advocating for new laws or reforming old ones. The

dissemination of GAC Act and other relevant laws and policies, information provision and some level of stakeholder trainings have been undertaken. Healthcare workers, law enforcement agencies, the judiciary, and on a limited basis the general population have been beneficiaries of such dissemination of relevant Acts and policies. CHRAJ currently executes the constitutional mandate to promote, protect and project human rights and have the requisite structures, systems and the expertise to play vital role as far as this strategic direction is concerned. Establishment of reporting mechanism on stigma, discrimination and human rights violations relating to PLHIV and key populations, such as that instituted by CHRAJ; and the sensitization on human rights reporting. The CHRAJ reporting system for reporting and responding to human rights violations have not worked well and have been underutilized; remodeling and making it more effective would contribute to the attainment of this strategic objectives.

ii. **Current Implementers:** GAC, CHRAJ

iii. Limitations/Challenges:

1. Limited capacity of GAC to handle human rights issues and barriers to effective advocacy for law and policy reforms and monitoring.
2. Limited programming and activities for monitoring and coordination of interventions for HIV and TB related human rights violations
3. Difficulty in engaging and coordinating interventions of law-makers, CHRAJ, law enforcement agencies and policy implementers.

3.5.2 Strategic Objective 2

To eliminate all forms of stigma and discrimination targeted at PLHIV, people affected by TB, and other KVP.

Stigma and discrimination relating to TB and HIV constitute a complex and major barrier to HIV and TB interventions and permeates every aspect of society including the healthcare setting. This strategic objective is to help identify the drivers of such barriers and put in place measures to address them comprehensively. It is important to build on work done in the past or currently ongoing by various stakeholders and implementers, initiate new innovative approaches based on evidence which may involve new stakeholders and implementers. Joining global platforms, such as the Global Partnership for Action to eliminate all forms of HIV-related stigma and discrimination which aims to translate country commitments into measurable policy change and programmatic interventions that result in the enjoyment of HIV-related rights by all and the implementation of commitments established in the 2016 Political Declaration would impact positively on the country interventions.

The involvement of PLHIV such as those who volunteer as Models of Hope both in the health facilities and the community has become an invaluable part of the right-based comprehensive care offered to ART clients in stigma free environment. According to the

National Association of Persons Living with HIV (NAP+), a Model of Hope is any person living positively and openly with his/her HIV status who volunteers his/her time, knowledge, and experience to other person(s) living with HIV (PLHIVs) in an antiretroviral therapy (ART) facility. Models of Hope are trained to provide HIV-related information and services in the community and at a health facility. A Model of Hope is usually open minded person: approachable and trustworthy, non-judgmental, and who exhibits virtues like patience, humility, and maturity.

One of the major sources of stigma and discrimination relates to segregation and isolation of TB and HIV care particularly regarding the siting of ART centres within health facilities which leads to negative branding of the clinics. This according to some PLHIV, as captured in the Baseline Assessment, and persons affected with TB make them feel condemned and thus have been calling for integration of ART with other clinical services. The NACP in a recent evaluation found that one of the reasons key populations do not remain in care is the branding of HIV services and facilities (NACP, 2017).

i. **Current Scope of Interventions and Responsible Organizations:** Stigma reduction interventions and activities have been undertaken through peer education by LRF, MICDAK, ADRA, HFFG, Ghana West African Program to Combat AIDS & STIs (WAPCAS), MIHOSO, Pro-Link, CEPEHRG, MLPF, Ghana Federation of the Disabled (GFD) and PPAG. The Network of Teachers and Educational Workers in HIV/AIDS (NETEWAG) have been involved in stigma reduction activities in the educational sector and have been able to address some of the peculiar stigma-related needs faced by teachers and educational workers to extent within the limited resource constraints. Ghana Community interventions by Models of Hope (MOH) have been implemented by LRF, NAP+ and HFFG. Outreach and mobilization activities of organizations such as LRF, ADRA, Pro-Link, SWAA, Solace Initiative, and PPAG have empowered and educated community members on 'know your rights', and on taking action against HIV stigma and discrimination. Most of the activities outlined so far as being undertaken by the various CSO have completed their funding cycles and therefore are no longer active and would require reviving and realignment. Interventions within the healthcare setting mostly relate to prevention, testing, treatment, care and support services and have been implemented mainly by the NACP/GHS/MOH through both public, quasi government, faith-based and private health facilities and sectors. However, health sector based stigma and discrimination still persists and new approaches are required to address them.

ii. **Implementer:** by LRF, MICDAK, ADRA, HFFG, WAPCAS, MIHOSO, Pro-Link, CEPEHRG, MLPF, GFD, PPAG, NAP+, SWAA, Solace Initiative

iii. **Limitations/Challenges:**

1. Lack of appreciation of the pervasive nature of stigma and discrimination and the extent to which human rights violations negatively affect PLHIV, persons affected by TB, other KVP, women and adolescent girls and PWD; and how these inhibits their access to HIV interventional services.
2. Weakness in reaching out to and addressing issues of the youth particularly adolescent girls, those living with HIV and both male and female young persons who sell sex
3. Lack of coordination and standardization of information for interventions aimed at reducing stigma and discrimination
4. Deficient capacity in addressing psychosocial and emotional concerns of affected persons
5. Purely voluntary nature of the work of the Models of Hope which sometime affects commitment and prioritization
6. Lack of standardization of pre-service training for healthcare practitioners.
7. Lack of interest by most governmental agencies in the stigma and discrimination reduction interventions leaving it purely in the hands of CSOs without providing clear direction and support
8. Unavailability of in-service training curricula for training on human right and stigma reduction interventions which makes standards and quality of work difficult to measure
9. Financial constraints are major limitations as the activities are dependent on donor partner support and voluntary contributions which are not sustainable.

3.5.3 Strategic Objective 3

To promote access to justice, HIV-and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy ("Know Your Rights").

The aim of this strategic objective is to create the enabling environment to promote access to justice by all, irrespective of their HIV or TB status, their sexual orientation and their social vulnerability. This is paramount in any intervention aimed at reducing stigma and discrimination and promoting human rights of all persons including PLHIV, FSW, MSM and other vulnerable groups. Although making new laws or amending old ones to address issues of human rights, stigma and discrimination are important interventions, advocacy for enabling policy environment and guidelines are required for rights protection and push for the zero stigma agenda, and the promotion of HIV-related legal services and human rights interventions at all implementation fronts.

Promoting legal literacy and undertaking human rights and legal education through **w**orkshops and sensitization on human rights for PLHIV, people affected by TB and other KVP

(particularly FSW, MSM, "Kayayei", adolescent girls, and PWD) and their associations are important strategic interventions that ought to be scaled-up. There is the need to bring on board all relevant stakeholders to collaborate in empowering the KVP to exercise their rights under the law and be able to institute complaints regarding human right violations and to develop the capacity for navigating the police complaint process. Para-legal training involving education and empowering of individuals to advocate for human rights among PLHIV, KP peers and communities are important and necessary.

Sometimes the implementation or enforcement of laws may not go as anticipated due to lack of sensitization and inadequate training of implementers or enforcement agencies such as the police. Establishment of reporting mechanism on activities of law enforcement agents which pose as obstacles to PLHIV and other KVP to justice and their sensitization on human rights would provide the necessary foundation to be built upon for the attainment of the set objectives. Accessible legal services may be difficult for the vulnerable. Scaling-up the establishment of free human rights clinics to offer support to PLHIV, persons affected by TB and other KVP as well as offer pro-bono legal services are important interventions to be pursued.

i. **Current Scope and Recent Interventions:** Providing guidance and support for PLHIV, people affected by TB and other KVP regarding their human rights and access to legal aid/representation and appropriate healthcare services is paramount. Some current ongoing interventions by implementers provide general information, undertake HIV risk reduction counseling and referrals; as well as provide information on HIV-related human rights and sensitization on stigma and discrimination. Project on violence against key and vulnerable populations, including training para-legals and linking community members to psychologists has been undertaken by Solace Initiative in only Accra and Kumasi in 2014. SWAA has also been involved in "Kayayei" empowerment in Greater Accra, Ashanti and Brong Ahafo between 2015 and 2017.

   Activities of interventions targeted towards the police have included pre-service training curricula review on stigma and discrimination against key populations, as well in-service training using rights-based approaches to policing. There has also been some training by CEPEHRG focused on key and vulnerable population with CHRAJ. Sensitization and training workshops for police officers on human rights, gender-based violence (GBV) and human rights protection against KP is being done on a limited scale. Human Rights Education was conducted by HRAC in some regions including Volta and Western Regions, particularly at the respective border towns of Aflao and Elubo in 2016/2017. The AfED provides assistance to KPs to access lawyers and report human rights violations to the police. The HRAC established avenues for

PLHIV and KPs to report cases of abuse, human right violations, stigma and discrimination through their established systems of reporting and to receive and be attended to in the Human Rights Clinic's walk-in facility and also through mobile clinic outreaches.

The recent collaboration of WAPCAS with the Ghana Police HIV Program is ongoing and beyond sensitization will involve pre- and in-service training through police training schools across the country.

In 2012 CHRAJ established a mechanism for reporting human rights violations and established a website to aid in online reporting across the country. CHRAJ has been collaborating with DOVVSU of the Ghana Police Service to facilitate workshops and sensitization activities for key populations, PLHIV and other vulnerable groups to understand their rights under the law. Together CHRAJ and DOVVSU work with some CSO such as WAPCAS and some governmental agencies such as GAC, GHS, NACP, Office of the AG to facilitate workshops, media engagements, social engagements and human rights training and formulation of policies.

ii. **Implementers:** CEPEHRG, MIHOSO, HRAC, WAPCAS, PPAG, CHRAJ, DOVVSU, AfED, LRF, HRAC, WAAF, HFFG, Solace Initiative, SWAA

iii. **Limitations/Challenges:**

1. No particular coordination of activities by state agencies aimed at promoting access to justice of especially PLHIV, persons affected by TB and other KVP
2. Trainings done by some organizations lack standardization, especially when it has to do with police training
3. Disconnection between existing laws, service delivery, human rights and law enforcement practices
4. Limited reach, as most of the interventions and activities were restricted to cities and limited locations within the cities; and persons in rural settings or urban poor communities may not have means and the capacity to utilize the reporting mechanism and the website.
5. Generally low utilization due to poor publicity about the availability of the service.
6. Due to stigma, identifying groups and putting training together for them can be a challenge.
7. Deficient capacity in addressing the complex psychosocial and emotional concerns.
8. Absence of interventions targeting PWD
9. Poor coordination and weak state involvement and support.

3.5.4 Strategic Objective 4

To remove gender-based barriers to human rights and healthcare service interventions, and to eliminate TB- and HIV-related gender discrimination and violence against women and adolescent girls.

This strategic Objective looks at programmatic efforts needed to eliminate gender-based violence (GBV) and to reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity both within and outside the healthcare setting. Workshops and trainings such as those outlined by the USAID/AED's 'My Life: Positive Living Toolkit' have been organized. Not much by way of programming is being done in the area of reducing HIV-related gender discrimination, harmful gender norms and violence against women and adolescent girls is being done. This leaves gaps that tend to make women and girls lag behind with respect to the diversity of interventions. Specific interventions therefore would have to be instituted to empower women and girls particularly those involved in sex work as well those living with or affected by HIV and TB. Sensitization and capacity building of healthcare workers, human rights organizations and other CSO, law enforcement agencies and the judiciary on gender-based violence, gender-related discrimination and human rights violations would be required.

i. **Current Scope and Interventions:** Community Engagement particularly targeting healthcare workers, church leaders, community leaders as well as FSW to reduce discrimination against women in the context of HIV has been undertaken by SWAA. There is a KP programme being undertaken by WAPCAS involving Peer education on GBV and stigma and discrimination education and reporting which aims at empowering the KP community. The Maritime Life Precious Foundation currently is undertaking a "know your rights" programme for FSW using BCC materials under the support of USAID/JSI in the Western Region, specifically in Shama and Sekondi-Takoradi Municipalities which are expected to end by close of September 2019.

