NATIONAL STRATEGIC PLAN FOR MOST AT RISK POPULATIONS
2011 – 2015

Leveraging a Public Health Approach for Universal Access

August 2011
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Leveraging a Public Health Approach for Universal Access

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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-Retroviral Drugs</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CBO</td>
<td>Community Based Organisations</td>
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<td>CSO</td>
<td>Civil Society Organisations</td>
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<td>CSS</td>
<td>Community Systems Strengthening</td>
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<td>DAC</td>
<td>District AIDS Committees</td>
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<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DHMT</td>
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<td>DIC</td>
<td>Drop In Center</td>
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<td>FBO</td>
<td>Faith Based Organisations</td>
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<td>Female Sex Workers</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, TB and Malaria</td>
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<td>GHANET</td>
<td>Ghana HIV and AIDS Network</td>
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<td>Ghana Health Service</td>
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<td>GIZ</td>
<td>German Aid International</td>
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<td>GoG</td>
<td>Government of Ghana</td>
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<td>HBC</td>
<td>Home Based Care</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>HTC</td>
<td>HIV Testing and Counseling</td>
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<td>Integrated Bio-Behavioural Sentinel Survey</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>Most At Risk Populations</td>
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<td>MAT</td>
<td>Medication Assisted Therapy</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NACP</td>
<td>National AIDS and STI Control Programme</td>
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<td>NAP+</td>
<td>National Association of People Living with HIV</td>
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<td>NGOs</td>
<td>Non-Governmental Organisations</td>
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<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<td>NSA</td>
<td>National Strategy Application</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother To Child Transmission</td>
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<td>PREP</td>
<td>Pre Exposure Prophylaxis</td>
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<td>PWID</td>
<td>People Who Inject Drugs</td>
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<td>Quality Improvement</td>
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<td>Strengthening HIV/AIDS Response Partnership and Evidence-</td>
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based Response  
SO  Strategic Objectives  
SOP  Standard Operating Procedures  
SRH  Sexual and Reproductive Health  
STI  Sexually Transmitted Infections  
TBD  To Be Determined  
TSU  Technical Support Unit  
DSW  Department of Social Welfare  
TB  Tuberculosis  
TG  Transgender Persons  
TWG  Technical Working Group  
UA  Universal Access  
UIC  Unique Identifier Code  
UNAIDS  Joint United Nations Programme on HIV/AIDS  
UNFPA  United National Population Fund  
UNGASS  United National General Assembly Special Session  
UNODC  United National Office on Drugs and Crime  
USAID  United Stated Agency for International Development  
WHO  World Health Organisation
Forward

Ghana has made significant strides in its progress towards achieving Universal Access to HIV services through the implementation of the National HIV&AIDS Strategic Framework 2001-2005 (NSF I), 2006-2010 (NSF II) and National Strategic Plan (NSP) 2011-2015.

The Ghana AIDS Commission (GAC) has led a robust campaign to prevent HIV transmission and mitigate its impact on women, men and children. Part of that effort has been to ensure timely and evidence-based prevention and care services for most-at-risk-populations (MARP) including female sex workers and their non-paying partners, men who have sex with men, people who inject drugs and prisoners. The NSP 2011-2015 outlines key objectives and activities to be achieved in preventing new infections in MARP by 2015.

To further elaborate activities and funds needed in scaling up services to MARP in support of the implementation of NSP 2011-2015, the GAC initiated a process from April to August 2011 of engaging a wide-range of stakeholders in the development of the National MARP Strategic Plan 2011-2015. Government, civil society organizations, MARP, development partners, faith leaders and others were involved in a series of consultations to ensure that the most pertinent services needed by each MARP population were reflected in the Strategy.

The goal of the strategy is to reach 80% of all identified MARP by 2015 with a comprehensive and evidence-based package of HIV prevention, protection, treatment, care and support services. The strategy is divided into four strategic objectives (SO): SO1: develop and implement evidence-based, comprehensive HIV prevention, protection, treatment, care and support services for MARPs; SO2: Create an enabling environment for MARP interventions through focused advocacy and community engagement to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination among MARPs; SO3: Strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services for MARPs; SO4: Strengthen the evidence base and MARP monitoring systems and to promote the generation of strategic information to improve MARP programming and inform key stakeholders and decision makers.

I am confident that the strategies outlined in this strategy are those that are the most likely to achieve the bold results we aim to reach by 2015. This document and its associated operational plan provide a strong roadmap and evidence-based strategies for achieving the ambitious results we have put forward.

We must all work together to fight the stigma and discrimination that hinders the efforts being made and which significantly prevents access to available HIV services. Let us move forward in the delivery of these critical services to MARP and making strides in keeping all of Ghana healthy.

Dr. Angela El-Adas, Director-General
Ghana AIDS Commission
Acknowledgements

The Ghana AIDS Commission acknowledges the significant contributions of all those who contributed to the successful development of the National MARP Strategic Plan 2011-2015. The insights and expertise of all those involved ensured a well thought through, evidence-based and comprehensive approach to the development of the plan. We recognize the team of Consultants; Stakeholders from Development Partners, Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs), Non-Governmental Organizations (NGOs), Community Based Organizations, Networks of People Living with HIV (NAP+), staff of the GAC and the National AIDS/STI Control Programme (NACP) for their insight, contribution, input, time and commitment throughout the development process.

We sincerely wish to thank the MARP Technical Working Group Steering Committee for guiding the development of the Strategy. Many long hours were required from its members for which we are grateful. In particular we recognize GAC for providing overall leadership for the MARP Technical Working Group Steering Committee; and the immense support of the respective chairs and Co-chairs of each of the sub-technical working group namely: female sex workers (FSW) led by Comfort Asamaah-Adu, WAPCAS and Julia Duodu, FHI 360; men who have sex with men (MSM) chaired by Nana Fosua Clement, FHI360 and Mac-Darling Cobbinah, CEPERGH; and Dr Holger Till (GIZ) and Francis Hagbe (Ghana Prisons Service) for chairing the people who inject drugs (PWID) and prisoners group.

In addition, we acknowledge the excellent technical support provided by the Lead Consultant, Gordon Mortimore, the Co-Lead Consultant, Mr. Abraham Nyako and the tireless input and support throughout the process from the FHI 360 team: Ms. Kimberly Green, Mr. Jacob Larbi, Ms. Nana Fosua Clement, Dr. Henry Nagai, Mr. Sam Wambugu, Ms. Deborah Kwablah, Ms Julia Duodu, Ms. Margaret Amposah and Ms. Debbie Mangortey.

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The exercise could not have been accomplished without financial and technical assistance and for this we are most grateful to USAID. Thanks goes to Peter Wondergem and Emmanuel Essandoh of USAID/Ghana and their colleagues in USAID Washington including Jessica Rose, Tim Mah and Clancy Broxton for their thorough and thoughtful review of the Strategy. UNAIDS provided excellent advice and direction from the inception of the process to the end and for this we recognize
in particular the contributions of Dr. Leopold Zekeng, Dr. Rangaiyan Gurumurthy and Ms. Jane Okrah. The strategic input provided by Dr Holger Till (GIZ) and Ms. Esi Awotwi (UNFPA) was also instrumental to the success of the entire process.
Executive Summary

The Ghana Most At Risk Population strategy 2011-2015 has been developed to provide a framework for the implementation of a comprehensive package of services designed specifically to reach four MARP subgroups, Female Sex Workers (FSW), Men who have Sex with Men (MSM), Injecting Drug Users (PWID) and Prisoners.

The National HIV & AIDS Strategic Plan 2011-2015 (NSP 2011-2015)\(^1\) implemented through the Ghana AIDS Commission (GAC) has identified significant gaps in the provision of services to these groups, combined with heightened levels of stigma associated with MARPs that translates into reduced access to critical clinical and non-clinical services being offered.

The goal of the strategy is to reach 80% of all identified MARP by 2015 with a comprehensive package of HIV prevention, protection, treatment, care and support service that is evidence based, accessible and acceptable to the specific groups. The services will include a range of:

- HIV prevention
- HIV treatment, care and support
- Psycho-social support

Complementing the package of services are specific evidence based strategies and interventions that aim to sustain the comprehensive package of services, reduce vulnerabilities and ensure that linkages are strengthened toward achieving the objectives of the NSP 2011-2015. These can be broadly classified as:

- Advocacy strategies designed to address specific vulnerabilities of the MARP subgroups.
- Interventions to reduce stigma and discrimination toward MARP subgroups by generating greater awareness from within the general population.
- Improving mapping, surveillance and other social research among MARP subgroups.
- Ensuring the meaningful engagement of MARP subgroups in the implementation, monitoring and evaluation of the MARP strategy.
- Data to support strategies to address policy gaps in the provision of services to MARPs in line with international best practice.
- Institutional capacity building to ensure frontline service providers, administrators and managers have the appropriate technical skills and attitudes to deliver quality assured, non-discriminatory services.
- Development of service packages and standard operating procedures (SOP) for each MARP subgroup.
- Strengthened coordination mechanisms between all stakeholders and increased capacity of the MARPs Technical Working Group (TWG) and subcommittees and regional and district technical support units to coordinate implementation of the MARP strategy.