   The HRAC is involved in gender-based interventions aimed at empowering FSW and MSM, human rights and legal training for police and healthcare workers on HIV prevention for key and vulnerable populations along the Elubo and Aflao borders of Ghana. Additionally, there has been the formation and training of networks consisting of service providers, human rights advocates, traditional and religious leaders, journalists and lawyers on human rights, GBV and HIV in relation to KPs. The Women's wing of NAP+ is one group whose resource can be explored in combating GBV and in the provision of psychosocial support to sexual and gender-based violence (SGBV) survivors.

ii. **Implementers:** SWAA, HRAC, Maritime Life Precious Foundation, WAPCAS, NAP+, DOVVSU of the Ghana Police Service

iii. **Limitations/Challenges:**

1. Limited reach of current interventions
2. Limited programming engaging men, partner testing
3. Poor coordination and limited state involvement of gender-based activities and interventions
4. Absence of clear strategies on addressing gender-related stigma and discrimination within communities and in the healthcare setting.

3.5.5 Strategic Objective 5

To build capacity of healthcare workers and managers on HIV and TB-related stigma, discrimination and human rights barriers that affect PLHIV, people affected by TB, and other KVP.

Stigma and discrimination as well as violations of the rights of persons living with HIV, persons affected by TB, other key and vulnerable populations and other marginalized persons within the healthcare sector is mainly the result of ignorance, fear and lack of appreciation of the negative impact such attitudes of stigma can have on interventions to address HIV and TB. These attitudes and behaviors become entrenched in the absence proper supervision and accountability on the part of healthcare managers and supervisors which tend to give the wrong signal that the healthcare worker can get away with such attitude and behavior without sanction. Building the capacity of healthcare managers and supervisors to effectively deal with issues of stigma, discrimination and human rights violations in the healthcare setting will go a long way in addressing these infractions of the rights of patients. Providing training for healthcare workers on human rights, stigma, discrimination and medical ethics related to TB and HIV will dispel ignorance and empower healthcare workers to appreciate, uphold and promote the rights of others, particularly that of their patients and other KVP. These responsibilities of healthcare professionals in ensuring the rights of persons within the health sector are upheld and promoted will be best served when healthcare practitioners are given the requisite training. Building on and scaling-up the work of WAPCAS and other implementers will be necessary for the quicker attainment of goals.

i. **Current Scope and Interventions:** Stigma reduction training and interventions are currently ongoing in some selected health facilities by WAPCAS under the Global Fund funding and with the support of USAID. Most interventional work by some implementers in the past happened between 2014 and 2017 but has not been sustained beyond the funding cycle which ended in 2017.
ii. **Implementers:** LRF, HRAC, WAAF, JSI, Pro-Link, ADRA, WAPCAS
iii. **Limitations:**
    1. Absence of standardized curriculum for HIV-related and medical ethics training in both pre-and in-service training.

2. Lack of understanding by supervisors on the main human rights issues they need to uphold and institute.
3. Lack of supervision and codes relating to human rights and absence of sanctions and accountability of practitioners
4. Disconnection between service delivery and human rights issues.
5. Healthcare managers lack interest in dealing with issues of stigma and discrimination emanating from their subordinates.

3.5.6 Strategic Objective 6

To reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV, people affected by TB and other KVP.

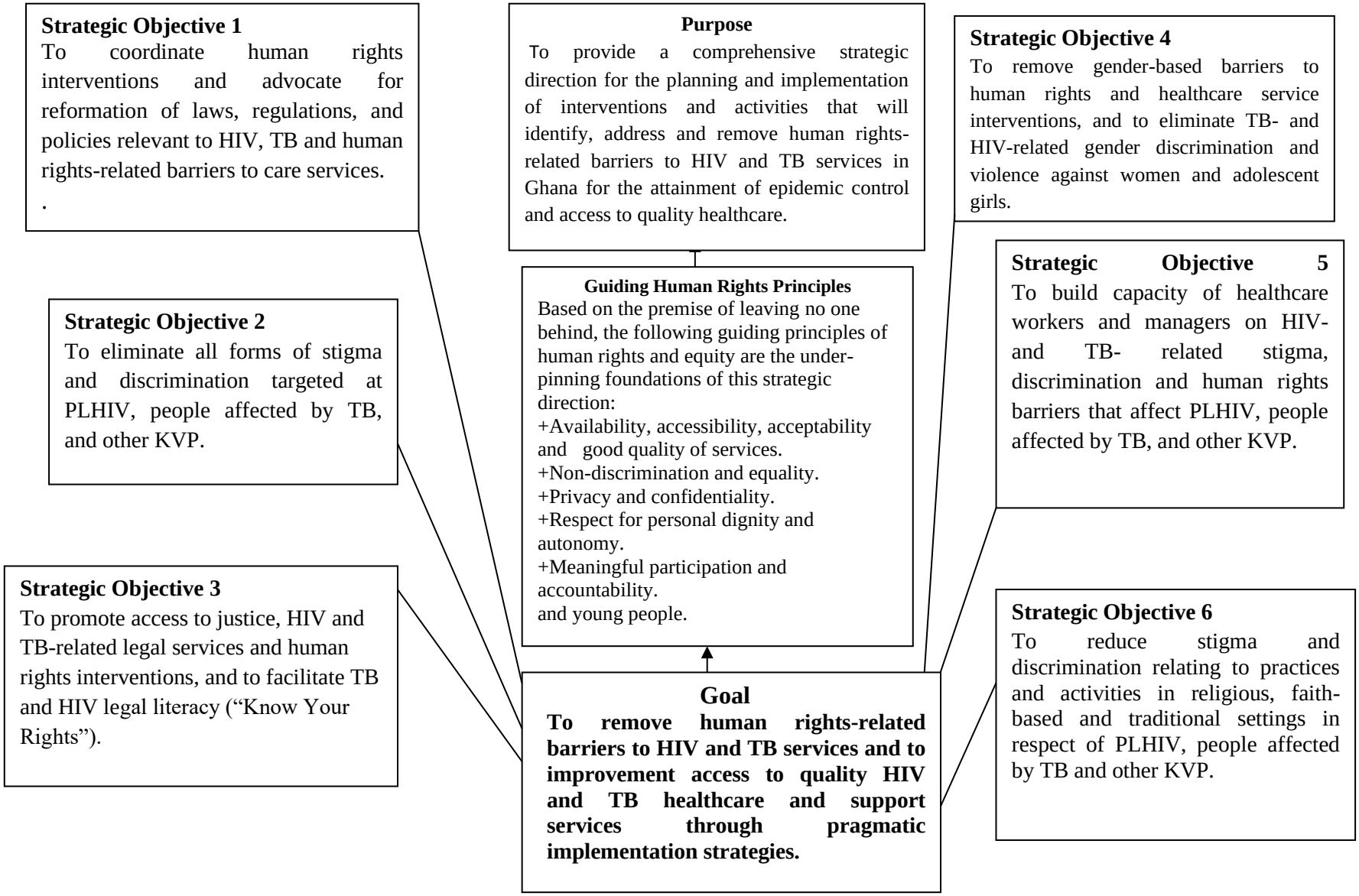
The complexities of health seeking behavior of the average Ghanaian when it comes to dealing with chronic medical conditions have often led people with chronic conditions being taken advantage of and subjected to all sorts of violations in the name of faith, believes, attitudes and actions which are influenced by religious, faith-based and traditional leaders, as well as traditional medicine practitioners whose activities have become a part of the TB and HIV response positively or negatively depending on the circumstance. Many persons who otherwise would have despaired due to their HIV status have received hope and counselling from religious and traditional practitioners. On the other hand, this space of intervention has also been inundated by many practitioners of faith and tradition who have acted in ways that have rather fueled stigma and discrimination. Their actions have imposed barriers in the way of PLHIV persons affected by TB, and thus preventing them from seeking appropriate treatment and other care and support interventions. The human rights of PLHIV, persons affected by TB and other KVP are pulled in multiple directions by the healthcare sector, the traditional authorities and medicine practitioners, and the faith-based and religious practitioners with the resultant effect of hindering access to prevention, testing and treatment services as offered by the health sector.

i. **Current Scope and Interventions:** Interventions relating to this strategic objective have in the past been undertaken in part by INERELA and Queen Mothers Association through the engagement, sensitization, training and capacity building of religious organizations and faith-based practitioners on HIV-related stigma and discrimination affecting PLHIV and other KP. These interventions have however not been sustained due to lack of funding. Previous activities involving the engagement of traditional leaders particularly queen-mothers in the past as a means of addressing HIV-related stigma and discrimination have also not been sustained.
ii. **Implementers:** INERELA, GAC
iii. Limitations/Challenges:

1. Diversity, differences and sometimes acrimony between faith-based practitioners.
2. Lack of regulation of activities of herbalists and faith-based organizations.
3. Strong religious and traditional believes which are contrary to scientific facts and reasoning.
4. Weakness in reaching out to and addressing peculiar issues of religious and traditional practitioners on the issues of health, HIV, TB and human rights.
5. Deficient capacity in addressing purely medical complications and thus making conditions of their clients worse over time.

3.6 Conceptual Framework

Strategic Plan for Addressing Stigma, Discrimination and Human Rights Related Barriers to HIV and TB Services in Ghana



4 FRAMEWORK OF THE STRATEGIC PLAN

Strategic Objective 1: To coordinate human rights interventions and advocate for reformation of laws, regulations, and policies relevant to HIV, TB and human rights-related barriers to care services

Specific objectives	Specific Activities /Interventions	Expected Results	Responsible Agency	Coordinating Agency	Time-frame	Budget ($)/ Source of Funding
SO1a. Institute a framework for monitoring and coordinating all human rights activities and interventions relating to HIV and TB as well those that affect PLHIV, people affected by TB, and other KVP	i. Put in place a human rights monitoring system. ii. Establish a coordinating mechanism for human right intervention relating to PLHIV, people affected by TB, and other KVP iii. Reconstitute and mandate the Human Rights Steering Committee (SC-HR)	i. Human right monitoring system established ii. Coordinating mechanism for human rights interventions instituted. iii. SC-HR providing technical support for monitoring and coordinating human rights interventions. iv Regular SC-HR quarterly meetings being held	**CHRAJ**	**GAC**	**Y1**	1,400,000/ Government of Ghana (GOG)
SO1b. Monitoring of TB and HIV-related human rights interventions by stakeholders and implementers	i. Develop monitoring tools for TB- and HIV- related human rights interventions. ii. Disseminate tools and sensitize stakeholders and implementers on it	i. Implementers and stakeholders applying the HR monitoring tools and reporting on outcomes.	**CHRAJ**	**GAC**	**Y1**	
SO1c. Identify areas of existing laws and policies that need review, gather evidence on the need for the review and advocate for the review of identified laws, policies and regulations.	i. Evaluate existing laws and policies and undertake law review to identify those that need review. ii. Collate evidence to advocate for new laws and policies. iii. Amend relevant existing, laws and review policies to address gaps in existing laws and policies.	i. Effective advocacy with resultant passage of new laws and formulation of policies to address HR gaps. ii. Reviewed laws and amended policies in place and being applied.	**GAC, AG, Parliament**	**GAC, CHRAJ**	Y1 Y2 Y3	
SO1d. Reformation of laws or enactment of new laws to address legal obstacles or remove barriers to realistic HIV and TB related interventions.	i. Sensitize law-makers on need for law reformation. ii. Advocacy with law-makers to push for reformation of existing laws or through new legislation or legislative amendment for passage of new laws to remove HR barriers to HIV and TB	i. Law-makers engaged and committed to reformation of laws; ii. New laws passed to remove barriers to HIV and TB interventions	GAC, AGD, Parliament	GAC, CHRAJ	Y1, Y2 Y3	

	interventions					

Strategic Objective 2: To eliminate all forms of stigma and discrimination targeted at PLHIV, people affected by TB, and other KVP

Specific objectives	Specific Activities /Interventions	Expected Results	Responsible Agency	Coordinating Agency	Time-frame	Budget ($)/ Source of Funding
SO2a. Standardize peer educator and Models of Hope training curricula are in use by implementing partners to cover a minimum set of information on TB, HIV, human rights, stigma and discrimination reduction.	i. Review and standardize peer educator training curricula. ii. Review and standardize Models of Hope training curricula iii. Disseminate and sensitize stakeholders and implementers on new training curricula iv. Develop new training materials for peer educator and Models of Hope training.	i. New training materials based on new curricula disseminated and Training of Trainers (ToT) undertaken for trainers of Stakeholders and implementers. ii. New training materials for peer educators and Models of Hope respectively produced for training.	GHS/NACP, Ghana West African Program to Combat AIDS & STIs (WAPCAS), John Snow, Inc. (JSI)	GAC, MoH	Y1, Y2 Y2	2,800,000/ GOG
SO2b. Build capacity of more peer educators and models of hope to increase coverage and scope and areas of work across all regions for maximum impact.	i. Recruit and train at least 50 new Peer Educators, 50 new Models of Hope and 50 new TB Champions within each region, for PLHIV and at least 10 new people with disabilities as Peer Educators per region. ii. Identify and sensitize at least 10 PWID in each region for training as peer educators to be equipped with capacity to provide human rights and legal literacy interventions for their peers; iii. Support PPAG to improve ongoing implementation of HIV and TB prevention and treatment activities in the prisons.	i(a). At least 800 new peer educators, 800 Models of Hope and 800 new TB Champions trained and deployed in all 16 regions i(b). At least 160 PWD trained and deployed in all 16 regions as peer educators ii. At least 160 PWID trained and deployed as peer educators and providing harm reduction service through gender-responsive and human rights-based approach in all 16 regions; iii, HIV and TB prevention and treatment activities yielding positive results with declining HIV prevalence	GHS/NACP, WAPCAS, JSI, Planned Parenthood Association of Ghana (PPAG), Ghana Prisons Service, Ghana Police Service, NAP+, TB Voices Network	GAC, WAPCAS, JSI, PPAG	Y2, Y3, Y4, Y5	

		rate and TB case detection, 100% ART initiation for those testing HIV positive and 100% cure rate for person affected by TB in all the prisons,				
SO2c. Involve Models of Hope and TB Champions in media and institutional campaigns and activities to address stigma and discrimination.	i. Train 200 Models of Hope and TB Champions in institutional and media campaigns on stigma reduction and human rights interventions; ii. Integrate Models of Hope into mainstream healthcare services in stigma reduction activities and support PLHIV, people affected by TB and other KVP to access human rights resources and interventions.	i. Awareness of human rights of PLHIV, people affected by TB increased at the institutional level ii. 40 Models of Hope and TB Champions engaged in media campaigns resulting in increased public awareness on human rights, stigma and discrimination pertaining to PLHIV, people affected by TB and other KVP. iii. PLHIV and person affected by TB receive support from Models of Hope to access human rights-based care, psychosocial and human rights support.	GAC, GHS, NAP+, TB Voices Network	GAC, GHS/MOH,	Y1 Y2	
SO2d. Incorporate HIV and TB prevention, care, testing and treatment; as well as human rights, ethics, stigma and discrimination relating to HIV and TB, in the training curricula of all cadres of healthcare workers	(Refer to Strategic Objective 5)					

SO2e. Standardize operations and tools for stigma reduction; and incorporate stigma, discrimination and human rights checklist as a guide for practitioners and their supervisors and managers.	i. Review exiting stigma reduction programmes ii. Review current approaches to stigma reductions interventions iii. Evaluate tools currently being used for stigma reduction activities and programmes iv. Develop, or adapt or revise existing zero-discrimination and human rights checklist as a guide for practitioners, supervisors and managers	i. Operations for stigma reduction programmes reviewed and standardized. iii. Stigma reductions tools evaluated, reviewed, standardized and being used by various implementers iv. Human rights and zero-discrimination checklist developed and deployed for use by practitioners, supervisors and managers.	GAC, GHS, WAPCAS, JSI/USAID, NAP+, TB Voices Network,	GAC	Y1 Y1 Y2 Y2	
SO2f. Integrate HIV and TB related services into mainstream healthcare services to reduce stigma, discrimination and eliminate human rights violations affecting PLHIV, people affected by TB, and other KVP including PWD and adolescents.	i. Build capacity of all front-line health worker in HIV and TB care and on TB- and HIV-related stigma and discrimination ii. Integrate TB and HIV-related care services as much as possible to avoid branding of HIV services and facilities iii. Provide comprehensive TB and HIV-related services in relevant health facilities; iv. Put in place sigma reduction strategies at facility levels.	i. Reduction of incidents of discrimination in the provision HIV- and TB-related care ii. TB and HIV care and treatment integrated into regular Out-patients' Department (OPD) and in-patient care services iii. Comprehensive TB and HIV-related services provided in targeted health facilities iv. Stigma reduction meetings and activities undertaken at the facility level.	Training Unit and Public Health Directorate of GHS	Policy Planning, Monitoring and Evaluation, and Institutional Care Divisions of the Ghana Health Service	Y1, Y2, Y3, Y4, Y5	
SO2g Establish a coordinated community outreach/mobilization programmes and activities at the national, regional, district, sub-district and community and workplace levels for CSO and agencies involved in interventions targeting key and vulnerable populations .	i. Integrate HIV and TB related service delivery into community mobilization programmes to hard-to-reach populations such as male sex workers, PWID, MSM, "*Kayayei*" and prisoners with TB- and HIV-related services in a stigma free environment. ii. Undertake outreach activities for PWD through collaboration with various stakeholders inclusive of the Ghana Federation for the Disabled (GFD). iii. Build capacity of state agencies to monitor and coordinate community outreach programmes at all level. iv. Integrate work of CSO in the area of stigma reduction into mainstream	i. TB and HIV related community mobilization programmes and services targeted at and actually reaching hard to reach populations such as male sex workers, young persons who sell sex, PWID, MSM, "*Kayayei"* and prisoners; ii. Specific outreach programmes established by relevant COS in collaboration with GFD to reach PWD with TB and HIV related services in a stigma-free environment. iii. Relevant state agencies monitoring and and receiving reports from community outreach programmes relating to stigma reduction and human	GAC, WAPCAS, GHS, NAP+, SWAA, LRF, PPAG, Pro-Link, Solace Initiative NETEWAG GAC, GHS, WAPCAS, GFD GAC, WAPCAS,	GAC, CHRAJ GFD, CHRAJ GAC	Y1, Y2 Y1 - Y5	

	healthcare outreach services to PLHIV, person affected with TB, other KVP, PWD, PWID, and adolescent girls.	rights promotion activities; iv. Outreach services and stigma reduction activities targeting PLHIV, people affected by TB and other KVP, including PWD, PWID and adolescent girls being undertaken through mainstream healthcare outreach service.	CHRAJ GHS	 GAC	Y1-Y5 Y1-Y5	
SO2h. Join the Global Partnership for Action to Eliminate all forms of HIV-related stigma and discrimination.	Undertake requisite steps and processes for attainment of membership of the Global Partnership	Membership of Global Partnership attained and country participating in activities	GAC UNAIDS	GAC	Y1	

Strategic Objective 3: To promote access to justice, HIV-and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy ("Know Your Rights")

Specific objectives	**Specific Activities /Interventions**	**Expected Results**	**Responsible Agency**	**Coordinating Agency**	**Time-frame**	**Budget ($)/ Source of Funding**
SO3a. To align and standardize curricula for judiciary and law enforcement agencies training on current HIV laws, GAC Act, Narcotic laws, Children's Act, Policies and global best practices, norms and trends; as well as align and standardize messages for media interactions and public education on access to justice.	i. Review, align and standardize training curricula of judiciary and law enforcement agencies to laws, policies and guidelines; ii. Review content of empowerment messages on HIV, human rights, stigma and discrimination targeted at PLHIV, people affected by TB and other KVP. iii. Incorporate human rights, stigma and discrimination and medical ethics into training materials of pre-service law enforcement, legal and judiciary training institutions.	i. Curricula of judiciary and police training aligned to current laws, policies, and guidelines ii. Appropriate human rights empowerment developed and disseminated to targeted PLHIV, people affected by TB and other KVP. iii. Training materials of police, legal and the judiciary pre-service training reviewed and include topics relating to HR, stigma and discrimination and medical ethics.	Judiciary Service, Police Service, AGD GAC, CHRAJ Judiciary Service, Police Service, AGD	GAC, CHRAJ GAC GAC, CHRAJ	Y1, Y2 Y1, Y2 Y2 – Y5	2,200,000/ GOG

SO3b. Scale-up TB and HIV Legal Literacy programmes of various implementers.	i. Expand existing human rights education and HIV legal literacy work through peer education and institutional and media campaigns beyond the current priority districts to all districts; ii. Educate KVP in legal education as peer paralegals and HIV legal educators to support KVP and address issues of human rights;	i. Increase in scale and scope of human rights education and HIV legal literacy; ii. Increased numbers of PLHIV, people affected by TB and other KVP who have been made aware of their legal rights and empowered to assert their rights and have the capacity to seek redress.	CHRAJ, GAC, HRAC, WAPCAS HRAC, AfED, NAP+, TB Voice Network, STOP TB Partnership	GAC, CHRAJ	Y1	
SO3c. Expand roundtable community engagement work by some CSOs particularly WAPCAS, HRAC and other stakeholders in collaboration with CHRAJ, DOVVSU.	i. Hold stakeholder community meetings to identify and harness the resources and expertise of various CSO to put in place plans for scaling-up HIV legal literacy interventions to cover TB and other KVP; ii. Facilitate collaboration between various CSO and implementers to enhance scaling-up and expansion of scope of anti-stigma and anti-discrimination interventions to key and vulnerable populations.	i. Community mapping of CSO done with resultant scale-up and collaboration of stakeholders for comprehensive legal literacy of PLHIV, people affected by TB and other KVP.	CHRAJ, WAPCAS, DOVVSU, HRAC, GAC, National Commission on Civic Education (NCCE), National Media Commission (NMC)	GAC	Y1, Y2	
SO3d. Empower KP and vulnerable groups on their rights through sensitization and trainings and online education as well as through media messaging.	i. Develop and/or review sensitization and training materials for scaling-up capacity building of KVP on their rights. ii. Develop messages and online human right education materials for both general population and KVP. iii. Support meeting of KP and PLHIV to disseminate messages and education/information materials to their community.	i. Improvement in knowledge of PLHIV, people affected by TB, and other KVP on human rights and access to human rights.	GAC, WAPCAS, JSI/USAID, GF; NCCE, NMC	GAC, CHRAJ	Y1 Y2 Y3	

SO3e. Provide orientation and training for commanders of law enforcement agencies and subsequent training of other officers on stigma, discrimination and human rights relating HIV- and TB-related services, and with regards to other KVP.	i. Undertake sensitization meetings and orientations for service commanders and supervisors of law enforcement agencies; ii. Continue the ongoing training of trainers (ToT) of Senior Police Officers and selected officers of other ranks on human rights, stigma and discrimination in all 12 Police Administrative Regions; iii.. Scale-up and expand training of police officers of all ranks in all regions on human rights, stigma and discrimination pertaining to KVPs. iv. Scale-up and expand training and HIV and TB preventive programmes and activities being undertaken in the Ghana Prisons for both staff and inmates.	i. Service commanders, and supervisors of law enforcement providing leadership on human rights by holding sensitization meetings and orientation for staff on HIV, TB and KVP; ii. Scaling -up of training targeting the over 38,000 police officers in all the police administrative regions instituted and being conducted regularly, at least quarterly; iii. Increase coverage of TB and HIV preventive programmes and activities within the Ghana Prisons.	WAPCAS, CHRAJ, GHS/NACP, UNFPA, DOVVSU of the Ghana Police Service, Ghana Prisons Service, PPAG	GAC	Y1 – Y5	
SO3f. Improve the mechanisms of the human rights reporting system of CHRAJ and to enhance utilization and efficient use of the system by PLHIV, persons affected by TB and other KVP.	i. Evaluate current system of human right reporting to identify weaknesses and reasons for poor utilization; ii. Based on the evaluation findings, redesign the HR reporting system as needed, to make it more user-friendly and efficient; iii. Build capacity of relevant staff of CHRAJ at national, regional and district levels to adequately respond to the needs of PLHIV, people affected by TB, and other KVP; iv. Engage media for public education and sensitization on human rights in general and the need to report human rights violations through the established reporting systems	i. Gaps and weaknesses in the HR reporting system identified; ii. Newly designed HR reporting system launched for public use. iii. CHRAJ staff at all levels responding appropriately to the HR needs of PLHIV and KVP; iv. Sensitization and education of the public on human rights and human rights reporting through the media.	CHRAJ, GAC, DOVVSU/Police Service, GHS CHRAJ, GAC Ministry of Gender, Children and Social Protection (MoGCSP)	CHRAJ CHRAJ National Media Commission	Y1 Y2 Y2 – Y5 Y2 – Y5	