Following the validation and costing of the NSP 2011-2015, the TWG and three subcommittees, FSW, MSM & PWID/Prisoner, prioritised the development of a MARP

\(^1\) Ghana AIDS Commission, 2010
strategy that was evidence based, consultative and including the meaningful participation of MARP community members.

During the National MARP Strategy Consultation a consensus was reached to divide the PWID/Prisoner subcommittee into separate and specific strategies to deliver a comprehensive package of services to their constituent members. The coordination of both the PWID and prison strategies will remain the responsibility of the subcommittee.

The processes involved in the development of the MARP strategy 2011-2015 are as follows:

1. The publication of a “Synthesis Report on Most At Risk Populations in Ghana: FSW, MSM, PWID/Prisoners”. The report covered the collation and review of qualitative information from a series of focus group and key informant interviews with members of the MARP TWG subcommittees; FSW, MSM and other key stakeholders. A literature review of current responses to identify key areas of development to build a MARP model and strategy was also undertaken. The report was a key document presented during the National MARP Strategy Consultation.

2. The MARP TWG, GAC and Family Health International (FHI), with support from NACP, USAID and UNAIDS organised a National MARP Strategy Consultation to review the current evidence on MARP epidemiology and programming to inform the development of the MARP strategy.

3. Based on the findings, recommendations and conclusions of the consultation a draft strategy was developed outlining the consensus on the critical elements of the strategy and the components of MARP specific comprehensive package of services.

4. Following an initial round of dissemination, review and modification the strategy was be presented during a validation workshop involving all key stakeholders and subsequently through formal GoG approval procedures.

5. A costed operational plan, developed from the strategic plan, will be integrated into the National HIV/AIDS Operational Plan 2011-2013 and shared with Development Partners.

As this is the first time that the GAC has developed specific strategies for MARP it is important to highlight that as new evidence and results emerge, the framework will evolve, including the possible inclusion of newly identified MARPs. Annual reviews of the operational plan will ensure that any modifications, driven by evidence, can be easily implemented.
Section 1

1.1. Rationale & Justification

Ghana is experiencing a mature mixed epidemic comprising of a low-level generalised epidemic coupled with a high prevalence epidemic among FSWs and MSM. Approximately 38% of HIV infections are attributable to MARPs with significant transmission between FSWs, their non-paying partners (NPP) and clients, and the primary sex partners of clients/NPP.

The NSP 2011-2015 recommends that critical steps be taken to further define and scale-up the MARPs response. This includes ensuring better data to improve coverage and targeting of services and the definition of a service package for MARPs through a national strategy and SOPs.

- Most At Risk Populations

The information provided in the following sections is limited to published epidemiological and behavioural studies. Very little data exists regarding MARP sub-populations and their relative HIV risk. This is a critical focus for future research.

I) Female Sex Workers: Surveillance among FSW indicates persistently high rates of HIV infection compared to the general population although there is evidence of reduction in prevalence over recent years. In 2006, a study conducted by the Academy of Educational Development (AED), found infection rates among FSW in Kumasi and Accra to range from 39.3% to 52.2% in “seaters” and 24% to 36.8% in “roamers”. Importantly, this study identified that while reported condom use with clients was 93%, only 27% used condoms with their non-paying partners. A 2009 biological behavioral surveillance survey among FSW in Accra and Kumasi identified an aggregate reduction in HIV prevalence from 37.8% in 2006 to 25%.

No accurate size-estimations of FSW are available although a 2004 analysis suggested that there were 22,000 FSW in Ghana. In 2008, the modes of transmission study estimated that there were about 34,000 FSW in Ghana. Forms of sex work are fluid in Ghana and size estimates most likely do not reflect those involved in less well-defined forms of sex work. The GAC has commissioned size-estimation as part of an integrated behavioral and biological surveillance study (IBBSS) that will be completed in 2011. However, research is needed to further describe the diversity of sex work populations, practices and behaviors.

II) Men who have Sex with Men: Bio-behavioral data on HIV prevalence in MSM is limited but a recently initiated GAC IBBSS and size estimation will provide much needed information regarding risk behaviors, and HIV and STI prevalence in MSM. A 2006 study using a convenience sample reported a combined HIV prevalence of 25.3% among MSM in Kumasi and Accra. Among respondents sampled, 62% identified as bi-sexual, 66% paid for sex with men and 48% used condoms. Around half of MSM surveyed reported having sex with both male and female partners.

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3 FSW biological behavioral surveillance survey, Accra, Ghana: AED, 2009
4 Lowndes CM et al., West Africa HIV/AIDS Epidemiology and Response Synthesis, 2008
5 MSM biological behavioral surveillance survey, Accra, Ghana: AED, 2006
Modeling indicates that MSM contribute to 7.2% of new infections with an estimated total population of approximately 13,500 MSM.\(^6\)

Very little information is available regarding MSM sub-populations and transgender persons (TGs) in Ghana. As with female sex workers, further research is needed to better delineate sub-populations and their relative risk to HIV.

III) Injecting Drug Users: To date, there is extremely limited data or anecdotal evidence related to HIV prevalence among PWID or other drug using populations. To begin to address this gap, GIZ and others are supporting research to map hotspots, conduct size estimations and measure risk behaviors. GAC modeling indicates IDUs contribute to 0.1% of new HIV infections but this estimate will need to be revised once further data is available.\(^7\) The GAC estimates that approximately 5,500 PWID exist.\(^8\)

IV) Prisoners: There are approximately 14,000 prisoners in Ghana. As with PWID, data is sparse related to prisoners and HIV prevalence. In a convenience sample of 1,366 prisoners drawn from eight of ten regional prisons in Ghana, Adjei et al found that 5.9% of prisoners were HIV seropositive (2008).\(^9\) A total of 29.5% of respondents reported that they were homosexual and 35.2% that they had ever injected drugs. Independent factors associated with HIV-positive status included history of injecting drug use, male-to-male sex and greater than 36 month incarceration.\(^10\)

Like other MARP subgroups more research is needed among prisoners to understand the relative prevalence of HIV, HIV transmission dynamics and how they may be addressed. GAC and GIZ are leading a study that will provide further information on HIV prevalence and risk behaviours among prisoners.

- **Multiple Current Risk Factors**
What is not well understood in Ghana is the extent to which multiple concurrent risk factors exist and contribute to heightened risk for HIV infection and transmission. Research is required to understand, for example, the proportion of FSWs, MSM and prisoners who use drugs, types of drugs consumed and how they are used.

- **Stigma**
HIV-related stigma is high in Ghana, and results in formidable barriers to HIV prevention and care. Stigma is complex, relating to fears of HIV and deeply entrenched social norms towards sex work and same-sex relationships. The 2008 Demographic Health Survey documented very low levels of HIV acceptance among the general population: only 19% of men and 11% of women expressed supportive attitudes towards people with HIV\(^11\). Laws against solicitation of sex and sodomy contribute to barriers which sex workers and MSM face in accessing key health and social protection services.

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\(^6\) UNAIDS, 2010

\(^7\) UNAIDS, 2010

\(^8\) Ibid


\(^10\) Ibid

\(^11\) Ghana Demographic Health Survey, Ghana Health Service: Accra, Ghana, 2008
Emerging prevention technologies
Recent research has demonstrated the efficacy of ART for HIV prevention among those vulnerable to HIV including women and MSM. This strategy notes the promise of ART as prevention in developing countries and that further analysis of its operationalization in Ghana be reviewed.12

Service delivery
In past ten years, USAID, DANIDA, the Global Fund, GIZ and other donors have funded MARPs prevention and care service delivery. These have included evidence based approaches to HIV prevention including peer-based promotion of condoms, lubricant, STI screening and HIV testing and counseling; and creation of a continuum of prevention and care among MARPs. However, without a nationally defined service package and SOPs, service delivery approaches vary and are not of adequate scale to address the epidemic.

1.2. Guiding Principles of the MARP strategy

The strategy is guided by a set of overarching principles that are based on global guidelines and best practices:

1. Political and Institutional commitment: Strong political leadership and commitment at all levels, especially at the highest level are integral to an effective and sustained MARPs HIV response. This also includes leadership to mobilise and manage human, financial and organisational resources in an effective, transparent and accountable manner.

2. Evidence based planning: The implementation of the MARPs strategy will be guided by available evidence and will include activities to improve the amount and quality of strategic information for decision making at all levels to ensure effective planning and allocation of resources where they are most needed.

3. Results orientated management: In line with the NSP 2011-2015, the management of performance and ensuring accountability is a key aspect of the strategy. In consultation with implementing partners and MARP representatives’, measurable, achievable targets will be set and monitoring systems established to focus on achieving large-scale impact of MARP interventions.

4. Promotion and protection of rights and responsibilities: The MARPs strategy adheres to standard human rights guidelines that protect the rights of people who remain uninfected as well as the rights of those living with HIV. It is internationally known that a critical aspect of the HIV response requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled. Likewise, MARPs have a responsibility to protect themselves and others from disease.

5. Meaningful participation and inclusion: The active and meaningful involvement of all stakeholders is necessary to ensure all objectives of the strategy can be achieved and will contribute to the national response. The meaningful involvement of MARP

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12 Grant RM et al: Pre-exposure chemoprophylaxis for HIV prevention in men who have sex with men, New England Journal of Medicine, 2010
communities including people living with and affected by HIV is equally vital to ensure that services and other activities remain appropriate and acceptable to their communities’ needs.

6. Gender sensitive: This strategy recognizes that discriminatory practices, including unequal gender relations, create and sustain conditions leading to heightened vulnerability to HIV and inequitable access to treatment, care and prevention. The strategy emphasizes gender equity and prevention of gender-based violence and the particular need for these efforts in FSW and MSM interventions.

7. Equity: No person should be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location or level of literacy.

8. Culturally relevant: While the strategy makes a conscious effort to adhere to global best practice and guidelines for MARP services it has ensured that the services and activities are culturally sensitive and acceptable, while not compromising on their effectiveness. Where legal statutes and laws may have a bearing on the interventions necessary, advocacy will be undertaken to generate a supportive environment.

9. Balancing prevention, care and treatment: The strategy advocates a balanced approach to tackling the epidemic by emphasising prevention while ensuring that those who are already HIV positive are provided access to necessary services and drugs for treatment, care and support.

1.3. MARP Typologies

<table>
<thead>
<tr>
<th>Definitions &amp; segmentation</th>
<th>Sex workers exchange sexual services (vaginal, anal and/or oral) in exchange for money, goods or services.</th>
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<tr>
<td></td>
<td>Sex work may vary in the degree to which it is more or less “formal”.</td>
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<td></td>
<td>The settings in which sex work may occur range from formal brothels and other establishments to working directly on the streets.</td>
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<td></td>
<td>In Ghana there are four identified and distinct subgroups of sex work that are primarily identified occurring to the setting in which they work. The four groups are:</td>
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For the purpose of this strategy, Most At Risk Populations are those subpopulations, within a defined and recognised epidemiological context that have significantly higher levels of HIV risk, mortality and/or morbidity; and whose access to or uptake of relevant services is significantly lower than the rest of the population.

- **Female Sex Workers**
- Seaters
- Roamers
- Clandestine groups who are less formal and will work under the supervision of a “madam” or associated with a particular bar or club.
- Those who do not self-identify as sex workers although engaged in sex work. Further data is needed to define these individuals and their risk factors.

### Risk Behaviours
- Unprotected sex with clients and non-paying partners
- Untreated STIs
- Multiple concurrent sexual partners
- Alcohol and drug use

### Vulnerabilities
- Punitive laws
- Harassment and abuse of human rights by clients, non-paying partners, police, local authorities etc.
- Limited ability to negotiate price: Clandestine workers most vulnerable
- Poverty: Roamers often forced to engage in higher risk behaviours to earn basic income
- Stigma and discrimination
- Gender-based violence

### Key Needs
**Integrated** HIV prevention services (e.g. condoms and lubricant, STI screening and treatment, HIV counseling and testing)
- Continuum of Care and treatment including ART
- Sexual & reproductive health services
- Post Exposure Prophylaxis (PEP) services and post-violence/rape care
- Training and involvement of non-paying partners
- Legal & social protection
- Alternative income and economic independence activities
- Empowerment and personal development
- Psycho-social/Peer support
- Services for children of sex workers
- Access to accurate and non-judgmental BCC on HIV and STI services

### Men who have Sex with Men

| Definitions & segmentation | Men who engage in male-to-male sex, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour, such as being “gay” or “bisexual”.

Globally, a distinction has been made between MSM and transgender people. Transgenders are those whose gender-identity is different from their biological sex. For example, a biological male who feels/self-identifies as a female and therefore lives/behaves like a female. Very little is known about transgenders in Ghana.

| Risk Behaviours | Unprotected anal sex
- Multiple concurrent or serial sexual partners
- Group sex
- Drug use

| Vulnerabilities | Punitive laws
- Wide-spread and entrenched stigma
- Sex work
- Harassment and/or arrest by police
- Drug use and elevated sexual risk taking behaviour


<table>
<thead>
<tr>
<th>Key Needs</th>
<th>• Gender-based violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>Integrated</strong> HIV prevention services (e.g. condoms and lubricant, STI screening and treatment, HIV counseling and testing)</td>
</tr>
<tr>
<td></td>
<td>• Continuum of Care and treatment including ART</td>
</tr>
<tr>
<td></td>
<td>• Sexual health services</td>
</tr>
<tr>
<td></td>
<td>• Post exposure prophylaxis (PEP) services and post-violence/rape care</td>
</tr>
<tr>
<td></td>
<td>• Legal &amp; social protection</td>
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<tr>
<td></td>
<td>• Alternative income and economic independence activities</td>
</tr>
<tr>
<td></td>
<td>• Empowerment and personal development</td>
</tr>
<tr>
<td></td>
<td>• Psycho-social/Peer support</td>
</tr>
<tr>
<td></td>
<td>• Social acceptance</td>
</tr>
</tbody>
</table>
### Injecting Drug Users

**Definitions & segmentation**

Injecting drug users inject directly into the body to administer their drug of choice.

Lack of information about this group in Ghana means that it is unclear to what extent drug injection is a factor.

In general, methods of drug use can be classified as:

- Injecting: eg heroin, amphetamines
- Snorting/sniffing: eg crack, cocaine
- Smoking: eg marijuana
- Drinking: alcohol

**Risk Behaviours**

- Injection drug use/Sharing of needles and syringes
- Unprotected sex

**Vulnerabilities (Assumed)**

- Harassment and/or arrest by police
- Highly stigmatised
- Associated criminal behaviour
- Drug dependence

**Key Needs (Assumed)**

- Access to harm reduction products and services
- Drug dependence treatment facilities
- Correct, non-judgmental information on drug use and safe injecting
- **Integrated** HIV prevention services (e.g. condoms and lubricant, STI screening and treatment, HIV counseling and testing)
- Continuum of Care and treatment including ART
- Sexual & reproductive health services
- Legal & social protection
- Alternative income and economic independence activities
- Empowerment and personal development
- Psycho-social/Peer support
- Services for children of drug users

### Prisoners

**Definitions & segmentation**

A prisoner is any person who is suspected or convicted of having committed a crime and committed to a recognized prison establishment by a court of competent jurisdiction

**Risk Behaviours**

- Injecting drug use
- Unprotected sex
- Tattooing
- Blood covenants

**Vulnerabilities**

- Coercive sex
- Lack of condoms/lubricant
- Sharing of needles/sharps
- Overcrowding
- Poor mental health
- Lack of conjugal visits

**Key Needs**

- Sensitisation and training of prison officials
- Access to HIV and STI prevention, treatment and care services
- TB screening and treatment
- Access to harm reduction services
- Access to personal hygiene products
- Post release linkages to social welfare and health care services
- Post release community integration assistance
Section 2
2.1. Goal of the MARP strategy

The goal of the strategy is to:

*Provide evidence-based prevention, protection, treatment, care and support services to 80% of all identified MARP groups by 2015.*

Achievement of the goal will directly contribute to the overall targets in the NSP 2011-2015 and specifically toward:

**Impact result #1: Reduction of new HIV infections by 50% by 2015.**

The focus is on the prevention of new infections to maintain a low HIV prevalence and aims to reduce new infections from an estimated 25,869 annually to under 13,000 by 2015.

To achieve a “halving” of new infections by 2015, in line with the UNAIDS “Getting to Zero” strategy, the specific targets for reaching FSW, MSM, PWID and prisoners require specific and tailored strategies as outlined in later sections of the MARP strategy.

The following table outlines the targets and indicators that will be used by the GAC to assess and attribute impact:

Table 1: Impact Result 1 targets and indicators

<table>
<thead>
<tr>
<th>Impact Result</th>
<th>Indicator</th>
<th>Baseline</th>
<th>Target by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of MARP who are HIV infected</td>
<td>FSW: 25% BSS 2009 20%</td>
<td></td>
</tr>
<tr>
<td>Reduction of new HIV infections by 50% by 2015</td>
<td>MSM: 25% BSS 2009 20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PWID: N/A N/A</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prisoners: N/A N/A</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

*Targets to be refined once FSW, MSM, PWID and prisoner IBBSS data are made available.