SO3g. Provide holistic intervention of medical, legal, psychosocial and emotional support and care services for both individuals and identifiable groups through collaboration of implementers (including CHRAJ, DOVVSU, GHS and CSOs).	i. Establish clear linkages between CHRAJ, implementers/ CSO and health facilities for comprehensive human rights interventions; ii. Equip KVPs to report and seek help on human rights violations, through messaging, sensitization and training workshops, media education, as well as through the establishment of network of linkages with M-watchers and M-friends; iii. Train and support at least 6 M-watchers per district to scale-up paralegal support to their peers; iv. Revitalize paralegal network to promote linkages to legal services instituted by AfED, and establish collaboration with the free legal consultation of HRAC to scale-up legal aid services to PLHIV, people affected by TB and other KVP; v. Expand the geographical reach and scale-up HR services of CHRAJ and other implementers to all 16 regions.	i. Comprehensive HR interventions being provided in a coordinated manner by a network of stakeholders and implementers; ii. KVPs reporting on human rights violations affecting them and their community; iii. Network of M-watchers constituted and providing paralegal support to PLHIV and other KVP; iv. Network of linkages established to provides access to legal services, including the provision of *pro bono* services and being utilized by KVP v. Comprehensive HR services accessible in all 16 regions by KVP, including people affected by TB, PLHIV, MSM, FSW, PLHIV, PWID,	GAC, AGD, DOVVSU/Police Service, WAPCAS, HRAC, AfED, CHRAJ	GAC, CHRAJ	Y1, Y2 Y3 Y4, Y5	

Strategic Objective 4: To remove gender-based barriers to human rights and healthcare service interventions, and to eliminate TB- and HIV-related gender discrimination and violence

Specific objectives	**Specific Activities /Interventions**	**Expected Results**	**Responsible Agency**	**Coordinating Agency**	**Time-frame**	**Budget ($)/ Source of Funding**

SO4a. Scale-up programmes and interventions aimed at combating gender-based violence and gender-related discrimination and human rights violations being undertaken by SWAA, WAPCAS, HRAC and other implementers to improve scope and geographical coverage.	i. Evaluate ongoing or existing programmes of SWAA, WAPCAS, HRAC and other implementers; ii. Foster collaboration between implementers for a comprehensive response to human rights barriers to accessing TB and HIV services with increased geographical coverage; ii.. Create data-base of stakeholders and implementers of gender-based violence and gender-related discrimination and human rights violation interventions.	i. Network of implementers established to address gaps in response to gender-based violence and gender-related discrimination and human rights violation with a scale-up from the current implementation in selected districts to all districts - national coverage; ii.. Data-base on being utilized for coordinating a concerted national response.	Ministry of Women, Gender and Social Protection, Ministry of Interior, Ghana Police Service/DOVVSU, CHRAJ, GAC SWAA, WAPCAS, HRAC	GAC CHRAJ,	Y1 Y2 – Y5	1,900,000/ GOG
SO4b. Increase male-centered gender-based interventions	i. Establish modalities for partner notification and testing of male partners of women testing positive particularly at PMTCT centre (Index Partner notification); ii. Sensitize healthcare workers on the rights of MSM and male sex workers to access care without discrimination; iii. Provide psychosocial and human rights support to male minors who sell sex; iv. Provide focused interventions for KVP affected by TB in the mining communities and prisons.	i. Increased Index partner testing under the PMTCT programme; ii. Reduction in reported cases of stigma and discrimination within the healthcare setting relating to MSM and male sex workers; iii. Rehabilitation of minors involved in sex work and linked back to school or to learn a trade; iv. Increased access of KVP to TB-related services in mining areas and the prisons.	GAC, WAPCAS, GHS/NTP /NACP, Ghana Prisons Service, CHRAJ, HRAC,	GAC, CHRAJ	Y1, Y2, Y3	
SO4c. Institute specific interventions for young and vulnerable women, including adolescent girls, "*Kayayei"* and FSW.	i. Educate HIV positive pregnant and breastfeeding mothers on their rights to treatment in a stigma-free environment under the PMTCT programme; ii. Provide peer paralegal and human rights-related support to vulnerable women including FSW, "Kayayei" and adolescent girls; iii. Use human rights and stigma-free messaging through media and within healthcare settings to educate and empower young and vulnerable women of their rights to care and to non-discrimination.	Specific interventions established and being accessed by young and vulnerable women, adolescent girls, FSW and "*Kayaye*i" with respect to PMTCT, human rights and paralegal support, empowerment through right-based education.	GAC, GHS, WAPCAS, DOVVSU	GAC, CHRAJ	Y1 –Y5	

SO4d. Eliminate police harassment and human rights violations of FSW, young persons engaged in sex work, and other vulnerable female communities	i. Sensitize the police and other law enforcement agencies on human rights; ii. Empower FSW and other key and vulnerable groups on their rights and on how to engage law enforcement agencies.	i. Police harassment and human rights violations reduced and police respecting rights of all including FSW and KVP. ii. FSW and other KVP positively engage law enforcement agents and able to assert their rights under the law.	WAPCAS, GAC, CHRAJ, DOVVSU WAPCAS, GAC, HRAC	CHRAJ, GAC CHRAJ, GAC	Y1 –Y5 Y1 – Y5	

Strategic Objective 5: To build capacity of healthcare workers and managers on HIV- and TB- related stigma, discrimination and human rights barriers that affect PLHIV, people affected by TB, and other KVP

Specific objectives	**Specific Activities /Interventions**	**Expected Results**	**Responsible Agency**	**Coordinating Agency**	**Time-frame**	**Budget ($)/ Source of Funding**
SO5a. Build capacity of healthcare managers on dealing with and addressing TB and HIV-related stigma, discrimination and human rights barriers affecting PLHIV, people affected by TB, and other KVP within the healthcare setting	i. Develop training curricula and manuals for training healthcare managers on human rights and gender-based approaches to health service delivery and supervision in the light of HIV, TB, KP and PLHIV ii. Train healthcare managers and supervisors of both private and public health facilities. iii. Develop supervisory took-kits on addressing stigma, discrimination and human rights violations in the healthcare setting iv. Empower healthcare managers and supervisors to sanction healthcare workers who violate the	i & ii. Training on TB and HIV-related stigma, discrimination and human rights of healthcare managers being conducted based on new HR training manuals for PLHIV, people affected by TB, and other KVP; iii. Human rights and stigma reduction Supervisory Tool-kits deployed and being used by healthcare managers; iv. Code of ethics disseminated and being used by healthcare managers to address violations of rights of PLHIV,	MOH, GHS, CHAG	GAC, CHRAJ	Y1 Y2 Y2	2,800,000/ GOG

	rights of patients and KVP. v. Develop checklist for supervisors on stigma, discrimination and human rights violations; vi, Develop and institute an open accountability checklist for all healthcare workers in the facility. checklist would be for the beneficiaries like an exit survey.	people affected by TB and other KVP; v. HR Check-list for supervisors being used for self-accountability; vi. Healthcare workers utilizing the self-assessment checklist through exit surveys.			Y2	
SO5b. Advocate for review of curricula of health training institutions to incorporate human rights, stigma and discrimination, patients' charter and medical ethics into the curricula of pre-service training for healthcare professionals.	i. Engage healthcare training institutions to include human rights, stigma and discrimination, Patients' Charter and medical ethics in curricula; ii. Standardize and incorporate content of HR, stigma, discrimination and ethics into training modules of healthcare training institutions as examinable courses.	Human rights, stigma, discrimination and ethics relating to HIV, TB and KVP modules standardized and incorporated into training modules and being offered as examinable courses and a pre-requisite for graduation.	GAC, GHS, MOH, CHAG	CHRAJ	Y1, Y2 Y3	
SO5c. Scale-up existing in-service training and institute new models of in-service training for healthcare workers on human rights and medical ethics, particularly relating to PLHIV people affected by TB and other KVP including women and adolescent girls.	i. Review and standardize in-service training curricula and training materials on HR, stigma and discrimination; ii. Conduct TOT for training healthcare workers; iii. Undertake in-service training for all cadres of healthcare workers in both public and private healthcare facilities. iv. Provide continuous professional development (CPD) and refresher courses on human and patient rights as a basic requirement for licensure renewal for all categories of healthcare professionals.	i.- iii. In-service training on human rights, stigma and discrimination being undertaken for all cadres of healthcare professionals at all levels of the healthcare delivery system, both private and public; iv. Accredited CPDs and refresher courses on HR and Patients' Rights being offered as prerequisite for licensure renewal.	MoH, GHS, CHAG, NACP, Ministry of Education (MoE), JSI, HRAC Teaching Hospitals, Medical and Dental Council (MDC), Nurses and Midwifery Council (NMC), Pharmacy Council (PC), Allied Health Council (AHC)	GAC, CHRAJ, MoH, MoE	Y1, Y2 Y2 Y3	
SO5d. Empower Clients/Patients including the KVP on their rights to enable them hold healthcare workers to account with respect to human rights infractions and of stigma and discrimination.	i. Educate patients on human rights and on the Patients' Charter; ii. Develop and deploy human rights and anti-stigma messages by way of pamphlets, posters and stickers as well as by audio-visuals and social media tools such as WhatsApp targeted towards PLHIV, people affected by TB, and other KVP, including women and girls, within and outside the healthcare setting;	i-iii. Patients/Clients, including PLHIV, people affected by TB and other KVP empowered and utilizing grievance procedures instituted in various healthcare facilities to report issues of stigma and discrimination, and human right violations. iv. Number of Models of Hope acting	GAC, WAPCAS, GHS, CHAG NAP+, TB Champions,	GAC, CHRAJ GAC,	Y1 – Y5 Y2 –	

	iii. Scale-up printing and dissemination of Patients' Charter pamphlets recently developed by WAPCAS to cover all health facilities in Ghana; iv. Involve Models of Hope in media and institutional campaigns on human rights relating to HIV, TB and KVP in the healthcare setting; Institute grievance proceedings within health facilities for patients/clients who may have complaints.	as champions for media and institutional human rights and anti-stigma campaign relating to HIV, TB, PLHIV and KVP; v. Patient complaint forms and grievance desks established for redress in all health facilities.	WAPCAS, JSI, NACP	CHRAJ, National Media Commission	Y5	

Strategic Objective 6: To reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV, people affected by TB and other KVP

Specific objectives	Specific Activities /Interventions	Expected Results	Responsible Agency	Coordinating Agency	Time-frame	Budget ($)/ Source of Funding
SO6a. Build capacity of leadership of faith-based and religious organizations, traditional authority and traditional medicine practitioners on HIV and TB- related stigma, discrimination and human rights	i. Engage and sensitize leaders of faith-based and religious organizations, traditional authority and traditional medicine practitioners on HIV and TB related stigma, discrimination and human rights violation affecting PLHIV, people affected by TB and other KVP and their access to HIV and TB services. ii. Institute Training of Trainers (ToT) for the leaders and key members of faith-based and religious organizations, traditional authority and traditional medicine practitioners on stigma and human rights relating to TB/HIV and KVP; iii. Empower the trained leaders to roll-out training of their members and communities on human rights in a sustainable manner. iv. Provide orientation on human rights and anti-stigma messaging to leaders and trainers of faith-based and religious organizations and traditional authority to reach out to their members and communities with relevant sensitization messages on anti-stigma, zero-discrimination and human rights.	i. Followers and community members of religion and tradition and traditional medicine being trained on stigma, discrimination and human rights relating to HIV and TB by their leader/trainers; ii. Followers, members and community of faith/religion and, tradition generally well informed and accommodating of PLHIV, people affected by TB, and other KVP and desisting from stigmatization; iii. Reduction in reported cases of HIV- and TB-stigma and discrimination and human rights violations emanating from religious, faith-based and traditional settings.	CHRAJ, Christian Council of Ghana, Federation of Muslim Councils, National and Regional Houses of Chiefs, Traditional Medicine Council, Ministry of Chieftaincy and Religious Affairs (MCRA). INERELA+	GAC, CHRAJ,	Y1 Y2 Y3 – Y5	1.100.000/ GOG
SO6b. Sensitize the public on human rights of PLHIV/TB including stigma and discrimination relating to key and vulnerable populations in religious and traditional settings.	i. Develop messages and education information in the form of pamphlets, stickers, fliers as well as audio-visuals for radio and TV to sensitize and educate the public on HR and stigma relating to persons affected with TB, PLHIV and other KVP in the context of religious and traditional settings	i. Messages for sensitization and education on HR and stigma and discrimination disseminated and reaching target population.	CHRAJ, GAC, INERELA	GAC	Y1	

SO6c. Establish linkage of monitoring and reporting systems of human right violations, stigma and discriminatory practices relating to, faith-based organizations, traditional authority and traditional medicine practice, as well as customary and cultural practices with the already existing CHRAJ reporting tool on stigma and discrimination.	i. Develop HR and stigma reporting tools relating to religious and faith-based organizations, traditional authority and traditional medicine practitioners; ii. Develop follow-up mechanisms to institute interventions for following-up on reports of violations of human rights, and perpetuation of stigma and discrimination; iii. Link the reporting system to the already existing stigma and discrimination reporting system of CHRAJ	i. HR and stigma reporting tools deployed and being used to capture information on target populations; ii. Follow-up on reported cases being undertaken in collaboration with the leadership of faith-based, religious or traditional authority; iii. CHRAJ reporting system reviewed to accommodate and highlight specific reports relating to religious, faith-based and traditional practices.	GAC, CHRAJ, INERELA, MCRA, Christian Council of Ghana, Federation of Muslim Councils, Pentecostal and Charismatic Council, Catholic Bishops' Conference, Office of the Chief Imam	GAC, CHRAJ	Y1 Y2 Y3	
SO6d. Empower chiefs, queen-mothers and community leaders to address and prevent stigma discrimination and HR violations.	i. Advocacy with Chief and queen-mothers on need to be empowered to address stigma and discrimination ii. Engaged chiefs and queen-mothers and other community leaders through workshops and information sharing on how to address stigma, discrimination and human rights violations.	Chiefs and queen-mothers become campaigners of HR, and stigma and discrimination reduction.	GAC, MCRA, Queen-mothers Association, National and Regional Houses of Chiefs,	GAC, CHRAJ	Y1 - Y5	

5 KEY CROSS-CUTTING ISSUES

For the successful implementation of this Five-Year Strategic Plan, the following key cross-cutting issues will need to be considered and addressed: leadership and coordination, funding and resource mobilization, advocacy, research, monitoring and evaluation.