2.2. Strategic Objectives

Note: A number of reference documents were used in the development of the strategic objectives. The documents, from sources including UNAIDS, PEPFAR, WHO and USAID, provided an overview of current thinking and best practice globally and provided some examples and models for adaptation to the Ghanaian context. The list of documents used in the development of the MARP strategy is found in annex 1.

Each of the four Strategic Objectives (SO) have been selected and developed during the National MARP Consultation and will ensure the availability of comprehensive services available to MARPs that are delivered through a variety of interventions specific to the needs of each MARP group.

---

In order to contribute to the impact targets set by the NSP 2011-2015 the SOs include specific advocacy, coordination, capacity building and evidence generation objectives to ensure harmonisation and alignment with the NSP 2011-2015. The four SOs are:

- **SO1**: To develop and implement evidence-based, comprehensive HIV prevention, protection, treatment, care and support services for MARPs. **MARP Specific.**
- **SO2**: To create an enabling environment for MARP interventions through focused advocacy and community engagement to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination among MARPs. **Cross-cutting.**
- **SO3**: To strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services for MARPs. **Cross-cutting.**
- **SO4**: To strengthen the evidence base and MARP monitoring systems and to promote the generation of strategic information to improve MARP programming and inform key stakeholders and decision makers. **Cross-cutting.**

A number of key institutions/sectors have been identified as pivotal partners in the successful delivery of the MARP strategy 2011-2015. Specific strategies and indicative activities are outlined in the following pages. In summary, as per the NSP 2011-2015, a specific focus is placed on MARP stigma, discrimination and violence reduction including the following stakeholders:

1. Healthcare providers from the public, private and NGO sectors.
2. Prison officers and medical staff.
3. Police.
4. Religious and community leaders.

**SO1: To develop and implement evidence-based comprehensive, HIV prevention, protection, treatment, care and support services.**

Note: This SO has four separate, but harmonised, strategies for each MARP group. Coordination of each component will be the primary role of the MARP TWG subcommittees.

A comprehensive package of services will be developed for each most at risk population included in this strategy and covers the continuum of prevention, treatment and care programmes and services, supported by the sustaining of an enabling environment and informed by local and relevant strategic information.

Strategies will be designed to ensure that the services offered are responding to the needs of clients in terms of accessibility (location, timing, cost, etc.) and acceptability (“MARP friendly”, standards of care, non-discriminatory and non-judgmental) to the client.

The way that services are delivered is as important as the individual components of each package. Some services are best delivered through NGOs or MARP specific community based organisations, others by the public health system or the private sector.
The services offered recognise that each MARP group and subgroups 14 are not a homogenous population and that services need to be tailored to meet the specific needs of the subgroups that exist within each MARP group and will take into account factors such as geographic location, socio-economic status, literacy, impact of specific behaviours. This tailoring of services will occur over time as more information is made available regarding MARP sub-populations and their specific risk factors and needs.

SO2: To create an enabling environment for MARP interventions through focused advocacy to i) address barriers (social, cultural, religious, political, and legal) to implement effective interventions and ii) reduce vulnerability, stigma, discrimination and violence among MARPs.

Note: This SO is cross-cutting and is designed to reach all MARP subgroups.

In order for the comprehensive package of services to be successfully implemented, structural and other barriers need to be identified and responded to.

At the individual level it is also essential to develop interventions aimed at reducing vulnerability, stigma, discrimination and violence experienced by MARPs and to ensure that these programmes are sustained and consistently implemented through advocacy, participation in planning and decision-making and awareness raising with key political, religious and community influencers, including healthcare providers from all sectors.

SO3: To strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services for MARPs.

Note: This SO is cross-cutting and is designed to reach all MARP subgroups.

The GAC, through the MARP TWG subcommittees, will be responsible for coordinating the implementation of each MARP strategies at the national level. At the regional and district level, the Regional AIDS Committees (RACS) and District AIDS Committees (DACS) will be responsible for local coordination in partnership with the Technical Support Units (TSUs). The MARP TWG will ensure that all relevant stakeholders from all sectors, including development partners and the private sector, are engaged at the appropriate levels. Coordination between each of the MARP subcommittees will also ensure that the strategic responses will be harmonised and will create opportunities for cross learning and sharing of experiences between each of the MARP subgroups.

To effectively implement the strategy, a key component will be the development of a capacity building programme for organisations monitoring and delivering services.

14 ‘MARP group’ refers to the 4 MARP populations represented in this strategy (FSWs, MSM, PWID and prisoners). ‘MARP subgroup’ or ‘FSW subgroup’, for example, refers to distinctly different populations within a specific MARP group, eg seaters and roamers.
SO4: To strengthen the evidence base and MARP monitoring systems and to promote the generation of strategic information to improve MARP programming and inform key stakeholders and decision makers.

Note: This SO is cross-cutting and is designed to reach all MARP groups and sub-groups.

There are a number of data gaps regarding MARPs in Ghana. SO4 aims to improve the generation and quality of MARP related data to inform, develop and advocate for policy and programmatic responses.

Types of data to be collected are: the size and locations of MARP subgroups, HIV and STI prevalence, risks associated with HIV infection, sexual and health seeking behaviours and vulnerabilities within each subgroup and about changes in these patterns and drivers over time.

M&E strategies will include key data collection methodologies including epidemiological and behavioural surveillance, programme data from MARP facilities and other health facilities, operational research reports, social, human rights and other relevant sources.

In addition to regularised and routine monitoring and data collection, quality improvement (QI) efforts, programmatic reviews and evaluations will be built into the overall operational strategy designed to measure performance and effectiveness of the programmes.

2.3. Strategic Framework

For each strategic objective a series of common strategies applicable to each MARP group has been developed. By tailoring specific interventions and activities based upon the needs of each MARP group to a common framework ensures harmonisation and cohesion of the strategy across each MARP group.

It is important to recognise that there is a considerable overlap of risk factors between the different MARP groups, particularly in relation to drug use. Licit and illicit drug use, including injecting, has been identified as a key risk factor among all MARP groups and as such drug awareness materials and training will be developed for all MARP groups and sub-groups.

- **SO1:** To develop and implement evidence based, comprehensive HIV prevention, protection, treatment care and support services for MARPs.
  - Strategy 1.1: Update existing, and generate new hot spot and services mapping, programme coverage and client needs information to plan and deliver targeted services.
  - Strategy 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each MARP subgroup.
  - Strategy 1.3: Implementation of a package of high quality, acceptable and accessible HIV treatment and care services for each MARP subgroup.
  - Strategy 1.4: Implementation of a package of high quality, acceptable and accessible psycho-social support services for each MARP subgroup.
• **SO2:** To create an enabling environment for MARP interventions through focused advocacy to i) address barriers (social, cultural, religious, political, and legal) to implement effective interventions and ii) reduce vulnerability, stigma and discrimination among MARPs.
  o Strategy 2.1: Advocate for changes in HIV policies, procedure and laws that might impede the HIV response among MARPs.
  o Strategy 2.2: Reduce stigma, discrimination and violence experienced by MARPs with a focus on healthcare providers.
  o Strategy 2.3: Engage with the broader community to establish linkages and coordination with human rights organisations, and community legal and social support bodies.
  o Strategy 2.4: Remove structural barriers to the use of services and programmes by MARPs.

• **SO3:** To strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services for MARPs.
  o Strategy 3.1: Increase the level of participation and representation of implementers and MARP representatives in TWG subcommittees and at the decentralized levels (RACS & DACS).
  o Strategy 3.2: Support training and capacity building of MARP service providers.

• **SO4:** To strengthen the evidence base and MARP monitoring systems and to promote the generation of strategic information to improve MARP programming and inform key stakeholders and decision makers.
  o Strategy 4.1: Finalise population size estimations and geographic mapping of all MARP subgroups.
  o Strategy 4.2: Conduct periodic IBBSS of targeted MARP subgroups.
  o Strategy 4.3: Ensure routine monitoring data collection system is in place, relevant outcome and output indicators are selected and used, and a QI system developed to routinely measure service quality over time.
  o Strategy 4.4: Develop and implement an operational and social research action plan for each MARP group that will contribute to improvements in the implementation and quality of the comprehensive package of services.
  o Strategy 4.5: Build the capacity of implementers and MARPs to monitor, evaluate, research and document their programmes.
  o Strategy 4.6: Establish a learning programme to document the key results and impact of the MARP strategy and to disseminate the results throughout the region and internationally.
  o Strategy 4.7: Conduct periodic programme reviews and outcome evaluation of progress toward achieving the MARP strategy goal.
**The MARP Specific Strategic Objective**

**SO1: To develop and implement evidence based, comprehensive HIV prevention, protection, treatment care and support services.**

Note: This SO is MARP specific and as such a separate framework for each MARP group outlining the comprehensive package of services is provided. The underlying principle behind the SO is to ensure that the continuum of prevention and care is strengthened between different health services and expanded to include a range of psycho-social support services essential to reduce vulnerabilities within each MARP subgroup.