5.1 Leadership and Coordination

The Ghana AIDS Commission (GAC) and the Commission on Human Rights and Administrative Justice health (CHRAJ) are the two state institutions empowered and mandated by law to address issues relating to HIV and AIDS, and Human Rights respectively. To the extent that this strategic document seeks to set out ways of dealing with issues pertaining to human rights in the context of TB and HIV/AIDS, these two institutions of state will be expected to play lead and coordination roles in ensuring that human rights, stigma and discrimination barriers to HIV and TB interventions are removed and right-based and gender-based approaches to interventions are promoted and facilitated. The respective components of the strategic programming shall be undertaken by the institution that has the comparative advantage.

State agencies such as the Office of the Attorney-General and Minister of Justice, the Judiciary, the Ministry of Health and the Ghana Health Service, the Ministry of Gender, Children and Social Protection, the Ministry of Chieftaincy and Religious Affairs, other Ministries, Departments and Agencies, including the security agencies; as well as non-State actors such as the CSO in HIV and human right advocacy will play critical programmatic and interventional roles in the overall implementation of the Strategic Plan.

The high-level involvement of CSO in the coordination of the overall implementation of the plan through collaboration with state agencies will foster accountability and ownership of plan for effective implementation. The strength of resources and know-how of various stakeholders and implementers, as well as the expertise of individuals with the requisite skill and insight into respective areas of intervention will have to be drawn on. These may require the involvement of academia, law-makers, policy formulators, advocacy groups, persons living with or affected by HIV and TB, and persons who suffer all forms of human rights abuses by the sheer reason of gender, disease, and presence of a virus or sexual practices.

5.2 Funding and Resource Mobilization

The GAC which is placed under the Office of the President already has the mandate for resource mobilization in respect of HIV and AIDS related interventions in Ghana. This has further been given the backing of legislation by the passage of the Ghana AIDS Commission Act which among other things provides for the statutory establishment of an AIDS Fund. Government already has a policy by which a percentage of the District Assembly Common Fund is required to be used to support HIV interventions in respective districts. This policy has not been adhered to by some of the assemblies and needs to be looked at again so as to make its benefits realizable. It may also be necessary to further advocate for an increment in the percentage of the Fund earmarked for the purposes of HIV and AIDS interventions at the district level.

It is envisaged that although donor support would still be needed to urgently push this Strategic Plan into fruition for the desired results in the shortest possible time, there is the urgent need for Ghana as a country to increase local funding of HIV interventions in general, but above that to prioritize

human rights related intervention for rapid response if Ghana is to achieve the UNAIDS 90-90-90 targets by 2020, and the 95-95-95 targets by 2030. The GAC and its partners must work to mobilize resources from both the public and private sectors of the economy which is envisaged in reality to be resources drawn from local and International funding sources and organizations.

The approximate costing of the budget of this plan which is attached to this plan as Annex B should be used to guide resource mobilization and programme implementation under the various strategic objectives and activities. The detailed costing of the implementation of this strategic plan should be undertaken for effective purposeful implementation.

5.3 Advocacy

To get the buy-in and embracement of this strategic plan and ensure its successful implementation, it is expected that all stakeholders including potential funding and technical support sources will be brought on board through direct and indirect advocacy tooling. The supra-ministerial, the multi-sectorial and the strategic positioning of GAC under the Office of the President must be leveraged as a strong advocacy tool to achieve, among other things, the following towards the attainment of the goal of the Strategic Plan:

i. Mobilize political support for the implementation and sustainability of the Strategic Plan and the overall HIV Response;
ii. Refocus political attention on the specific needs of KVPs, in particular adolescent girls and young women (AGYW), so as to put specific national programmes in place to address their needs that go beyond the scope of interventions outlined in this document;
iii. Provide information on human rights violations and gender-based violence that act as barriers to accessing TB and HIV care services and interventions;
iv. Provide evidence through data collation and information gathering to engender change;
v. Publicize the strategy as envisaged by this document to ensure understanding of the issues, the complexity of the challenge, previous interventional attempts, current envisaged implementation approaches, leadership and coordination mechanisms;
vi. Foster collaboration and build partnerships, linkages, networks, funding mechanisms and coalitions among stakeholders;
vii. Establish linkages among local level institutions that are implementing human rights and gender-related health (particularly TB and HIV) interventions and care and to coordinate their activities;
viii. Network with community groups, including associations of PLHIV, people affected by TB and other KVPs that have the clout to call for change and have lobbying skills and experiences to push for it;
ix. Facilitate review of laws or the call for new legislation where need be, and push for revision and implementation of relevant policies and enforcement of laws that address stigma, discrimination, gender-based violence and human right violations pertaining to PLHIV, people affected by TB and other KVPs.

5.4 Research

In order to sustain advocacy in the light of the dynamism of both HIV science and human right interventions this strategic document draws on the need for ongoing research which must be evidence-based, documentation of all programmes and activities at the various levels of implementation and the collation and analysis at the national level by the GAC must be paramount, as that will form the bases of evidence gathering that will form the basis of research for change in the future.

5.5 Monitoring and Evaluation

For the guidance and successful implementation of the strategic plan it should be possible to assess the level and quality of implementation at any point. This requires the institution of monitoring and evaluation modalities to be used to assess the quality and scope of coverage of programmes and activities under each strategic objective. Monitoring and evaluation reports generated will be used to strengthen strategy implementation regularly. It is envisaged that there will be a mid-term review of the implementation of the five-year strategic plan which would require the reliance on monitoring and evaluation reports, which therefore ought to be done dedicatedly and timeously. The basic sets of indicators for monitoring and evaluating the full implementation of this strategic plan are expressed in the Monitoring and Evaluation Framework attached to this document as Annex A.

6 IMPLEMENTATION PLAN

The Human Rights Strategic Plan is a five-year multi-sectoral plan that seeks to harness the expertise and experiences of all stakeholders of HIV, TB and human rights interventions to address challenges and TB/HIV-related and gender-based barriers impeding access to prevention, testing, treatment and care services for HIV and TB. The position of GAC as a supra-ministerial body allows it to effectively coordinate the implementation of the plan by being able to bring all stakeholders together as well as hold them accountable to their mandates and deliverables.

The expanded Human Rights Steering Committee under the direction of the GAC shall be empowered to play the technical coordination role as well as act as an advisory unit for the implementation of the plan. All stakeholders and implementers in the arena of the plan would be expected to have an obligatory responsibility of reporting to the GAC as the coordinating body. To this end the GAC will have to depend on the technical support and expertise of CHRAJ to be able to monitor and manage the reviews of the implementation by all assigned institutional responsibilities as indicated in the strategic framework.

The GAC and the Steering Committee will assign an officer to be responsible for liaising with stakeholders, and administratively support the oversight functions of the GAC and the Steering Committee, and further be responsible for compilation of reports and coordination of monitoring and evaluation reporting, and the compilation of data for evidence-building and advocacy.

The multi-stakeholder and multi-sectorial approach to the implementation of the strategic plan requires that although the plan may have budget estimates for specific activities, it should be imperative for each stakeholder institution, implementer, ministry, department or agency to incorporate areas of implementation that fall under their purview and mandate into their annual plans and budget. It is envisaged that additional funding locally generated or external source will be utilized to support and facilitate the overall implementation of the plan and specifically address overarching and cross-cutting issues.

This guide to implementation outlines the levels of implementation at the following levels: community, sub-districts, facilities, and district, regional and national levels. It is expected that implementers and stakeholders will pursue their mandate along the decentralized lines of the district assemblies and their departments. Ideally, where the nature of the intervention and the funding thereof so requires implementing partner institutions must undertake their programmes and activities along the five implementation levels of community, sub-district, district, regional and national.

6.1 Community Level Implementation

This requires that particular needs of specific communities must be taken into consideration in designing and instituting programmes and activities to address them. Demand creation for services will be the focus of the community-based intervention and must allow for ease of access to TB and HIV services devoid of stigma, discrimination and human rights violations from both community/social workers and healthcare workers. Peer Educators and Models of Hope trainings and capacity building must be done based on equitable community representation. Referral to healthcare facilities or for legal aid or human rights interventions may be done to the sub-district, district or regional levels depending on need, and must form part of a comprehensive service delivery and integrated intervention approach. Implementer at the community level will have their activities coordinated through the district assembly and the community-based health management teams and HIV/TB focal persons.

6.2 Sub-District Level Implementation

This level of implementation will be done in tandem with the community implementation plans to provide a conduit for implementation support and supervision at the community and facility levels. A full range of preventive, testing, treatment, care and support services which addresses the needs of PLHIV, people affected by TB, and other KVPs, including adolescent girls will be provided at this level. Unit committee members, community health workers, social workers, human rights workers and advocates will collaborate with the sub-district health teams to constitute teams responsible for coordination and implementation of the aspects of the strategic plan that fall under their jurisdiction.

6.3 District Level Implementation

With the expansion of the District Health Management Team to now include inter-sectoral representation, it is appropriate to have this team being responsible for coordination and implementation of the strategic plan. Where further expertise is needed this may be drawn from the relevant ministries, departments and agencies. A district officer of CHRAJ must be an integral part of the team in order to have it strengthened in management and technical skills with the added human rights responsibilities. The representation of the law enforcement agencies will add a further spoke to strengthen the wheels of human rights interventions relating to HIV, TB and gender at the district level. A focal person who is empowered must be mandated to be the liaison and facilitate partnerships and collaboration amongst implementers and stakeholders within and outside the healthcare delivery sector.

6.4 Regional Level Implementation

The Regional Health Management Team (RHMT), like that of the district has now been expanded to include inter-sectoral representation and it would be appropriate to have the team collaborate with the GAC regional technical support unit (TSU) to implement and coordinate the strategic plan at

regional level bearing in mind the oversight of the community, sub-district and district level implementations. Where further expertise is needed this may be drawn from the relevant ministries, departments and agencies. An additional regional officer of CHRAJ must be an integral part of the team in order to have it strengthened with the requisite human rights technical skills. The representations of the regional commands of law enforcement agencies as well as the judiciary will further strengthen the technical capacity for effective implementation of the plan of making human rights interventions relating to HIV, TB and gender at the regional level more accessible. On the health sector front the RHMT will be expected to integrate programmes and activities outlined in the strategic plan into its annual programme of work and see to its implementation. The overall regional coordination of the implementation of the plan will be better served if a focal person, preferably the regional technical support officer of the GAC is mandated as the focal person to liaise with and facilitate networking and collaboration amongst implementers and stakeholders.

6.5 National Level

The GAC with the human rights technical support of CHRAJ be responsible for coordinating the implementation of the strategic plan at the national level and through the working of the Human Rights Steering Committee will be responsible for reviewing and monitoring the implementation of the plan based on the assigned responsibilities of the various stakeholders, implementers with respect to specific activities. The composition of the Steering Committee is drawn from the main sectors that are involved in the implementation of this multi-sector strategic plan. These include GAC, CHRAJ, UNAIDS, USAID, WAPCAS, NACP, NTP, NYA, Ghana Police Service, UNDP, USAID Care Continuum Project/JSI, HRAC, NAP+, TB Voices Network/TB Partnerships, SWAA, INERELA+ and Traditional Authority.