It is not intended that all services begin immediately. Priority interventions will be identified during operational planning for each group. Additional services should be added, as needed, to the basic package of services over the duration of the strategy (and beyond) and detailed as part of the Operational Plan.

**Female Sex Worker Comprehensive Framework**

<table>
<thead>
<tr>
<th>HIV Prevention</th>
<th>HIV Treatment, Care &amp; Support</th>
<th>Psycho-Social Support</th>
</tr>
</thead>
</table>
| • Condoms & lubricants  
• HIV testing & counseling  
• STI testing & treatment  
• Targeted BCC  
• Sexual & reproductive health including PMTCT  
• Post exposure prophylaxis in cases of rape and sexual assault | • Prevention, diagnosis and treatment of OI/TB  
• STI treatment  
• Antiretroviral Therapy  
• Palliative care including symptom management  
• Home based care  
• Nutrition support | • Mental health diagnosis, counseling & care  
• Legal advice & support  
• Income generation & alternative livelihood access  
• Child care and support  
• Personal development and empowerment  
• Establishment of peer support groups and networks  
• Training and involvement of non-paying partners |
| If required:  
• Harm reduction services  
• Overdose management  
• Drug detoxification  
• Drug dependence treatment | | |

**Cross Cutting Elements**

<table>
<thead>
<tr>
<th>HIV Prevention</th>
<th>HIV Treatment, Care &amp; Support</th>
<th>Psycho-Social Support</th>
</tr>
</thead>
</table>
| • MARP friendly drop-in centers and clinics  
• Case management  
• Peer Education | • Life skills training  
• Referrals to services  
• BCC | |
### Men who have Sex with Men Framework

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Treatment, Care &amp; Support</th>
<th>Psycho-Social Support</th>
</tr>
</thead>
</table>
| • Condoms & lubricants  
• HIV testing & counseling  
• STI screening & treatment  
• Targeted BCC (through peers, mobile phones, internet, etc)  
• Male sexual health  
• Post exposure prophylaxis in cases of rape and sexual assault | • Prevention, diagnosis and treatment of OIs/TB  
• Vaccination, diagnosis and treatment of viral hepatitis  
• Antiretroviral Therapy  
• STI treatment  
• Palliative care including symptom management  
• Home based care  
• Nutrition | • Mental health diagnosis, counseling & care  
• Legal advice & support  
• Income generation & employment  
• Personal development and empowerment  
• Establishment of peer support groups and networks |

**If required:**  
• Harm reduction services  
• Overdose management  
• Drug detoxification  
• Drug dependence treatment

### Cross Cutting Elements

- MARP friendly drop-in centers and clinics  
- Case management  
- Peer Education  
- Life skills training  
- Service referrals  
- BCC

### Injecting Drug User Framework

**Note:** Little is known regarding the extent of PWID practices in Ghana. Once data is available from the GAC/GIZ PWID mapping study, further work can be done to develop a service package for PWID based on global best practice and local context. At minimum, the below detailed HIV prevention, treatment, care and support services should be made available in any identified PWID hotspots.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Treatment, Care &amp; Support</th>
<th>Psycho-Social Support</th>
</tr>
</thead>
</table>
| • Condoms & lubricants  
• HIV testing & counseling  
• STI screening  
• Targeted BCC  
• Sexual & Reproductive health  
• Basic health care: TB, viral hepatitis, injection site care | • Prevention, diagnosis and treatment of OIs/TB  
• Vaccination, diagnosis and treatment of viral hepatitis  
• Antiretroviral Therapy  
• STI treatment  
• Palliative care including symptom management  
• Home based care  
• Nutrition | • Mental health diagnosis, counseling & care  
• Legal advice & support  
• Income generation & employment  
• Personal development and empowerment  
• Establishment of peer support groups |

**To consider if sufficient numbers of PWID identified/high drug dependency identified:**  
• Safe injection kits  
• Medication Assisted Therapy  
• Overdose management  
• Drug detoxification  
• Drug dependence treatment

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24
Cross Cutting Elements
- MARP friendly drop-in centers and clinics
- Case management
- Peer Education
- Life skills training
- Service referrals
- BCC

**Prisoner Strategic Framework**

Note: The prisoner subgroup, like PWID, will require the generation of more evidence to guide development of interventions. These will need to be discussed and agreed with prison authorities and other key partners.

A review of current global best practices will form part of the planned assessments to develop the models and basic package of services.

Peer development and capacity building of prison staff are the basic and initial components to be implemented, supported by specific advocacy initiatives and activities focused on key policy makers and prison authorities.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Treatment, Care &amp; Support</th>
<th>Psycho-Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bleach/decontamination for safer injection, tattooing</td>
<td>• Prevention, diagnosis and treatment of OI/TB</td>
<td>• Mental Health diagnosis, counseling &amp; care</td>
</tr>
<tr>
<td>• Personal hygiene kits to prevent disease transmission</td>
<td>• Vaccination, diagnosis and treatment of viral hepatitis</td>
<td>• Legal advice &amp; support</td>
</tr>
<tr>
<td>• Targeted BCC</td>
<td>• Antiretroviral Therapy</td>
<td>• Education programmes</td>
</tr>
<tr>
<td>• STI screening and treatment</td>
<td>• STI treatment</td>
<td>• Personal development and empowerment</td>
</tr>
<tr>
<td>• Voluntary HIV testing and counseling</td>
<td>• Palliative care</td>
<td>• Establishment of peer support groups</td>
</tr>
<tr>
<td>• Basic prison health care: prevention and management of TB, viral hepatitis prevention interventions, hepatitis B vaccination, etc.</td>
<td>• Nutrition support</td>
<td>• Post release support and community reintegration</td>
</tr>
<tr>
<td>• Post exposure prophylaxis in the event of rape/sexual assault</td>
<td></td>
<td>• Linkages with livelihoods support and other social welfare service post release</td>
</tr>
</tbody>
</table>

**Essential but requiring advocacy:**
- Condoms & lubricants

**To consider if sufficient numbers of PWID/high drug dependency identified:**
- Safe injection kits
- Medication Assisted Therapy

**Drug detoxification and dependence treatment**

**Cross Cutting Elements**
- MARP friendly drop-in centers and clinics
- Case management
- Peer Education
- Life skills training
- Service referrals
- BCC

**Nutrition support**
- Mental Health diagnosis, counseling & care
- Legal advice & support
- Education programmes
- Personal development and empowerment
- Establishment of peer support groups
- Post release support and community reintegration
- Linkages with livelihoods support and other social welfare service post release
### Strategies for achieving SO1

- **Strategy 1.1:** Update existing, and generate new hot spot mapping, programme coverage and client needs information to plan and deliver targeted services.

#### Indicative activities

- Map current MARP programme reach and coverage using GIS.
- Design rapid assessment for PWID.
- Prepare separate MARP (eg one for FSW, one for MSM) service coverage plans based on existing coverage, size estimation and hot spot mapping.
- Conduct periodic service needs and satisfaction reviews with MARP service users.

- **Strategy 1.2:** Implementation of a package of high quality, acceptable and accessible HIV prevention services for each MARP group.

#### Indicative activities

- Develop peer education and outreach worker standard operating procedures and establish case management approaches as part of peer education.
- Develop and implement standardized peer education training curriculum.
- Prepare drop-in center SOP to guide basic/comprehensive package of services offered through MARP friendly DICs.
- Procure relevant prevention related supplies and equipment.
- Identify and refurbish as needed DICs/clinics/other facilities in hotspots. Explore range of location options to provide greater choice. Target Accra for increased number of DIC given high concentrations of MARP.
- Train DIC and other key stakeholders in SOPs.
- Pilot test 100% condom use campaign among FSW in selected districts.
- Pilot test campaign to increase condom use among NPP of FSW.
- Explore use of the internet to increase access to hard to reach MSM.
- Establish data collection and quality improvement systems and reporting mechanisms; conduct mystery client surveys for QA and adherence to MARP friendly service standards.
- Establish referral system for prevention, treatment, care and support services or other psycho-social support.
- Establish specific referral linkages for post release prisoners who are HIV positive or require continued drug treatment.
- Establish mechanisms for clients/service users to provide views and opinions of services/facilities being offered and to encourage broader participation of clients in the programme.

- **Strategy 1.3:** Implementation of a package of high quality, acceptable and accessible HIV treatment and care services for each MARP.

#### Indicative activities

- Train HIV clinicians and PMTCT service providers in “MARP friendly” service provision.
- Establish support groups for HIV positive MARP (eg for positive MSM).
- Provide basic care services through DICs and peer educators/case managers including symptom management, positive health counseling and adherence support.
• Depending upon the initial findings of the PWID mapping and planned situation assessment, the development of drug dependence treatment programmes may be required for PWID and with close collaboration and coordination with the Narcotics Control Board and other drug enforcement agencies.

• Strategy 1.4: Implementation of a package of high quality, acceptable and accessible psycho-social support services for each MARP subgroup.