The CHRAJ and the MOH/GHS/NACP will specifically provide the needed respective human rights and healthcare technical support in the area of capacity building, service provision and interventions at the national, regional, district, sub-district and community levels of implementation across public and private sectors.

7 ANNEXES

7.1 Annex A: Monitoring and Evaluation Framework of the Human Rights Strategic Plan

Strategic Objective 1: To coordinate human rights interventions and advocate for reformation of laws, regulations, and policies relevant to HIV, TB and human rights-related barriers to care services.

	Indicator	Definition	Baseline	Target	Data Source	Frequency	Responsible	Reporting
SI.1	Number of HR interventions and HR law reforms monitoring reports filed by stakeholders and implementers	Number of TB and HIV-related HR monitoring reports filed with CHRAJ and GAC within the year.	0	40 (at least for reports per implementer/ stakeholder)	GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outcomes	i. Number of review meetings of Implementing partners and stakeholders	Number of times review meeting of TB and HIV- related HR implementers and stakeholders were held	0	Twice a year	GAC	Half yearly	GAC/ SC–HR	SC–HR half-yearly reports
	ii. Number of laws, policies and regulations newly enacted, amended, reviewed or reformed	Number of TB- and HIV-related laws/policies/regulation newly passed, reviewed or amended and disseminated.	0	At least one	GAC	Annual	GAC	GAC Annual Report
Outputs	i. Number of advocacy engagements of Law-makers reformation of laws;	Number of representation of proposal for law reforms made to Parliament, meeting with relevant select committees of parliament or advocacy meeting with MPs	0	At least two	GAC	Annual	GAC	GAC Annual Report

	ii. Number of HR monitoring tools developed and being used by implementers and stakeholders	Number of types of new TB- and HIV-related HR monitoring tools developed and being utilized for reporting by implementers and stakeholders	0		GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	iii. Proportion of Implementers and stakeholders applying the HR monitoring tools and reporting on outcomes	Number of Implementers and stakeholders apply HR monitoring tools divided by number of implementers and stakeholders of HR interventions	0	50%	GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	iv. Number of sensitization meetings held for stakeholders on new laws and policies relating to removing barriers to HIV and TB services	Number of meetings with stakeholders on new laws and policies relating to removal of barriers to TB and HIV services			GAC	Annual	GAC	GAC Annual Report

Strategic Objective 2: To eliminate all forms of stigma and discrimination targeted at PLHIV, people affected by TB, and other KVP.

	Indicator	**Definition**	**Baseline**	**Target**	**Data Source**	**Frequency**	**Responsible**	**Reporting**
SI.2	SI.2.1. Percentage of PLHIV, people affected by TB and other KVP who reported experiences of HIV-related discrimination in health- care settings	Number of PLHIV, people affected by TB and other KVP who reported TB- and HIV-related discrimination in the healthcare setting divided by the total number of PLHIV, people affected by TB and other KVP	0	Less than 5%	GAC, CHRAJ GHS/MOH data sources on discrimination	Annual	GAC/ SC–HR	GAC and CHRAJ Annual reports; Annual SC–HR

		assessing care in the healthcare setting within the same period.						Report
	SI.2.2. % reduction in reported cases of TB- and HIV-related discrimination	(Number of reported cases of discrimination in the current year minus the number of reported cases of discrimination in the previous year divided by number in the previous year) x 100	0	30%	GAC and CHRAJ data sources on discrimination	Annual	GAC/ SC–HR	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outcomes	i. Percentage of Peer educators of PLHIV, persons affected by TB, PWD and PWID trained under the new curricula who are actually providing targeted interventions and services in each region;	(Number of trained Peer educators of each category providing targeted interventions and services per region divided by the Number of each category) x 100	0	50%	Implementing Partners	Annual	GAC/ SC–HR	Annual SC–HR Report
	ii. Number of Trainings conducted for Peer Educators, Models of Hope and TB Champions based on new curricula and with newly standardized training materials.	Number of trainings conducted Peer educators, models of hope and TB champions in each of the 16 regions within the year.	0	2 trainings per region per year	GHS/NACP/NTP GAC	Annual	GAC	GAC Annual Report

	iii. Number of reports filed on usage of stigma reduction tools by implementers and on HR and zero-discrimination Checklist by healthcare practitioners, supervisors and managers.	a) Number of reports filed by CSO implementers using stigma reduction tools and b) Number of reports filed on usage of HR and zero-discrimination checklists by healthcare practitioners, supervisors and managers	0	a) 16 b) 16	a) Regional GAC TSU/ CSO implementers b) GHS Regional reports	Quarterly	GAC	GAC Annual Report GHS Annual Report
	iv. Proportion of estimated number of PWD in need of TB- and HIV-related HR services being purposely reached though outreach programmes	Number PWD reached with TB- and HIV-related HR services divided by Estimated number of PWD in need of TB- and HIV-related HR services.	0	50%	GFD Reports CHRAJ Reports	Half-yearly	GAC	GFD Annual Report GAC Annual Report
Outputs	i. Number of healthcare workers trained to deliver stigma free TB and HIV related services;	Number healthcare workers trained on stigma and discrimination elimination to deliver stigma free TB and HIV services in the healthcare setting	0	1200	GAC	Annual	GAC	GAC Annual Report
	ii. Number of healthcare facilities with TB and HIV care services integrated into regular services.	Number of healthcare facilities newly offering integrated services including TB and HIV services	0	200/year	GHS/NACP/NTP	Annual	GHS	GHS, NACP, NTP Annual Report
	iii. Number of peer educators, models of hope and TB champions trained and deployed in all 16 regions	Number of: a) Peer educators b) Models of hope c) TB champions trained with newly standardized	0	a) 800 b) 800 c) 800	GHS/NACP/NTP	Annual	GHS	GHS, NACP, NTP Annual Report

		training materials under newly developed curricula						
	iv. Number of PWD trained and deployed in all 16 regions as peer educators	Number of PWD trained and deployed in all 16 regions as peer educators	0	160	GHS/NACP/NTP	Annual		GHS, NACP, NTP Annual Report
	v. Number of PWID trained and deployed as peer educators and providing harm reduction services through gender-responsive and human rights-based approaches in all 16 regions	Number of PWID trained and deployed as peer educators and providing harm reduction services through gender-responsive and human rights-based approaches in all 16 regions		160	GHS/NACP/NTP GAC CHRAJ Implementers	Annual		GHS, NACP, NTP Annual Report GAC Annual Report
	vi. Number of models of hope and TB Champions engaged in media campaigns on human rights, stigma and discrimination pertaining to PLHIV, people affected by TB and other KVP.	Number of models of hope and TB Champions engaged in media campaigns on human rights, stigma and discrimination pertaining to PLHIV, people affected by TB and other KVP.	0	40	GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report

Strategic Objective 3: To promote access to justice, HIV-and TB-related legal services and human rights interventions, and to facilitate TB and HIV legal literacy ("Know Your Rights")

	Indicator	Definition	Baseline	Target	Data Source	Frequency	Responsible	Reporting
SI.3	Number and % of TB- and HIV-related human rights violations and discrimination complaints successfully resolved	a) Number of TB- and HIV-related HR violations and discrimination complaints made that were successfully resolved within the year b) (Number of TB- and HIV-related HR violations and discrimination complaints made that were successfully resolved within the year divided by Total number of TB- and HIV-related HR violations and discrimination complaints made within the year) x 100	0	a) 40 b) 80%	CHRAJ Records on HR Monitoring and Reporting Law reports, Judiciary Service registry, Ghana Police Service Records, Reports from Attorney-General's Department (AGD)	Annual	GAC/ SC–HR	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outcomes	i. Number (and percentage) of targeted judiciary, legal and law enforcement officers trained based on newly revised and standardized curricula relating to current HR laws, policies and guidelines relating to PLHIV, persons affected by TB, and other KVP	a) Number of judiciary, legal and law enforcement officers trained on current HR laws, policies and guidelines b) (Number of judiciary, legal and law enforcement officers trained on current HR laws, policies and guidelines divided Total Number of judiciary, legal and law enforcement officers targeted for trained on current HR laws, policies and guidelines) x 100	0	2400 half-yearly	CHRAJ Training Reports Judiciary Service, Ghana Police Service and Attorney-General's Department training reports	Half yearly	CHRAJ GAC/ SC–HR	CHRAJ Reports GAC/SC–HR half-yearly reports

	ii. % of PWD who successfully accessed TB- and HIV- related HR and anti-discrimination interventions	(Number of PWD who successfully accessed TB- and HIV- related HR and anti-discrimination interventions divided by Total number of PWD who experienced TB- and HIV- related HR violations and discrimination) x100	0	50%	CHRAJ HR Reporting records	Half yearly	CHRAJ GAC/ SC–HR	CHRAJ Reports GAC/SC–HR half-yearly reports
	iii. % of young persons who successfully accessed TB- and HIV-related HR and anti-discrimination interventions	(Number of young persons who successfully accessed TB- and HIV-related HR and anti-discrimination interventions divided by Total number of young persons who experienced TB- and HIV- related HR violations and discrimination) x100	0	50%	CHRAJ HR Reporting records	Half yearly	CHRAJ GAC/ SC–HR	CHRAJ Reports GAC/SC–HR half-yearly reports
	iv. Number of Training done on HIV and TB Legal Literacy	Number of Training done on HIV and TB Legal Literacy per region	0	32 (2 per region) half-yearly	Reports of Implementing Partners, CSO	Half yearly	CHRAJ GAC/ SC–HR	CHRAJ Reports, GAC/SC–HR half-yearly reports
	v. % of Legal Literacy Training done targeting respectively, MSM, FSW, PWD and young persons	(Number of Trainings done on HIV and TB Legal Literacy respectively targeting MSM, FSW, PWD and young persons divided by Total number of Trainings done on HIV and TB Legal Literacy) x100	0	30%	Reports of Implementing Partners, CSO	Half yearly	CHRAJ GAC/ SC–HR	CHRAJ Reports, GAC/SC–HR half-yearly reports
Outputs	i. Number of graduates of judiciary, legal and law enforcement training institutions equipped with	Number of graduates of judiciary, legal and law enforcement training institutions passing out with knowledge on human rights, stigma and discrimination as evidence by content	0		CHRAJ Training Reports, Judiciary Service, Ghana Police	Annual	GAC	GAC Annual Report

	knowledge on human rights, stigma and discrimination	of exams and pass list			Service and AGD Training Reports			
	ii. Number of meetings of the HR Steering Committee for the review and approval of empowerment messages on human rights, and stigma and discrimination targeted at PLHIV, people affected by TB and other KVP.	Number of SC - HR meetings per year	As and when	4	SC – HR Meeting Minutes	Quarterly	GAC	GAC/SC–HR half-yearly reports
	iii. Number of Commanders and Senior Police and Prisons Officers Trained as trainers (ToT) for training other officers on human rights, stigma and discrimination in all 18 Police Administrative Regions	Number of commanders and Senior Officers taken through ToT and equipped to train other officers on HR, stigma and discrimination		180	Implementing Partner/ CSO (WAPCAS) Training Reports	Quarterly	GAC	GAC/SC–HR half-yearly reports
	iv. Number of sensitization meeting and HR, stigma and discrimination trainings conducted by trained Service Commanders	a) Number of sensitization meeting held for staff and officers on HR, stigma and discrimination relating TB and HIV; b) Number of trainings done on HR, stigma and discrimination relating to TB and HIV for Police and	0	a) 48 b) 80	GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report

	and supervisors for their staff and officers;	Prison Officers in all 16 regions						
	v. Number Police Officer trained as part of scale -up training targeting the over 38,000 police officers in all the police administrative regions quarterly.	Number of Police officer trained quarterly on HR, stigma and discrimination relating to TB and HIV and affecting KVP	0	1900	Police Training Reports; Implementing Partner reports;	Quarterly	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	vi. Number of M-Watchers trained and providing paralegal support to their peers;	Number of M- Watchers trained HR and promoting access to justice and HR interventions who are providing paralegal support to their peers;	0	1270 (5 per district)	GAC and CHRAJ Records on HR Monitoring Implementing Partner/ CSO Training Reports	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	vii. Number of KVP accessing legal services including pro bono services through the network of established linkages	Number of KVP accessing legal services including pro bono services in relation to HR violations and discrimination.	0		GAC and CHRAJ Records on HR Monitoring Implementing Partner/ CSO	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	viii. Number of Human rights reports generated monthly based on New Human Rights Reporting System	Number of Human rights reports generated and disseminated monthly based on New Human Rights Reporting System	0	12	CHRAJ HR Reporting System Monitoring Reports	CHRAJ GAC	Monthly	CHRAJ Reports

Strategic Objective 4: To remove gender-based barriers to human rights and healthcare service interventions, and to eliminate TB- and HIV-related gender discrimination and violence against women and adolescent girls.

	Indicator	Definition	Baseline	Target	Data Source	Frequency	Responsible	Reporting
SI.4	% of TB- and HIV- related gender-based human rights violations or/and discrimination complaints of women and adolescent girls successfully resolved	a) Total number TB- and HIV- related gender-based human rights violations or/and discrimination complaints made by women and adolescent girls in the year(A) b) Number of TB- and HIV-related gender-based human rights violations or/and discrimination complaints of women and adolescent girls successfully resolved within the year (B). c) % of TB- and HIV- related gender-based human rights violations or/and discrimination complaints of women and adolescent girls successfully resolved (B/A x100)	0	c). 67%	Ministry of Women, Gender and Social Protection, Ghana Police Service/DOVVSU, CHRAJ, GAC SWAA, WAPCAS, HRAC and other Implementing Partners' Reports	Annual	GAC/ SC–HR CHRAJ	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outcomes	i..Number of vulnerable women (young women, FSW, 'Kayayei' and	Number of vulnerable women (young women, FSW, 'Kayayei' and adolescent girls)	0	1920	WAPCAS, DOVVSU and HRAC Report and	Annual	GAC, GHS CHRAJ	GAC Annual Report

	adolescent girls;) provided with peer, paralegal and human rights-related support	provided with peer, paralegal and human rights-related support the past 12 months. .			data.,			CHRAJ Annual Report
	ii. Percentage of women attending ANC under the PMTCT programme who had their male partners tested for HIV	(Number of pregnant women attending ANC (under the PMYTCT programme) who had their male partners tested for HIV divided by the total number of pregnant women attending ANC during the same period) x100	0	Y1-10% Y2- 20% Y3- 30% Y4- 40% Y5- 50%	GHS/NACP,	Half yearly	GAC/ GHS	GHS Annual Report NACP Annual Report GAC/SC–HR Annual reports
	iii. Percentage reduction in reported cases of gender-based police harassment and human right violations targeted towards vulnerable women – FSW, adolescent girls who sell sex and other female KVP	{(Number of reported cases of gender-based police harassments and human rights violations of the year under review minus that of the previous year) divided by that of the previous year} x100	0	Y1-15% Y2- 15% Y3- 30% Y4- 20% Y5- 15%	Ghana Police Service/DOVVSU, CHRAJ, HRAC, WAPCAS and Other Implementers' Reports or data sources	Annual	GAC, Ghana Police Service/DOVVSU CHRAJ	GAC Annual Report CHRAJ Annual Report Ghana Police Service/DOVVSU Annual Reports
Outputs	i. Number of trainings targeting healthcare workers on gender-based HIV- and Tb-related human rights barriers to	Number of trainings conducted per quarter targeting healthcare workers on gender-based human rights barriers to healthcare service relating to	0	16	GHS/NACP/NTP Training Reports	Quarterly	GHS, GAC	GHS Annual Report; GHS half-yearly review reports.

	women and adolescent girls accessing healthcare service.	women and adolescent girls						
	ii. Number of reported cases of Police harassment and human rights violations targeted towards vulnerable women including FSW and adolescent girls who sell sex.	Number of reported cases of Police harassment and human rights violations targeted towards vulnerable women including FSW and adolescent girls who sell sex in the last quarter.	0	Y1 – 60 Y2 – 48 Y3 – 32 Y4 – 16 Y5 – 0	Ghana Police Service/DOVVSU, CHRAJ, HRAC, WAPCAS and Other Implementers' quarterly reports or data sources	Quarterly	GAC, Ghana Police Service/DOVVSU CHRAJ	Half-yearly GAC/SC–HR Reports GAC Annual Report CHRAJ Annual Report Ghana Police Service/DOVVSU Annual Reports
	iii. % FSW and other female KVP who successfully engage law enforcement agents on issues of human rights affecting them without help or support from CSOs	(Number of FSW and other KVP who successfully engage law enforcement agents on issues of human rights affecting them without help or support from CSOs divided by total number of FSW and other female KVP who engaged law enforcement agents on issues of human rights affecting them within the period with or without help or support from CSOs) x100	0		Ghana Police Service/DOVVSU, CHRAJ, HRAC, WAPCAS and Other Implementers' quarterly reports or data sources	Quarterly	GAC, Ghana Police Service/DOVVSU CHRAJ	Half-yearly GAC/SC–HR Report, GAC and CHRAJ Annual Reports, Ghana Police Service/DOVVSU Annual Report

	iv. Number of graduates from police training institutions who have been trained on gender-based HIV- and TB- related human rights violations and discrimination the last 12 months.	Number of graduates from police training institutions who have been trained on gender-based HIV- and TB- related human rights violations and discrimination the last 12 months.	0	3000	Ghana Police Training School graduating reports. Curricula of Police training.	Annual	Ghana Police Service Training Institutions, DOVVSU CHRAJ	Annual SC–HR Report GAC/ SC–HR / CHRAJ, Ghana Police Training Graduation Reports.
	v. Number of practicing police officers who have been trained on gender-based violence (GBV), HIV- and TB- related human rights violations including communicating with key populations and stigma reduction on a quarterly basis	Number of practicing police officers who have been trained on gender-based violence (GBV), HIV- and TB- related human rights violations including communicating with key populations and stigma reduction in the last quarter.	0	1900	Ghana Police Service/DOVVSU, CHRAJ, HRAC, WAPCAS and Other Implementers' quarterly reports or data sources	Quarterly	GAC, Ghana Police Service/DOVVSU CHRAJ	Half-yearly GAC/SC–HR Report, GAC Annual Report, CHRAJ Annual Report, Ghana Police Service/DOVVSU Annual Reports
	vi. Number of different stigma-free messaging, gender and human rights information disseminated through the media and within the healthcare settings to educate and empower young and vulnerable women of their rights to care and to non-discrimination.	Number of different stigma-free messaging, gender and human rights information disseminated through a) through media b) within the healthcare settings to educate and empower young and vulnerable women of their rights to care and to non-	0	a) 5 b) 10	National Media Commission data, GAC, SC-HR GHS	Annually	GAC CHRAJ GHS	GAC/SC–HR Reports GAC Annual Report CHRAJ Annual Report GHS Reports

		discrimination.						

Strategic Objective 5: To build capacity of healthcare workers and managers on HIV- and TB- related stigma, discrimination and human rights barriers that affect PLHIV, people affected by TB, and other KVP

	Indicator	**Definition**	**Baseline**	**Target**	**Data source**	**Frequency**	**Responsible**	**Reporting**
SI.5	SI.5.1 % of health facilities that have their healthcare managers and workers trained on human rights, discrimination elimination and medical ethics relating to PLHIV, persons affected by TB and other KVP.	(Number of health facilities with both healthcare managers and workers trained on human rights, discrimination elimination and medical ethics relating to PLHIV, persons affected by TB and other KVP; divided by Number of health facilities targeted for the stigma reduction, discrimination elimination and human rights intervention.) x100	0	Y1- 30% Y2- 50% Y3- 80% Y4- 100% Y5- 100%	GHS/NACP/NTP Training Reports; GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report
	SI.5.2 % of healthcare facilities with HR and Stigma Reduction Supervisory Tool-kits and Accountability Check-list Reporting Forms deployed and being used by healthcare managers.	(Number of healthcare facilities with HR and stigma reduction Supervisory Tool-kits and Accountability Check-list being used and reported on by managers divided by total number of healthcare facilities targeted for the intervention) x100		Y1- 20% Y2- 40% Y3- 70% Y4- 90% Y5- 100%	GHS/NACP/NTP Training Reports; GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report

Outcomes	i. % of health facilities with managers using the Code of Ethics to address violations of rights of PLHIV, people affected by TB and other KV P;	(Number of health facilities with managers using the Code of Ethics to address violations of rights of PLHIV, people affected by TB and other KV P; divided by Number of facilities where the Code of Ethics have been disseminated) x100	0	Y1- 40% Y3- 70% Y5- 100%	GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report
	ii. % of Supervisors of healthcare facilities utilizing HR Check-list for self-accountability	(Number of Supervisors of healthcare facilities utilizing HR Check-list for self-accountability; divided by total number of targeted facilities for the stigma reduction and discrimination elimination intervention) x100	0	Y1- 40% Y3- 70% Y5- 100%	GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report
	iii. % of healthcare facilities where healthcare workers are utilizing the HR self-assessment checklist through exit surveys.	(Number of healthcare facilities where exit surveys are conducted for healthcare workers on the utilization of the HR self-assessment checklist; divided by total number of targeted facilities for the stigma reduction and discrimination elimination	0	Y1- 40% Y3- 70% Y5- 100%	GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report

		intervention) x100						
	iv. Percentage of complaints and grievances received that have been addressed through the grievance procedure established within the healthcare facilities.	(Number of complaints and grievances received that have been addressed through the grievance procedure established within the healthcare facilities divided by Number of patients/clients, including PLHIV, people affected by TB and other KVP who made grievance complaints relating to stigma and discrimination, and human rights violations in the healthcare facilities) x100.	0	Y1- 30% Y3- 50% Y5- 100%	GHS Monitoring Reports; Stigma reduction Accountability Checklist Reporting Forms.	Annual	MOH/GHS; GAC/ SC–HR	MOH/GHS and GAC Annual Reports; Annual SC–HR Report
Outputs	i. Number of trainings conducted for healthcare managers on dealing with HIV and TB related stigma, discrimination and human rights barriers.	Total number of trainings conducted for healthcare facility managers across the country per year.	0	50	GHS/NACP/NTP Training Reports; GHS Monitoring Reports;	Annual	MOH/GHS;	MOH/GHS Annual Reports;
	ii. Number of healthcare managers trained in HR based on new HR training manuals for managers and supervisors.	Number of healthcare managers trained in HR management per year based on new HR training manuals for managers and supervisors.	0	1500	GHS/NACP/NTP Training Reports; GHS Monitoring Reports;	Annual	MOH/GHS;	MOH/GHS Annual Reports;
	iii. Number of healthcare facilities whose managers have been trained on HR supervision.	Number of healthcare facilities whose managers were trained HR supervision within the year.	0	300	GHS/NACP/NTP Training Reports; GHS Monitoring Reports;	Annual	MOH/GHS;	MOH/GHS Annual Reports;

	iv. % of healthcare training institutions using a human right-based approach curricula relating to HIV, TB and KVP in training as well as having examinable courses relating to HR as requisite for graduation.	(Number of healthcare training institutions applying the HR-based curriculum relating to HIV, TB, and KP made same examinable courses and pre-requisite for graduation divided by total number of healthcare training institutions) x100	0	Y1- 30% Y3- 50% Y5- 100%	MOH/GHS, Ministry of Education (MoE); Teaching Hospitals, MDC, NMC, PC, AHC, Schools of Nursing, Pharmacy, Medicine, Allied Health	Annual	MOH/GHS; MoE	MoH/GHS, MoE Annual Reports.
	v. Proportion of targeted healthcare facilities that have undertaken in-service training on HR, stigma and discrimination relating to PLHIV people affected by TB and other KVP including women and adolescent girls;	Number of healthcare facilities that have undertaken in-service training on HR, stigma and discrimination; divided by Total number of healthcare facilities targeted for the training.	0	100% by end of year 3	GHS/NACP/NTP Training Reports; GHS Monitoring Reports;	Annual	MOH/GHS;	MOH/GHS Annual Reports;
	vi. Proportions of healthcare professionals who participated in HR-relevant CPDs accredited by the respective professional councils	Number of healthcare professionals who participated in HR-relevant CPDs accredited by the respective professional councils divided by the total number of respective healthcare professional that participated in any accredited CPDs of the respective councils.	0	At least 50%	MOH/GHS, MDC, NMC, PC, AHC	Annual	GAC/ SC–HR / CHRAJ	Annual SC–HR Report
	vi. Proportion of grievance reports made by PLHIV, people affected by TB, other KVP in	Number of grievance reports filed by PLHIV, people affected by TB, other KVP in relation to human rights, stigma and discrimination at	0	<3 out of 10	GAC and CHRAJ Records on HR Monitoring: GHS/NACP/NTP	Annual	GAC/ SC–HR / CHRAJ	CHRAJ Annual; Annual GAC/ SC–HR Report

	relation to human rights, stigma and discrimination;	the healthcare facility level; divided by total number of grievance reports made by all clients and patients of the facility relating to human rights, stigma and discrimination			HR Reports; GHS Monitoring Reports;			MOH/GHS Annual Report; NACP and NTP Annual Reports