<table>
<thead>
<tr>
<th>Indicative activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pilot and scale up MARP protection networks in partnership with local leaders such as lawyers, police, district assembly members (eg M-Friends, M-Watchers)</td>
</tr>
<tr>
<td>• Establish linkages and referral systems with social support, mental health, legal and human rights organisations including those that have access inside prisons and other places of detention and including post-release prisoners.</td>
</tr>
<tr>
<td>• Develop SOPs for clinical and psycho-social management of sexual violence and rape</td>
</tr>
<tr>
<td>• Support the development of MARP specific networks (eg network of sexworkers)</td>
</tr>
</tbody>
</table>

The Cross-cutting Strategic Objectives

SO2: To create an enabling environment for MARP interventions through focused advocacy to i) address barriers (social, cultural, religious, political, and legal) to implement effective interventions and ii) reduce vulnerability, stigma and discrimination among MARPs.

• Strategy 2.1: Review and advocate for changes in HIV policies, procedures and laws that might impede the HIV response among MARP

<table>
<thead>
<tr>
<th>Indicative activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review policies and laws and identify areas of weakness and gaps</td>
</tr>
<tr>
<td>• Consult with MARPs to document harassment (eg of MSM) and arrest (eg of FSW)</td>
</tr>
<tr>
<td>• Finalise and implement advocacy priorities and approaches</td>
</tr>
</tbody>
</table>

• Strategy 2.2: Reduce stigma and discrimination experienced by MARPs with a focus on healthcare providers and key gatekeepers.

<table>
<thead>
<tr>
<th>Indicative activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish policies on non-discriminatory practices among health care providers and management</td>
</tr>
<tr>
<td>• Develop and implement a strategy for positively engaging the media</td>
</tr>
<tr>
<td>• Integrate MARP sensitization into existing awareness building activities among religious leaders, public security officials and policy makers</td>
</tr>
<tr>
<td>• Develop and implement standardized MARP-friendly training for health-care workers</td>
</tr>
</tbody>
</table>

• Strategy 2.3: Engage with the broader community to establish linkages and coordination with human rights organisations, and community legal and social support bodies.
Indicative activities
- Develop and implement MARP stigma reduction strategies at the community level.
- Assist MARP groups in the formation of peer support groups and networks
- Build the capacity of MARP leaders to represent their constituencies.
- Assess feasibility of establishing specific FSW and MSM legal support services
- Identify and partner with key community influencers who can support advocacy efforts

- Strategy 2.4: Remove structural barriers to the use of services and programmes by MARP groups.

Indicative activities
- Support facilitation of MARP enrolment in national insurance scheme
- Develop life skills training tailored to needs of MARPs including coping skills
- Increase access to microfinance and other economic opportunity programmes.
- Develop linkages with private sector opening access to employment
- Establish guidelines to minimize discrimination in the workplace and engage with private sector to introduce workplace awareness training

SO3: To strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services for MARPs.

- Strategy 3.1: Increase the level of participation and representation of implementers and MARP representatives in TWG subcommittees and at the decentralized levels (RACS & DACS)

Indicative activities
- Review ToR of MARP TWG and amend if required to facilitate coordination of strategy
- Engage and support implementer participation in RAC and DAC meetings.

- Strategy 3.2: Support training and capacity building of MARP service providers

Indicative activities
- Tailor organizational development (OD) assessment tools for MARP CBOs and other implementers
- Provide targeted training, mentoring and support in OD and technical competencies

SO4: To strengthen the evidence base and MARP monitoring systems and to promote the generation of strategic information to improve MARP programming and inform key stakeholders and decision makers.

- Strategy 4.1: Finalise population size estimations and geographic mapping of all MARP subgroups.
Indicative activities
- Disseminate and validate current/due to be completed studies
- Create a directory of all MARP related research and make available to all stakeholders
- Synthesise research and generate a National MARP profile briefing including typologies, vulnerabilities, keys needs, knowledge and attitudes.

- Strategy 4.2: Conduct periodic IBBSS of targeted MARP subgroups and integrate increased MARP specific service delivery points into the IBBSS.

Indicative activities
- Review research agenda and develop road map for conducting periodic IBBSS and include additional sites when needed
- Conduct periodic IBBSS among MARP subgroups
- Widely disseminate findings of IBBSS

- Strategy 4.3: Ensure routine monitoring data collection system is in place, relevant outcome and output indicators are selected and used, and a QI system developed to routinely measure service quality over time

Indicative activities
- Based on service standards and SOPs, develop quality improvement (QI) processes and checklists.
- Train and mentor supervisors, TSU, and MARP to conduct quality improvement assessments and develop and implement QI plans.
- Review the national M&E indicators to ensure that MARP programming and outcomes are adequately captured.

- Strategy 4.4: Develop and implement an operational and social research action plan for each MARP group that will contribute to improvements in the implementation and quality of the comprehensive package of services.

Indicative activities
- Identify key objectives: clinical, social, financial
- Establish baselines and benchmarking for assessing quality improvements
- Identify research agencies to manage studies
- Publish papers and disseminate findings
- Ensure findings are linked into planning and decision-making forums

- Strategy 4.5: Build the capacity of implementers and MARPs to monitor, evaluate, research and document their programmes.

Indicative activities
- Develop and document models and successes of the MARP strategy for scaling up the response
- Establish a database of MARP research and knowledge
- Develop and disseminate knowledge management templates and guidelines to assist implementers and stakeholders in developing a documentation
- Provide templates and guidelines for recording data and training in data analysis
- Provide technical training in implementing research (qualitative & quantitative)/developing protocols
- Develop and provide guidelines for quality assurance of strategic information generated in the programme.

- Strategy 4.6: Establish a learning programme to document the key results and impact of the MARP strategy and to disseminate the results throughout the region and internationally.

**Indicative activities**
- Develop a documentation and dissemination plan.
- Participate and present successes and learnings of MARP programme at regional and global conferences.
- Establish exchanges and study tours with other countries in the region and in other regions to learn and share experiences.
- Publish research and other papers in peer reviewed journals.
- Establish a “virtual” MARP resource center, building on the current resources available.

- Strategy 4.7: Conduct periodic programme reviews and outcome evaluation of progress toward achieving the MARP strategy goal.

**Indicative activities**
- Conduct annual review of progress against operational plan
- Conduct a third party mid-term evaluation of strategy
- Conduct an end line evaluation of strategy
Section 3
3.1. Monitoring & Evaluation

The aim of this monitoring and evaluation framework for the national MARP strategy is to help MARP programs to know whether the interventions being implemented address MARP needs, are resulting in the intended outcomes and are in large enough scale. The contents of this section were derived primarily from ‘A framework for monitoring and evaluating HIV prevention programs for most-at-risk populations’.

In addition, ethical procedures are followed in data collection so that results will not have negative repercussions on the populations being targeted by the interventions. Rather, the results need to be used constructively to best inform the design and implementation of interventions targeting MARPs. At the aggregate level, determining the effectiveness of the national response to the epidemic is critical for policy and advocacy, programme planning and M&E. The monitoring and evaluation framework for the MARPs can be summarised in the 7 steps below:

1. **Identifying the problem**: Given that this Strategy aims to support evidence-based programming, all MARP programs need to undertake a situation analysis, gap analysis of the problem. This will require extracting data from national surveys, related documents, informant interviews and field observations.

2. **Determining the contributing factors of risk of infection**: This information will be obtained from rapid assessments; knowledge, attitude, behaviour surveys, biological surveys and operation studies. This information is critical in helping to design the appropriate and effective programmes.

3. **Determining appropriate interventions**: Where insufficient evidence exists, evaluation studies may need to be implemented to support evidence-based decision-making.

4. **Assessing the quality of interventions**: To ensure quality interventions are implemented under this strategy, process monitoring, evaluations, and other forms of quality assessments will need to be performed, especially as new programmes are getting underway. Intervention standards need to be set in order to have a basis for quality assessments.

5. **Examining the extent of programme outputs**: As the programs are implemented, monitoring efforts will strive to examine the extent of programme outputs, answering questions of ‘how many?’ and whether the programme is being implemented as planned and reaching its intended target population. This information should be routinely collected in a project record-keeping system.

6. **Examining programme outcomes**: Outcomes will need to be examined so as to answer questions about intervention effectiveness. Evaluation methods are outlined in the monitoring and evaluation plan for National Strategic Plan (NSP).

7. **Determining overall programme effects**: This final step focuses on determining overall programme effects and collective effectiveness. In addition, the systematic collection of programme-related qualitative data assists in interpreting programme outcomes and impact and contributes to our understanding of what is or is not working. Such information could also identify

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unexpected results and community perceptions that influence programme results and cannot be answered using trend data alone.

Ethical considerations in data collection

Socially vulnerable or marginalized for their behaviours, data collection efforts that identify or bring attention to MARPS may place them at additional risk. Partners implementing activities among the MARPS will need to be cautious about how information is collected and how it is stored, analysed and presented to ensure the confidentiality and protection of private information. These might include conducting interviews in private spaces, using Unique Identifier Codes (UIC) rather than names to refer to individuals, and storing private or individually identifiable information in a secure environment.

In addition, data collection activities that can be classified as research will require appropriate and ongoing review by qualified individuals and institutions to ensure that the study protocol and procedures will protect the rights of human subjects.

Indicators

These indicators represent those behaviours believed to be most implicated in the transmission of HIV and which are expected to be changed as a result of HIV prevention programmes. Among the MARPS, the focus is on high-risk partnerships such as sex with a sex worker, unprotected sex with IDUs, unprotected anal sex among MSM, and using non-sterile injecting equipment. In addition to behavioural indicators, it may also be useful to monitor levels of knowledge about HIV prevention within these populations. See 3.2 for MARP core indicators.

Outcome: Knowledge

a. Percentage of [most-at-risk populations] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Outcome: Behaviour

b. Percentage of female and male sex workers reporting the use of a condom with their most recent client
c. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
d. Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse
e. Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

Impact: Behaviour

f. Percentage of [most-at-risk populations] who are newly HIV infected

Socio-behavioral Research and Evaluations

A number of surveys have been recommended to be undertaken in this strategy to gather additional strategic information related to MARPs over and above routinely collected information. More data is needed to understand sexual networking and risk taking behaviors, better define sub-populations and their specific HIV prevention and care needs, and the outcomes of interventions described in this strategy. This
will require the use of qualitative and quantitative methods. The selection of the most appropriate sampling methods for surveys of most-at-risk populations will depend on characteristics of the population, such as whether the population is hidden or visible, whether members of the population congregate in sites that can be identified, how closely their social networks are, and how dispersed they are geographically. Whichever method is chosen for monitoring indicators in most-at-risk populations, instruments should be standardized by both population and geography. Steps to assess group membership of all respondents should be consistent across surveys. Interviewers must be well trained, empathic and non-judgmental.

The national MARPs program will need to be evaluated. One approach would be a prospective cohort study, tracking changes in knowledge and behaviors over time across different GAC and donor supported programs. In addition, it is recommended that specific intervention evaluations be conducted to test the effectiveness of new MARP interventions.

**MARP Size Estimation**

Estimating the size of a population, particularly a hidden population, can be difficult to achieve. There are, however, methods for size estimation that can provide a reasonable estimate and that can be used for programme planning and assessment. A primary reason for conducting population size estimations is to understand the scope of the problem and the scale of the response that is needed. Sizes estimates for FSW and MSM are ongoing (at the time of writing this strategy). Estimates for PWID will also need to be established. With this information, programme managers can then assess resource requirements and the capacity that is needed to plan an appropriate response with sufficient coverage.

There are several methods for engaging the population of interest, and estimating the denominator. These methods include snowball sampling or respondent-driven sampling, capture-recapture, compartmental methods and others. Methods engaging general populations such as network scale up may provide a more accurate estimate of population denominator size in some settings.

For M&E purposes, population size estimates serve as denominators in calculations of programme coverage. They are also used to project the likely course of the epidemic (in combination with behavioural and seroprevalence data); which is a useful tool for advocating for appropriate interventions and resources.

**Data quality**

1. Partners implementing MARP programs will be expected to use standardized approaches so to maintain quality. Standardization will also enable comparison between sites over time. Program guidelines will be developed to decide which definitions should be used, who will collect data and how frequently, and who will collate data and how frequently.
2. Explicit instruction sheets for completing all forms, including definitions for each item of data will be developed.
3. Capacity of partners will be built to enable them to document the entire process in an M&E plan. A Data Quality Assessment protocol will be developed and agreed upon which will be used consistently in the program.

4. To increase chances of obtaining correct and complete information, M&E formats will be designed so that they are easy to fill in by busy people who will use them.

5. Match the responsibility of collecting data to the people who are responsible for conducting the activity.

6. Reduce chances of duplicate recording of the same information in multiple tools and registers.

7. Ensure timeliness of data collection and analysis to improve use.

8. Ensure integrity of the data including confidentiality.

**Data Use**

This strategy outlines ways of implementing evidence-based MARP programs. To achieve this data use is critical. Data collected either through routine M&E activities or through surveys will be analysed and packaged in order to benefit the MARP programmes through:

- Assisting strategic programme planning for the future.
- Informing capacity-building plans and activities.
- Directing programme staffing plans and decisions.
- Influencing funding efforts and decisions.
- Affecting development of and changes to organizational policy.
- Providing valuable information about lessons learnt for agencies planning to implement similar programmes.
- Influencing government policy and procedures.
- Comparing performances across programs and regions.
- Determine whether programs are making a difference.

**Quality Improvement for MARP Programming**

Standards and standards operating procedures (SOPs) are required for the MARP service package (e.g., DICs, peer education, access to health services, referrals). These standards form the basis of the minimum quality that is required to successfully implement the service package.

QI checklists (that are based on service package standards/SOPs) will need to be developed as part of this strategy that are used by programs, MARPs and the TSUs to assess the degree to which services meet standards and make recommendations for how quality may be improved.

**3.2. MARP Indicators**

For each MARP subgroup a series of programmatic, impact and service delivery indicators have been identified that will be used to develop an overall performance framework for the MARP strategy. Indicators were derived from the national HIV M&E Plan, UNGASS, UNAIDS and PEPFAR indicators related to MARPs.  

Targets for each MARP subgroup will be set following the results of initial mapping and size estimations planned for 2011 that will comprise the baseline for the strategy.

- **Female Sex Workers**

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement of Goal</strong></td>
</tr>
<tr>
<td>• Reduction of new HIV infections among female sex workers by 50% by 2015</td>
</tr>
<tr>
<td><strong>Achievement of objectives</strong></td>
</tr>
<tr>
<td>• % of FSW who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>• Number of FSW reached by interventions disaggregated by i) prevention, ii) treatment, care and support, iii) psycho-social</td>
</tr>
<tr>
<td>• Number of FSW referred to other services (illustrative examples include: STI, HTC, ARV, Care and Support, PMTCT, Family Planning/Reproductive Health (FP/RH), Antenatal Care (ANC), Life Skills, Drug Treatment)/total number of individuals receiving intervention</td>
</tr>
<tr>
<td>• Total number of referrals/total number of referred</td>
</tr>
<tr>
<td>• Number of prevention commodities distributed (condoms, lubricants, needles)</td>
</tr>
<tr>
<td>• Number of targeted condom service outlets, disaggregated by new and continuing sites</td>
</tr>
<tr>
<td>• Number of dedicated FSW drop-in centers</td>
</tr>
<tr>
<td>• Number of peer support groups formed</td>
</tr>
<tr>
<td>• Number of healthcare workers trained as FSW-friendly</td>
</tr>
<tr>
<td>• Number of peer educators recruited and trained</td>
</tr>
</tbody>
</table>

| Achievement of strategies                                                                 |
|• % of FSW surveyed reporting the use of a condom with most recent client, by age            |
|• % of FSW surveyed reporting use of condom with every client in the last month            |
|• % of FSW (by age) surveyed who received an HIV test in the last 12 months and know results|
|• % of FSW reporting the use of a condom with NPP at last sextact                            |
|• % of HIV positive FSW surveyed by age                                                       |
|• % of HIV positive FSW surveyed receiving care services                                       |
|• % of HIV positive FSW surveyed receiving ARV treatment                                       |

- **Men who have Sex with Men**

<table>
<thead>
<tr>
<th>Indicators</th>
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<tbody>
<tr>
<td><strong>Achievement of Goal</strong></td>
</tr>
<tr>
<td>• Reduction of new HIV infections among men who have sex with men by 50% by 2015</td>
</tr>
<tr>
<td><strong>Achievement of objectives</strong></td>
</tr>
<tr>
<td>• % of MSM who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>• Number of MSM reached by interventions disaggregated by i)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Number of MSM referred to other services (illustrative examples include: STI, HTC, ARV, Care and Support, Life Skills, Drug Treatment)/total number of individuals receiving intervention</th>
<th>Total number of referrals completed/total number of referrals</th>
<th>Number of prevention commodities distributed (condoms, lubricants)</th>
<th>Number of targeted condom service outlets, disaggregated by new and continuing sites</th>
<th>Number of dedicated MSM drop-in centers</th>
<th>Number of peer support groups formed</th>
<th>Number of healthcare workers trained as MSM-friendly</th>
<th>Number of peer educators recruited and trained</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement of strategies</strong></td>
<td>% of MSM surveyed who have had anal sex with more than one male partner in the last 6 months</td>
<td>% of MSM surveyed who received an HIV test in the last 12 months and know results, by age</td>
<td>% of MSM surveyed reporting condom use at last insertive anal sex with male, by age (n)</td>
<td>% of MSM surveyed reporting condom use at last receptive sex with male, by age (n)</td>
<td>% of MSM surveyed reporting consistent condom use during anal sex with a male during the past three months, by age (n)</td>
<td>% of HIV positive MSM surveyed who are HIV positive</td>
<td>% of HIV positive MSM surveyed receiving care services</td>
<td>% of HIV positive MSM surveyed receiving ARV treatment</td>
</tr>
</tbody>
</table>