Strategic Objective 6: To reduce stigma and discrimination relating to practices and activities in religious, faith-based and traditional settings in respect of PLHIV, people affected by TB and other KVP

	Indicator	**Definition**	**Baseline**	**Target**	**Data Source**	**Frequency**	**Responsible**	**Reporting**
SI.6	SI.6.1 % of population 15-49 of followers and members of faith-based, religious and traditional practices and medicine organizations who express accepting attitudes towards PLHIV, persons affected by TB and other KVP	(Number of followers and members of faith-based, religious and traditional organizations expressing accepting attitudes to PLHIV, persons affected by TB and other KVP divided by total number of followers and members 15 – 49 years interviewed) x100	0	Y1- 20% Y2- 40% Y3- 70% Y4- 90% Y5- 100%	Survey to be conducted annually; GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR, CHRAJ, Christian Council of Ghana (CCG), Federation of Muslim Councils (FMC), National and Regional Houses of Chiefs, Traditional Medicine Council (TMC), Ministry of Chieftaincy and Religious Affairs (MoCRA). INERELA+	GAC and CHRAJ Annual reports; Annual SC–HR Report

	SI.6.2 % of PLHIV, persons affected by TB and other KVP reporting they feel less discriminated against in faith-based, religious and traditional practice and medicine settings	(Number of PLHIV, persons affected by TB and other KVP reporting they feel less discriminated against in faith-based, religious and traditional practice and medicine settings; divided by total number of PLHIV, persons affected by TB and other KVP interviewed) x100		Y1- 20% Y2- 40% Y3- 70% Y4- 90% Y5- 100%	Survey to be conducted annually; GAC and CHRAJ Records on HR Monitoring	Annual	GAC/ SC–HR, CHRAJ, Christian Council of Ghana, Muslim Council, National and Regional Houses of Chiefs, TMC, MoCRA; INERELA	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outcomes	i.. Proportions of reports filed on HR, discrimination and stigma emanating from faith-based and traditional settings using newly developed reporting tools for which feedback reports on follow-up interventions were filed.	Number of reports filed on HR, discrimination and stigma in the faith-based and traditional setting for which follow-up was done and reported on using feedback forms divided by total number of reports made reports	0	Y1- 40% Y3- 70% Y5- 100%	Feedback forms and reports on follow-up interventions filed and collated monthly.	Half yearly	GAC/ SC–HR , CHRAJ, CCG, MC, TMC, MoCRA, INERELA	SC–HR half-yearly reports
	ii. Proportion of Chiefs and Queen-mothers who have undertaken stigma reduction activities and interventions relating to PLHIV, person affected by TB and other KVP in their traditional areas and communities.	Number of traditional areas and communities where the chiefs or queen-mothers have undertaken stigma reduction interventions and activities divided by total number of traditional areas and communities targeted for the intervention.	0	Y1- 30% Y3- 50% Y5- 90%	Monitoring reports of CHRAJ and GAC; MoCRA	Annual	GAC/ SC–HR, CHRAJ, National and Regional Houses of Chiefs, MoCRA;	GAC and CHRAJ Annual reports; Annual SC–HR Report
Outputs	i. Number of leaders of faith-based organizations, traditional authority, and	Number of individual leaders of faith-based organizations, traditional authority, and	0	80 per quarter (Average	Sensitization Reports of Implementing	Quarterly	GAC, CHRAJ	SC–HR half-yearly reports; GAC Annual

	traditional medical practitioners sensitized on HR pertaining to PLHIV and KVP.	traditional medical practitioners who attended sensitization meeting on HR pertaining to PLHIV and KVP per quarter.		of 5 per region)	partners and of GAC and CHRAJ			Report
	ii. Number of leaders trained and empowered, and providing training to their followers and members	Number of leaders from various faith-based, religious or traditional settings trained as trainers (ToT) and training their followers and members.	0	80 (5 per region)	Training Reports of Implementing partners and of GAC and CHRAJ	Annual	GAC, CHRAJ	SC–HR half-yearly reports; GAC Annual Report
	iii. Number of followers/members of religious and traditional set-up trained on HR, stigma and discrimination relating to PLHIV, TB and KVP.	Number of members or followers of religious and traditional practice and medicine trained on HR, stigma and discrimination relating to PLHIV, TB and KVP.	0	480 (average of 30 per region per year)	Training Reports of Implementing partners and of GAC and CHRAJ	Annual	GAC, CHRAJ	SC–HR half-yearly reports; GAC Annual Report
	iv. Number of durbars and other engagements with community undertaken by Chiefs and Queen-mothers in particular town or traditional area during which issues of human rights, stigma and discrimination were addressed. .	Number of durbars and/or community engagements undertaken by Chiefs and Queen-mothers to address issues of human rights, stigma and discrimination.	0	254	Queen-mothers reports; GAC and CHRAJ monitoring reports.	Annual	GAC/ SC–HR, CHRAJ, National and Regional Houses of Chiefs, MoCRA;	SC–HR half-yearly reports; GAC Annual Report

7.2 Annex B: Approximate Cost (Summary Budget) of the Human Rights Strategic Plan

		YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTALS
Program Areas		**$**	**$**	**$**	**$**	**$**	**$**
SO1: Human Rights Interventions Coordination and Law Reforms		200,000	300,000	500,000	200,00	200,000	1,400,000

SO2: Stigma and Discrimination Elimination		500,000	500,000	800,000	500,000	500,000	2,800,000
SO3: Access to justice, HIV-and TB-related legal services and human rights interventions		400,000	400,000	800,000	300,000	300,000	2,200,000
SO4: Removal of gender-based barriers to human rights and healthcare service interventions		300,000	350,000	550,000	350,000	350,000	1,900,000
SO5: Capacity Building of healthcare workers and managers		500,000	500,000	800,000	500,000	500,000	2,800,000
SO6: Dealing with Stigma and Discrimination in religious, faith-based and traditional settings		200,000	200,000	3,00,000	200,000	200,000	1,100,000
Program Area Subtotal		**1,900,000**	**1,950,000**	**3,250,000**	**1,850,000**	**1,850,000**	**10,800,000**
Program management	20%	380,000	390,000	650,000	370,000	370,000	2,160,000
M&E	2%	38,000	39,000	65,000	37,000	37,000	216,000
Research	3%	57,000	58,500	97,500	55,500	55,500	324,000
Program Management, M&E, Research Subtotal		***475,000***	***487,500***	***812,500***	***462,500***	***462,500***	***2,700,000***
Total Program Area plus Program Management, M&E, Research Costs		**2,375,000**	**2,437,500**	**4,062,500**	**2,312,500**	**2,312,500**	**13,500,000**

7.3 Annex C: List of Participants for Development of Human Rights Strategic Plan 2020 - 2024

a) Members of Steering Committee

Mr. Kyeremeh Atuahene	GAC, Chair
Ms. Angela Trenton-Mbonde	UNAIDS, Co-Chair
Dr Jane Okrah	UNAIDS
Dr Stephen Ayisi Addo	NACP
Ms. Edith Amenudzie-Darku	NACP
Ms. Hilda Smith	National TB Control Programme
Mr. Paschal A. Edwards	National Youth Authority
Dr Isaac Annan	Commission on Human Rights and Administrative Justice
C/Supt. Julius Yankson	Ghana Police Service
Ms. Belynda Amankwa	UNDP
Mr. Nabil Alsoufi	USAID
Dr Henry Nagai	USAID Care Continuum Project/JSI
Ms. Rachel Ofori-Atta	WAPCAS
Mr. Kofi Owusu-Anane	WAPCAS
Ms. Cynthia Nimo-Ampredu	HRAC
Mr. George Owoo	HRAC
Mr. Bradford Yeboah	NAP+ Ghana
Ms. Genevieve Dorbayi	TB Voices Network
Ms. Nancy Ansah	SWAA
Rev. John Kworshie Azumah	INERELA
Naa Amankwah Aduoye I	Ga Traditional Council
Mr. Cosmos Ohene-Adjei	GAC
Mr. Emmanuel Larbi	GAC
Ms. Dinah Akukumah	GAC

b) Participants of Multi-Stakeholder Engagements Consultation and Validation

Prof. Kofi Awasabo-Asare	University of Cape Coast
Amb. Dr. Mokowa Adu-Gyamfi	Office of the President
Mr. Kyeremeh Atuahene	GAC
Mr. Anthony Obeng	GAC
Mr. Jacob Sackey	GAC
Mr. Cosmos Ohene-Adjei	GAC
Dr. Fred Nana Poku	GAC
Mr. Emmanuel T. Larbi	GAC
Dr. Stephen Ayisi Addo	NACP/GHS/MOH
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Ms. Mabel Tetteh	NTP
Mr. Salifu Abdul Razak	NPC
Dr. Leticia Appiah	NPC
Ms. Mavis Agbebo	NPC
Nii Odoi Odotei	NDPC
Ms. Mercy A. Issah	NDPC
Mr. Joseph R Ampong-Fosu	Ghana Judicial Service
Justice Gifty Agyei Addo	Ghana Judicial Service
Ms. Tricia Quartey	AG&MOJ
Dr. Isaac Annan	CHRAJ
Mr. Clement Kadogbe	CHRAJ
Ms. Natalie Tzianas Al-Ahmar	CHRAJ
Mr. Terry Nartey	MCRA
Ms. Linda Aboah	Legal Aid Commission
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Mr. Faustus Dasaah	CCM Secretariat
Mr. Daniel Norgbedzie	CCM Secretariat
Mr. Benjamin S. N. Cheabu	CCM Secretariat
Ms. Hyeyoung Lim	Global Fund
Ms. Gayane Arustamyan	Global Fund
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Dr. Jane Okrah	UNAIDS
Ms. Nish McCree	UNAIDS
Ms. Esther Mpagalile	UNAIDS
Ms. Elinam A. Teinor	UNAIDS
Ms. Charlotte Kanstrup	UNFPA
Dr. Robert K. Mensah	UNFPA
Ms. Yoko Reikan	UNDP
Ms. Nina Anderson	UNRCO
Ms. Juliana Y. Owuna	UNHCR
Mr. Nabil Alsoufi	USAID
Ms. Nadia Tagoe	USAID
Mr. Emmanuel Essandoh	USAID
Dr. Henry Nagai	USAID Care Continuum/JSI Project
Ms. Angelina K. Nyanor	USAID Care Continuum/JSI Project
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Mr. Kofi Owusu-Anane	WAPCAS
Mr. Rachel Ofori-Atta	WAPCAS
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Mr. Rafy Abdul-Salam	HRAC
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Ms. Priscilla Ama Addo	HFFG
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Mr. David Kwesi Afreh	Stop TB Partnership Ghana
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Ms. Charity Owusu Danso	Heart-To-Heart Ambassador
Ms. Lydia Azumah	Heart-To-Heart Ambassador
Mr. Isaac Ampomah	Concern Health
Ms. Elsie Ayeh	Non-State Actors
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Ms. Norman Cooper	Non-State Actors
Ms. Doreen Pokua Gyan	Non-State Actors
Chief M. Mbilla	CHAG

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Rev. Cyril Fayorsey	Christian Council of Ghana
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Ms. Lordina Nortey	Presbyterian Church of Ghana
Very Rev. Philip T. Norgbodzi	Methodist Church
Ms. Sophia Nmai	Presby Relief Services and Devt. Agency
Apostle Samuel Teye Doku	Council of Independent Churches (CIC)
Rev. John Azumah	INERELA
Alhaji Dr. Mubarak Kwasi-Osei	Ahmadiyya Muslim Mission
Alhaji R.Y. Yusuf Quainoo	Ahmadiyya Muslim Mission
Mr. Saeeda Yawson	Ahmadiyya Muslim Mission
Sheikh Kpakpo Addo	Federation of Muslim Councils
Mr. Enoch Addo	Greater Accra Regional House of Chiefs
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Mr. Daniel Epeh	GAC
Ms. Dinah Akukumah	GAC
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