**Injecting Drug Users**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Reduction of new HIV infections among people who inject drugs by 50% by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement of objectives</strong></td>
<td>% of PWID who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
</tbody>
</table>
Achievement of strategies

- % of PWID surveyed reporting condom use at last sex, by sex and age
- % of PWID surveyed reporting condom use at last sex with regular partner
- % of PWID surveyed reporting use of sterile injecting equipment at last injection, by sex and age
- % of PWID receiving medication-assisted treatment (MAT)
- % of PWID surveyed, by age and sex, receiving HIV test in last 12 months and know result
- % of PWID surveyed by age and sex in last month reporting sharing injecting equipment at last injection,
- % of HIV positive PWID surveyed by age
- % of HIV positive PWID surveyed receiving care services
- % of HIV positive PWID surveyed receiving ARV treatment

Prisoners

<table>
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<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of Goal</td>
</tr>
<tr>
<td>Reduction of new HIV infections among prisoners by 50% by 2015</td>
</tr>
<tr>
<td>Achievement of objectives</td>
</tr>
<tr>
<td>% of prisoners who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>Number of prisoners reached by interventions disaggregated by i) prevention, ii) treatment, care and support, iii) psycho-social</td>
</tr>
<tr>
<td>Number of prevention commodities distributed (condoms, lubricants, needles)</td>
</tr>
<tr>
<td>Number of peer educators recruited and trained</td>
</tr>
<tr>
<td>Number of prison infirmaries refurbished to provide HIV and harm reduction services</td>
</tr>
<tr>
<td>Number of prison officer staff trained in HIV &amp; prisoner issues</td>
</tr>
<tr>
<td>Achievement of strategies</td>
</tr>
<tr>
<td>% of prisoners surveyed by age and sex reporting unprotected last sex</td>
</tr>
<tr>
<td>% of prisoners surveyed by age and sex receiving HIV test in last 12 months and know result,</td>
</tr>
<tr>
<td>% of prisoners surveyed by age and sex in last month reporting sharing injecting equipment at last injection</td>
</tr>
<tr>
<td>% of HIV positive prisoners surveyed by age</td>
</tr>
<tr>
<td>% of HIV positive prisoners surveyed receiving care services</td>
</tr>
<tr>
<td>% of HIV positive prisoners surveyed receiving ARV treatment</td>
</tr>
</tbody>
</table>

3.3. Roles and responsibilities

Ghana AIDS Commission (GAC) was set up by an Act of parliament (Act 613) in 2002, with the sole mission of providing effective and efficient leadership in coordination of all HIV and AIDS programmes and activities of all stakeholders at all levels.

GAC in accomplishing this mission has an overarching objective of setting up Technical Support Units (TSUs) to strengthen the decentralized HIV Response to
strengthen partnerships and inter-sectoral collaboration at the regional and district levels which will lead to attaining the principle of the “Three Ones”.

GAC has developed the National Strategic Plan (NSP) 2011 – 2015 in which clear steps are laid out as to how to coordinate the national response including interventions to MARP.

**Purpose:** With the development of the MARP strategy as part of the NSP 2011-2015, it has become necessary to clearly define operational roles and responsibilities of key partners in the response for MARPs based on their core mandates. The main purpose is to streamline actions at the national and decentralized levels for MARPs to enhance coordination at all levels.

Below is a matrix that describes the roles and responsibilities of key actors in the MARP arena.

**Key partners in MARP interventions and key roles**

<table>
<thead>
<tr>
<th>Partner</th>
<th>Geographic focus</th>
<th>Key role</th>
</tr>
</thead>
</table>
| GAC SECRETARIAT | National level | • Policy formulation and coordination  
• Mobilize resource for MARPs  
• Support Generation of Strategic Information for policy making  
• Support M&E for MARPs |
| GAC- Technical Support Units (TSUs) | Regional and districts | • Strengthen community advocacy, community outreach and mobilization of MARPs  
• Strengthen coordination of MARP interventions at the regional and district levels  
• Strengthen monitoring and supervision of MARP programmes  
• Harmonize district level reports into regional reports and submit to the National level  
• Support regional and district level MARP related research  
• Identify training needs and support continued training to improve on RACs/DACs relevant skills to play their roles effectively and efficiently  
• Identify training needs and support continued training to improve on MARP CSOs relevant skills to play their roles effectively and efficiently |
| National AIDS Control Programme (NACP) of GHS | National coverage | • Provision of HIV related health services to all who need including MARPs |
### Key role
- Support capacity building of Health Workers for them to be MARP friendly
- Provide HIV test kits for HTC for MARPs
- Support HMIS at the facility level
- Contribute to the generation of strategic information

<table>
<thead>
<tr>
<th>Partner</th>
<th>Geographic focus</th>
<th>Key role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Coordination Councils (RCCs)</td>
<td>Regional levels</td>
<td>Support the decentralized response via RACs and DACs</td>
</tr>
<tr>
<td>Regional /District Health Management Teams (R/DHMTs)</td>
<td></td>
<td>Coordinate health services provision for MARPs Support TSUs, RACs and DAC on HIV services for MARPs</td>
</tr>
<tr>
<td>Civil Society Organizations (CSOs)</td>
<td>Community, district and national coverage</td>
<td>Direct implementation of interventions targeting MARPs and other related populations</td>
</tr>
<tr>
<td>Development Partners (bilateral and multilateral)</td>
<td></td>
<td>Provide Technical Assistance and financial resources for MARPs</td>
</tr>
</tbody>
</table>

### 3.4 Resource mobilisation

In the past five years, development partner contributions to address HIV prevention and care among MARPs have increased although scope and scale of services requires further scale-up. This strategy presented here is currently funded in part through the generous contributions of the Global Fund, USAID, USCDC, GIZ, UNFPA and other donors. However, looking forward, strategic funding mobilization will need to occur to ensure that the strategy is fully funded.

The GAC and its partners will work with development partners to seek funding for this strategy. It is envisaged that, as a component of the NSP-III, this strategy will be funded through the Global Fund National Strategy Application (NSA). To better gage the amounts needed from 2011-2013, the GAC and partners will develop a costed operational plan.
### Annex 1: References

<table>
<thead>
<tr>
<th>Publishing Organisation</th>
<th>Title</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female Sex Workers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FHI 360</td>
<td>Interventions for female sex workers and their clients</td>
<td>2010</td>
</tr>
<tr>
<td>WHO</td>
<td>HIV prevention with sex workers: operational guidelines</td>
<td>2009</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>UNAIDS Guidance Note on HIV and sex work</td>
<td>2009</td>
</tr>
<tr>
<td><strong>Men who have Sex with Men</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FHI 360</td>
<td>Reaching MSM, Male Sex Workers and Trans Gender persons</td>
<td>2009</td>
</tr>
<tr>
<td>FHI 360</td>
<td>Interventions with MSM and Trans Gender</td>
<td>2009</td>
</tr>
<tr>
<td>World Bank</td>
<td>The Global HIV epidemics among MSM</td>
<td>2011</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Action Framework: Universal Access for MSM and Trans Gender people</td>
<td>2009</td>
</tr>
<tr>
<td>USAID AIDSTAR-One</td>
<td>HIV prevention for hard to reach men who have sex with men</td>
<td>2011</td>
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<tr>
<td>WHO</td>
<td>Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach</td>
<td>2011</td>
</tr>
<tr>
<td><strong>Injecting Drug Users</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Comprehensive HIV prevention for people who inject drugs: revised guidelines</td>
<td>2010</td>
</tr>
<tr>
<td>FHI 360</td>
<td>Interventions for people who use drugs in Asia</td>
<td>2010</td>
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<tr>
<td><strong>Prisoners</strong></td>
<td></td>
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</tr>
<tr>
<td>UNODC</td>
<td>HIV prevention, care, treatment and support in prison settings</td>
<td>2006</td>
</tr>
<tr>
<td>WHO/UNAIDS/UNODC</td>
<td>Effectiveness of interventions to manage HIV in prison:</td>
<td>2007</td>
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<tr>
<td></td>
<td>• Condoms and other HIV prevention</td>
<td></td>
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<tr>
<td></td>
<td>• Needle and syringe exchange, bleach and decontamination strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV care, treatment and support</td>
<td></td>
</tr>
<tr>
<td>UNODC/WHO</td>
<td>HIV/AIDS in places of detention: A toolkit for policy makers, managers and staff</td>
<td>2007</td>
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